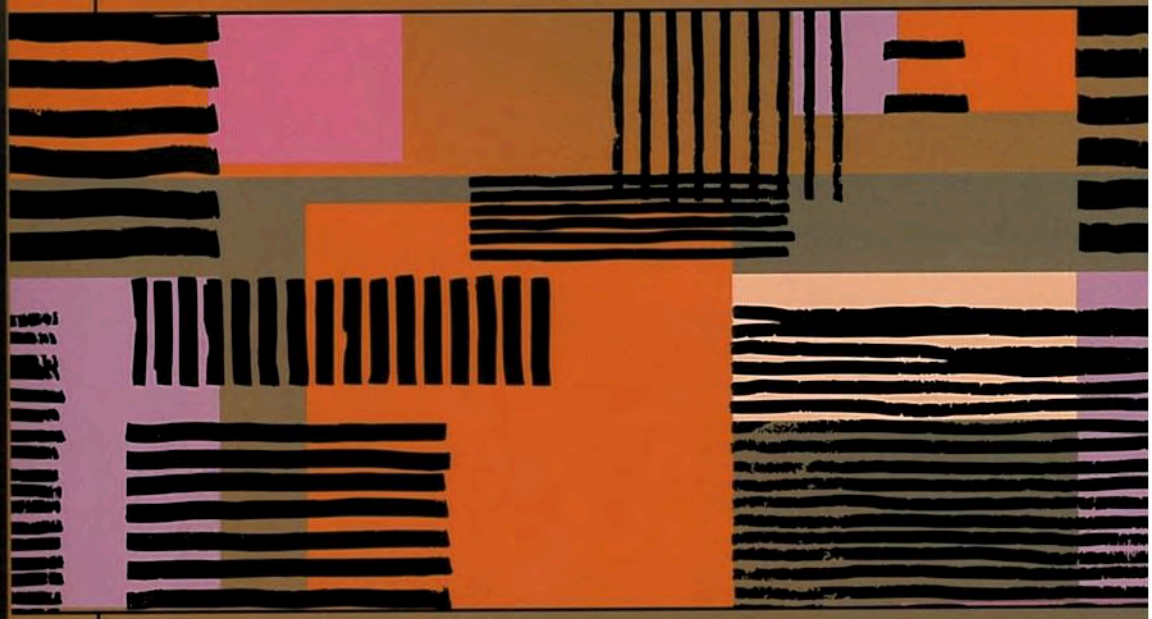
POSITIVE PSYCHIATRY

A Casebook



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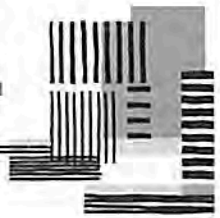
TAKE-HOME POINTS

- Positive psychological therapy addresses patient strengths and is particularly useful for patients who are not treatment compliant.
- Positive psychological therapy can enhance the therapeutic relationship and allow for improved collaboration involving psychopharmacological treatment.
- Family-centered approaches are consistent with positive psychological therapy.

CHAPTER 4



MDMA-Assisted Psychotherapy for Posttraumatic Stress Disorder

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Editors' Introduction

This extraordinary narrative of a woman with a trauma history who undergoes treatment with 3,4-methylenedioxymethamphetamine (MDMA) describes the transformation of her frightening and overwhelming inner memories and flashbacks into a powerful experience of safety and calm. The use of visual images and metaphor under the gentle guidance of the therapist, assisted by the pharmacological effect of MDMA, allows for a deeply moving and apparently persistent change in her subjective experience and identity.

The authors would like to acknowledge the subject of this case, SG, for her generosity and willingness to share her experiences in therapy. Additionally, we would like to acknowledge Sara Gael, M.A., and Saj Razvi, L.P.C., for their invaluable work with the patient.

Summary

The patient (whom we will call SG) is a partnered woman in her late 30s with a lengthy history of posttraumatic stress disorder (PTSD). Specific details of her story have been changed to protect her identity. This case is being shared with her permission.

SG presented to the practice of one of us (AP) at the suggestion of a psychotherapist colleague who was working with her on Seeking Safety–based trauma skills (Najavits 2001) and exposure therapy for her chronic PTSD. The consultation question was whether medications might help SG's long-standing chronic PTSD.

SG had a history of sexual abuse from early childhood until early adolescence by a caregiver, with the abuse occurring in the context of willful neglect of this abuse from other caregivers. For approximately 20 years she has suffered from complex PTSD with prominent symptoms of hypervigilance, associated with feeling a lack of global sense of safety in her life.

Person

History

From as early as she could recall until approximately age 13, SG was subjected to ongoing sexual abuse from a caregiver. (SG has asked that the identity role of this person be withheld.) Additionally, another caregiver who had knowledge of this ongoing abuse at the time of its occurrence failed to act to prevent it from continuing, and at a later date, this caregiver attempted to discredit SG's claims of the abuse by questioning both the veracity of the claim and SG's mental health.

SG had been in individual interpersonal therapy for over 15 years and had recently completed a PTSD skills and exposure therapy group. She had tried complementary and alternative medicine treatments, including acupuncture and meditation, without significant benefit. She had been wary of using psychotropic medication, having only taken oxazepam for many years to address anxiety and sleep. She had never been psychiatrically hospitalized and, despite experiencing episodes of significant hopelessness, had never experienced suicidal ideation. She is a college graduate and works in the field of sales and marketing. She was previously married and was in a long-term relationship at the time of the intervention.

