A Clinical Perspective on 3,4 Methylenedioxy-methamphetamine-Assisted Psychotherapy

Pedro Luis Camejo Benach

A Clinical Research Project presented to the faculty of the Hawai'i School of Professional Psychology at Chaminade University of Honolulu in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology.

Honolulu, Hawai'i
December, 2019

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This Clinical Research Project by Pedro Luis Camejo Benach, directed and approved by the candidate's Clinical Research Project Committee, was approved by the faculty of the Hawai'i School of Professional Psychology at Chaminade University of Honolulu, in partial fulfillment of the requirements of the degree of Doctor of Psychology in Clinical Psychology.

Sean Scanlan, PhD, Program Dean
Clinical Psychology Program

Clinical Research Project Committee

Lianne T.S. Philhower, PsyD
Chair

Patrick Kamakawiwo'ole, PsyD
Committee Member

December 10, 2019
Date

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Pedro Luis Camejo Benach

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This qualitative study explores various components of 3,4-methylendioxymethamphetamine (MDMA), such as how it functions in the brain, its prosocial and empathogenic effects, its efficacy, how it promotes healing in patients whom experience symptoms associated with psychopathology, and a brief overview of its history. MDMA is typically associated with the street drug "Ecstasy," however, the positive stigmas associated with the drug (e.g., subjective empathogenic feelings towards the self and others) assist with the healing process when MDMA is administered in conjunction with psychotherapy (MDMA-assisted psychotherapy). Currently, MAPS.org is in its 3rd clinical trial and final phase of tests prior to it possibly being approved as a legal and effective form of therapy in the treatment of psychopathology. This qualitative study investigates the healing effects it has on individual(s) whom have taken MDMA in a setting that promotes healing, in addition to any interpersonal experiences they have had with MDMA.

Keywords: 3,4-methylenedioxymethamphetamine, MDMA, empathy, healing

Dedication

I would like to dedicate this to the generation of students that haven't yet reached their potential but will do great things, including helping those with PTSD and other psychological difficulties.

Acknowledgments

First, I would like to thank our Lord and Savior, Jesus Christ for all of his guidance through this journey. I would like to thank my family, especially my Mom and Tia for supporting me unconditionally. I am sure they are happier than I am now that this is completed. I am so thankful for all the support of my friends, and my family, especially Louie, Josh, Zack, JT, and Big Jose. Lastly, I would like to thank my two incredible advisors, Drs. Lianne Philhower and Patrick Kamakawiwo‘ole, for believing in me.

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CHAPTER I. INTRODUCTION

In qualitative inquiry, the researcher is required to situate their study. This is done by examining how the study is conditioned into the personal biases of what is meaningful to the study by the researcher (Lave & Wegner, 1991; Rossman & Rallis, 2016). Situating a study allows the researcher to consider the *wanna-do-ability* of the study (Rossman & Rallis, 2016). The researcher considers their personal stakes in the study, and the stakes of others. Walcott (1990) stated that the researcher impacts the study by their presence, their assumptions and biases, and how the phenomenon impacts us.

As a child growing up in the 1980s, I was raised to believe that mind-altering substances were harmful to my brain and body. This is likely due to my cultural influences as a Cuban-American being raised in the Los Angeles area by a Cuban family. Substances such as alcohol, tobacco, marijuana, cocaine, and other drugs are used in the Latino culture to cope with daily stressors and life experiences. I now realize that all drugs are not harmful, and in fact, there are substances that promote interpersonal healing. These types of drugs are referred to as empathogenic substances and have properties that reduce the effects of symptoms associated with pathology.

Education has afforded me the opportunity to broaden the way that I view substances that may have stigmas associated with them. The generations before mine typically look down upon individuals who use substances, even though some are gaining traction as alternatives to medicine in the medical and psychological fields (i.e., marijuana [THC + CBD], cannabinoid [CBD]). The stigmas surrounding psychoactive substances (e.g., marijuana) consist of thoughts that people who “smoke weed” are “high school dropouts,” and/or people who are “lazy.” Another example of a stigma is individuals who take “molly” (the street name for MDMA) at a

party of any type is they are “killing their brain.” Another well-known drug, Ecstasy, is typically associated with raves and the music festival scenes. Additionally, this type of substance is associated with “love” and “openness” and is in-line with its empathogenic properties.

