

2. THE THERAPEUTIC USE OF MDMA

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1. INTRODUCTION

This chapter describes a method for the therapeutic administration of MDMA ((+/-), 3,4-methylenedioxymethamphetamine) to humans and includes five case reports. Comparisons are made to the approach of "Twelve Step programs" for substance abuse treatment and to sacred rites of passage. The importance of the mental set of the patient and therapist and the psychological preparation of both are emphasized. Screening criteria and informed consent information are also discussed. Results from 80 patients indicate that MDMA seems to decrease the fear response to a perceived threat to a patient's emotional integrity, leading to a corrective emotional experience that probably diminishes the pathological effects of previous traumatic experiences. The acquisition of effective skills for communicating feelings to family members also occurs. Psychological benefits were lasting up to a two-year follow-up for many patients, and relief from chronic pain and premenstrual symptoms occurred for one patient each. Double-blind controlled experiments utilizing the method presented are not feasible because the mental set is affected and the MDMA effect is easily perceived by patient and therapist. Suggestions for potential applications include the prevention and treatment of dysfunctional family relationships and of substance abuse.

We supervised MDMA-assisted therapy sessions for patients from 1981 until 1985, when MDMA was placed in Schedule I by the Drug Enforcement Administration. An outline of our method and a detailed summary of

the results reported by the first 29 people administered MDMA have been published elsewhere [1].

2. THE ROLE OF MENTAL SET

The term "mental set" refers to the overall belief of both patient and therapist as to what the goal of the session is; how the therapist, the session procedure and the drug will help the patient achieve the goal; and what results are to be expected. From our own experiences and from the reports of other therapists, we found that the goal of developing a more compassionate attitude toward oneself and others was easily achieved by people undergoing MDMA-assisted therapy. Also, relief from chronic symptoms and behavior problems seemed greater when such a change in attitude occurred. Based on the success of other methods utilizing altered states of awareness to achieve this healing attitude, we approached sessions more as sacred rites of passage than as conventional therapy sessions [2-4]. We also viewed the effect of MDMA as secondary to the effect of the therapeutic ritual: assisting more than causing the patient to achieve the desired outcome from the session.

After the choice of the session goal, we found that the quality of the relationship between patient and therapist was the next most important variable in predicting the outcome for an MDMA session — more important even than the dose taken. In the absence of a healing-oriented relationship in which the patients felt safe enough in the therapists' presence to open themselves fully to new and challenging experiences, one was apt to have a more superficial experience. An essential factor in establishing a therapeutic relationship was the patient's knowing that the therapists had undergone MDMA sessions themselves and so would be able to understand the kind of experience the patient would be having. Hearing the stories of the therapists' experiences and seeing that no harmful effects had occurred served to provide hope and reassurance that the session would go well. Special preparation of the therapists before they began to supervise MDMA sessions was crucial for both enhancing the therapeutic relationship and for understanding the effect of MDMA on the therapy process.

3. PREPARATION AND MENTAL SET OF THE THERAPISTS

We first learning about MDMA-assisted therapy from a clinical psychologist, Leo Zeff, Ph.D., in 1980. Zeff had conducted LSD-assisted therapy sessions in the early 1960s and was the first psychotherapist to use MDMA extensively, beginning in 1976.

Zeff's approach was based on the concepts and techniques derived from the LSD research of psychiatrist Stanislav Grof [2], the peyote rituals of the Huichol tribe in Mexico [3], Buddhist Vipassana (Insight) meditation [4], the mystical traditions of both East and West, as well as his training and experience in traditional Western psychology and psychotherapy. He saw that Using MDMA had similarities to the Twelve Step programs that have proven to be

so effective in the treatment of addictive behaviors: the surrender of the patient's individual will to a Higher Power for personal guidance in order to achieve healthy self-control. The surrendering attitude is seen as essential for achieving a profound release from addictive attachment to relationships, beliefs, and behaviors that have been destructive in the person's past.