Diagnostic Assessment

The results of SG's ongoing and complex interpersonal childhood trauma were symptoms consistent with PTSD, including hypervigilance, avoidance of relationships with other people, intrusive memories, and constricted affect. Symptoms of major depressive disorder, anxiety disorders, psychotic disorders, personality disorders, and substance use disorders were absent.

SG showed symptoms of complex PTSD (not a DSM diagnosis), evidenced by her shame and her feelings of being damaged, unworthy of happiness or to have normal human relationships. van der Kolk (1996, 2014) and others describe complex PTSD as a change in multiple domains of psychological functioning as a result of trauma, particularly in alterations in self-perception, relationships with others, systems of meanings, and states of consciousness.

Formulation

Problems

SG exhibited classic DSM-5 symptoms of chronic PTSD, including hypervigilance, avoidance, intrusive memories, and constricted affect (American Psychiatric Association 2013). She described regular experiences of feeling horror, disgust, anger, sorrow, and shame when recalling her abuse experiences. These emotions often led to physical panic experiences of tachycardia, shortness of breath, and tremor.

Therapy became an aversive experience, and at times SG avoided it to prevent the exacerbation of intolerable PTSD symptoms. She described the "adult parts" of herself as able to understand cognitive restructurings of her trauma experience, but her "child parts," without a felt sense of safety, could not trust the therapist or the therapeutic process. Her defensive structures that permitted her to survive the abuse also prevented her from being able to feel vulnerable in therapy and therefore limited her ability to progress in treatment. This lack of progress in therapy added to a growing hopelessness that she would ever respond to treatment. Increasingly, she felt numb and removed not only from her experiences of the past but also from her ability to be present and feel a full range of emotions, including joy, in the present moment. She struggled with and found painful this inability to feel a full range of emotions. In her relationships, she felt self-loathing and unworthy of love.

Most concerning to SG was her growing hopelessness that she would ever recover from her experience and heal from her PTSD. Later, after completing the MDMA study, she admitted that she had been slowly losing hope and felt increasingly despairing that she would never improve.

Strengths

SG came to the MDMA-assisted psychotherapy trial with multiple strengths, the most significant being the absence of other significant psychopathology,

personality disorder, or substance use disorders. She had a supportive long-term partner and had avoided the disruption of relationships often seen in people who survive long-standing childhood sexual abuse. She appeared to have excellent self-awareness, ability to tolerate emotional distress, and ability to self-regulate intense emotional states. She was also functional in her day-to-day life and had been able to maintain employment steadily through her adult life and, as a result, was able to provide for her own material needs. SG also came into treatment with superior verbal and written communication skills and a native intelligence for narrative therapy, which allowed her to express a largely ineffable experience of psychedelic experiences in the form of a complex but clearly meaningful narrative, described below (see "Interventions").

Interventions

SG enrolled in the Colorado site of the Multidisciplinary Association for Psychedelic Studies (MAPS)–sponsored study of MDMA-assisted therapy for PTSD (Clinical Trials Registry No. NCT01793610), of which coauthor MOG is the principal investigator. In this Phase II pilot study, qualified patients were randomly assigned to receive preparatory psychotherapy with two study psychotherapists before receiving either 125 mg of MDMA, 100 mg of MDMA, or a 40-mg comparator dose of MDMA (a dose generally considered too low to have any therapeutic effect, therefore serving as an "active placebo") in a randomized, double-blind design. Subjects who remained within cardiovascular parameters following MDMA administration were offered a second "booster" dose 1.5 hours after the initial dose at a quantity of 50% of the first dose. This psychotherapy + MDMA intervention was repeated within 3–5 weeks of the first session at the same dose as in the first session. After the second session, the blind was broken and participants who received either 125 or 100 mg of MDMA were offered a third, open-label session with the same dose of MDMA used in the first and second sessions. Participants who received the 40-mg comparator dose were offered open-label treatment with a randomized dose of either 100 or 125 mg of MDMA with psychotherapy. SG was randomly assigned to the 125 mg of MDMA study arm and underwent three sessions at this dose, with the third session dose known to the patient and the study clinicians, per the open-label design.

The study's primary outcome measure was change in the Clinician-Administered PTSD Scale (CAPS) score, which was administered at baseline and 1 month after the second MDMA-assisted psychotherapy session. Additional outcome measures are described on the study's Web site (https://clinicaltrials.gov).

Why This Is a Positive Intervention

Positive psychiatry, with its emphasis on optimism, agency, autonomy, and hope, is well suited to help explain the psychotherapeutic benefits of MDMA-assisted psychotherapy for PTSD. This treatment for PTSD represents an extension of psychedelic-assisted psychotherapy models that were first pioneered in the 1950s in both Europe and North America by clinicians such as Stanislav Grof, Humphry Osmond, and Ronald Sandison, among others (Sessa 2013). As substances such as LSD (lysergic acid diethylamide) became diverted to the youth counterculture of the 1960s, a backlash resulted, leading to the Controlled Substances Act (CSA) of 1970, which was signed by President Richard Nixon. According to the CSA, Schedule I substances, including psychedelic compounds, are defined as having "no accepted medical use, a lack of acceptable safety for the use of the drug under medical supervision, and a high potential for abuse" (U.S. Food and Drug Administration 1970). This designation made conducting serious research on these substances impossible. When the National Institute of Mental Health–funded Maryland Research Center in Spring Grove, Maryland, ceased research on psilocybin in 1977, a period of nearly 30 years began during which no research was done on psychedelic-assisted psychotherapy in the United States (Richards 2016).