I have had conversations about the use of MDMA with friends of mine whom attend various clinical psychology programs throughout the country. MDMA is sometimes also referred to as Ecstasy, however, MDMA in its purest form is natural, whereas Ecstasy is synthesized with MDMA and other substances (i.e., caffeine, cocaine). Through my personal interest in MDMA, I realized that many of my highly-educated friends were strong believers in the use of empathogenic substances (i.e., MDMA, marijuana, mushrooms, LSD, and ayahuasca). In fact, the common response when asked about their thoughts on these types substances was, “You have to try it. It can be a really great experience.”

One of my peers introduced me to the use of MDMA in the treatment of Posttraumatic Stress Disorder. I became evermore curious as to how MDMA can be used in combination with psychotherapy. The manifestation of trauma intrigues me as a clinician, specifically how it creates other forms of pathology. When I began to research the effectiveness of MDMA, I quickly realized how important it is to conduct psychological research on the efficacy of alternative methods and empathogenic treatment of pathology. Meanwhile, while in my diagnostic practicum year, I began to see the long-term effects of untreated complex trauma. During my tenure at the Hawaii State Hospital’s intake unit, I continued to see the effects of complex trauma. I then set out to understand how an empathogenic substance, such as MDMA, can assist me as a clinician to understand and treat pathology.

Through this study, I would like to understand MDMA from the perspective of a therapist. With this, I hope to understand how it can be used in conjunction with psychotherapy.

It appears that the use of MDMA and other empathogenic substances have healing properties. Transversely, I have also heard of negative and aversive experiences, especially when the natural properties are chemically synthesized (e.g., Ecstasy). Aversive experiences are fairly common. There are a plethora of stories about individuals whom have overdosed or overheated due to dehydration and others who remembered past experiencers that they previously had forgotten about. On one side, some say that they were able to process it in a whole new way, while some have had a negative experience reliving a past memory. Empathogenic substances, when used in a healthy setting, can assist in re-writing past experiences. Additionally, this process allows the person to experience new memories that stem from the past and ones that are occurring in the present.

Review of the Literature

A qualitative literature review is a survey of academic articles, books, periodicals, and other sources of information that allows the researcher to gain a comprehensive overview of the theory, research, and practices related to the specific phenomenon they are researching (Glesne, 2016). A comprehensive literature review assists the researcher in a multitude of ways:

1. The review of literature informs the research design;
2. The review of literature informs the interview questions (e.g., grand tour questions);
3. The review of literature focuses the topic of study; and
4. The review of literature informs the researcher of what is missing in the current body of literature; thus, the review of literature assists in informing the researcher and provides a comprehensive understanding of the phenomenon by providing knowledge that is not just based on content (e.g., methodological information; Glesne, 2016).

Through the process of literature review, the researcher gains a knowledge and understanding of the success and failures of past research projects. Thus, Glesne (2016) recommended the researcher to cast a wide net to seek sources from all possible areas, including other disciplines (e.g., sociology, anthropology).

History of 3,4 Methylenedioxy-Methamphetamine as an Empathogenic Substance

Empathogenic substances have been used for self-healing and spiritual practice for centuries. In a modern world where psychotherapy and pharmacological medication is used for healing, empathogenic substances are combined with psychotherapy to promote healing. In today's world, experiences that promote self-healing are sought. Both psychotherapy and spiritual practices to support us in our journeys are sought as part of self-development. A less westernized culture, such as the culture found with the Native American Indians, tend to group self-healing, psychotherapy, and spiritual practice/healing into one cluster of healing, unlike westernized cultures that separate the three, most specifically in the medical models.

In an example by Adamson and Metzner (1988), American Indians conduct ceremonies that include peyote and sweat lodge rituals to promote healing, curing, and problem solving. The traditional use of empathogenic substances for healing assists in the dissolution of defensiveness that occurs when we experience intrapsychic separation from our mind, our body, and our spirit/soul (Adamson & Metzner, 1988). When this occurs, we can process our experiences, self-heal, and our heightened levels of spirituality promote a sense of interpersonal therapy that we might otherwise seek out in psychotherapy (Adamson & Metzner, 1988; Brown, 2007).