At the time we learned of Zeff's work, he had conducted hundreds of MDMA sessions and had achieved dramatic results without complications. Because he had done his work away from the public eye and had written nothing about it, we saw a need both to offer sessions and to document the results so that the research community would learn about the potential of MDMA as a pharmacological catalyst for psychotherapy. We began conducting sessions and recording information about patients both before and after their sessions. This information gathering was more in the spirit of a descriptive "medical anthropology" study than a rigorously controlled experiment designed to determine the efficacy of MDMA-assisted therapy [1].

Regarding our own preparation, one of us [GG] was a Board-Certified psychiatrist, had studied the same subjects as Zeff, had undergone long-term insight-oriented psychotherapy, and had practiced Vipassana meditation. The other [RT] practiced Vipassana and was a Master's level psychiatric nurse. Our training for conducting MDMA sessions began with our own experience taking it together. We were most impressed with the ease we had in communicating our feelings and thoughts about each other that previously had been too emotionally charged to be discussed, as well as with the effortless forgiveness we experienced for times we felt we had been hurt by the other, all with a clear sensorium and cognitive faculties. In the eight years since, we have continued to utilize the skill of intimate communication that developed spontaneously during that first session.

Daily practice of meditation helped us to develop the skill of observing the details of inner experience during the MDMA state of consciousness and, because we learned to achieve similar states of mind without the drug, prevented our seduction into the belief that MDMA was an exclusive panacea. In addition, having a few MDMA sessions supervised by a therapist experienced in its use made us familiar with the range of its effects. The experience of fearless communication and spontaneous forgiveness, or letting go of resentments, was particularly important in understanding how MDMA can be used effectively.

4. SCREENING AND PREPARATION OF PATIENTS

To foster development of the optimal mental set for patients, we essentially followed Zeff's method for screening, preparing, and conducting sessions, and we added pre- and post-session questionnaires and written informed consent. The entire procedure was also reviewed and approved by a peer review panel of psychiatrists and a psychologist who were experienced with the use of drug-assisted psychotherapy and with the effects of MDMA. When pro-

pective patients requested to be considered for a session, we always asked them what they already had heard of our work, to help us assess their expectations. We then sent them a screening questionnaire, informed consent information, and an essay that addressed our philosophy of the use of psychoactive medicines in therapy. The questionnaire elicited a personal, medical, and psychiatric history and information about their use of other drugs. It also asked questions designed to orient them toward having the session, e.g., "What is your purpose in having a session with MDMA?" and "What are your expectations and/or fears of what will happen?"

Screening of candidates was very important and involved several issues. Medically, we excluded those who were hypertensive or had cardiovascular disease; were taking psychotropic medication; were hyperthyroid, epileptic, diabetic, or hypoglycemic; or had liver disease, actual or possible pregnancy, or any other medical condition that would have placed the person at risk for significant morbidity or mortality. We also excluded those who, due to a mental or emotional disturbance, had been unable to function at work or socially for more than a day or so. For those who were in psychotherapy, we obtained clearance from their therapists to give the session. Although sessions with MDMA were useful to individuals who were at times unable to take care of themselves due to psychiatric problems, we only worked with functional, relatively well-adjusted people [5].

If, after reviewing the questionnaire, there were no reasons for not having the session, we arranged to have a screening interview. This interview was usually held in our home, as were most of the sessions. Opening our home to the patients allowed them both greater physical comfort and greater trust from knowing us better, than if we had used an office setting. We began by asking if they had any questions based on what they might have heard or read about MDMA. We then reviewed the questionnaire with the patient, having him or her clarify or elaborate on issues that interested or concerned us. We pursued any areas of past difficulty, and reviewed their medical history, paying special attention to any history of significant losses, their attitudes and beliefs about death, and their general spiritual orientation.

The most important information we elicited from the patient was a clear statement of the purpose for having the session. If the stated purpose was in clear opposition to our own philosophy (e.g., if they *only* wanted an enjoyable experience, wished to avoid issues of current or past pain, or wished *only* to focus on their spouse's problems), further interviews would have been scheduled, or the applicant would have been excluded. In addition, we did not administer MDMA to those who aroused any feeling of uneasiness in either of us. We had learned that giving MDMA in the presence of an ill-defined hissing in the therapist almost always resulted in complications in managing the session. We also refused sessions to those whose spouse or therapist was not supportive of the plan.