After this government-mandated interregnum, MDMA-assisted psychotherapy for PTSD began in 1996 with preliminary work published by Grob et al. (1996) and was followed up in 2000 with a study conducted by Michael and Annie Mithoefer in Charleston, South Carolina. Their work, published in 2011 (Mithoefer et al. 2011), showed that 83% of subjects treated with MDMA-assisted psychotherapy no longer had symptoms that met criteria for a PTSD diagnosis, compared with 25% of the subjects who received placebo treatment with psychotherapy. SG was a subject in an additional Phase II investigation into this treatment model, described in detail in the MAPS study treatment manual (Mithoefer 2013).

As with MDMA-assisted psychotherapy in general, the study in which SG participated administered MDMA for only a limited number of sessions. There was a total of 12 manualized psychotherapy sessions. MDMA was administered in only 3 of the 12 sessions.

Several putative neurobiological mechanisms have been identified by which MDMA may reduce PTSD symptoms following treatment. MDMA has been reported to attenuate amygdala responses to pictures of fearful or angry faces (Bedi et al. 2009) and/or reduce the connectivity between the amygdala and the left anterior temporal cortex when subjects are hearing their own narrative story of negative life events (Carhart-Harris et al. 2014).

This modulation of fear responses may facilitate the effectiveness of exposure therapy, which is a primary modality for the treatment of PTSD. Edna Foa (2011) describes exposure therapy, in which the person with PTSD is exposed to in vivo or in vitro cues of the trauma experience so that the anxiety response can be repeatedly elicited, eventually leading to an extinction of the pairing of cue and response. For this extinction to occur, the patient must be neither overwhelmed and flooded with the emotional response to the traumatic stimuli nor understimulated or disassociated by the exposure to the traumatic stimuli. The goal is an "optimum arousal zone," which allows the patient enough exposure to the feared stimuli to fully elicit the distress response, but not so much that the patient disengages or disassociates from exposure to the traumatic stimuli. It appears that MDMA, possibly via effects on the amygdala and related limbic structures, may help to reduce this neurological expression of fear and permit a freer exploration of traumatic memories that were previously aversive, with the result that patients reorganize a previously disorganized and distressing narrative into what has been called a "coherent narrative" of life events (Siegel 2015). If the narrative can change to become more coherent and less distressing, it is understandable how this might reduce the symptoms of PTSD.

Process of the Treatment: Sequence of Interventions and Assessment of Responses

Despite SG's wariness regarding the use of psychotropic medicines, she sought consultation in hopes of learning more about potential medication treatments for PTSD. We discussed, at length, standard treatments such as selective serotonin reuptake inhibitors and α- and β-noradrenergic antagonist medications. In response, she expressed apprehension about using daily medication. She asked if there were any new treatments being studied. She was informed about ongoing Phase II research on MDMA-assisted treatment of PTSD.

She was interested in knowing more and asked about the more common name of this drug. When we explained that MDMA is often called "ecstasy," she recalled a time in her early 20s when the memories of her childhood abuse were beginning to surface. At that time she had a boyfriend with whom she had taken ecstasy on several occasions (she stated that this was out of character for her, and she had not taken this or other psychedelic drugs since). When asked to recall what that experience was like for her, she replied, without hesitation, "It was the first time in my life I ever remember feeling safe. I see why it could be useful in therapy."

She asked if she could receive MDMA treatment from one of us (ADP) and was told that because it is a Schedule I drug, it could only be delivered in research settings. She asked for information about the trials and was provided with the Web site for ClinicalTrials.gov (https://clinicaltrials.gov) and the Web site of the sponsoring organization, MAPS (http://maps.org). On her own initiative, she then began to pursue enrollment in one of these trials, which was difficult because there was more demand than supply for this experimental treatment.

After 8 months, SG was enrolled as a subject in a Phase II trial with one of us (MOG) and the therapy team in Boulder, Colorado. This required her to make trips every 2–3 weeks over the next 3 months from California to Colorado.

Screening and assessment were completed using the CAPS, the Structured Clinical Interview for DSM-IV Axis I Disorders, Clinician Version (SCID-I; First et al. 1994), and the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First et al. 1997). SG's CAPS score at baseline was 108, indicating a significant burden of PTSD symptoms.

It is important to note that this treatment protocol is a psychotherapeutic one, enhanced by the use of MDMA as a catalyst to the healing process. MDMA serves to enhance the therapeutic process but is not therapeutic in isolation. Therefore, it is crucial to underscore the importance of the therapeutic relationship in psychedelic-assisted psychotherapy.

