

# MDMA-Assisted Psychotherapy: How Different is it from Other Psychotherapy?

MICHAEL MITHOEFER, MD



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**“HAVE A BIG STORY OR no story at all, but don’t have a small story.”**

These words resonated deeply for me when I first heard them from Stan Grof over 20 years ago. They’re always in the mix when I think about what we know and what we’re discovering about psychological healing—even the term “psychological healing” implies a small story separating psychology from physiology, spirituality, and other possible levels of healing. In research we need to formulate and test hypotheses, which are of necessity small stories or only small parts of a much bigger story. However elegant and illuminating our hypotheses may be, there is the danger that they will become conceptual traps limiting our capacity to observe and respond to the unexpected. A comprehensive understanding of the human psyche remains elusive and is no doubt far beyond any of our limited hypotheses.

For me, doing MDMA research in a rigorous, scientific way always involves a tension between striving to understand and not needing to understand. The ongoing challenge is to balance my intention not to be attached to any story at all—to be open and receptive to unexpected discoveries when we’re sitting with people in MDMA psychotherapy sessions—with the inescapable and potentially fruitful propensity of my rational mind to weave new discoveries into our evolving understanding of therapeutic methods and mechanisms. Without losing sight of this compelling tension, which is inherent to some degree in any psychotherapy, I want to discuss some of the similarities and differences between MDMA-assisted psychotherapy and other approaches to psychotherapy for Posttraumatic Stress Disorder (PTSD).

No one knows how any psychiatric treatment, psychotherapy, or psychopharmacology actually works, even when we understand the essential elements or many of the physiologic effects. MDMA-assisted psychotherapy is especially complicated in this regard because it combines psychotherapy and psychopharmacology. There are many papers describing MDMA’s effects in the brain and the rest of the body, and some speculating on the mechanisms of its therapeutic effects, but there are no published studies designed to test hypotheses about pharmacological and psychotherapeutic mechanisms of MDMA-assisted psychotherapy. MAPS-sponsored studies thus far are designed to measure safety and effectiveness, but not to determine mechanism of action. As funding allows, we hope to investigate potential mechanisms by adding neuroimaging and other physiologic measures to future protocols. In addition, other researchers are beginning to conduct qualitative analyses of our session recordings in attempts to discover more about the psychotherapeutic process involved. In the meantime, our observations about possible therapeutic mechanisms are speculative, based on clinical observations

during MDMA research sessions and limited in precision by the complexity of the process.

Psychotherapy exerts effects on many levels, emotional, cognitive, physical, energetic, and spiritual. The course of therapy is determined by the individual's own inner healing intelligence interacting with facilitation by the therapists in the context of the therapeutic relationship. In MDMA-assisted psychotherapy, the direct pharmacologic effects of MDMA are occurring in conjunction with this complex psychotherapeutic process, hopefully acting as a catalyst to its healing potential. Further, this interaction is a two-way street: Neurophysiologic effects influence psychotherapy and psychotherapy itself changes the brain. At this stage, no discussion of the therapeutic elements involved can encompass more than part of the picture. We can learn from this reductionism but should be careful not to "confuse the map with the territory." We strive to do rigorous science without losing sight of the remarkable richness of the process as we observe and participate in it.

My wife Annie and I have had the opportunity to act as co-therapists in MDMA-assisted psychotherapy for PTSD in our first MAPS-sponsored study completed in 2008 and our ongoing study with veterans, firefighters, and police officers suffering from chronic PTSD. We've also learned from many others by reading and sharing observations and insights with other researchers: Jose Carlos Bouso, Marcela Ot'alora, Peter Oehen, and Verena Widmer, who have done or are doing similar studies, and with George Greer, Reque Tolbert, Stanislav Grof, Ralph Metzner, Torsten Passie, and others who had experience doing MDMA-assisted psychotherapy before it became a scheduled compound. The comparisons I draw below are based on these

opportunities to learn about MDMA-assisted psychotherapy contrasted with my training and clinical experience using other methods over the years.