After going over the questionnaire, we always told people of our own

backgrounds and how we came to work with MDMA. We asked that this information be held in confidence, just as we held information about them in confidence. This mutual sharing established a context of equal status in collaboration, intimacy, confidentiality, and trust. It also discouraged the development of transference projections, distinguishing our approach from that of traditional analytically oriented psychotherapy. We preferred to serve only as "sitters" or assistants to patients who were exploring themselves, rather than to involve ourselves in a long-term relationship in order to allow a classical transference to emerge and to be worked-through. If transference phenomena emerged, we helped the person understand and use them in a clinically appropriate manner and scheduled follow-up therapy sessions with or without MDMA, as indicated. (This occurred only once: with the single patient who was in psychotherapy with one of us [GG] before having MDMA sessions.)

To establish an attitude of safety and security and to further screen out inappropriate patients, we required patients to make an explicit contract of four agreements. These served as the core structure of our relationship with them: 1) therapists and patients all agreed to remain on the premises until all agreed that the sessions was over and that it was safe to leave; 2) the patients agreed to refrain from any activity that could have been destructive to themselves, to others, or to any property; 3) there would be no sexual activity between the patients and the therapists; and 4) patients agreed to follow any instructions given to them by a therapist, when it was explicitly given as part of the structure of the session. This last agreement did not include various therapeutic suggestions we made.

Through the agreements, patients were asked to allow us to manage issues of physical safety during the course of the MDMA session. We believed that if there were some distrust of us, it would have been brought out during the discussion of the contract. If patients were uncomfortable with any of these requests, more time could have been spent in preparation until agreement occurred. It was never necessary to exclude patients due to their inability to accept the ground rules, and all were able to respond appropriately at the rare times when these rules were invoked.

With the agreements in place, we encouraged patients to ask for anything they wanted during the sessions, in order to encourage their becoming conscious of repressed desires, knowing that they would not be allowed to act them out destructively. For example, with an explicitly stated agreement of "no sex," one could feel, express, and even fulfill an infantile desire to be held or comforted without fear of a therapist taking sexual advantage. Within the context of safely defined external boundaries, patients could devote full attention and concern toward introspection.

5. INFORMED CONSENT

A major consideration in our using MDMA was informed consent. After a discussion of personal histories, the informed consent information was re-

viewed. In addition to going over all the known possible benefits and risks, the form listed the members of our peer review committee, stated the above-mentioned agreements and the protocol for the session, and listed alternative procedures for achieving similar results.

Benefits were briefly and generally described and included improved communication, personal insights, and elevated mood. Physiological side effects were primarily those that came from stimulation of the sympathetic nervous system: muscle tightness, restlessness, nausea, increased pulse, and increased blood pressure. If we were still conducting sessions at this time, we would also inform patients of the reports of human deaths associated with recreational MDMA use and the reports of serotonin depletion and neurotoxicity in rats and primates, as well as any other risks that might be known at the time of our obtaining informed consent [6-8]. The translation of human mortality data from use in uncontrolled situations and animal toxicology data into risk factors for humans under medical supervision is highly controversial and a matter to be decided by peer review and human experimentation review panels.

The issue of unwanted, or "negative," psychological effects or emotions was a special one to consider. With MDMA, as with any other drug that can compromise psychological defense mechanisms, it was common to see the pain of unfinished grief or earlier traumatic experience arise both psychologically and somatically. Physical symptoms such as headache, shortness of breath, pain, or other discomforts sometimes occurred and often were felt by the patient, to be associated with previously forgotten memories or repressed feelings. Depression and/or anxiety occasionally were felt during the session or in the days that followed until the person felt a sense of completion with the pertinent issues.

