A Method of Conducting Therapeutic Sessions with MDMA†

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Abstract—A method for preparing clients and conducting therapeutic sessions with 3,4-methylenedioxymethamphetamine (MDMA) is described, with emphasis on the need for careful attention to the mental set of therapists and clients and the setting of the session. The therapists' belief was that MDMA inhibited the fear response to a perceived emotional threat, allowing the client to place the emotional sequelae of past experiences into a more realistic perspective in their current emotional lives and relationships. Clients were carefully screened and prepared until they had a clear purpose for the session, including a willingness to experience and to learn from anything that might happen. Sympathomimetic effects of MDMA determined the medical contraindications, and clients with histories of serious functional psychiatric impairments were excluded. Total doses of 75-150 mg, plus 50 mg if requested later, were administered, followed by clients lying down and listening to music with eyeshades and headphones during the peak MDMA effect. Screening and follow-up questionnaires were utilized. Two case histories are presented: a man achieving relief of pain from multiple myeloma, and a woman finding relief from problems as the daughter of Holocaust survivors. Use of consciousness-altering drugs in other contexts is discussed.

Keywords—alternative medicine, drug therapy, intractable pain, N-Methyl-3,4-methylenedioxyamphetamine, psychotherapy, therapeutics

In the context of his 15 years of research with LSD-assisted psychotherapy, Stanislav Grof, M.D. (1994) has commented repeatedly on the importance of nondrug factors in the clinical use of psychoactive medicines, and especially on the issues of "set and setting":

> The term *set* includes the expectations, motivations and intentions of the subject in regard to the session; the therapist's or guide's concept of the nature of the LSD experience; the agreed-upon goal of the psychedelic procedure; the preparation and programming for the session; and the specific technique of guidance used during the drug experience. The term *setting* refers to the actual environment, both physical and interpersonal, and to the concrete circumstances under which the drug is administered.

The factors involved in set and setting are discussed in the following description of the method used by the authors from 1980 to 1985 in conducting MDMA sessions for about 80 clients. The expectations, motivations and intentions of the subject" (the first factor in set) were unique to each client, and were made as explicit as possible during the preparation session(s). In regard to the second factor, our concept of the nature of the MDMA experience was based on anecdotal reports that MDMA inhibited the subjective fear response to an emotional threat. With the habitual reaction of fear abated, we believed that the clients experienced a more accurate and healthy perspective of who and what they were psychologically and, sometimes, spiritually. We also believed that their recollection of this experience helped them become less influenced by

†A description of the method presented here was also published by the authors as a chapter in the book *Ecstasy: The Clinical, Pharmacological and Neurotoxicological Effects of the Drug MDMA*. (Greer & Tolbert 1990).

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neurotic fears about themselves and the relationships in their daily lives. This was our explanation for why some clients reported, from days to years later, that they "felt more loving," "could easily forgive the pain of the past" or "let go of grudges or misunderstandings." To achieve these results, we believed (as Grof had described above) that the mental set of the client, the relationship between the client and therapist, and the setting of the session were all critical variables.

Regarding the third factor defining set, "the agreed-upon goal of the psychedelic procedure," we felt the clients' optimal goal for the session would be a conscious intention to learn from whatever they experienced and to accept whatever happened during the entire experience, no matter how unpleasant or disturbing it might be. The relationship should be oriented toward a general healing for the client, who should feel safe enough in the therapists' presence to open fully to new and challenging experiences. Therefore, we believed that establishing the optimum therapeutic relationship for MDMA-assisted therapy sessions required as much attention as possible to maintaining a therapeutic intention while conducting the details of the screening and preparation of the client.

SCREENING, PREPARATION AND PROGRAMMING FOR THE SESSION

Most people who came to us for a session with MDMA had heard about their friends' experiences with MDMA, and already had some concept of what could be achieved and how a session was conducted. We never recommended an MDMA session to anyone seeking to be a passive participant who would be "cured" of or "treated" for a psychological problem; we believed that the person treated or cured themselves, with the assistance of MDMA and their relationship to us. They decided whether a session might be worthwhile after being told about the possible risks and discomforts.

