Psychedelic Education, New Modalities, and Coming Opportunities in Mental Health

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Many readers of this Bulletin may already know or have heard how powerful the MDMA experience can be. To use the phrase "game-changer" in describing how MDMA-assisted psychotherapy will alter the field of mental health is not hyperbole; it is backed by the quantitative data as well as the qualitative reports we have seen in the clinical research trials sponsored by the Multidisciplinary Association for Psychedelic Studies (MAPS). These phase 2 results are impressive and show a high degree of promise. Accordingly, we can expect strong interest from therapy consumers that will necessitate an equally strong, game-changing shift in the training of therapists, the modalities we use, and the economics of mental health.

As a clinical sub-investigator in the Boulder, Colorado, Phase 2 MDMA-assisted psychotherapy for posttraumatic stress disorder (PTSD) trial and also the Executive Director of Trauma Dynamics, a psychotherapy training that focuses on trauma and the body, I was asked by MAPS to write about how Food and Drug Administration (FDA) approval for MDMA will alter the field of mental health. This question has been on my mind since sitting with my first study participant a few years ago and seeing what is possible when psychedelics meet psychotherapy.

One significant shift that will take place in the field of mental health post-FDA approval is the need for therapists to become, at the very least, informed about MDMA. Clinicians who work at hospitals, addiction treatment centers, private practice settings, the Department of Veterans Affairs, or public mental health agencies stand a good chance of working with someone who either wants the treatment, someone who has had the treatment, or someone who ought to receive the treatment as an evidence-based best practice for the condition of PTSD.

Becoming MDMA-informed can mean a number of different things. Generally speaking, therapists will need to alter the theoretical lens through which they understand their clients' experience. This is no easy task. If therapists have not had their own experience with MDMA or other psychedelics, they may have difficulty connecting with the world their clients are trying to convey and the experiential processing that is integral to this type of healing. We are leaving Kansas in a significant way when it comes to how unique progress and processing can look with psychedelics.

On the occasions when I've given presentations to thera-

pists about processing trauma and the topic of MDMA-assisted psychotherapy has come up, I find that many clinicians simply don't have a category in their mind in which to put it. They often do not believe the results coming out of the trials because the findings are so out of the norm. There is a lot of clinical experience showing that chronic, treatment-resistant patients have a much longer, weaker arc of improvement with psychotherapy, if they improve at all. Psychotherapy often appropriately aims for symptom management in these cases and not a true resolution of a condition, and so the durable remission we are seeing with many study participants in a relatively short span of time is difficult to comprehend.

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Another key part of becoming an MDMA-informed therapist is to distinguish between psychedelic medicines and psychiatric medications that are aimed at symptom management like Zoloft, Xanax, or the heroin substitute Suboxone. Current medical education has few reference points for drugs that actually help people engage with themselves more deeply, feel more fully, and work through very difficult states. Furthermore, many people's only experience with a chemically altered state of consciousness is with alcohol or cannabis and so they will understandably reference these as a way to try to understand MDMA. Entering into a psychedelic process is very different from becoming high or intoxicated. Quite the opposite, MDMA is a highly associative experience.

For therapists who want to train and work with psychedelic medicines, there will be changes beyond simply becoming MDMA-informed. We get hints of how trainings for MDMA-assisted therapy may eventually look from the Therapist Training Program MAPS is already developing to prepare clinicians for Phase 3 MDMA trials (**maps.org**). They note:

> *The Therapist Training Program is a four-module training, 1) a 10-hour online course about MDMA and study design, 2) 7½ day in-person training with lead MDMA therapists, 3) home study assignment to include a workshop or experiential training of therapist's choice 4) a second week-long in-person gathering bringing all training groups together.*

A notable element about training of future MDMA therapists is that MAPS is leaving room for modalities that the therapist may already be trained in or is interested in learning as part of their larger training to work with psychedelics. This is because MDMA has many different pathways for effecting change. There are simply too many variables between individuals (their needs, their biology, their history, their defense structure) to limit the therapeutic pathways this medicine will take. We have seen participants spontaneously engaging in cognitive restructuring during one part of the day, working with disintegrated self states (parts work) at another time and engaging in deep autonomic processing at yet another point. What is clear is that MDMA is significantly expanding the ways in which we are able to process. While some participants can have a linear, talk therapy focused MDMA session, many do not. Participants can enter a far more visceral reality that may not operate on the same principles as does the rational mind. People report a vivid re-experiencing and renegotiation of memory in a deeply supportive, embodied and often highly relational space.