Rarely did unwanted reactions last more than a day or two, and usually the person found those experiences quite useful, although difficult. Even at the time of this writing (1988), we have not heard of any long-lasting problems following MDMA sessions supervised by professional psychotherapists. Because of this fact, we have not been overly concerned by the reports of neurotoxicity in animals [7, 8]. We currently believe that, for all but extremely rare cases, there is a significant gap between the highest therapeutic doses of 200 mg taken monthly and clinically significant toxic doses [9]. Further support for this view comes from the fact that fenfluramine, an appetite suppressant approved for daily use by the Food and Drug Administration, elicits a neurotoxicity pattern in animals that is very similar to that of MDMA (Molliver, M., personal communication) [10, 11].

Because we could not predict all of the specific elements of a difficult experience, patients were required to be willing to experience anything that might arise during or after the session, including the worst experience they had ever had in the past. If there was at least a conscious desire to open oneself to pain without resisting, then when painful experiences did occur, they could be worked through more quickly.

Hearing the details of the many unpleasant physical symptoms that we described in giving informed consent could have added an unnecessary element of anxiety. In spite of these considerations, a thorough process of informing people of what they might experience was both ethical and practical. If individuals were so frightened by our process of giving informed consent that they chose not to have a session (and this happened several times), then we believed that it was not a good time for them to have the experience in the first place.

As much as possible, everything we did or said in preparing people to take this compound attempted to give this implicit message: "You are consciously taking a medicine to open yourself to whatever teachings you may need at this time. Neither you nor we know what these teachings are or how they may occur. We will provide a safe place for your explorations and be available to assist you with any difficulties, but all that you learn that is real comes from yourself or from the Divine within you — not from us or from the medicine itself."

We found that the more attention patients placed on their preparation, the more meaning and value was achieved from the session, and the more the person claimed responsibility for it. It was useful for them to have a clear notion of what their expectations were, not so much to be able to fulfill them, but to facilitate a letting go of them beforehand. Meditation, keeping a journal, or other practices could all potentiate the effect of the session.

On the practical side, regular consumption of alcohol or other psychoactive drugs seemed to decrease the effects of MDMA; so abstaining from any use of these compounds was advised for the few days before the session. Food, especially milk products, seemed to decrease absorption of MDMA in the stomach and to predispose patients to nausea or vomiting. For this reason, fasting overnight or for at least six hours before ingesting MDMA was advised. Additionally, in planning when to have the session, we instructed patients to refrain from making any work or social obligations the day after. Frequently, there was much psychological material for the person to consciously integrate, as well as a tendency to feel tired.

With regard to alternative procedures, we knew of no other drug or procedure that produced the characteristic effects of MDMA. However, we informed patients of the many ways to achieve similar results with varying degrees of success. These included other techniques using MDMA or other mind-altering compounds, special deep breathing techniques, practices of meditation and prayer, hypnosis, psychotherapy, prescribed psychotropic medications, and certain massage and bodywork techniques. We felt the procedures that did not involve the use of drugs, when supervised by a skilled practitioner, were generally safer than those that did. Before giving someone a session, we made sure that the probable benefits significantly outweighed the risks when compared to the alternative procedures. We believed that for a person who was fully committed to a goal of honesty, psychological growth, and well-being, there was no one method that was necessary to make progress

toward a therapeutic goal. The commitment and the willingness to encounter the difficulties that arose were all that were really required.

6. CONDUCTING THE SESSION

When patients arrived for their sessions, they were first given time to bring us up to date on their lives. Decisions about exact dosages of MDMA were then made. For men, the range was usually from 100 to 150 mg. Women took 75 to 125 mg. We did not know if there was a sex difference or a difference based solely on weight, but women seemed to be more sensitive to MDMA than were men. If the session was for an individual who wished primarily to focus his or her attention internally, a larger dose was suggested. For couples who wanted to spend time together, a smaller dose was more useful. Often the general intensity of effects and side effects was described for the dosage ranges, the person indicated his or her wish for a "low, medium, or high" dose, and we translated that into an actual amount. Especially in an initial session, we believed this ability to have some control over the situation would be comforting.

