Testimony of Philip E. Wolfson, M.D.

I am testifying out of my concern for the proposed scheduling of MDMA in a Schedule I category by the DEA. Having used MDMA clinically in cases of severe emotional distress where prognosis was poor and having seen its positive effects, I am extremely concerned that this promising new psychotherapeutic agent will be lost to the medical profession. My experience indicates that MDMA is relatively free of hazard in the short period of follow-up that I have had with my patients, has a low abuse potential, and appears to me to be efficacious in the treatment of a variety of psychiatric disorders, including psychosis. I have used MDMA in a family setting, having administered the substance after preparing it myself, with an elaborate informed consent procedure, plus discussion with other physicians. This has been my first and only clinical use of an agent not in the pharmacopia.

I am graduate of New York University School of Medicine - 1968. For the past 14 years I have practiced psychiatry full time in both private and public settings. My resume is included with this testimony. For many years I have worked with individuals and families experiencing a psychotic crisis. For two and one-half years I ran an alternative psychiatric inpatient unit for Contra Costa County, which was family centered and used little or no medication in dealing with people going through a madness experience. My own experience with psychoactive agents is

vast, and I employ them frequently in my practice. I have also done a great deal of medical-legal work, including malpractice reviews. I am currently on staff at Sequoia Hospital in Redwood City and am awaiting a faculty appointment at the University of California-San Francisco School of Medicine, where I teach in the Psychiatric Aspects of Medical Practice Program.

I have used MDMA with three different families. In two there was a psychotic member, and in one there was an individual recovering from a psychotic depression. In all three cases I have been the second treating psychiatrist, and prior diagnoses had been made either in an inpatient setting where the first two gentlemen were diagnosed as schizophrenic, or by an independent psychiatrist treating for a year prior to my entry into the case where the diagnosis was major depression with congruent psychotic features. Thus there is an independent statement in each case of severity, prognosis, and diagnosis. Also, with each of these individuals my use of MDMA came after a significant period of treatment with psychotherapy and psychoactive agents. In the cases of the two psychotic men, ages 19 and 26, treatment was with lithium and navane, and in the case of the 37-year old woman, treatment was with anti-depressants, then anxiolytic agents used as needed. With respect to the two men in psychotic crises, MDMA was used when other measures had failed over a substantial period of time to alleviate symptomologies significantly. Suicidal ideation and the

possibility of an overt suicide attempt was present in both cases and growing. MDMA was used with the informed consent of members of the family and their participation using the substance with their children and siblings. Family members in both cases had never had experience with a psychoactive substance in the past, whereas the three subjects had degrees of such experience, especially use of marijuana. The 19-year old male had significant episodes of LSD usage beginning at age 13, as well as "speed" and a variety of other agents.

In the case of the 37-year old woman, who was much more in touch with reality than the other two subjects, there was an immediate burst of insight and a working-through of some of the substantial blocks to her resumption of functionality and of a significant lifting of her depression. Her two sessions were conducted with her sister who had been of major support to her in her recuperation from depression. There has been a long-term benefit from these sessions in terms of a view of herself as more open and free of depression (having had this experience within the period of MDMA's pharmacological action).

The first male with whom I used the medication was in a state of suicidal despair with both depressive and manic elements vying for control. Delusions, persecutory hallucinations, and a profound paranoia as well as homophobia characterized his attitude. Negativism and self-despair characterized much of his experience of self. Truly