SG began meeting with her study therapists, a male-female dyad, who would work with her in preparing for the sessions, would sit with her for the duration of each session, and would do integrative psychotherapy in the days and weeks following the MDMA-assisted psychotherapy. She met with them three times, for 90 minutes each, before the first MDMA session to develop a therapeutic container, help them understand her history, and develop the expectations and trust needed to allow the therapeutic process to continue safely. As part of the preparation for the MDMA therapy sessions, there is intentional discussion about therapeutic use of touch during the session. Appropriate therapeutic, consensual, nonsexual touch, such as holding the hand of the therapist, can be a critical component of the therapy process. Many people with PTSD, especially those who have endured early childhood abuse, have not experienced healthy touch and can find the experience of appropriate physical contact to be therapeutic. Any physical contact between the patient and the therapist is always under the control of the patient, and any request to cease contact would be immediately honored. Additionally, the presence of a male-female dyad and the videotaping of all sessions provide additional security to both the patient and the therapists.

It is important to note that when compared with classical tryptamine psychedelic drugs such as LSD or psilocybin, the phenethylamine MDMA is typically less likely to cause visual hallucinations. Nonetheless, SG described her experience with MDMA-assisted psychotherapy as intensely narrative and richly symbolic, and it is that account which she shared with one of us

(ADP) in integrating the experience of the therapy at the completion of the clinical trial. At that time, she met with ADP for seven additional sessions to discuss and integrate her experiences in the study, which are described below. The phantasmagorical images she described can be seen as both a literal revisiting of events of childhood and a working-through of psychological themes expressed metaphorically.

MDMA SESSION 1

SG spent the night before her first MDMA-assisted psychotherapy session in a hotel. That night, while meditating on the upcoming events of the next day, she experienced a vision of herself as a fetus before birth, untouched by the abuse that she would experience in her childhood. She called this her "original self" and returned to this image repeatedly throughout the treatment sequence that followed over the succeeding 3 months.

The next morning, she reported to the study clinic. The therapy setting was a comfortable, living-room type of environment with a couch. Eyeshades and relaxing music via headphones were provided to reduce outside stimuli and allow her to direct her attention inward. She was given a capsule and then a booster 1.5 hours after the initial capsule. After the blind was broken, she and the researchers learned that the initial capsule and the booster contained 125 mg and 62.5 mg of MDMA, respectively. She reported that the first session commenced with some difficulty, as she experienced a sense of terror and became tremulous. She later realized that she was beginning to re-experience the felt sense of violation and fear that she had felt as a child. Usually a reserved person, she began to feel self-conscious about being vulnerable in front of the study therapists.

She experienced a vision of a massive black hole, a void, which came to represent the space and time in which her sexual abuse occurred. As a result of the psychedelic-induced perspective shifting, she was able to visualize herself as being inside the hole, looking up to the light and also looking down into the darkness within the hole.

Despite SG's self-conscious feeling of vulnerability in front of the therapists, the psychotherapy sessions she underwent before the MDMA session had provided her with a felt sense of nascent trust that allowed her to think that she might be able to heal herself through connection with other people. She recalled having the thought "I might be able to get out [from her past and her PTSD]," which she described as "the first deeply felt sense of hope I had experienced in my life."

As her perspective shifted, SG found herself sitting on the edge of this abyss, looking down into the hole. She saw a little girl, whom she would later recognize as a younger version of herself, approach her adult, first-person self. She watched the young child sit down next to her. The little girl suggested, "Why don't we look up at the sky?" SG described this experience as being "shown the way out…by my authentic self." This younger version of herself was to become a guide, a Virgil to her Dante, as she transited through the experiences occasioned in the MDMA-assisted psychotherapy.

Later in this first session, she saw a brilliant, bright blue light shining from the top of a pole and saw a suit of armor made of shining white metal. She felt that the light and the suit of armor represented both omniscience and "total protection," both of which were capable of keeping her out of harm's way as she proceeded through the next sessions.

Following the session, she wrote in her journal, "Your right to know what [safety] is like, to be in the world and not be cowering and to be safe. Believe in this. This is your right."

She later stated that after the first session ended, she had about 10 days with no symptoms of PTSD, and although this feeling faded after about 2 weeks, she was left with a residual knowledge that such a feeling was possible, and she told herself that it was important that she "[remember] this, so I don't forget," a kind of touchstone of possibility that she returned to frequently in the ensuing weeks of treatment.

BETWEEN MDMA SESSIONS 1 AND 2

Following the first MDMA session, SG stayed overnight at the clinic and was attended to by an overnight monitor. In the 3 weeks between the first and second sessions, she had several experiences of clinical importance. The first experience was a dream in which she was with the same little girl who had appeared at the edge of the abyss in the first session. As she and the girl were flying over a dark body of water that evoked, for her, the blackness of the abyss in the first session, she had the thought "I might be going in there [the dark water]," but she did not feel fear or apprehension.

Later, she spoke to her study psychotherapist about the parts of herself that she had to detach from as a child during her years of abuse. She was using the metaphor of shells that sea creatures discard, and that later wash up on the beach, as representing defenses of tender parts of her psyche that were wounded during the abuse. She realized that to defend herself, she had had to distance herself from normal parts of childhood, such as a sense of wonder or an intrinsic sense of being safe, and that she had felt alienated from those parts of herself for many years.

She also recalled that during the MDMA session, she experienced the felt sense that she had lived with while being abused as a child. She stated, "MDMA took me to the fear, the horror. It mirrored the same sense I had as a child, the same fear and horror. [MDMA] was not warm and fun."

At a later session with the study therapist during which she was discussing how trauma treatment challenges the long-standing defenses she had held

since childhood, she had a daydream of a piñata surrounded by younger iterations of herself at ages 2, 6, and 9 years, and imagined the study therapist tossing her a stick that she used to break open the piñata, which contained what she described as "insights."