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At first glance, MDMA-assisted psychotherapy looks very different from any conventional treatment: participants lying on a futon, sometimes with eyeshades and headphones listening to music with male and female therapists sitting on either side for at least eight hours (not exactly the approach I was taught in psychiatry residency, though very much like the approach we learned in the Grof Transpersonal Training). Despite these obvious dramatic differences, with a closer look most

therapists would recognize that MDMA-assisted psychotherapy includes familiar elements that play important roles in the beneficial effects of other models of therapy. This is not surprising since each approach, in the context of a therapeutic relationship, is stimulating access to the

individual's innate, universal healing capacity. Many of the therapeutic elements that are directly elicited by therapists in more established methods occur spontaneously with the less directive approach we use in MDMA-assisted therapy.

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#### **ELEMENT 1**

##### **Establishing a Safe and Supportive Therapeutic Setting and a Mindset Conducive to Healing**

These are essential elements of any safe and effective treatment for PTSD. At the outset of all established therapies and in the introductory sessions preceding MDMA-assisted therapy, therapists play an active role in establishing a therapeutic alli-

ance. In order to safely proceed, therapists must assess and possibly augment a client's support systems and their own resources for affect management and self-care. People with PTSD often have difficulty trusting, so trauma therapists of all kinds know that the therapeutic alliance and the client's resources may be thoroughly tested during the emotional challenges of trauma processing. MDMA-assisted psychotherapy is by no means immune from these challenges, but does have a potential advantage. The effects of MDMA appear to increase the likelihood that participants will be able to maintain enough trust in the therapists and a broad enough perspective about their own inner experience to process their fears without emotionally or physically withdrawing from the therapeutic alliance. (Sections in italics are quotes from study participants.)



Michael Mithoefer, MD working with study data.

*“I keep getting the message from the medicine, ‘trust me.’ When I try to think, it doesn’t work out, but when I just let the waves of fear and anxiety come up it feels like the medicine is going in and getting them, bringing them up, and then they dissipate.”*

*“Without the study I don’t think I could have ever dug down deep, I was so afraid of the fear.”*

*“Maybe one of the things the drug does is let your mind relax and get out of the way because the mind is so protective about the injury.”*

## ELEMENT 2

### Anxiety Management Training (AMT)/Stress Inoculation Training (SIT)

Any psychotherapy that involves revisiting and processing trauma is likely to temporarily increase anxiety and other powerful emotions, so participants should have tools for managing symptom exacerbations as needed throughout the course of therapy. Cognitive Behavioral Therapy (CBT), including Prolonged Exposure (PE) and others, usually includes teaching a relaxation method at the outset. Eye Movement Desensitization and Reprocessing (EMDR) calls for this as well, often using guided visualizations. During introductory sessions in MDMA-assisted psychotherapy we teach mindful diaphragmatic breathing or reinforce any other method the participant may have

found effective. It’s important not to underestimate the degree to which participants in MDMA-assisted psychotherapy for PTSD may need and benefit from ongoing support during the integration period in the days and weeks following MDMA-assisted sessions. MDMA catalyzes deeper processing during MDMA-assisted sessions, so it often requires closer attention to the challenges of integrating these deep experiences into everyday consciousness and daily life.

*“Now that the medicine has worn off I sometimes feel guilty for saying the things I did about my parents not being emotionally available. I know it wasn’t about blame, but there’s still that judging voice that says we don’t talk about any of this.”*

*“I got a glimpse of more of what I’m capable of growing into...I’m motivated to keep practicing openness until it gets more developed.”*

## ELEMENT 3

### Exposure Therapy

Revisiting traumatic experiences during therapy is a mainstay of Prolonged Exposure, Cognitive Processing, and other types of Cognitive Behavioral Therapy for PTSD. In these models, “imaginal exposure” is accomplished by asking the participant to repeatedly read or recite an account of their traumatic experience. Likewise, EMDR starts with a “target,” usually an image, associated with a traumatic event that carries an emotional charge and associated negative cognitions.