fearful for his safety, and seeing him move towards a chronic way of life (this following two hospitalizations, the first having lasted some three months at another facility than the one with which I am connected and with another doctor), I suggested the possibility to the father and patient of doing an MDMA session with me. Remarkably, the brother and sister of the patient also came, and the family as a whole ingested the substance with the patient. Over the year that I had been working with the patient, we had conducted multiple family sessions. Inasmuch as this is a family that has been fractured into many subsets with multiple divorces by both parents, the inability of the family to cohere has been a major drawback to treatment. The MDMA session united the family at least temporarily and provided a context in which the patient could view himself slightly on the positive side and absorb some of the love and intimacy offered to him. Heretofore, he had rejected much of this, feeling unworthy or angry at those offering it. There was a brief afterglow lasting some two to three days. There was some beginning questioning of his psychotic frame of reference after the first session. This was enough to encourage my continuation. Incidentally, lithium and navane were suspended for 24 hours prior to use of the substance, and reinstituted at the same dosages afterwords. A subsequent second session several weeks later deepened the sense of positive self-regard and established a toehold for a positive sense of self. Interaction improved thereafter.

Medication was eventually reduced and three subsequent sessions consolidated the patient's gains, resulting in a return to a higher level of function. He began working, and paranoia was markedly reduced. Social relationships that had been neglected for two years were resumed with some vigor.

The MDMA experience was not a panacea per se. This individual has little impulse control and resumed using street substances despite advice to the contrary. At a party with friends he subsequently ingested both cocaine and "speed", to the point where he resumed hallucinating and subsequently required hospitalization. This occurred some five months after the first use of MDMA, and did not appear to be at all related to the MDMA usage. Rather, it seemed to be a resumption of former behavior in a social context that he had hitherto been unable to be part of - this for two years - in which his lack of impulse control and desire to belong thrust him into activity that was beyond his capacity to handle. His psychosis is just now beginning to abate, and he is refractory to neuroleptic medications, but I remain hopeful for his future and continue to stay involved. Throughout the course of his treatment, other professionals were consulted including some people of stature working in the field of psychosis. Parents and siblings expressed a desire to repeat the experience of the MDMA session because of its benefit for themselves personally and the family as a whole. I would hope that this remains a

possibility for the future, depending on the scheduling of the substance.

The third case I wish to report is the case of a 27-year old male who I would describe as a "flagrant" borderline individual with long bouts of psychosis beginning in his 25th year. He was hospitalized at that time with symptoms of frank delusions, hallucinations, extreme paranoia, negativism, homophobia, and a fixed persecutory set of delusions centered around an entity called the "force." Of a well-to-do family, this individual was sent to some of the better institutions in this country in the family's quest for help. This man remained largely refractory to lithium, which was given to control manic elements, and to neuroleptics. I first saw him a year prior to this report under intensive family and individual treatment circumstances on an outpatient basis in San Francisco. His family took up residence in the city in order to work with me. He was extremely elusive, negative, lacking in insight, and extremely suspicious and guarded. He refused to use medication immediately after discharge from the hospital in Texas where he had been confined after having demonstrated his psychosis to the local police there. The parents had brought him by air to San Francisco and we began our work. The work was successful in allowing him to continue his travels with an increased degree of safety and a reduction in paranoia. He refused to stay put and intimacy issues were of such a nature as to preclude a positive transference

for any length of time or a positive interaction that would allow for reduction of symptoms based on increased trust. A period of re-parenting with the mother's cooperation was partially successful in re-establishing a connection that needed to be bolstered. However, he could not move from a regressed state to a more integrated ego state. I followed his activities at a distance in consultation with the parents as he used up his money and used up his options. Hospitalizations occurred along the road. Calls from doctors would arrive shortly after he left their protective umbrella. Eventually he ended up with his brother in Denver, quickly wore out his welcome by outlandish activities, and ended up voluntarily admitting himself to a state hospital after having committed some bizarre acts following their initial refusal to take him in. After several weeks of hospitalization, with his consent and his parents' consent, he and they came to California and therapy was resumed, this time with the aid of MDMA. The first session was profound in the change in this individual's sense of self. Connections of an affectional nature were made with his parents and myself and the openings of a trust experience began. For the first time in some two years he experienced a glimpse of a positive self-image and of loving feelings that did not panic him. The afterglow of this session lasted several days with intensity, but the recognition of that positive self-image has lasted permanently. A second session ten days later consolidated his sense of difference,