Prospective clients were always asked how they had heard of our work, and if they knew anyone who had attended a session with us, or with others, in the past. This told us something about the clients' mental set toward the session. We inquired briefly about their medical and psychiatric history, if any, in an initial telephone interview. If there were no significant contraindications, we sent a background questionnaire, informed consent information, and an essay which addressed our philosophy on the use of psychoactive medicines (which is available from the authors on request). The questionnaire elicited personal, medical, and psychiatric history and information about use of other substances. It also asked questions designed to orient the person toward the session: "What is your purpose in having a session with MDMA?", "What are your expectations and/or fears of what will happen?", etc.

Screening of candidates involved several issues. Because of MDMA's sympathomimetic effects, we excluded for medical reasons those who should avoid such drugs because they had any medical condition that would have placed them at risk for significant morbidity or mortality, such as: hypertension, cardiovascular disease, hyperthyroidism, epilepsy, diabetes, hypoglycemia, liver disease, and actual or possible pregnancy. Given the 15 years since the time of these sessions, we would now have additional medical concerns—such as the report of deaths from cardiovascular events (Dowling 1987)—since more has been learned about MDMA. Those who had been unable to function at work or socially for more than a day or so due to psychiatric or emotional disturbance were also excluded. For those who were in psychotherapy, approval was obtained from their therapist for the client to have a session with MDMA. We informed the therapist of our method of working with MDMA, the possible benefits and risks, and offered to provide follow-up information.

Although we were aware of some sessions with MDMA that had been useful to individuals who were, at times, unable to take care of themselves due to psychiatric problems (Wolfson 1986), we only worked with functional, relatively well-adjusted people. We were not affiliated with any inpatient facility that had a program designed to care for people after an MDMA experience, and we could not have provided adequate follow-up to those people who might have needed inpatient care. Occasionally, we discouraged prospective clients from using MDMA at a certain time because they were undergoing major personal changes, and did not need any assistance to intensify the process. For example, we discouraged a woman from having a session whose husband had recently been murdered. She was actively grieving, and she did not feel safe anywhere. We thought that an intensification of her psychological process with an MDMA session was unnecessary, and that the experience could be very difficult for her both during and after the session.

If, after reviewing the questionnaire, we found no strong reasons against having the session, a screening interview was held. This interview was usually held in our home, as were most of the sessions. We felt that opening our home as a married couple to clients allowed them both greater physical comfort and greater trust (from knowing us better) than if an office setting had been used. The initial interview served various purposes, both real and symbolic. It was the final opportunity for screening, and also the main preparation for the session. We explained our therapeutic perspective, and established a relationship with enough mutual trust to make everyone feel comfortable about going ahead with the session.

We began the interview by asking if there were any questions based on what the client might have heard or read about MDMA. The questionnaire was then reviewed in the client's presence, allowing the client to clarify or elaborate on issues that interested or concerned us. We pursued any areas of past difficulty, reviewed medical histories,

and paid special attention to any history of significant losses, the client's attitudes and beliefs about death, and the client's general spiritual orientation. The most important information elicited at this time was a clear statement of the client's purpose for having the session. If the stated purpose was in clear opposition to our own philosophy (e.g., if they wanted only an enjoyable experience, wished to avoid issues of current or past pain, or wished only to focus on their spouse's problems), further interviews were scheduled, or the client was screened out. We also refused sessions to those whose spouse or therapist was opposed to the idea.

In addition to previously stated reasons for screening clients, we also did not administer MDMA to those who aroused any feeling of emotional uneasiness in either of us. We believed that giving a psychoactive compound to a client in the face of an ill-defined misgiving on the part of the therapist usually resulted in some difficulty that made the session unproductive. The client's history (as stated) and reasons for seeking out this sort of experience were obviously important information; however, our decision to supervise someone in an altered state of consciousness was also made according to clinical judgment, intuition and even gut feeling.