When change in conscious awareness is experienced, we in turn experience changes in our attitude towards ourselves (e.g., mind, body, soul), prompting a regenerative process (Adamson & Metzner, 1988). Empathogenic substances assist in the shift of perspective that

occurs when beliefs are reframed and healing in our spiritual journeys is promoted (Adamson & Metzner, 1988). Empathogenic substances such as 3,4-methylendioxymethamphetamine (MDMA) are associated with states related to ecstasy, empathy, openness, compassion, peace, acceptance, forgiveness, healing, oneness, and caring, amongst other interpersonal states that are also synonymous with successful psychotherapy (Adamson & Metzner, 1988). Adamson and Metzner (1988) suggested that the "Adam experience" (a code name for MDMA in the use of therapy in the 1970s) helps facilitate the dissolution of barriers between the mind, body, and soul that prevent us from resolving interpersonal conflicts and long-standing intrapsychic interpersonal conflicts in relationships. Empathogenic substances such as MDMA aid in not only entering an altered state, but a higher level of consciousness.

Doblin (2002) of the Multidisciplinary Association for Psychedelic Studies (MAPS) stated that empathogenic substances filters the speed (e.g., slows down) of our mental processes and systems, allowing us to have a broader sense of consciousness. Thus, in turn, we become unified with ourselves, others, and our environment. This suggests that we experience a deeper and broader connection with life as we develop a separation from our ego that is typically developed later than our natural connectedness. According to Brown (2007), psychedelics affect all areas of an individual's mental functioning (e.g., perception, emotion, cognition, body awareness, and one's sense of self). Therefore, when it is combined with psychotherapy, a patient can work through their transference and the illicit processes that arise while using an empathogenic substance. Transference and countertransference are typically associated with psychodynamic psychotherapy, with the aim to make the unconscious conscious (Mithoeffer, 2013). This insight assists in the therapeutic process when a patient has been administered MDMA in conjunction to psychotherapy. Mithoeffer et al. (2013) suggested that a patient's

capacity to acknowledge and discuss their interpersonal experiences with transference increase as their tolerance also increases, promoting a faster rate for change in the therapeutic process.

Brown (2007) stated that psychedelics enhance an individual's symbolism and imagery, increases subjective suggestibility in addition to heightened levels of connectedness (e.g., contact between emotions and ideations), and can also control regression. In an altered state of enlightenment or consciousness, a patient can have feelings of returning to their natural state of innocence (before the ego has developed feelings such as guilt and shame or unworthiness). Therefore, the patient experiences feelings of connectedness and bonding with themselves, others around them, nature (e.g., animals, plants, and their natural environment), and other energies that exist in the world (Adamson & Metzner, 1988). According to Buzzell and Chalquist (2009), the methods offered in other therapeutic modalities, such as ecotherapy, exist on a spectrum and are relatively inexpensive due to the methods being earth-based. Through modern research these applications are being backed by the developing body of literature (Buzzell & Chalquist, 2009). In the acceptance of nature, it is asserted that the individual makes the connection within themselves; thus, he or she will then address the relationship between their human experience in existence with their individual relationship to nature. Furthermore, the interpersonal connection one experiences with their environment allows them to reach higher levels of consciousness. When a person uses empathy to gain better insight into themselves to promote healing, a shift in identification with the ego and larger "self" occurs (Adamson & Metzner, 1988).

On May 24, 1912, Merck of Darmstadt, Germany, patented a drug named methylhydrastinin, more commonly known as 3,4 Methylenedioxy-Methamphetamine (MDMA), often referred to as "ecstasy." Merck, who frequently collaborated with Sigmund Freud in

cocaine studies, did not experiment with MDMA on human subjects. It was not until the 1950s (Maps.org) that MDMA was rediscovered and once again used in a research setting by the United States Government as part of the Central Intelligence Agency's (CIA), in corroboration with the U.S. Military, development of weapons for chemical warfare (maps.org). However, they did not test the drug on human subjects. In the early 1970s, the Drug Enforcement Administration (DEA) first recognized MDMA when they found that MDMA was being used on the street (Gatson & Rasmussen, 1972).