In MDMA-assisted psychotherapy we have an agreement with participants that the therapists can bring up the index trauma at some point during each MDMA session if it does not come up spontaneously, but in almost 100 MDMA research sessions to date we have never had to do so. The trauma always comes up, and we think it is preferable to allow it to come up at whatever time and in whatever way it does so spontaneously for each individual. This is in keeping with the principle that the optimal tactic is for the therapists and the participant to approach each session with a largely non-directive stance, or “beginner’s mind,” in order to allow the individual’s own healing intelligence to determine which course the session will take. At some point in the session this will result in a form of exposure

therapy in which MDMA acts as a catalyst by providing emotional connection, increased clarity about trauma memories, and a sense of confidence that painful experiences can be revisited and processed without becoming overwhelming. In many cases this imaginal exposure occurs early in the session, but sometimes it comes up only after affirming experiences have provided greater inner strength from which to face the trauma memories. These affirming experiences are important elements of the therapy and we encourage participants to accept them as such, rather than assume, as some participants do, that facing pain is the only productive use of the time.

*“I had never before felt what I felt today in terms of loving connection. I’m not sure I can reach it again without MDMA but I’m not without hope that it’s possible. Maybe it’s like having an aerial map so now I know there’s a trail.”*

*“The medicine just brought me a folder. I’m sitting at this big desk in a comfortable chair and the medicine goes and then rematerializes in physical form bringing me the next thing—this is a folder with my service record. It says I need to review it and talk to you about it from the beginning so it can be properly filed.”*

*“It’s like, every time I go inside I see flowers and I pick one, and that’s the thing to work on next. And there are things that are hard to take, but each time I move through them it feels so much better.”*

*“I realize I’m not trying to break through anything. It has to be softly opening. With the medicine nothing felt forced. I know I’m going to have to feel the feelings and there’s still fear that the grief will be overwhelming, and I know feelings are unpredictable and the currents can be swirly, but yesterday when I put my toe in it felt so wonderful to feel. I remember every detail, it’s a pristine, pristine image.”*

*“It wasn’t an easy experience but it was so worth it. It was a very spiritual experience, very expansive. I feel a sense of calm and stability now.”*

#### ELEMENT 4

##### Cognitive Restructuring

Cognitive Behavioral therapy teaches people to recognize negative thoughts and beliefs and cognitive distortions, to challenge them using the Socratic method and then modify them by arriving at a rational response. In EMDR the approach is largely nondirective and cognitive restructuring often occurs spontaneously, sometimes catalyzed by the therapist adding a

“cognitive interweave” if needed. In psychodynamic therapy, with the help of interpretations from the therapist, clients come to understand the meaning of traumatic experiences and the associated reactions and beliefs based on developmental history and prior relationships and psychological conflicts.

In MDMA-assisted psychotherapy, cognitive restructuring may result from dialogue with the therapists using elements of CBT, psychodynamic therapy, and other methods according to the individual therapists’ training and experience as allowed for in our research Treatment Manual [available at [maps.org](http://maps.org)]. In addition, the effects of MDMA can lead to profound insights about cognitive distortions with little or no intervention from the therapists. Our largely nondirective approach often results in spontaneous cognitive restructuring resulting from qualities engendered by MDMA: increased mental clarity, confidence, and the courage to look honestly at oneself.

*“I feel like I’m walking in a place I’ve needed to go for so long and just didn’t know how to get there. I feel like I know myself better than I ever have before. Now I know I’m a normal person. I’ve been through some bad stuff, but...those are things that happened to me, not who I am... This is me, the medicine helps, but this is in me.”*

#### ELEMENT 5

##### Transference and Countertransference

These terms refer respectively to the feelings that arise in the client toward the therapists and vice versa, as they are unconsciously influenced by earlier experience, especially childhood experiences with parents. Awareness of these feelings is important in any psychotherapy and is specifically addressed in psychodynamic psychotherapy, aimed at making the unconscious conscious as this becomes tolerable in the course of therapy. In MDMA-assisted psychotherapy we discuss transference and countertransference in the introductory sessions in preparation for the fact that these feelings can be considerably heightened by MDMA and the setting of all-day sessions. We introduce them as normal phenomena that provide an opportunity for discovering and processing previously unconscious material in the present moment.

We know that participants taking MDMA can be exquisitely sensitive to verbal and nonverbal expression from the therapists, and we encourage honesty and openness about any feelings that arise. We make explicit our intention to be forthcoming about any questions participants may have about us and not to take it personally if they are angry or displeased in reaction to anything we say or do. MDMA may make the unconscious conscious at a rapid rate while also increasing the partici-

part's capacity to acknowledge and discuss transference issues and to tolerate and benefit from this faster rate of change. At the same time the therapists are challenged to be aware of their own reactions and to be honestly and empathically engaged with the participant from moment to moment. Happily, if the therapists are honest about their own limitations and blind spots the participant taking MDMA is likely to be empathic toward them.