After going over the questionnaire, we described our personal and professional backgrounds and how we came to work with MDMA. We requested that the personal information be held in confidence, just as we held information about the clients in confidence. We believed that this mutual sharing established a context of equal status in research collaboration, intimacy and trust. It also discouraged the development of transference projections, thus distinguishing our approach from that of traditional psychoanalytically-oriented psychotherapy. We preferred to serve only as "sitters" or assistants to clients who were exploring themselves in a deeply personal educational process, rather than to become involved in a traditional psychoanalytic relationship (which would involve a long-term course of therapy to allow the transference to emerge and then be worked through). We saw the clients as the principal investigators in the experiment to determine what they could learn from taking MDMA in the chosen setting.

Because most clients had only one session, we felt that fostering any transference other than that of benevolent attendants would have contributed to a dependent relationship for which no time had been allotted to work it through to resolution. The most lasting and useful transformative experiences could occur when clients felt that they were responsible for their own experience. By disclosing a fair amount of information about who we actually were, we hoped to dispel whatever fantasies the person might have had about us or our role in their learning. Presenting ourselves as a married couple and placing most of the sessions in our home provided further reality testing toward this end. Of course, if transference phenomena emerged, we attempted to help the client understand and use them in a clinically appropriate manner, and scheduled follow-up therapy sessions (with or without MDMA, as indicated). This occurred in an obvious way only once, with someone who was in semiweekly insight-oriented psychotherapy with one of us [GG] in addition to having a series of MDMA sessions.

INFORMED CONSENT

A major consideration in using MDMA was that of informed consent. After a discussion of personal histories, the informed consent information was reviewed with the client. (This document is available from the authors on request.) The form listed the names of the psychiatrists who were members of our Peer Review Committee and the address of the state medical society in case there were any complaints; it stated security agreements and protocols for the actual session, and listed possible benefits, risks, side effects and alternative procedures. The security agreements were adopted from therapists who had used various psychedelic compounds in psychotherapy for many years; they were referred to as the "structure," and functioned as a contract of trust between sitter and client. The structure was: (1) the therapists and clients agreed to remain on the premises until all agreed that the session was over and that it was safe to leave; (2) the clients 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 clients and therapists; and (4) clients agreed to follow any instructions given to them by any therapist when it was explicitly given as part of the structure of the session (this, naturally, did not include various therapeutic suggestions we made to enhance the experience).

Clients were essentially asked to turn over control of their physical and interpersonal safety to us during the course of the MDMA session. We believed that any distrust of the therapists would be brought out by the clear language of the structure. If clients were uncomfortable in yielding to any part of these controls, further time could be spent in preparation until they were able to agree to the structure, they could decide not to have a session, or they could be screened out. However, this was never necessary. Clients without exception were able to respond appropriately at the rare times when this agreement was called upon, no matter to what degree their normal psychological functions might have been altered during the session.

By the same token, clients were encouraged to ask for anything that they wanted, again knowing that they could trust us to provide for their needs as was appropriate. For example, if there was an explicitly stated agreement of "no sex" in place, the client could ask to be held or comforted without fear of sexual involvement. Within the context of the structure which defined safe external boundaries, we believed the clients could explore the almost limitless

territory of their interior worlds. They could be, feel and do anything, knowing that we would set limits if necessary.

With the agreements made, we then reviewed the risks. Side effects were primarily those that came from stimulation of the sympathetic nervous system: muscle tightness, restlessness, nausea, etc. The issue of unwanted, or "negative," psychological effects or emotions was a special one to consider. With MDMA, as with any other catalytic or psychoactive compound, it was common to see the pain of unfinished grief or earlier traumatic experiences manifest itself both psychologically and somatically. Physical symptoms such as headache, shortness of breath, pain, or other discomforts might occur, with or without a connection to previously forgotten memories or repressed feelings. Depression and/or anxiety occasionally were experienced during the session or in the days following, until the client reached closure with the pertinent issues. Rarely did such reactions last more than a day or two, and usually the person reported the experience was quite useful, though unpleasant at times.