There is one general rule of thumb that we can say about therapeutic interventions as people enter non-ordinary states of consciousness for processing. No longer is it appropriate to approach healing from structured therapy protocols. As a client's inherent sanity leads the way, approaches to trauma that follow a step by step structure will not fit with the fluid nature of the mind and body while under the effects of MDMA. As noted by the Principle Investigator for the Boulder Phase 2 trial, Marcela Ot'alora, the MDMA therapist will need to be a well-informed, non-directive, yet highly engaged "guide who follows".

There are a few early adopter programs working to meet the needs created by this mixing of psychedelics and psychotherapy. The Center for Optimal Living offers a harm reduction model of approaching psychedelics by offering psychotherapy and psycho-educational resources for individuals who have had or wish to have psychedelic experiences (**psychedelicprogram.com**). Clinicians can also turn to this program to learn how to best work with patients who have a history of psychedelic use. While not actually facilitating psychedelic sessions, the goal is to mitigate the potential risks involved and to incorporate the valuable insights from these experiences into psychotherapy.

Scheduled to launch later this year is the Certificate in Psychedelic-Assisted Therapies and Research program at the California Institute of Integral Studies (CIIS) for licensed and pre-licensed professionals and clergy (**ciis.edu**). This program has roots in transpersonal psychology, consciousness studies, psychoanalysis, comparative mysticism, and anthropology. Impressive is the group of foundational thinkers and researchers in the field of psychedelic studies that have served as advisors to this program. To be clear, CIIS notes that its certificate course "…serves a growing need for the training of skilled therapist researchers who will ideally seek advanced training for future FDA-approved psychedelic-assisted and entactogen-assisted psychotherapy research." While there is no guarantee that clinicians who complete the certificate program will be given research positions in future FDA trials of psychedelics, CIIS reports a robust level of interest from therapists and one can easily imagine this program as a kernel for a full-fledged masters or Ph.D. track once MDMA is approved.

Lastly, there is the Trauma Dynamics training, which I direct at the University of Denver (**traumadynamics.com**).

Trauma Dynamics training at the University of Colorado Anschutz Medical Campus, Spring 2014.

While the skill sets and interventions of Trauma Dynamics or other somatic modalities were developed without the consideration of medication or psychedelics, there is no doubt that the body-oriented, entactogenic ("touching within") nature of MDMA greatly enhances and supports the processing of trauma that occurs within the autonomic nervous system. As we approach legal medical use (whether that is the expanded access status that MAPS will apply for in the 2018 time frame or full FDA approval around 2021), there is a growing conversation in our trainings about how interventions and therapeutic processes are achieved without and with medicine support. It is our clear intention to embrace MDMA and create a trauma education track specifically designed around this medicine.

We find that MDMA-assisted psychotherapy makes certain aspects of working with trauma become easier, while other aspects become more complex. The initial conditions necessary for processing traumatic memory (such as safety, the establishment of resources and trust), which need to be developed and put into place before a client's system will allow them to engage in deep healing, are to a large extent facilitated by MDMA. Establishing these initial conditions is a significant part of therapeutic training and can take a good deal of time in therapy (even years for people who are chronically under-resourced from an abuse-filled childhood). In contrast, the MDMA patient is able to begin deep processing in a relatively short time as long as the set, setting, and rapport have been established.

Another example of how processing trauma becomes easier is in the very significant problem of memory linking. Briefly put, linking is when a stressful or traumatic event in a client's life is tied to other difficult events due to circumstantial similarities. Let's say the client is talking about a car accident in which they broke their arm (A). This can ping the memory of being seven years old and losing their father in a car accident (B) which can remind them of memories of their father when he was critical and harsh (C) which can link to yet another memory involving dad, cars, or injury to the same arm (D). This type of linking (where A=B=C=D) creates a tangled trauma cluster that is much more difficult to piece out and resolve then any one of those memories would be alone. If you pull one string in a trauma cluster, the whole tangled ball of traumatic memory gets pulled; this can become an overwhelming cascade of memory, and the end result is that nothing moves. This clustering of traumatic events takes great care and skill to untangle and is one of the single most significant reasons why treatment often stalls.

