Adherence Rating in MDMA-Assisted Psychotherapy for PTSD Research

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HISTORY AND TREATMENT OF PTSD

Symptoms of posttraumatic stress disorder (PTSD) have been articulated in mythologies, religions, histories, and literary works for centuries (Friedman 2015). These narratives document the experiences of individuals and communities that have been impacted, and their struggles to find meaning and healing. Over the last several hundred years, this group of symptoms has been given various names and attributed to various causes. However, it wasn't until 1980 that PTSD was first introduced as a discrete psychiatric diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders, Version 3 (DSM-III).* Since that time, numerous studies have helped to further refine our understanding of pre-disposing factors, causes, symptomology, and effective methods of treatment.

One of the primary tasks of trauma therapy is to help clients to achieve a sense of safety and stabilization before any processing can occur. Friedman (2016) has reviewed recent findings focused on the neurobiological aspects of trauma, and deepened our understanding of how to regulate somatic and sensory systems while working with traumatic material. Current approaches include diaphragmatic breathing, guided visualizations, focused expression of affect, and sensory grounding. Another important aspect of developing safety is the therapist's capacity to build rapport, connect empathically, and maintain a non-judgmental attitude with respect to the client's experience. This helps to build a therapeutic container that can then allow for processing and integration of traumatic experiences. Although these methods have been shown to be effective, they can take time to implement and develop. In some cases, there is a back-and-forth movement between containment and processing periods, which can lead to longer therapies and frustration for both clients and therapists.

In the *Treatment Manual for MDMA-Assisted Psychotherapy for PTSD* (**maps.org/treatmentmanual**), the authors draw upon previous research with MDMA and suggest that one of the effects of the medicine is to provide a kind of experiential container in which the body is more regulated. From this place, participants appear more capable of tolerating and expressing difficult emotional experiences associated with the trauma, thus stepping out of the flooding and numbing cycle. MDMA has also been associated with increased empathic connection, which may allow for deeper exploration of relationships, healing of attachment wounds, and feelings of interpersonal safety. These particular benefits of MDMA allow for the possibility of a sufficient container to be built more quickly and begin a more tolerable healing sequence for the participant. The therapists are then able to join the participant in their healing more as guides rather than directors, helping them to stay open and curious with whatever is arising. The synthesis of this therapeutic approach and the pharmacological attributes of MDMA appears to result in a powerful and rapid approach to working with PTSD.

THE ROLE OF PROTOCOL ADHERENCE IN THE VALIDITY OF CLINICAL TRIALS

In order for MDMA to be approved by the U.S. Food and Drug Administration (FDA) as an adjunct to psychotherapy for PTSD, and thus made more broadly accessible, clinical trials must demonstrate treatment efficacy, and these results must be both valid

and reliable. Adherence raters have the task of verifying that the procedures and approach outlined in the *Treatment Manual a*re being applied accurately and consistently. This process enhances internal validity, a measure of the level of confidence that the differences measured between groups are due to the independent variables and not to random variation. In MDMA-assisted psychotherapy for PTSD research, adherence to the protocol is measured across two separate domains: One relates to specific tasks and therapeutic objectives such as psycho-education, safety precautions, and gathering relevant history; while the second domain relates to competence of the therapists in various areas including non-directive stance, empathic connection, and communication. Study therapists receive ratings as a form of feedback that allows for refinement of techniques within the study.

TRAINING AND IMPLEMENTATION

In a prior MAPS *Bulletin* article, Sola and Gelfand (2013), wrote about the first adherence rating team and the importance of being able to carefully articulate relevant skills so that adherence rigor could be maintained in the next generations of raters. There were several valuable aspects of the training process that continue to inform my work both as a rater and as a therapist. One of the first tasks was developing familiarity with the theories behind MDMA-assisted psychotherapy for PTSD treatment, including concepts such as *inner healing intelligence, non-directive stance,* and *beginner's mind*. These terms are not inherently complicated, but they reflect a kind of disciplined awareness and inquiry that is in some ways similar to meditation practice. In order to be able to rate the therapy, we had to develop our own experiential capacity to engage in it. We practiced these skills through hours of individual practice ratings followed by group discussion.

In the trainings, we also learned to rate less discreet variables, such as *empathic attunement*. This required being able to recognize and interpret more subtle interactions between therapists and participants. Being able to witness these kinds of interactions not only enhanced my ability as a rater, but also as a therapist. Seeing the effect of a validating comment like "It makes sense to me that you would feel that way," has helped to shape my own practices in the office. Another feature of this training experience is developing the capacity to stay focused and centered. Although we are watching videos instead of actually being in the room, the experience can be very intense and may sometimes evoke a parallel process in us. It is imperative for us to be able to develop the capacity to maintain awareness of both empathic connection and our own grounded being, so that we don't inadvertently communicate to our clients that their trauma is too big or too scary to hold.