Time was sometimes spent in silence, prayer, or meditation before taking the MDMA. After ingestion, the patient sat quietly waiting to feel the effects, or lay down, donning eyeshades to decrease outside distractions. Music was played, usually via headphones, and was always instrumental, except for vocal pieces sung in foreign languages. The genre was classical, ethnic, or modern. Typical composers included Mahler, Beethoven, Wagner, Fauré, and Deuter. The decision to play a given piece of music at any given time was usually made intuitively by one of us. Patients could ask to change a piece of music or have silence.

Couples were encouraged to begin their experiences in separate rooms. This allowed them to attend to individual issues in the MDMA state and to notice fully the initial physical effects. After a couple of hours, partners usually had much to talk about with each other and so came together when they both felt ready.

We rarely initiated psychotherapeutic interaction with people during their sessions. We were, of course, available and supportive if difficult or painful experiences occurred. After conducting the first few sessions, we found that talking about or "reporting" one's experience and thoughts during the session was often done with *our* benefit in mind and only diluted the inner process. If this sort of "monologue conversation" with us occurred, we suggested that the person either talk into a tape recorder for future reference or simply focus his or her attention inside rather than toward us. We could hear about it when it was all over. The main thing for us to do was to be available to provide for physical needs and comfort and to help give perspective when requested.

After one-and-a-half to two hours, patients were offered an additional dose of MDMA (usually 50 mg) to extend the peak part of the experience another hour and to make the wearing off of the drug more gradual. Since dehydration

was a common effect, water was offered periodically. After patients felt that the MDMA state had mostly passed, they usually set up and began talking to us about what had happened. We usually spent one to three hours discussing the session, to assist in the integration of the experience into daily life. In all, either or both of us usually spent a total of six to eight hours with the patients on the day of their session. We did not routinely offer interpretations of the meaning of the experiences, but tried to facilitate a smooth transition back to the usual state of consciousness.

We made sure that patients were alert and able to function normally, before they were allowed to leave. Blurred vision due to pupillary dilatation, and the visual "trails" that were rarely seen behind moving objects, had to be absent before we allowed anyone to drive. To gather follow-up information, a questionnaire was given, to be answered after one or two weeks. The Peak Experience Profile (Pahnke, W., Grof, S., and Dileo, F., 1981, unpublished manuscript) was also given to patients during the latter years of our work, to be completed as soon as possible. All patients were encouraged to call us whenever they wanted to discuss any problems or to relate their thoughts about the experience.

Roughly 90% of the people we saw in this context had powerful and generally positive and useful experiences, according to their follow-up reports [1]. About one third returned to have a single subsequent session, and another third had more than two sessions. The following are the stories of five people who had more dramatically beneficial sessions than most, though the quality of the sessions was typical for the other seventy-five people who had sessions with us:

Case 1: A married man in his early seventies with two grown children

A retired geophysicist and farmer, he had always been a successful man in charge of his own life. At the time of his sessions, he had been told that he was among the longest-living survivors to date with multiple myeloma, which had been diagnosed in 1975. He had undergone group therapy for two years (predating his cancer diagnosis) to help with depression over family problems. On being diagnosed with cancer, he began therapy in a group format, where he learned deep relaxation, meditation, and visualization to combat his cancer and to assist in pain control. He did, in fact, learn to achieve states where his pain was as reduced as it was with narcotics, but he still endured much pain.

At the time of our first meeting, his main complaint was "movement pain" from four collapsing vertebrae, secondary to the myeloma. Over the preceding months, the pain had increased, decreasing his physical and sexual activity and his ability to go fishing or to fly his plane. He was also troubled by the depression that usually followed the numerous fractures of his spine, which necessitated confinement to bed. The goal for his session with MDMA, which he wished to take with his wife, was to cope with his pain in a better way and to receive help in adjusting to his current life changes.

He took 125 mg, his wife took 100 mg, and they remained in separate rooms listening to music, with eyeshades and headphones. He hummed along with the classical music being played. Shortly after his second dose of 50 mg of MDMA, two hours after the first, he announced ecstatically that he was free of pain and began singing aloud with the music and repeatedly proclaiming his love for his wife and family. He spent several hours in this rapturous state. Afterwards he said it was the first time he had really been pain free in the four years since the current relapse of his myeloma had begun. He described his experience of being inside his vertebrae, straightening out the nerves, and "gluing" fractured splinters back together.