At the time the sessions were conducted, data on potential neurotoxicity of MDMA were not available. Many studies of rats and primates and a few human studies have been conducted since then with varied and somewhat controversial results. Grob and Poland (1997) recently reviewed the literature on MDMA neurotoxicity and could find no demonstration of functional or behavioral abnormalities in rats and primates, in spite of a great deal of evidence of the reduction of both serotonin levels and serotonin nerve terminals when high doses of MDMA were administered. In humans, one study (McCann et al. 1994) found relatively lower personality measures of impulsivity and hostility in recreational users of MDMA (who also had relatively lower levels of the serotonin metabolite, 5-HIAA, in their cerebrospinal fluid); this contradicted the expected correlation of reduced 5-HIAA and increased aggression found in many, but not all, studies (Coccaro et al. 1997).

Because it was impossible to predict all of the specific elements of a difficult experience, clients were asked whether they were 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 emotional pain without resistance when difficult material did arise, we believed that it could be moved productively. If there were any issues or kinds of emotional or physical experiences that the person was not willing to experience and accept, then we withheld the session until the client did have such a willingness and commitment.

It could be argued that dwelling on negative effects and physical problems seen in others' sessions could have hypnotically suggested to the clients that they might experience those same problems. Hearing the details of the many unpleasant physical symptoms that we described in obtaining informed consent could have added an unnecessary element of anxiety. In spite of these considerations, it was believed that a thorough process of informing clients of what they might expect was both ethical and practical. If some clients were so frightened by this information that they chose not to have a session (and this happened several times), then we believed that it was not a good time to have the experience in the first place.

As much as possible, everything done or said in preparing clients to take this compound attempted to give this 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 will be or how they may occur. We will provide a safe place for your explorations, and will be available to assist you with any difficulties; but all you learn that is real comes from within you—not from us, or from the medicine itself."

We felt that the more attention the clients placed on preparation for the experience, the more meaning and value was achieved, and the more they could claim responsibility for it. It was useful to have a clear notion of what one's expectations were, not so much to be able to realize them, but to facilitate a letting go of such expectations beforehand. Fasting, meditation, keeping a dream journal, etc., as preparation were encouraged to enhance the potential value of the session. Regular alcohol or marijuana consumption seemed to decrease the effects of the MDMA, so abstaining from the use of these compounds was advised for a few days beforehand. Food, especially milk products, seemed to decrease intestinal absorption of MDMA, and to predispose the client to nausea or vomiting. Therefore, fasting overnight or for at least six hours before ingestion of MDMA was advised. Additionally, in planning when to have the session, we instructed clients to refrain from scheduling any work or social obligations on the day afterward. Frequently there was much psychological material for the person to consciously integrate, as well as a tendency to feel tired, and we believed that having free time the day after was worthwhile. When screening and preparation were scrupulously attended to, conduct of the session rarely held any unexpected difficulties.

ALTERNATIVE PROCEDURES

Though we knew of no other medication or procedure that produced the characteristic effects of MDMA, we informed clients of other ways to achieve (with varying degrees of success) similar results. These included other methods of using MDMA or other mind-altering compounds, special deep breathing techniques, various practices of meditation and prayer, hypnosis, psychotherapy, standard psychotropic medications, and certain types of massage and bodywork. When supervised by a skilled practitioner, the procedures that did not involve the use of medications were generally safer, in our opinion, than those that did. Before giving someone a session, we

made sure that all concerned agreed 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 specific method that was necessary to make progress. The commitment and the willingness to encounter the difficulties that arose were all that were required, regardless of the method. Clients were encouraged to intuitively decide which methods offered them the best opportunities for reaching their goals.

SESSION SETTING, PROCEDURE AND TECHNIQUE OF GUIDANCE

Sessions were held in either the client's or our own home. We believed the home setting was best for facilitating a sense of safety and trust. When the session was begun, the client was first given time to bring us up to date on the recent events in his or her life. Decisions about the exact dosage 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 difference based solely on sex or on body mass, but women seemed to be more sensitive to MDMA than men). If the session was for an individual who wished primarily to focus his or her attention inward, a larger dose was suggested. For couples who wanted to spend time together, a smaller dose was recommended. 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 and increase the client's sense of full responsibility for the experience.