increased his ability to cope with the delusions that he continued to experience, and enabled him to view himself as potentially redeemable from the "ape" image that he carried of himself. We are now in the third stage of psychotherapy, there having been a hiatus of six weeks between this last experience and the start of this new work. A considerable distance needs to be traveled. Longstanding characterological issues are in the way. Manic energy and a depressive core remain apparent. Nonetheless there is a greater sense of independence, and an ability to tolerate some degree of aloneness and perceptual-cognitive changes that allow for a new experience of the world. Much remains to be done and MDMA is a vital ally in this work. This man continues on other medications which are suspended for brief periods of time when doing work with MDMA.

There are many tentative conclusions that can be drawn from this work. They are tentative inasmuch as the work has just begun. The first is that MDMA is a tool of the psychotherapist. It does not stand by itself, especially with the severely negative individual. Secondly, use in people whose judgment is compromised should -- whenever possible -- be supported by consent and participation of family members. Family therapy is always the best approach to working with people going through altered states, in that the family provides the most trusting context for any work, whether using MDMA or doing simple psychotherapy, despite differences and anger between members. Furthermore, the

family provides a context within which meaning and behavior become clear to all parties. Thirdly, there is often an immediate action with respect to MDMA's effects. However, that action, while suggestive to individuals in altered states of consciousness, is not sufficient, and generally speaking, multiple sessions are required in an overall strategic approach to working with the psychotic. It is not sufficient simply to administer the drug. Rather, ongoing therapy, verbalization of gains and insight, facilitation of communication between members, setting of limits, and providing a safe environment are essential components to the work. Fourthly, over time, it appears to me that MDMA provides a positive alternative to the dark and negative experiences of people experiencing psychotic states. Integration with reality demands and performance is necessary, and long-term psychotherapy seems imperative. I am talking about working with individuals who might otherwise be doomed to a chronic lifestyle. Fifthly, I have seen no "bad trips" and no persistent or significant side effects of the use of MDMA, now after many sessions. As reported in the clinical toxicology study that was done on prior users, there is a pressor effect of the drug, jaw clench, nystagmus, and a variety of minor autonomic side effects may occur. Thus, under medical supervision, it is my experience that MDMA is relatively hazard-free in the short term. Long-term use, obviously, has not been explored nor long-term side effects. In the study of users, some of whom had been consuming MDMA

for three years, there were no signs of significant illness or negative effects. Seventh, MDMA has a short-term but powerful anti-manic effect. In an individual experiencing a full-blown manic episode, this may only be a partial effect but may last for one-half hour to one hour providing a margin of relief and new experience. It is possible that this effect may prove of some value in the treatment of manic patients. The related effect is its anti-anxiety quality. Individuals who are extremely tense lose that tension during the course of their experience and often seem to have their anxiety rheostat set to a lower level for a significant period of time in the aftermath.

With respect to abuse potential, the three patients mentioned have requested MDMA sessions again. None of them has gone outside of my relationship to find MDMA. The formerly depressed woman has not requested a further session with MDMA after the second session which we had. The two males have asked for sessions in order to continue their experience and to enhance their sense of positive self-regard. But sessions have occurred weeks apart with a great deal of work in between and these requests do not seem to be part of a drug mediated or induced craving. In the toxicology study which I participated in as a clinician responsible for assessing neuro-behavioral effects on 22 subjects who had prior experience with the drug, use was sporadic. Almost no one reported having sessions more frequently spaced than once per-week. There appeared to be a

tapering of usage with time rather than an increase in frequency. People described experiences that seem to involve "learning" what MDMA could provide and referencing their drug experiences without need to repeat directly the use of the agent. Based on these observations, it is my impression that this is a drug with low abuse potential. Supporting this is its lack of effect when used on a frequent basis. There is no loss of its potency for side effects; however, the principal psychoactive effects diminish when frequency falls within a three to five day timeframe.