THERAPEUTIC CONTAINMENT

Even with this "dual awareness," it is still necessary to take breaks, especially when rating an entire experimental session. However, even with breaks it can still be mentally and emotionally challenging. During an experimental session, therapists are present for the duration of the active time of the drug, which can be up to six hours with only short breaks. So how do the therapists stay regulated? There may be several protective factors that allow therapists to stay engaged in trauma process for so long. One of these could be related to an understanding of the potential of the MDMA to keep emotions and somatic processes within a tolerable range. This may help to maintain a positive expectation of healing. Another factor could be related to having a therapist team rather than a single therapist, which creates an environment where the therapists can draw on each other for resourcing if needed.

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One of the rating items during the experimental session regards our belief of which dose the participant received. In the absence of other data to confirm my guess, I am left to consider my observations of participant expressions and therapist responses. Generally, participants seem to experience some shift at the lower dose, but it does not seem to be enough to create a sufficient sense of containment for deeper work to happen. Participants may be more frustrated, engage in self-critique, or have difficulty trusting the inner healing intelligence. Therapists may become more directive, draw more heavily on specific tools and techniques, and experience more difficulty staying empathically attuned. It would seem that this is an area where MDMA, in the right dose, is particularly effective and sets the stage for the rest of the healing process to occur.

INNER HEALING INTELLIGENCE

The *Treatment Manual* designed by Mithoefer and colleagues describes the concept of the *inner healing intelligence*. Briefly, this is the idea that each of us has within the necessary ingredients for our own healing; we simply need to have the right circumstances. The *Treatment Manual* compares this to a physical injury; we may go to a doctor for stitches but the body does the real healing. One of the ways of to support the process is to treat anything that arises as being relevant to the participant's healing. This may occur in a variety of ways: somatic sensations, affects, memories, images, perceptions, or interactions with the therapists. One might think of the healing process as weaving together disparate threads of sensory experience in an associational process. The meaning or significance may not be appreciated until later, when the pattern of the weave begins to emerge. Having seen this process many times now, I have more trust that

healing is happening even when I can't quite see the whole pattern. The goal then becomes to support the participant in staying present to emerging experience and trusting the process.

One of the ways this is achieved is through using a non-directive approach. The *Treatment Manual* suggests that by following the participant's lead, the therapist can then join the participant as a companion to offer suggestions and emotional support throughout the journey. One of the primary benefits of this stance is that it does not engender reliance on the therapists or the medicine. Instead, participants become active participants in their own healing. This is a crucial part of resolving experiences of powerlessness, hopelessness, and brokenness that so often accompany trauma.

Trusting the inner healing intelligence may be one of the harder tasks for both clinicians and participants. From the participant standpoint this is likely a completely new concept, and may take time and experience to undo past therapy, or to trust that their bodies and minds can engage in a healing process instead being constantly hijacked by symptoms. This level of trust may also be difficult for clinicians after having been inundated with more directive therapeutic techniques and theories. There may be an experience factor that helps clinicians relax and sink into an embodied faith in the process. It also seems that the capacity of the clinician to achieve that level of trust facilitates the deepening of the participant's level of trust as well.

MULTIPLICITY

The *Treatment Manual* describes the importance the importance of validating and exploring experiences of *multiplicity* if they arise. Many psychological schools have rejected a unitary theory of the psyche, instead seeing it as composed of multiple parts, sub-personalities, or subjectivities with different frames for understanding and engaging with the world. On one level, these different self-images represent the psyche's way of adapting in order to contain experience that is overwhelming. In many cases, these adaptations were—at one point in the participant's life—necessary for psychological survival. These subjectivities can become guardians of experiential memory, holding it until it can be safely processed. It is vital for both the participants and the therapists to stay engaged and curious about these subjectivities, as they often hold keys to healing.

This is where the practice of going within with music can be particularly effective. In this way participants have the opportunity to dialogue with various parts of the self: the ones that carried the experience of trauma, the warriors/protectors, the nurturers, etc. Several of the soldiers in the study accessed powerful insights and healing through coming into balance with the part of them that is a warrior. Working with multiplicity also provides room for spiritual and archetypal realms of experience that have an impact on the healing work. Guides, allies, saints, or spirits, can show up in various ways: bringing experiences of compassion, reconnecting to religious or spiritual practices, or pointing the way towards some new understanding or experience. This is a very important aspect of healing, since the connection to the multiplicity within may pave the way to connection with the outer community, beginning the process of reintegration.

PERSONAL NOTE

Working as an adherence rater for MAPS has been a profound experience for me personally and professionally. I was unprepared for the strength of the work, for the depth of my reaction, the compassion of the researchers, and the vulnerability of the participants as they share their stories. Watching each session, I had the opportunity to see them urge themselves forward, to watch themselves find a sense of safety, and to observe bodies begin to release trauma, bit by bit. I also contacted places within me that were in need of healing and support, and learned to engage in my own self-care. While the tasks of an adherence rater are straightforward, it is a participatory experience that can lead to personal transformation. For this I am grateful and humbled by each reminder of the resilience of the human spirit.

I am also grateful to be a part of the team that is working to create a new approach for working with trauma and helping people heal. But most importantly, I thank those who have participated in this research. Thank you for having the courage and vulnerability to share your healing stories with us. I feel blessed to have witnessed your work.

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