If desired or felt to be appropriate, some time was spent in silence or meditation before taking the MDMA. A copy of the following prayer was given to be read with the suggestion to take from it what was useful, and let go of the rest. It was one that had been used by the therapist who taught us how to conduct MDMA-assisted therapy sessions, and we chose it to foster an attitude of surrender to a source of wisdom beyond one's ego or individual personality:

> Lord, I know not what I ought to ask of thee; Thou only knowest what I need; Thou lovest me better than I know how to love myself. O Father, give to Thy child that which he himself knows not how to ask. I dare not ask either for crosses or for consolations; I simply present myself before Thee, I open my heart to Thee. Behold my needs which I know not myself; see and do according to Thy tender mercy. Smite, or heal; depress me or raise me up; I adore all Thy purposes without knowing them; I am silent; I offer myself in sacrifice; I yield myself to Thee: I would have no other desire than to accomplish Thy will. Teach me to pray. Pray Thyself in me. Amen. (Fenelon ca. 1700)

We believed these words reinforced the most useful attitude one could have right before MDMA was ingested. From our own MDMA experiences, we had come to believe that an attitude of surrender to a transcendent Reality helped to ease unnecessary anxiety going into the experience, and facilitated the emergence of whatever was helpful thereafter. Since the early 1980s, there has been much scientific research on the effects of prayer on healing (Dossey 1993). In light of that research, it appears that the prayer was a critical factor in the set and setting of the session and could have had a significant effect on the therapeutic outcome.

After ingesting the compound, the client sat quietly waiting to feel its effects, or lay down, wearing eyeshades to decrease outside distractions. Music was played, usually via headphones, and was always instrumental except for vocal pieces in foreign languages; the genre were 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. Clients could suggest or veto a piece of music, or choose to have silence. Couples were encouraged to begin their experience in separate rooms to allow 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, but were, of course, available and supportive if difficult or painful experiences occurred. It was our opinion that talking about, or "reporting," one's experiences and thoughts during the session was often done with the therapist's benefit in mind and only diluted the inner process. If this sort of reporting or "monologue conversation" with us occurred, we suggested that the client 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. (One client reported later that she felt somewhat abandoned when we had her record her thoughts, but no one else mentioned this as a problem.) Our chosen role was to be available for physical needs, to comfort, and to help give perspective when requested. To maintain the optimal therapeutic mental set for client and therapists, we believed that it was best to make the session relatively comfortable for ourselves; it generally was not useful to overextend ourselves so much that it might lead to either a negative countertransference, or to feeling resentment toward the client if the outcome of the session did not meet our own expectations. Intense therapeutic communication for two to three hours or long periods of massaging tight muscles or embracing a client who wants to be held could have made us feel drained of physical energy, therapeutic p[illegible]spective and compassion. In this regard,

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we felt it also was useful to have two sitters present, especially with couples, to help maintain an optimal therapeutic relationship.

After one-and-a-half to two hours, clients were offered an additional dose of MDMA (usually 50 mg) for the purpose of extending the peak part of the experience for another hour and to make the subsidence of the effects of MDMA more gradual. Since dehydration was a common effect, water was offered periodically. After clients felt that the MDMA state had mostly passed, they usually sat up and began talking to us about what had happened. Usually one to three hours were spent discussing the session to assist in the integration of the experience into daily life. 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 clients were alert and able to function normally before we left, if the session was in their home, or before they were allowed to leave, if the clients had traveled to our home. Blurred vision and the visual "trails" that were occasionally seen behind moving objects had to have abated before we allowed anyone to drive.

To gather further information on clients' sessions, a follow-up questionnaire that essentially repeated the same questions in the screening questionnaire was given for them to answer after one or two weeks. It was sent again after one to two years to gather follow-up data for a report on the first 29 clients (Greer & Tolbert 1986). If any problems or difficulties were experienced during the session, the client was monitored by telephone or in person over the following days. All clients were encouraged to telephone to discuss any problems or to relate their thoughts about the experience.