The first scientific study of MDMA's healing effects on human subjects took place in 1978 by Shulgin and Nichols. The researchers suggested that MDMA creates an 'easily controlled altered state of consciousness with emotional and sensual overtones' (Parrott, 2007; Shulgin & Nichols, 1978). MDMA was again rediscovered in 1985 (Bouso, Doblin, Farré, Alcázar, & Gómez-Jarabo, 2008), where it was used in psychotherapy settings to assist in the therapeutic process of healing (Bouso et al., 2008; Grinspoon & Bakalar, 1986). However, no formal studies were underway to show the efficacy and effectiveness of treatment with MDMA. Rosenbaum and Doblin (1991), the latter of which is currently at the forefront of the MDMA movement, stated that approximately 4,000 individuals were introduced to MDMA assisted psychotherapy in that era by Leo Zeff, Ph.D., who was termed as the "Secret Chief" of alternative treatment methods, such as MDMA assisted psychotherapy (Shulgin & Shulgin, 1991; Stolaroff, 1997).

Before MDMA became a Schedule I controlled substance in 1985, Doblin (2002) stated although the legal use of MDMA was no longer legally accessible, it was shown to be effective. The author further stated that the MDMA, in adjunction to psychotherapy (e.g., MDMA-assisted psychotherapy) has been effective in treating differential symptoms. Additionally, Doblin (2002)

suggested that MDMA had been used to treat individuals, couples, and groups. Greer and Tolbert (1986) were the only researchers at the time whom had published quantitative data that showed the effectiveness of MDMA-assisted psychotherapy. Greer and Tolbert (1986) conducted a study that resulted in positive effects for their participants. They administered MDMA across their patients in conjunction to psychotherapy (n=80, 90%), and found that the participants experienced positive and long lasting effects in a 12-month, long-term follow up (LTFU) in patients who met diagnostic criteria for mixed personality disorder, post-abortion phobia of sexuality, adjustment disorder with depressed mood, and schizophrenia (Bouso et al., 2008; Grinspoon & Bakalar, 1986).

Participants involved in these early studies reported to have extremely positive experiences (Grinspoon & Bakalar, 1986). The researchers of this era reported that the patients experienced heightened levels of warmth, interpersonal security, enhanced ability to communicate with others, positive feelings, interpersonal depth, being able to feel their "real self," reduced anxiety, heightened levels of love, compassion, and intimacy/connectedness with their personal feelings and towards others (Brouso et al., 2008; Greer & Tolbert, 1986; Grinspoon & Bakalar, 1986). These reports also consisted of increased interpersonal sensitivity and sensuality, heightened senses of touch, and warmth (Bouso et al., 2008; Greer & Tolbert, 1986; Parrott, 2007). Additionally, the subjects of the study reported that these subjective feelings of empathogenic effects were unusual or new experiences to them (Parrott, 2007). A study published by Metzner and Adamson (2001) expanded on these initial reports of participant's experiences with MDMA-assisted psychotherapy. Their participants expressed greater feelings of freedom, interpersonal strength, higher levels of joy, and decreased levels of pain (Grinspoon & Bakalar, 1986; Metzner & Adamson, 2001). The authors of this study stated

that their patients could respond to love more openly than they were able to prior to their participation in MDMA-assisted psychotherapy (Holland, 2001; Metzner & Adamson, 2001). This finding suggests that these types of interpersonal experiences with MDMA in conjunction with individual psychotherapy expanded the patient's interpersonal views and beliefs about themselves and the world around them.

Current literature by Hysek et al. (2013) also suggested that MDMA produces subjective prosocial feelings and increases levels of empathy, in addition to sociability (i.e., virtues for successful treatment in psychotherapy, such as cognitive and emotional processes; Blair, 2005; Dumont, Grosse, & Slater, 2009; Mithoefer et al., 2013). A study by Hysek et al. (2013) showed that explicit and implicit empathy was increased across participants who were exposed to positive valence stimuli and not for negative valence stimuli. This suggests that MDMA decreases the emotional response to negative stimuli. The authors stated that MDMA influences emotional empathy and other empathogenic effects when administered to both male and females. The authors also found that when their subjects were administered MDMA (125mg), both men and women in the study tended to increase their "preference for fairness," in comparison to participants who were administered a placebo (Hysek et al., 2013). Further, the authors stated the subjective effects of MDMA on social cognition assist in the facilitation of how people process material and stimuli that causes emotional distress, specifically when MDMA is used in conjunction with psychotherapy (e.g., MDMA-assisted psychotherapy; Hysek et al., 2013; Mithoefer et al., 2013).

