Speech Acts Associated with **MDMA-Assisted Psychotherapy**

Vicka Rael Corey, Ph.D.

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vicka@andor.org

MAPS' therapists Michael and Annie Mithoefer have spent many, many hours providing talk therapy to patients suffering from posttraumatic stress disorder (PTSD). On a few special occasions, these sessions run as long as eight hours–rather than the ordinary fifty-minute visit to a shrink. What makes those long sessions special is that the patients have, possibly, ingested MDMA as an adjunct to their therapy–or gotten a placebo instead.

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The big question is, of course, whether the MDMA-assisted therapy can help the patients' health improve. There are many ways to measure this, and many were already in place when I first heard about their study, in the summer of 2005. There are standardized tests that ask about intrusive thoughts, nightmares, and other symptoms of PTSD; there are measurements such as a patient's need for other medications to manage their disorder, and of course the patients' subjective sense of their own well-being. All these will become the hard data with which we can determine whether MDMA belongs in the psychiatric pharmacopeia.

As I read through the study protocol, I was initially struck by this sentence: "Comparison of information gathered from these [recordings] may be qualitatively or quantitatively examined in an attempt to gain a better understanding of the effects of MDMA within a psychotherapeutic context." I wondered what sorts of comparisons were being done. I believe that the process of science is rather like the metaphorical exploration of the elephant by the blind. I wondered what sorts of comparisons I might find striking. I contacted both MAPS and the Mithoefers and eventually received a bundle of CD's containing recordings made during the patients' therapeutic visits.

Keep in mind that MDMA is not the only therapeutic element in these patients' treatment. The MDMA (or placebo) sessions take place within a quite standard therapeutic context in which the subject and therapists meet many times to discuss the patient's feelings, symptoms, and history to work toward ways for them to heal from their disorder. So my first transcriptions, which were of non-drug sessions, mainly served to introduce me to the patients' and therapists' ways of talking together without any particular involvement of medications. Then, when I moved on to the drug-or-placebo blind sessions, I could see what, if anything, struck me as different.

When I was in graduate school, I spent a few years studying high-school physics classes–relating who learned how much to what kind of classroom they were in. Did it matter if students were allowed only to answer teachers' questions? What if students were pressed to keep talking, to explain their reasoning, to come up with various hypotheses, and to respond to other students' statements? My most delightful finding was that girls in classes that enabled them to talk about physics at length learned as much physics as boys did–the only such finding in an American high school, where the "knowledge gap" between genders in hard sciences generally only widens from year to year, from elementary school through graduate school.

Something unusual about my finding was that it was about students' talk, while the vast majority of educational-context discourse studies have been on what teachers say. This is not unreasonable, as it is much more likely that a teacher, rather than a class full of students, will read a classroom research study. In the case of the Mithoefers' study, what is at stake was not who had read which journal articles, but who had or had not received MDMA. In no case would this be the therapists, nor would they know for sure whether or not the patient had (though they might be able

to make some informed guesses). Consequently I concentrated on the patients' talk. What differences might I find in the recordings of what the patients said?

Empathogen, Entactogen, or Ensuigen

When I look back over my original notes, made before I had heard any of the sessions, I had a great many hypotheses to think about. Subjects on MDMA might talk more due to its stimulant qualities, or their diction might be changed by MDMA's tendency to tighten the muscles of the jaw. However, as I listened to the data, what struck me most was not any mechanical change. Instead, I found that some patients said some kinds of things rarely heard in ordinary psychotherapy:

"I was worried about you guys at first, 'cause I was like oh, they must be so bored."

"I hope you guys don't want to go."

"So what does doing this, I mean being here for this therapy, mean for you?"

When I talked to friends and acquaintances that practice ordinary (by which I mean non-drug-assisted) talk therapy, they said they rarely if ever had heard patients express interest in, or concern for therapists' feelings. It quite inverts the usual paradigm in which the subjects' feelings are the only proper subject at hand. Yet when I considered the history and usual characteristics imputed to MDMA, I immediately found the term "empathogen"–loosely defined as a substance that brings out an individual's empathy, or their concern for others' feelings. This was a major theme in the 1980's-era use of MDMA in marital therapy, as the medicine was considered to be helpful in opening the participants to be interested in and perceptive of one another's emotions.

Once I had found "empathogen" patient talk in my data, it was a short step to looking for–and finding–"entactogen" talk:

"It feels nice, you holding my hand."

"....the degree to which I'm gripping your hand."

Although the two terms are often used interchangeably, I found it easy to qualify some statements as "empath-" and others as "entact-" (from the Latin "tactus", English "touch"). As I continued to score data and draw what I found out on graphs, I saw that entactogenic and empathogenic utterances tended to appear in the same therapy sessions. In others, utterances of either kind were much less likely.

I also encountered a type of utterance I suspect may be of very great therapeutic value, though I had not heard of it before:

"I know stuff I've heard about this drug, but I don't really want to like tell you guys I love you or anything. I don't want to say that to anybody but myself."

"I just don't feel like killing myself at all right now. It's strange."

I'm still working out just how to classify these speech acts. They are not empathogenic or entactogenic, nor do they seem to co-occur with either kind very much. However, I think they represent a tremendous shift in a patient's mindset, a shift from seeing themselves as victims (of themselves as well as others) to people worthy of love and life. I am tentatively calling this effect "ensuigenic"–bringing about a sense of self–though of course I don't yet know if it is related to MDMA at all. Only time and data analysis will tell.

As I write this, I am still "blind"–I do not know which subjects have received MDMA and which placebo. I have not even finished scoring my data–I am waiting on some more, and better, recordings and to solve some technical issues impeding my ability to score others. However, I have a hypothesis that I think is both interesting and testable: are "entactogen" and "empathogen" (and perhaps "ensuigen") quantifiable terms, which we can use to describe drugs by the way they influence patients' behavior–like "stimulant" or "sedative"? Can such findings, if correlated with successful outcomes in terms of the patients' disorders, help guide us in drug selection and treatment for certain conditions?

I don't yet have the answers, only the tantalizing theory. The end of the study is in sight, and therefore the end of my blindness and the ability to test my hypothesis properly. If it is correct, it begs a series of further questions: Do these patient's effects change the therapists' behavior in turn? Does the therapeutic relationship change after the use of the drug? How does the presence or absence of MDMA in this session affect the course of the patient's disorder and its treatment?

I can hardly wait to find out!