In another psychotherapy session, she was exploring how as a child she had to believe the distortions of her abuser because she was dependent on that person. She discussed how later in life, when she began to tell others about the abuse she suffered as a child, the abuser raised questions of her credibility by saying that she was severely mentally ill. She thought, "What if I don't believe their lies anymore?" and felt that she had begun the process of "liberating myself from the abuser's story."

MDMA SESSION 2

SG reported that she went into the second MDMA-assisted psychotherapy session (again, a blinded dose that was later revealed to be 125 mg followed by a 62.5-mg booster dose 1.5 hours later) with a sense of apprehension and doubt, thinking, "I'm crazy, I'm wasting their time." This feeling of dysphoria and anxiety persisted as the drug began to take effect. She felt regressed to being 5 years old and felt as if she were hiding under the bedsheets. She stated that she felt physically uncomfortable, wanting to get off the study couch and to take off the eyeshades that were used to screen out unnecessary visual stimuli. She felt a certain degree of fear of the study therapists, which she later realized was part of her historical PTSD response but unwarranted by the current circumstances. She wanted to leave the room but knew this was not allowed under the study protocol. She had considerable apprehension about taking the booster dose of MDMA at 1.5 hours. She realized that if she took the optional dose, there was "no going back."

SG began to reframe her abuse in her mind as something she had survived, and to realize that she was making a conscious choice to return to recalling the trauma. She remarked, "It was like walking back into hell. I would see my younger self, who would run away from me saying, 'I don't trust you. You [adult self] left me here in this hell. You never listened to me; you left me here in this house.'" She decided to take the second dose as a way of intentionally choosing to go back into the trauma memories. She later remarked, "I've had to become an amazing parent to myself. My fear, my anxiety, my insomnia made sense, became perfectly congruent.... In trauma, nothing feels safe. You don't know why you feel anxious. I was getting all my parts back."

Later in the second MDMA session, SG imagined herself back in the house of her childhood where her abuse took place. She found an old key that she intuitively knew "unlocked" the past story. She described the experience as retuning to and reexperiencing her childhood home and engaging with the younger version of herself that was locked in the house as she was being abused. She felt compelled to free her from the house, but said that when she found the young child version of herself, the child was wary and did not trust her.

Regaining the trust of this "inner child" who had experienced abandonment in the midst of the abuse became a critical theme of the second MDMA session. Despite the fear that she experienced earlier in the session, SG stated that she made a conscious decision, which she expressed to one of the therapists, that she wanted to keep going more deeply into her trauma material.

She felt that she could transfer the wisdom and knowledge that she had gained about her abuse and about trauma to the younger version of herself, and by doing so, she hoped she would feel connected to that younger part of herself. A scene occurred in which the adult and child parts of herself reconciled, and the younger version of herself was able to give voice to feeling abandoned and left in a harmful environment. In response, the adult version of herself was able to acknowledge the pain that this abandonment had caused her. She described that she and her younger child self felt liberated and joyful after this reconciliation.

From this point onward, the younger version of herself became a frequent companion to the first-person adult during the MDMA sessions. This was not a psychotic or dissociative phenomenon, because SG was well aware that this person represented a younger version of herself from whom she had become estranged during her abuse and in later years. The reconciliation between this younger, wounded part of herself and her current adult self was to become a recurring and important theme in the therapy.

After this reconciliation, SG found herself with her younger self in a variant of her childhood bedroom, except there were no doors. She was holding a mirror that reflected an image of the people who had abused her. She realized in that moment that she was not going to get an apology from them, and that she now had the courage to look at the truth of what had occurred when she was a child.

She then saw her younger self in a scene of sexual abuse. She remembered feeling the physical sensation of being violated. She recalled a sense of disaffection, thinking how routine the abuse had become, but also recalled thinking as a child, "This is all I'm good for." But in the MDMA psychotherapy session, she questioned that assumption and had the spontaneous thought that "I know I'm worth more."

The second MDMA session came to a close, and again SG stayed at the clinic with an overnight safety monitor. As she was getting ready for bed, she had a spontaneous memory of being about 8 years old and contemplating committing suicide in a violent and gory manner to communicate to her abusers how much pain she was in, and how enraged she was at being abused. The next morning, she went on a hike; thinking about the choice not to end her

life as a child, she felt gratitude that she had lived, and she honored the younger part of herself that chose not to act on the suicidal impulse that she had felt many years before.

BETWEEN MDMA SESSIONS 2 AND 3

Between the second and third sessions, SG recalled a dream in which she was inside an empty sea cave when a massive wave entered the cave and battered her against the stone in darkness. She awoke thinking, "What has this therapy done to me? Maybe the enormity of this is too much for me." She discussed this with one of the study therapists, who reassured her that she would be okay. She found this reassurance to be very powerful, stating, "She had faith in me, even when I didn't have it in myself."

Additionally, in the therapy sessions between MDMA sessions 2 and 3, SG began to develop a greater sense of trust in her own recollection of events from childhood, something that had always been difficult for her after her veracity had been questioned in the past.

She discussed how the therapy sessions helped her to integrate her feelings about her life at a younger age with how she saw her life now. She experienced grief at the memory of what she now considered "self-betrayal"—for example, when she used alcohol (in the past) and anxiolytic medication to avoid "all the things I couldn't handle or address." She stated that when she was younger, she felt that "when I left home, I was never going home again, but with MDMA [therapy], I went home again. I wish I could have done this when I was younger, before I had amassed negative experiences, failures, and negative self-beliefs."