In a letter written two weeks after his session, he stated that his pain had returned, but that his ability to hypnotically "re-anchor" his pain-free experience greatly assisted him in reducing the pain by himself. He had four MDMA sessions spaced over the course of nine months; each time he achieved relief from his physical pain, and he had greater success in controlling painful episodes in the interims by returning himself to an approximation of the MDMA state. He noted in particular that the feelings of "cosmic love" and especially forgiveness of himself and others would usually precede the relief of physical pain. He described an episode from his second session:

As I was finishing the meditation, time ceased to exist, my ego fell away, and I became one with the cosmos. I then started my visualization of my body's immune system fighting my cancer, of the chemo[therapy] joining with my immune system to kill the cancer cells in my vertebrae, and of positive forces coming from the cosmos to fight my cancer. Gradually I went deeper in to where the feeling of love, peace, and joy were overwhelming. Although I had heard the new age music before, many details of the music became clear and more beautiful.

The series of sessions stopped because MDMA was placed in Schedule I by the DEA. The FDA denied us permission to continue the treatment, pending further animal studies. He remained quite functional and mostly pain free for a few months after the last session, but eventually his pain began to return and he died very peacefully in his wife's presence soon afterward.

Case 2: A single man in his mid-30's and administrator of a small inpatient substance abuse treatment facility

He had taken LSD in Vietnam and was a little concerned that he might have flashbacks to those times during the session. However, he had no significant psychological problems when he came to us, was curious about MDMA, and wanted a session to find out new things about himself. He was a smoker and was surprised to find he had no desire for a cigarette for the few hours during the session. He was given 125 mg of MDMA with diazepam (5 mg) to reduce muscle tension, followed by another 50 mg of MDMA after an hour. One of us [GG] took the same combination for the purpose of learning how it would affect the relationship. (This procedure was followed in a few cases where

more of a research goal than a specific therapeutic goal was the purpose of the session [12].) He listened to music with headphones for about an hour and then spent the rest of the time in conversation with us.

Three days later he said that he felt none of the physical tensions he feared he would feel from memories of his LSD experiences. Two days later, at work, he noticed he felt more relaxed on the job than ever before. Two years later he was sent the follow-up questionnaire and reported that, "It was a very enjoyable experience. I experienced a state, while under the MDMA influence, in which I found it difficult to concentrate on negative subjects (thoughts or feelings)." He did not expect to feel as close to us as he did: "I felt as if they were able to understand how I was feeling and thinking." The only unpleasant aspect was that the MDMA "wore off," because it had felt so good. His curiosity had been satisfied, but he did not believe he learned anything new about himself. He concluded his report by saying, "I believe the most beneficial aspect of how I felt during the session was that I felt very little defensiveness. . . . I thought about things in myself I didn't like. I was able to accomplish this without feeling guilty or defensive." He reported no long term benefit from the session.

Case 3: A real estate agent in her mid-thirties, married and mother of two daughters

She is the child of two Jewish Holocaust survivors from Poland and was born in a displaced persons' camp after the war. Her parents live in her community, and she had always been close to her father, who had been in a concentration camp, but she had a fairly difficult relationship with her mother. She had experienced some "anxiety attacks" in graduate school and had dropped out for some time. Subsequent to psychotherapy and re-entering school, she completed a Master's Degree in counselling. Her only significant medical history was a complaint of premenstrual syndrome — she would become quite irritable and emotionally labile during the premenstrual period every month. Her expressed purpose in having an experience with MDMA, which she wished to take with her husband, was to achieve "increased awareness and personal expansion."

She took 100 mg for her first session with no second dose. During the initial phase of the experience, she felt that she was "in Eternity" and was among the clouds (her eyes were closed). Then, gradually, disturbing thoughts intruded, and each one heralded a wave of nausea. Various fears and associations to a concentration camp were prominent. She tried to vomit several times but could not. Her nausea subsided as she released much of her "concentration camp consciousness" and the associated emotions. She felt she had taken on those feelings and attitudes from her parents, who had lived through the "Holocaust nightmare" where so many in their families had died. She noted that the pain of those years and, indeed, of the entire Holocaust had subtly colored her emotions and her life. It was after her "decision" to vomit during her session that her fears subsided, "moved through" her, and left. She felt a

new appreciation and love for her parents for enabling her to be living in the world. The rest of her experience was generally positive.