3,4-Methylenedyoixy-methamphetamine and the Brain

Research conducted by Liechti, Gamma, and Vollenweider (2001) indicated that the activation of 5-HT (serotonin) is imperative to the combination of psychological and

physiological effects of MDMA, as 5-HT plays a role in the regulation of mood, specifically in the pathophysiology of pathology (i.e., anxiety and depression). The above-mentioned researchers noticed changed in their participant's moods after they were administered doses of MDMA. In particular, it was observed that MDMA heightened the participant's mood, self-confidence, and their levels of extroversion (e.g., sociability). Additionally, MDMA also significantly increased thoughtfulness-contemplativeness, and participants were in a "state of dreaminess and lost in thought" (Liechti et al., 2001). The results are likely due to the effects of MDMA on the brain.

Oehen, Traber, Widmer, and Schnyder (2013) stated that the current neurocircuitry of individuals whom have experienced trauma and symptoms as a result have "uncontrolled and exaggerated" responses in the amygdala. This is likely due to stimulated responses from a past traumatic event (i.e., 1. Fear/hyperarousal; 2. Intrusive experiences; and 3. Numbing/withdrawal symptoms) which can significantly impact and impair a patient's emotional and behavioral health. Green, Mechan, Elliott, O'Shea, and Colado (2003) and Hegadoren, Baker, and Bourin (1999) stated that the neurochemical activation in the brain has various psychobiological functions. These functions include a deficient top-down inhibition of the amygdala by the ventromedial prefrontal cortex (vmPFC; Oehen et al., 2013), orbitofrontal cortex (Frewen & Lanius, 2006), in addition to inhibition of the hippocampus (Frewen & Lanius, 2006; Oehen et al., 2013; Rauch, Shin, & Phelps, 2006). These deficient functions of the brain have effects on the mood and a patient's overall psychological functioning (Parrott, 2007). These abnormalities in the brain can be decreases and reversed by MDMA (Gamma, Buck, Berthold, Liechti, & Vollenweider, 2000; Oehen et al., 2013). The neurochemical interaction MDMA has with the brain leads to the release of serotonin as it activates the 5HT receptor, in addition to the release

of dopamine and norepinephrine (Oehen et al., 2013), and leads to the positive attributes and effects of MDMA (e.g., positive cognitive emotional state, reduction in fear response; Farre et al., 2007; Liechti et al., 2001; Oehen et al., 2013). This is further corroborated by research conducted by Rudnick and Wall (1992) and Schmidt (1987), suggesting that there is a predominant release of 5HT (serotonin), and to a lesser extent, dopamine (Gamma et al., 2000; Yamamoto & Spanos, 1988).

Current and past literature related to fear conditioning and the amygdala implicate that the amygdala becomes activated during fear conditioning (LeDoux, 1996; Rauch et al., 2006). As mentioned previously, the amygdala plays a vital role in our behavior (e.g., fear response to stimuli, positive and negative emotions, and social behavior; Morris et al., 1996). The amygdala is responsible for a patient's emotional responses and reactions, while the medial prefrontal cortex inhibits the activity of the amygdala (Kujala, Carlson, & Hari, 2012; Rauch et al., 2006). Patients who have experienced trauma have a greater activation in the amygdala and smaller activation in the medial prefrontal cortex (Rauch et al., 2006).

Statement of the Problem

The statement of the problem provided me with the rationale for the study I am proposed and helped me provide a focus for my thinking (e.g., through data collection and analysis). When the research is completed, the comprehensive review of the current body of literature generates the frame and rationale of the study based on observations in the omission of the body of the exact literature (e.g., what's missing?), in addition to the "social cost of these omissions" (Glesne, 2016). Furthermore, the statement of the problem assists me in the setting forth a basis of argument or posit the utility in terms of moral praxis of the study (Glesne, 2016).