MDMA SESSION 3

SG arrived at the third session with confidence, stating, "I arrived as my adult self. Something amazing happened. I knew how to do the work of healing. I grew. I was present as an adult for the first time, and I was ready. The little girl was ready to go with me. We went in as a team, and I didn't know what to expect, but I knew I could handle it." She went on to say that she expected to encounter traumatic material again, as she had in the first two sessions, but that this time "the old demons aren't truth anymore. I had to go in to tear them down."

For this session, SG received an open-label dose of 125 mg of MDMA without the 50% booster dose because of transient hypertension, above the study cutoff, that occurred after receipt of the initial dose. As the MDMA began to take effect, she set an intention to connect with the most wounded parts of herself. She envisioned a beautiful light and found herself drawn to it. She also knew that she needed to work with darker parts of her experience, but she realized that doing that would not diminish the metaphorical experience of light and that, in fact, the younger parts of her were an embodiment of this light.

At this point, she had a transference-type experience with the male study therapist, asking him, "Can you look at me as if I were your child, so that I know that I am cherished?" He said he could do this, and she found this experience to be healing and corrective, as she felt that she could both be cherished and have her boundaries respected. She reported, "I asked the therapists for human connection, to be held." She reported that the safe, consistent, and appropriate physical contact with the therapists allowed for the development of significant trust, which facilitated deeper exploration of her trauma.

Going forward in the session, she made a conscious decision to go back into the trauma material, and again she encountered her inner younger self, who told her, "I'm ready to take you," at which point she found herself descending into the earth in a cage. She described this as being "like I was going thousands of feet [down] within myself." She instructed the younger part of herself to stay "aboveground" where she would be safe.

When this descent stopped, she found herself alone, outside a massive cage, some 40 feet tall, with bars as thick as trees. She noticed an opening between the bars and decided to enter. It was very dark inside. Inside the cage, she saw spheres, like cannonballs, arranged in circles on the ground. Once she was in the middle of the cage, multiple images of her abuser arose from the spheres like holograms. He was naked and omnipresent. She felt surrounded and trapped. She quickly left the cage, feeling terrified.

She opened her eyes and told one of the therapists what she had seen. The therapist asked her, "What can you bring into the cage?" She recalled the light that she'd evoked in meditation at the start of the session and decided to bring it into the cage. She said, "Okay, I'm going back in there. I'm going to bring this radiant light back in there. It's not so scary. I have light, power, and truth. I'm out of the shadows."

She reentered the cage, this time bearing a bright light, and again saw the figure of her abuser inside the cage. This time, the multiplicity of images of him had been replaced with only one figure, and he was naked, afraid, and ashamed, running away from her to the dark corner of the cage, away into the darkness. She thought, "I see you for who you are." She later described in an integrative psychotherapy session the thought that "the shame I have been carrying my whole life is not my shame. It's his shame, and I don't have to carry it anymore." She credited MDMA with her ability to tolerate the shame that she usually felt when thinking about her abuse and to have more options with which to interpret the experiences of her childhood.

With the abuser figure now gone, she lifted up one of the spheres that littered the floor of the cage. Although it was heavy, she was able to throw it on the ground, where it cracked into two perfect hemispheres. She described the

interior of one of the spheres as having a bucolic scene of a meadow full of flowers. The other half contained a violent memory of her childhood abuse, with all the attendant emotions of pain, fear, and horror. She felt like she had a choice about where to direct her attention. She felt like she had the courage, because of the MDMA, to enter the scene of abuse and to comfort her younger self and reassure her that she would be okay. She then experienced a compassionate distance from the experience and the suffering she experienced.

After this scene, she found herself descending through the earth again, with the younger part of herself having rejoined her at her side. She emerged in a large, ornate, gilded ballroom that was brightly lit and beautiful. She and the younger part of herself twirled, back to back, around the dance floor. She described feeling a sense of wonder and awe at the spaciousness and the decor. She noticed that there were spheres, similar to those in the cage, on the floor, but they were not just black; there were both colorful spheres and black spheres. She realized that the spheres represented different memories in her life, and although the black memories (of trauma) still existed, they were now contextualized in the whole of her life. In an integration psychotherapy session, she later remarked, "More memories will surface, and that will be okay."

Later, after the MDMA session was complete and she was contemplating these images, SG began to think about suffering, and about her self-identity as a damaged, unwanted, uncared-for survivor of sexual abuse. She summarized this reframing of her experience by saying, "These things happened to me, but they are not who I am." She began to realize that for the first time in her life, she could assume that her current life had a reasonable margin of safety rather than assume the world was always dangerous.

SG discussed with one of us (ADP) how the treatment had changed her symptoms of PTSD. She discussed her lifelong recurrent nightmares of being hurt in bed, where most of the abuse had occurred. She stated, "Lifelong insomnia was the most debilitating part of my PTSD, but I'm not afraid to go to sleep now." SG also discussed how she left the treatment study with a changed outlook, characterized by a deeply embodied sense of hope. She remarked, "It's not something you talk about. It's something you feel."