The next day she was intensely angry for a short period of time and had her "worst fight in thirteen years" with her husband, as both continued to release old tensions and negative feelings. For the next two days, although she continued to have some nausea and her digestion was retarded, she felt well emotionally and more grounded than usual: "I was a different person."

She subsequently had eight MDMA sessions over the course of a year; four of those times she took only 50 mg during her premenstrual periods for the relief of tension and irritability, which she unexpectedly had discovered it offered. Her marijuana intake decreased from several times a week to occasional use, and cocaine ceased to have any appeal. Generally, she felt that the release of negative and painful material gave her more energy and creativity. She has observed that she argues less with her mother and feels closer to her. At the same time, she is less concerned with her parents' inevitable deaths, having a newly reinforced belief in the eternity of the soul — that "we are *not* our bodies."

Almost three years after her first session she said:

I still am a different person. I'm not prone to getting caught up in the negative dark influences that are present in my character. I have more choice over how I feel. I can handle my emotions and I understand how they work more.

Cases 4 and 5: A married couple in their early 30's with no children

The husband was teaching creative writing and writing a novel, and the wife was a graduate student in foreign literature. She had undergone an abortion a few months before because their lives simply did not have room for a child, though they both wanted to have children later.

In stating her purpose for the session, the wife said, "I hope to achieve a new level of communication with [my husband] — one we can remember and continue to draw on in the future." He wrote, "I hope to clarify my thinking about myself, my work, and my short-term goals, and to share a visionary and intensely conscious experience with [my wife]."

One of us [GG] and the husband took 75 mg initially, the other [RT] and the wife took 50 mg. All four of us took three more doses of 50 mg each at 45 minutes, 1 ½ hours, and 4 hours after the initial dose. They spent their session talking with us, alternating with time to themselves. Two weeks later, the wife wrote the following:

I wish I could be writing to tell you that the exhilaration both [my husband] and I felt two weeks ago is still alive. . . . but with a return to the daily world of responsibilities, the feeling has diminished. Not that it's left completely: what has remained is the memory of that [day] and the clarity of thought and emotion it left me with. And that is very precious indeed. . . .

I fell in love with [my husband] all over again, and I seemed to see how the anxieties of this year have taken their toll on him. . . . But when I saw his face released from cares, it was a great insight to me — and this was the face I first loved. So we've had some long talks and a lot of things that had been only superficially resolved now seem completed. We vow to work always to be more open with each other.

Perhaps the most obvious and delightful effect of the drug was that it freed me from feeling trapped inside my body. These past few months following the abortion have been excruciating, apart from the emotional pain. [My husband] and I have always enjoyed each other tremendously — physically — and somehow I was so shaken by what our bodies had done, that I developed a kind of fear or reluctance to take any more chances. This was exaggerated by the complications I had, but even once I got back onto a normal cycle, I could hardly believe that simple pills could prevent pregnancy. None of this was deep-rooted in me, because I had never felt it before and was consciously trying to overcome it. But the MDMA did the trick, like a miracle. I was able to put everything into perspective and realize that one accident does not necessarily mean another, and that in the meantime there is a lot of enjoying to do.

In her follow-up questionnaire much later, she wrote, "There was a great sense of communality — that we're in this life together — and we are still drawing on this shared realization now, after 1 ½ years."

He wrote the following after ten days:

The positive effects of the drug — calmness, fearlessness, renewed love for [my wife], a sensation of personal intensity or power, re-alignment of one's proper place in the universe — all these have been wearing thinner over the past week and a half.

Still, the effects haven't entirely worn off, and I'm happy that it's the feeling of renewed love which has held up the best. The sensation was (and still is) as if I were seeing [my wife] through new eyes, not unlike the eyes I saw her with when we first fell in love, but not quite the same ones either. Wider ones, I think; less wary ones, for sure.