Societal views on alternative medicines and holistic interventions are shifting. The use of psychotropic medications in the treatment of pathology is common practice but does not always "cure" the symptoms a patient experiences as a result of their psychological functioning. Differential diagnosis, such as posttraumatic stress disorder, are difficult to treat due to the characteristics of the symptoms. Although research has been conducted to show positive results on the use of empathogenic substances, such as MDMA, the intrinsic value is not completely understood by clinicians and patients alike. The landscape of therapeutic interventions is constantly changing, and the likelihood of the clinical paradigm is in a state of flux. Because of this, clinicians and the general population are looking for alternative ways to promote interpersonal change.

The study focused on a treatment modality that will likely change the way clinicians approach psychopathology in the future, thus permanently evolving the clinical practice of psychology. Furthermore, the importance of this study cannot be fully understood until phase III of clinical trials are completed by the Multidisciplinary Association for Psychedelic Studies (MAPS), and the implementation of this treatment modality is approved by the Food and Drug Administration (FDA) in approximately 2019-2020. Thus, this unique, qualitative study will provide valuable information to the current body of literature.

Purpose of the Study

A qualitative researcher generates the statement of purpose of the study because it is directly linked to the utility of the study, specifically that of its ethical commitment to moral praxis (Glesne, 2016). It was recommended that the purpose of the study be credible to its potential consumers, as it reflects the emergent nature of qualitative inquiry. The purpose of the study helps the researcher provide the framework in the study they are conducting (Glesne,

2016). Creswell (2014) suggested that the researcher should contain the following in their purpose statement: information about the phenomena that the researcher is studying, the participant(s) that are involved in the study, and the research site. With the content of the purpose statement identified, the researcher will be able to narrow the study to a specific idea (Creswell, 2014; Glesne, 2016).

I explored the experience and the meaning of MDMA by its consumers. The study sought information on how a therapist who has experience in treating clients with trauma views the use of MDMA as an auxiliary treatment in conjunction with therapy for trauma. This study sought to explore the objective and subjective factors of therapy in conjunction with MDMA to treat posttraumatic stress disorder (PSTD) from the lens of a therapist. I also explored the perceptions that professional psychologists may have of using MDMA in conjunction with therapy to treat trauma. The study explored the objective and subjective factors that contribute to the development of using MDMA as a therapeutic intervention. The results were an analysis and discussion of themes and patterns recorded during the semi-structured interview. After this was concluded, an exploration of repeated themes was conducted. Further, any biases or preconceptions were managed by the use of epoché in the correspondence of meaning from the themes and commonalities amongst the participant's experiences (Creswell, 2014). I intended to explore and examine the participant's personal understanding of the potential healing qualities of MDMA. Therefore, the purpose of this research project was to understand and explore the central phenomenon that is the perceptions of the use of MDMA-assisted psychotherapy to treat long-standing trauma.

Research Questions

Creswell (1998) and Rossman and Rallis (2016) stated that a research question is the first and most critical step in a research design. This starts with the *how* (e.g., process) or a *why* (e.g., meaning) question. Such as the statement of problems, the research question helps the researcher focus on the study (e.g., data collection and analysis), thus providing the intent of the study in addition to indicating the bounding of the qualitative study. Glesne (2016) stated that it is important for the researcher to investigate all possible questions, and to focus on investigating the present and central issue of the qualitative study by eliminating or setting aside questions that do not pertain to the current study, and by further categorizing their questions. In transcendental phenomenological research, Moustakas (1994) stated that the research questions seek to reveal the human experience and is what this study hopes to do through understanding the participant's experiences of healing using an empathogenic substance (e.g., MDMA). Moustakas (1994) further stated that rather than uncovering the quantitative factors in the participant's behaviors, it is recommended the researcher looks at the qualitative experience and understanding of how healing occurs with MDMA. The goal is to engage the participant in their personal involvement and not to seek or predict a causal relationship in the way a quantitative research would do. Furthermore, the qualitative experience is favorable, as opposed to measurements, ratings, or scores that a researcher would favor in a quantitative study (Moustakas, 1994).

In a phenomenological study, Moustakas (1994) identified four categories of research that are used to define/inquire about the researched phenomena: descriptive, experiential, process, and meaning. A *descriptive* question explores the participant's interpersonal perceptions of what the phenomenon is (e.g., What is part of it? What is not?). An *experiential* question is designed to inquire about the participant's personal experiences related to the phenomena being

studied. The *process* question is asked by the researcher to understand the process to which the participant has gone through in relation to the phenomena. Lastly, the purpose of a *meaning* question represents an understanding as to what the phenomena means to the participant. For this study, my identification questions were:

RQ1 (Descriptive): How is MDMA used therapeutically?