In contrast, one of the true gifts of combining MDMA with psychotherapy is how it uses that same linking tendency of trauma in the nervous system to resolve the entire cluster. With the support of MDMA, we can trust and actually encourage the client's system as it moves from one linked event to another linked event without becoming overwhelmed and bogged down. MDMA turns one of the most significant problems in trauma therapy into an asset. This is a significant way in which trauma therapy and training therapists becomes far easier with the addition of this medicine.

One way in which MDMA actually adds complexity to psychotherapy is in the need for therapists to address traumatic transference. More so then any other topic, transference and the need for training around it came up in virtually every Phase 2

clinical team meeting we had. Briefly put, transference is when the client places the perceptions, feelings, thoughts, and sensations that are part of their unresolved past on to the therapist or other current relationships in their life. Countertransference is when the reverse happens, when the therapist places their own unresolved material onto the client. Think of it like a film negative of the past laid over present moment reality. It becomes difficult for the client (and therapist) to discern what perception is coming from where. If this transference is traumatic in nature, the client will believe the therapist may not care about them, or will hurt them in a way similar to how they were hurt in the past. This is one of the reasons the Phase 2 trials operated with a female and male therapist team: it allows for parental transference to emerge. Participants will often quickly and powerfully choose one therapist to hold their hopes and desires for an ideal parent (positive transference) and just as quickly identify the other therapist as either a bystander parent (characterized by being neglectful or incompetent) or as a perpetrator (negative transference). MDMA evokes this layer of traumatic transference very effectively, which is both an extraordinary therapeutic opportunity to heal relational wounds, yet also making it wickedly difficult for the therapist to hold. Without training in transference, therapists can get overwhelmed and become reactive to how they are being seen by the client. Therapists need training in how not to refuse the role being handed to them by the trauma patient. Unfortunately, transference work is no longer taught in the vast majority of graduate schools (it's not part of CBT's six-session model of therapy), and shockingly it's not part of most trauma therapy modalities either. In adapting the Trauma Dynamics model to meet the needs of MDMA-assisted psychotherapy, we have added an entire level of education around working with traumatic transference.

While we have some clarity around the type of skills the psychedelic therapist will need to work with MDMA, we are still learning how the logistics of training and licensure will actually look. The FDA will create its own regulations for the use of MDMA-assisted psychotherapy based on data provided by MAPS' studies through ongoing dialogue between MAPS and regulatory officials. It's likely that MAPS will be the governing body that certifies individuals and clinics to work with MDMA. In addition to any other training a therapist has received, it is likely that the in-house Therapist Training Program which MAPS is developing for Phase 3 will also be required for clinicians to gain certification post-approval. To be clear, MAPS' mission is to make MDMA-assisted psychotherapy available for as many people as possible, and therefore will not try to maximize profits by limiting availability through monopolizing education or limiting treatment center options.

As MDMA-assisted psychotherapy enters the mainstream of mental health, we can expect to see changes to the field beyond the training of therapists. We can expect to see an increase in the effectiveness of psychotherapy for PTSD with improved client outcomes, a decrease in the overall duration of therapy, a decrease in overall treatment costs, and potentially a large increase in the number of people seeking treatment. While MDMA research has focused on trauma patients—and there is good evidence to show that the majority of people entering psychotherapy have symptoms stemming from trauma (see **ACEstudy.org**)—it is a reasonable assumption that psychedelic therapy will be effective for other conditions as well. The potential use for autism, addiction, attachment disorders, couples counseling, anxiety or depressive symptoms that are not trauma based, or your garden-variety neurosis is promising and should be investigated in future clinical trials.

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We can also consider people who enter therapy not because they are suffering but because they want to grow in self-awareness or improve some aspect of their life in which they are already functioning well; think of the person who would never see a therapist but would see a life coach. Might corporations send their management teams off to gain clarity around their mission, vision, and values using MDMA? We have found that in contrast to psychiatric medication that many people tend to keep secretive, many (though not all) MDMA study participants are eager to communicate their experience to family and friends, or with anyone that asks. There is good reason to assume that therapists will have a good deal more clients and opportunities for growth with the introduction of this medicine to the field of mental health.

On a final note, it should be clarified that MDMA is not a magical pill that solves all problems. It is ultimately a catalyzer of psychotherapeutic processes and innate healing mechanisms that require a great deal of work, engagement, and skill from both client and therapist to achieve. It uses the same somatic, relational, cognitive, transpersonal pathways that are already available to us. To borrow from George Greer's thinking, "there's nothing you can do with MDMA that you can't do without MDMA; you just might not get to it in this lifetime".

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