Therapeutic Relationship

The relationship between therapist and client is unique in MDMA-assisted psychotherapy. In the case of SG, the experiences occasioned by MDMA provided safety and trust in the self early on in the treatment. In general, as clients experience themselves less defensively and with greater acceptance, their sense of wholeness emerges and genuine connection is possible. When an authentic self emerges, there is room for truth and compassion for all parts of the self, creating fertile ground for healing to take place.

The therapist's responsibility in the alliance is to be authentically present without the need to "do" something. A mindset that has been characterized as "beginner's mind" (Suzuki 1970) is an essential component, because it allows for curiosity and a nonjudgmental stance that brings spaciousness and safety to the container being developed. The therapist's role is not to "give" something to the client but to be engaged in the act of empathic attunement. Empathy grows out of the desire to fully understand the client and becomes a potential antidote to the shame clients often feel and are weighed down by. As a witness, the therapist is affected by the client's experience and also feels his or her own self-empathy.

Interweaving of Traditional Psychiatric Interventions With Positive Interventions

Traditional psychotherapeutic approaches to help patients afflicted by trauma seek to reduce their maladaptive responses to internal and external trauma cues (e.g., hypervigilance, avoidance, withdrawal) and to return patients to a kind of autonomic homeostasis when presented with reminders of the trauma. One example of this type of approach is prolonged exposure, an evidence-based behavioral therapy that seeks to overcome avoidance of trauma cues, which is common for patients with PTSD, by repeated and controlled exposure to memories and reminders of the traumatic event(s). Eye movement desensitization and reprocessing (EMDR) derives from a similar therapeutic model and adds bilateral stimulation of the brain through alternating, lateralized visual, auditory, or tactile stimuli that are used while the patient is recalling traumatic memories. Although effective, both therapies are often difficult for patients to tolerate, and the dropout rate is high. It is clear that although both of these modalities have contributed greatly to the treatment of PTSD, additional, more tolerable methods are needed.

MDMA-assisted psychotherapy utilizes an eclectic methodology (Mitheofer 2013) that includes aspects of exposure therapy, internal family systems therapy, cognitive-behavioral therapy, narrative therapy, Holotropic Breathwork (a means of generating and working with non-drug-induced nonordinary states of consciousness developed by Grof and Grof (2010), and somatic-based therapy modalities such as Somatic Experiencing (Levine 2010) and Hakomi therapy (a mindfulness-based, somatically organized psychotherapy model) (Kurtz 2007). Because the therapy involves far more than merely administering the drug, it is clear that the therapeutic relationship established at the onset, continued through the MDMA psychotherapy sessions, and enduring through the integration of the treatment, is a critical aspect of the psychotherapy.

An important premise of MDMA-assisted psychotherapy is that the client is the expert and already holds the capacity needed for healing and the heal-

ing takes place not by getting rid of something, but rather by making room for the inner, innate healing intelligence to emerge. Therapists bring into the room their own resources and preferred therapeutic modalities but hold these lightly, suspending agendas and remaining conscious that their interventions are in the service of supporting awareness and must not impede the patient's present-moment experience.

Therapeutic skills are used to clarify when there is confusion or the client is stuck and to solidify integration. Therapeutic theories complement the process of the patient but are not the centerpiece of the work. MDMA provides a grounding field in which the client is able to experience a sense of connection between mind, body, and spirit in the present moment, which allows for integration to take place through the senses in a nonlinear manner. The therapist's role is to follow and to be a witness to the unfolding process.

Therapeutic modalities that support this process are those that focus on the body as an agent of truth since the body becomes the guide and informs movement. Therapies that work with transpersonal experiences as a way of understanding connection to self and other are also useful. MDMA facilitates experiences in which the client can hold several perspectives at the same time and can often experience the self and the observer simultaneously.

Therapies, such as internal family systems (Schwartz 1997), that focus on bringing awareness to "parts" of the self are helpful, given that marginalized aspects of the self emerge naturally during MDMA therapy. When this occurs, the experience typically promotes a sense of permission from protective parts of the self to explore wounded parts that have previously not been given a voice. This capacity for integrating representations of oneself from an earlier age was also noted in a qualitative study of participants in a psilocybin-assisted psychotherapy protocol for patients with life-threatening illnesses (Belser et al. 2017).

Attachment themes often emerge. With a male-female dual-therapist model, the therapists hold different transferential roles during the session and are often secure attachment figures available to the patient for contact and bonding. Consistent with this, the working-through of transferential material appears to have been a critical part of the improvement experienced by SG as a result of the treatment.

In their seminal article on positive psychology, Seligman and Csikszentmihalyi (2000) emphasize the importance to positive psychology of realistic, even stoic, optimism, based in autonomy and self-determination. As SG transited through her treatment, her optimism grew from a vague hope that things could improve to a confidence that despite her past trauma she would be able to live a fulfilling life. Because of this, her healing came not from forgetting the trauma she had experienced, but rather from learning to maintain a dispassionate yet self-compassionate stance toward her own experience. She states that she now has a different relationship with trauma-related symptoms, such as anxiety, and is more able to sit with the distress created by the emotion, and feels less compelled to run from the feeling. She stated in a later interview, "I have happiness. I have love. I also have anxiety. It's just okay. I listen to all of me."