We heard many similar stories from other therapists who used MDMA differently from us, though their basic attitudes and purposes were the same.

7. CONCLUSION

From our own observations and those of others, we believe that, in the right circumstances, MDMA reduces or somehow eliminates the neurophysiological fear response to a perceived threat to one's emotional integrity. Though we do not understand how MDMA reduces the experience of feeling threatened, it does consistently reduce the primary somatic symptom of fear: the tightness and nervous feeling in the throat, chest, abdomen, and skeletal musculature. There is also a moderate anesthesia to pain (but not to touch) in the skin during the acute effect, which may parallel the anesthesia to emotional pain or fear without reducing emotional sensitivity. With this barrier of fear removed, a loving and forgiving awareness seemed to occur quite naturally and spontaneously. People found it unusually comfortable to be aware of, to commu-

licate, and to remember thoughts and feelings that are usually accompanied by fear and anxiety. Alcohol can reduce the same kind of fear, but cognitive clarity and conscious recovery of repressed feelings are not possible. Anxiolytic drugs and beta sympathetic blockers also reduce anxiety but do not facilitate the access of repressed memories or feelings.

Presumably both common and unique childhood traumas had caused the formation of conditioned fear responses, which made it desirable for patients to avoid having certain feelings or thoughts symbolically associated with the traumas. Without the conditioned fear inhibiting access to the information contained in these thoughts, feelings, or memories, patients' value judgments about their past, their relationships, and their self-worth could be based upon more accurate information. They could reassess any aspect of their lives and relationships that they chose, from the broader perspective of security and love, rather than from one of vulnerability and fear. With the fear removed, a corrective emotional experience could occur, and it seemed natural and easy for most people to begin to trust the validity of their own unafraid feelings, as well as those of a significant other who was experiencing the same state with them.

Because MDMA did not distort perception, thinking, or memory (except in doses well over 100 to 150 mg), the learning that took place during the session often became consolidated and applied to patients' everyday lives long after the session had ended. Couples who had a session together frequently began to base their relationships much more on love and trust than on fear and suspicion. Some of our patients said that under the influence of MDMA, and for days to years afterward, they "feel more loving," "can easily forgive pain of the past," or "let go of grudges or misunderstandings." We believe these results were not caused by MDMA, but were achieved by the patients making decisions based on what they learned during their MDMA sessions, and by their remembering and applying those decisions for as long as they were able to and willing to after the session was over. We believe this occurred because taking MDMA with an intention to learn, with an attitude of acceptance, and in a safely structured setting enabled people to experience their true nature, which is essentially loving and forgiving. About 75 of the 80 patients we treated reported significant benefit from their session(s).

Unfortunately, a double-blind controlled experiment testing the efficacy of our method is impossible because the optimum mental set requires that the patient and therapist know that MDMA is being taken and because the MDMA altered state is so obvious to both. Motivation would be severely compromised if therapists and patients thought there was only a 50% chance that they were really taking MDMA and that the primary goal of the session would be to study the effects of the drug itself rather than for the patients to learn something for themselves.

One potential application of MDMA therapy could be in the prevention and treatment of addictive behaviors. Pathological childrearing, with its traumas

and deprivations, is a major cause of the development of both addictive behaviors and the co-dependency of family members, which helps sustain the addiction. If those at risk could acquire the skills of becoming aware of their deepest feelings and communicating these to family members, it could prevent the transmission of dysfunctional family relationships from one generation to the next.

Traditional cultures often used consciousness-altering drugs in a ritual context as a rite of passage into adulthood, while such powerful rites are virtually absent in modern Western culture. As an example, the Native American Church has successfully used peyote rituals within a Christian context to treat alcohol abuse among its members [13]. A number of our patients spontaneously reduced their intake of cocaine and marijuana and noticed a decreased desire to consume them, even though that was not a goal for having a session [1]. Such potential benefits of the careful use of MDMA should be considered when evaluating the potential risks of toxicity from therapeutic doses.

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