Some comments on my overall experience of MDMA. MDMA enhances social communication by reducing psychic defensiveness, and by enabling an integration of conflicting personality elements into a cohesive sense of self. It is a drug that provides a "centering" experience, rather than an ego diffusing experience. In this sense it conforms to an ideal model of what a "tranquilizer" should be, in that it enables an individual to heal old wounds, or to unite diverse and divergent tendencies in a framework of an overall sense of peace and openness to one's experience of self. Most often, there is an incredible calm, rather than the experience of an artificially stimulated energy trip such as that of the amphetamines or cocaine or to a lesser extent, caffeine. There is no need to attack and no fear of being attacked. Rather, there is a sense of security and an ability to handle life's turmoil.

MDMA provides an extraordinary social experience and awareness, especially to people who are lacking in social coping skills. There is no sense of a loss of ego boundary. Rather, ego boundaries appear to be strengthened and, in may respects, the need for them eliminated inasmuch as defensiveness is eliminated. Thus, MDMA tends to have an anti-paranoid effect and to open discourse between people on matters that previously may have been painful and suppressed.

MDMA as an experience tends to linger long beyond the activity of the drug itself. That is to say, MDMA is a learnable experience. One can in fact develop the ability to return to the peaceful landscape that MDMA provides without the drug itself after one to several sessions. Thus the therapeutic potential of MDMA in a limited dosage is enormous, and its abuse potential tends to be lower because the experience is replicable given the presence of the element of "learning the drug." MDMA does not create new forms of consciousness. Rather it allows the self to recognize peaceful and loving paths of experience contained within.

For these reasons, it seems to me that MDMA should be designated as a new kind of compound. It has aspects of a tranquilizer, aspects of a stimulant, and aspects of an anti-anxiety agent. Certainly there is a profound anti-psychotic effect, especially with use over time. There is also an anti-depressant effect. Thus it contains seeds from many different realms. However, in and of itself, it is a

different experience than any available with known medicines. "Empathogen" has been used as one descriptor. I myself prefer the term "psychic integrator," as it proposes basically an intrapersonal format for the drug. Because of the integrating power of MDMA, it seems to me that borderline diagnosed subjects and people such as chronic schizophrenics, are natural subjects for demonstrating the effectiveness of the drug. Especially, given the "splitting" present in borderline persons, MDMA's powerful integrational properties make it an excellent agent. Also because of its reduction of the fear of intimacy, it should be a powerful enabler of psychotherapy. Depression, anxiety, and panic states would also be amenable to MDMA's effects.

In conclusion, it is my experience that MDMA is a potentially valuable therapeutic agent that should not be lost to the psychiatric profession or to human beings. Its uses and value as a psychotherapeutic agent demand exploration in the interests of all of those people who are doomed to a life of chronicity. In sophisticated psychotherapeutic hands, within an overall program of psychotherapy, I believe MDMA will prove to be a boon to those of us interested in helping individuals going through terrible states of mind. The cost to society, and the level of misery of the family and of the individual should focus our attention on the search for a new means to help those in torment. MDMA is such a path, and I would urge its exploration. A Schedule III or lower designation would enable this to occur. Sup-

port for this research should be made available, potentially through the National Institute of Mental Health with the cooperation of the Food and Drug Administration. I would be happy to participate in such an endeavor.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on 4/24/85

Philip E. Wolfson, M.D.

STATE OF CALIFORNIA
CITY AND COUNTY OF SAN FRANCISCO).

On April 24, 1985 before me the undersigned personally appeared Phillip E. Wolfson, known to me to be the person who executed the above instrument and acknowledge to me that he executed the same.

OFFICIAL SEAL
MAX M SELVA
NOTARY PUBLIC - CALIFORNIA
SAN FRANCISCO COUNTY
My comm. expires FEB 25, 1989

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