Roughly 90% of the people we saw in this context had personally significant and generally positive and useful experiences according to their follow-up reports (Greer & Tolbert 1986; also unpublished data). About one-third returned to have a single subsequent session, and another third had more than two. Each session was approached as a unique event, and not as a series of therapy sessions.

The following cases reflect the experiences of two clients who reported more dramatically beneficial sessions than most, though the quality of their experiences were typical of the other seventy-five people who had sessions with us.

CASE 1

A married man in his early seventies, father to an adult son and daughter, had experienced successful careers as a geophysicist and farmer. At the time of his sessions, he had been told that he was among the longest-lived survivors of multiple myeloma to date (this metastatic, cancerous condition of the bone marrow had been diagnosed about 10 years earlier). He had attended group therapy for two years (previous to his cancer diagnosis) to help with depression over family problems. On being diagnosed with cancer, he began a different type of therapy in a group format, where he learned deep relaxation, meditation, and visualization to combat his cancer and assist in pain control. He had, in fact, learned 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 with him, his main complaint was "movement pain" from four collapsing vertebrae, secondary to the cancer. Over the past months, the pain had increased, decreasing his physical and sexual activity, ability to go fishing, or to fly his plane. He was also troubled by depression, which 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.

During his first session, he and his wife remained in separate rooms with eyeshades and headphones on for five hours. He would hum along with the classical music being played. Shortly after his extra dose of 50 mg of MDMA, 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 elated state. Afterwards he said it was the first time he had really been free of pain in the four years since the current relapse of his myeloma had begun. He described his beautiful experience of being inside his vertebrae, straightening out the nerves, and "gluing" fractured splinters back together.

In a letter 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 had greater success in controlling painful episodes in the interim 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.

His sessions stopped when MDMA was placed in Schedule I by the Drug Enforcement Agency (DEA) in 1985. The Food and Drug Administration denied permission to continue treatment with MDMA 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. He died very peacefully in his wife's presence soon afterward.

CASE 2

A married woman in her mid-thirties, mother of two daughters, was the child of two Jewish Holocaust survivors from Poland, and was born in a displaced persons' camp after the war. Her parents lived in her community, and she had always been close to her father, who had been in a concentration camp, but 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 reentering school, she completed a Master's Degree in counseling. Her only significant medical history was a complaint of premenstrual syndrome with irritability and emotional lability. Her expressed purpose in having an experience with MDMA, which she took with her husband, was to achieve "increased awareness and personal expansion."

During the initial phase of her first experience, she felt that she was "in Eternity," and was among the clouds (her eyes were closed). Then, gradually, disturbing thoughts would intrude, and each one would herald a wave of nausea. Various fears and associations relating to concentration camps 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" in which 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 trip, that her fears subsided, "moved through" her, and left. She felt a new appreciation and love for her parents because they enabled 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 13 years" with her husband, as both continued to release old tensions and negative material. 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. She stated "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 to achieve the relief from tension and irritability that she unexpectedly had discovered it offered. Generally, she felt that the release of negative, painful material gave her more energy and creativity. She observed that she argued less with her mother and felt closer to her. At the same time, she was less concerned with her parents' deaths, having a newly reinforced belief in the eternity of the soul—that basically, "we are *not* our bodies."

Toward the end of the period in which she had her sessions, she said this of the knowledge she gained from her experiences:

> I had many important insights regarding my feelings about light and darkness and the importance of living on the "bright side" as opposed to the "dark underside" where I have occasionally ventured. I made an important choice—to no longer co-create darkness in my being—to strive for freedom and light. . . . My goal was to "lift the sorrow" I had been feeling. I did that.

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.

We heard many similar stories from other therapists who used MDMA with methods and procedures different from ours (though their basic attitude and purposes were similar).

CONCLUSION

From our own observations and those of other therapists, 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 seem to 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 effects, 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. Clients found it comfortable to be aware of, to communicate, and to remember thoughts and feelings that are usually accompanied by fear and anxiety. Alcohol, anti-anxiety drugs and beta sympathetic nervous system blockers also can reduce fear but are not reported to facilitate the access of repressed memories or feelings.