*“OK, I’m ready to talk to you now Michael. Have you noticed that every time I’ve talked to you before I’ve tried to impress you with how smart I am? That’s what I did with my father because he was smart and wasn’t around much. Now I’m ready to have a real conversation with you.”*

## ELEMENT 6

### Working with the Multiplicity of the Psyche

The human psyche is not unitary; we all have different parts. This phenomenon is widely recognized, but in psychiatry the terminology and theories about it are far from unified. Nevertheless, I think “dissociation,” “parts,” “sub-personalities,” “selves,” and “complexes” are all referring to the same or to overlapping phenomenon. When manifestations of multiplicity are on the extreme end of the spectrum they’re called Dissociative Identity Disorder (formerly Multiple Personality Disorder). In the soon-to-be-released DSM-V there will be a new “dissociative subtype” of PTSD—a recognition that people with PTSD often have increased levels of dissociation or blending with their parts.

Several psychotherapy models recognize multiplicity as a normal phenomenon (though problematic at the more extreme ranges of the spectrum), and provide specific methods for working with it therapeutically. These models include Psychosynthesis, Voice Dialogue, and Internal Family Systems Therapy (IFS). In our experience, MDMA in a therapeutic setting often raises awareness of different “parts” of the psyche and simultaneously brings forth more “self-energy” to allow exploration of the parts with greater compassion and clarity (“parts” and “self-energy” are IFS terms; other models would describe the same phenomenon somewhat differently). We’ve been conducting a small internal pilot study within our current study of veterans, firefighters, and police officers with PTSD, tracking how often awareness of parts comes up. Our preliminary analysis reveals that study participants have spontaneously brought up their awareness of different parts of themselves in 81% of the MDMA-assisted sessions, and greater understanding and acceptance of these parts have often been important elements in the therapeutic process.

*“I realize that part of me is not a monster, he’s a warrior, a valuable part of me, and he needs healing too.”  
(paraphrased)*

## ELEMENT 7

### Somatic Manifestations of Trauma

CBT, EMDR, and psychodynamic therapy may bring attention to somatic experiences, but do not include working directly with the body through movement or physical touch. There are, however, a number of innovative and effective methods that emphasize connections between psychological symptoms and physiological states. These methods—Sensorimotor Psychotherapy, Somatic Experiencing, Holotropic Breathwork, Hakomi, and others—use focused attention, breath, movement, and/or touch to encourage expression and release of sensations that come up in the body during trauma therapy. MDMA-assisted psychotherapy often includes focusing attention on body sensations and using breath and movement to facilitate awareness, expression and release of tensions, or pains in the body. Our approach can also include either nurturing touch or focused bodywork, always with careful attention to permission from the participant. Working with these body sensations led to release of much of the anger and sadness.

*“The anger feels like a volcano, I’m afraid of being a one man wrecking crew, I feel such sadness, loneliness, nausea.”*

The factors that lead to healing in MDMA-assisted psychotherapy are no more mysterious than those in any other method of therapy. Some factors are recognized and can be refined and disseminated, others are on the brink of being discovered, and many remain hidden in the complexities and mysteries of a much bigger story about the true mechanisms of human growth and healing. Since imagery is the language of the unconscious, images may come closest to describing what occurs. As an Iraq war veteran who participated in our study recently put it:

*“It feels almost like the inner healer or the MDMA is like a maid doing spring cleaning. It’s as if you thought you were cleaning before but when you got to things you didn’t really want to deal with you’d just stick them in the attic. If you’re going to clean the house you can’t skip the stuff in the attic.”* 🌀

**Michael Mithoefer, MD** is a psychiatrist practicing in Charleston, SC, where he divides his time between clinical research and outpatient clinical practice specializing in treating posttraumatic stress disorder (PTSD) with an emphasis on experiential methods of psychotherapy. He is a certified Holotropic Breathwork Facilitator and trained in EMDR and Internal Family Systems Therapy. He can be reached at [mmithoefer@mac.com](mailto:mmithoefer@mac.com).

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—study participant*