Posttraumatic growth, defined as wisdom and meaning emerging out of traumatic experiences, has been discussed extensively among advocates of positive psychology (Calhoun and Tedeschi 1998) and existential psychotherapy (Frankl 1946). Such growth emphasizes changing the valence of a traumatic event from one of victimization without agency toward one of perspective and growth despite adversity. Certainly, the perspective that SG gained through her MDMA-assisted psychotherapy is an example of such growth. Ongoing Phase II MDMA-assisted PTSD therapy studies are using the Posttraumatic Growth Inventory as a secondary outcome measure (Mitheofer 2013).

Outcome

How the Treatment Ended

SG's experimental treatment ended after completion of the integration sessions that followed the third MDMA psychotherapy study session. Psychometric measurements were completed at the end of the treatment. Her CAPS score had dropped from 108 prior to treatment to 51 at the end of the study. A CAPS score of ≥50 indicates moderate to severe PTSD, and a drop of ≥ 30% is considered a clinical response (Mithoefer et al. 2011).

SG returned from Colorado and resumed psychotherapy with one of us (ADP) in California. She reported feeling significantly better and deeply grateful for the treatment. She and ADP discussed what she felt she needed going forward. She asked for additional opportunities to discuss her experiences and process the MDMA treatment sessions and integration. She and ADP met for about 12 hours over the course of seven sessions. She stated that she wished she could draw some of the images she had seen during the MDMA sessions but that her artistic skills were limited. One of the study staff suggested she use Google Image Search to find approximations of what she saw during the therapy sessions. She used the images she found to make approximately 75 storyboard cards that she used in integrating the sessions. She stated that the process of making the cards helped her to organize her experiences and to create a cohesive narrative of her story, which was additionally therapeutic.

Symptoms and Positive Experiences, Strengths, and Satisfaction

A year after the treatment, SG continued to be clinically free of PTSD. Her CAPS score continued to drop in that ensuing year, from 51 at study endpoint to 26 at 1-year follow-up. She continued to use hypnotic medication about 5–8 nights per month but takes no other psychotropic medications. She has not used MDMA again and has no interest in using it outside a therapeutic environment. In later interviews, she described the MDMA psychotherapy process as a kind of "inverted PTSD" in that by reversing the slow accretion of childhood trauma that led to the burden of PTSD symptoms, this therapy slowly allowed her to increase her feelings of safety and thereby unburdened her from the symptoms of PTSD.

She has been able to make changes in her work and personal relationships that required her to make some difficult decisions. She feels that she has been able to end relationships that were no longer working for her and to act more decisively in her own best interests. She reports, "I often feel a deep, heartfelt sense of joy for simply being alive and fully present in the moment." She has been more able to utilize therapy and meditation to further advance her healing. She reports feeling more connected with the important people in her life.

She is deeply appreciative of having been included in the study. Because of the high media profile of the experimental treatment, she has been approached to speak about her experiences publicly at conferences or in media interviews. She has thus far declined these invitations, but she has permitted us to share her story in professional and educational settings, because she feels it is important that the community of mental health clinicians know about the potential benefits of this treatment protocol.

Assessment of the Patient's Progress and Response

In our clinical opinion, SG has markedly improved as a result of her MDMA-assisted psychotherapy treatment. Her symptoms of PTSD remain largely absent. Her use of psychotropic medication is minimal. She has improved her functioning in both interpersonal and occupational spheres. She told about asking for a raise at work, recalling the time in the treatment where she realized she was worth much more than just being the victim of abuse; this realization had bolstered her confidence. These gains have persisted for more than 1 year after her last MDMA-assisted psychotherapy session.

Why the Positive Intervention Mattered

The experience of long-standing trauma, especially early in life, not only creates the symptom cluster of hypervigilance, avoidance, reexperiencing, and mood disruption that is categorized as PTSD, but also often deeply damages the sense of self and the narrative of how one came to be an adult. The experience of trauma becomes central to the sense of self. Qualities deeply valued by positive psychology, such as optimism and autonomy, are often profoundly impacted. The clinically supervised and time-limited use of MDMA that occurs within a psychotherapeutic relationship may allow for a rewriting of the trauma narrative through the eyes of the adult in a way that promotes a deeply held sense of mastery over one's experience. Trauma memories, no longer central, can now share space with experiences of the current, adult self. The enhancement that MDMA provides to the psychotherapeutic relationship has the potential to allow for a felt sense of trust. For SG, MDMA-assisted psychotherapy allowed her to have for the first time a deeply felt experience of safety, upon which she was able to build a foundation for additional healing and growth.

TAKE-HOME POINTS

- Studies to date suggest that 3,4-methylenedioxymethamphetamine (MDMA)–assisted psychotherapy is a safe and effective treatment modality for posttraumatic stress disorder (PTSD).
- MDMA-assisted psychotherapy for PTSD allows those who have experienced trauma to explore their experience in a safe therapeutic setting.
- Posttraumatic growth, a key concept in positive psychology, is a likely outcome of MDMA-assisted psychotherapy for PTSD.
- The cautious and controlled use of MDMA-assisted psychotherapy for PTSD may allow people who have experienced trauma to revise their narrative of the traumatic experience in a way that renders them in control of their experience, rather than as the victim of circumstance.

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Keri-Leigh Cassidy, M.D., FRCPC, Professor, Department of Psychiatry, Dalhousie University; Clinical Academic Director, Geriatric Psychiatry/Seniors' Mental Health Program; Founder, Fountain of Health Initiative of Optimal Aging

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