We theorize that presumably unresolved emotional conflicts from the past caused the formation of conditioned

fear responses, which made it desirable for clients to avoid having certain feelings or thoughts symbolically associated with the conflicts. Without the conditioned fear, access to the information contained in these thoughts, feelings or memories was enhanced, allowing clients' value judgments about their past, their relationships and their self-worth to be based on more accurate information. They could reassess any aspect of their lives and relationships that they chose from a broader perspective of security and love rather from one of vulnerability and fear. With the fear removed, a corrective emotional experience could occur. It seemed natural and easy for most clients to begin to trust the validity of their own feelings without fear, and those of significant others who were experiencing the same state with them as well.

We speculate that because MDMA did not significantly 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 clients' everyday lives long after the session had ended. Couples who had a session together frequently reported basing their relationships much more on love and trust than on fear and suspicion. We believe these results were not caused by MDMA, but were achieved by the clients 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 and willing after the session was over. A collection of personal accounts of MDMA experiences in a variety of settings reported a variety of benefits as well (Adamson 1985).

A double-blind controlled experiment of psychotherapy with and without MDMA is necessary to prove the efficacy of MDMA under current scientific standards. However, we would argue that the method presented here could not be evaluated by such testing because the method requires that the client and therapist both know that MDMA is being ingested, and because the MDMA altered state is so obvious to both when it occurs. Furthermore, assuming that the purpose of the session is the primary variable in the mental set, changing the purpose from treatment to treatment research could have an important influence on the outcome of the session. Motivation would be significantly affected if the therapist and client believed that the primary goal of the session was studying the therapeutic effects of the drug itself rather than helping the client learn something beneficial. Also, the knowledge that there was only a 50% chance that the client was actually receiving MDMA would have further impact on the client's psychological preparation for and attitude toward the session. Therefore, in a sense, the therapeutic method is not separable from the ingestion of MDMA, and comparing the therapeutic method with and without the use of MDMA, or the use of MDMA with or without the therapeutic method, invalidates the examination of the method. However, valid comparisons to other psychotherapeutic methods that involve altered states but do not utilize MDMA could be accomplished.

From 1988 to 1993, several Swiss psychiatrists treated patients with MDMA sessions or MDMA sessions followed by LSD sessions. The sessions included both individual and group treatment. The psycholytic therapy method of Hanscarl Leuner, M.D., using low to medium doses and continuous verbal therapy in a group setting, was employed. The psychedelic therapy method of Stanislav Grof, M.D. (which is similar to the method presented here, using high doses while the patient listened to music instead of verbal therapy) was also utilized. A follow-up questionnaire surveyed all 171 of the patients who (a) had been treated by any of the three members of the Swiss Medical Society for Psycholytic Therapy who utilized MDMA during the entire five-and-a-half years of the program and (b) had completed their treatment by 1993. Seventy-nine percent of the patients responded to the survey. Diagnoses were made informally based on the primary problems reported, with personality disorders, adjustment disorders and affective disorders predominating. On average, patients had 70 nondrug sessions and seven sessions with MDMA or LSD over three years, with an average time before the follow-up of two years. After treatment, 65% of the patients reported "good" improvement and 26% "slight" improvement. Reduction in the use of nicotine and alcohol were reported by 20% each, and reduction of cannabis use was reported by 7%; increases in use of these substances were reported by 2% to 3% of patients (Gasser 1995).

In addition to MDMA use in a medical/psychotherapeutic context, it has also been utilized in large and somewhat ritualized dance settings called "raves," with both beneficial and harmful results reported (Cohen 1998; Grob & Poland 1997; Saunders & Doblin 1996; Beck & Rosenbaum 1994). Cohen (1998) discusses a study in Australia in which some subjects reported feeling more open-minded and close to others and gaining more insight during their MDMA experiences in the rave setting, although half reported no effect on their psychological state (Solowij, Hall & Lee 1992).

Some indigenous cultures also use consciousness-altering drugs in ritual contexts, including rites of passage into adulthood; though such sanctioned rites are virtually absent in modern Western culture. The Native American Church has successfully used peyote rituals within a somewhat Christian context, and claims to have reduced alcohol abuse among its members (Grinspoon & Bakalar 1979). A number of our clients 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 (Greer & Tolbert 1986).

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

deprivations, is a major factor in the development of both addictive behaviors and the codependency among family members that helps sustain addiction. If those at risk could acquire the skills necessary to become aware of and communicate their deepest feelings to family members, it could prevent the transmission of dysfunctional family relationships from one generation to the next. Such potential benefits from the careful use of MDMA should be weighed against the potential medical risks from therapeutic doses.

REFERENCES

Adamson, S. 1985. *Through the Gateway of the Heart: Accounts of Experiences with MDMA and Other Empathogenic Substances.* San Francisco: Four Trees Publications.

Beck, J. & Rosenbaum, M. 1994. *Pursuit of Ecstasy: The MDMA Experience.* Albany: SUNY Press.

Coccaro, E.F.; Kavoussi, R.J.; Cooper, T.B. & Hauger, R.L. 1997. Central serotonin activity and aggression: Inverse relationship with prolactin response to d-fenfluramine, but not CSF 5-HIAA concentration, in human subjects. *American Journal of Psychiatry* 154 (10): 1430-5.

Cohen, R. 1998. *The Love Drug: Marching to the Beat of Ecstasy.* Binghamton, New York: Haworth Medical Press.

Dossey, L. 1993. *Healing Words: The Power of Prayer and the Practice of Medicine.* San Francisco: Harper San Francisco.

Dowling, G.P.; McDonough, E.T. 3rd & Bost, R.O. 1987. "Eve" and "Ecstasy": A report of five deaths associated with the use of MDEA and MDMA. *Journal of the American Medical Association* 27 (12): 1615-7.

Fenelon, F. ca. 1700. Untitled prayer.

Gasser, P. 1995. Psycholytic therapy with MDMA and LSD in Switzerland. *Bulletin of the Multidisciplinary Association for Psychedelic Studies* 5 (3): 3-7. (Full text at http://www.maps.org/news-letters/v05n3/05303psy.html.)

Greer, G. & Tolbert, R. 1990. The therapeutic use of MDMA. In: S.J. Peroutka (Ed.) *Ecstasy: The Clinical, Pharmacological and Neurotoxicological Effects of the Drug MDMA.* Norwell, Massachusetts: Kluwer Academic Publishers.

Greer, G. & Tolbert, R. 1986. Subjective reports of the effects of MDMA in a clinical setting. *Journal of Psychoactive Drugs* 18 (4): 319-27. (Full text at http://www.heffter.org/SUBJREPT.HTML.)

Grinspoon, L. & Bakalar, J. 1979. *Psychedelic Drugs Reconsidered.* New York: Basic Books.

Grob, C.S. & Poland, R.E. 1997. MDMA. In: J.H. Lowinson; P. Ruiz; R.B. Millman & J.G. Langrod (Eds.) *Substance Abuse: A Comprehensive Textbook. Third Ed.* Baltimore: Williams & Wilkins.

Grof, S. 1994. *LSD Psychotherapy.* Alameda, California: Hunter House.

McCann, U.D.; Ridenour, B.S.; Shaham, Y. & Ricaurte, G.A. 1994. Serotonin neurotoxicity after (+/-) 3,4 methylenedioxymethamphetamine (MDMA; "ecstasy"): A controlled study in humans. *Neuropsychopharmacology* 10:129-38.

Saunders, N. & Doblin, R. 1996. *Ecstasy: Dance, Trance and Transformation.* Oakland, California: Quick American Archives.

Solowij, N.; Hall, W. & Lee, N. 1992. Recreational MDMA use in Sydney: a profile of "Ecstasy" users and their experiences with the drug. *British Journal of Addictions* 87:1161-72.

Wolfson, P.E. 1986. Meetings at the edge with Adam: A man for all seasons? *Journal of Psychoactive Drugs* 18 (4): 329-33.