RQ2 (Experiential): How is MDMA therapeutically experienced?

RQ3 (Process): How do consumers come to use MDMA? What is the therapeutic process as described by a therapist?

RQ4 (Meaning): What is the meaning of the MDMA experience?

Grand Tour Questions

As mentioned, the four grand tour questions are the *descriptive, experiential, process,* and *meaning* questions. They are considered open-ended questions to provide the researcher with a "grand tour" of the participant's experiences in relation to the study. These "open ended" questions help the researcher engage in focused conversation with the participant about their experiences of the phenomenon (Glesne, 2016). Grand tour questions assist the research in the collection of information about the personal feelings and beliefs of the participant's experience, their intentions, prior behaviors, and the meanings of their experience by facilitating the sharing of the participant's experiences (Glesne, 2016; Moustakas, 1994). Further, the purpose of the research question was to elicit a descriptive narrative of the participant's experiences in relation to the phenomena being studied.

The following questions were the proposed initial grand tour questions for this qualitative study:

1. (Descriptive) Tell me about a situation in which you used a clinical intervention in therapy to treat trauma. Can you also describe how this intervention would look if it were couple with MDMA assisted-psychotherapy?
2. (Experiential) Following this experience, did you notice any change within the other person whom received the intervention? In your clinical perspective, how would this experience be if it were in MDMA assisted psychotherapy?
3. (Process) Tell me about a time that you noticed a change in the client after you used an intervention strategy to treat trauma. Can you explain what that process was like? If you were to combine MDMA to the intervention, what would this process look like?
4. (Meaning) What did you take away from this experience(s)? Did you notice a change in the client when you used your intervention strategy? When accessing the traumatic events and experiences through an intervention strategy such as MDMA-assisted psychotherapy, how would the meaning of the experience be explained in your clinical experience?

Significance of the Study

The significance of the study is a general aspirational statement that I hope for the study (Glesne, 2016). It is of importance, as it requires the identification of potential stakeholders for the study's findings, and how the stakeholders may benefit from the study (Glesne, 2016). The stakeholders of the study are clinicians and practitioners of psychology, various types of therapists, researchers, students, and other mental health professionals that treat symptomology associated with psychopathology. Further, the stakeholders had a deeper understanding and

insight into how an empathogenic substance can facilitate therapeutic change within the context of psychotherapy.

This study was one of the first truly qualitative studies in the field of research associated with MDMA and its effectiveness as an agent for change in the context of therapy. The study will significantly contribute to the scholarly research and literature of clinical psychology. I hope to broaden the understanding of how empathogenic substances, such as MDMA, can be used in conjunction with psychotherapy. I hope to contribute to the meaning of MDMA and how it can be helpful from the lens of a therapist. This study also provided a qualitative perspective of MDMA from the perspective of a therapist that has used an intervention to treat trauma, and what it would look like if a client were to participate in MDMA-assisted psychotherapy. With this, I hope to improve clinical practice by providing clinicians with literature on how we can use empathogenic substances in conjunction with psychotherapy. By understanding which factors of the MDMA experience have the most impact, we can delimitate and identify the best factors, and improve how we select interventions when we treat pathology.

CHAPTER II. APPROACH

Rationale for Use of Qualitative Methodology

Quantitative research is designed with the intent of making generalizations about some social phenomena, creating predictions, then providing casual explanations of the phenomena (Glesne, 2016). Qualitative research methods are used to understand the perspectives of those involved in a social phenomenon, to contextualize issues in their sociocultural-political milieu, and transform or change social conditions (Glesne, 2016). The rationale for a qualitative researcher's study is to capture the social phenomena from his or her participant's personal experiences so the researcher can have a deeper understanding about the social phenomena being studied (Rossman & Rallis, 2016). The unique feature of a qualitative design is the means through which the study is conducted as the researcher tries to gain insight about the social world (Glesne, 2016).

Quantitative and qualitative researchers approach their methodology differently due to differences of intent. A quantitative study begins with a master theory, and then the researcher tests the veracity of said theory. This assists the quantitative researcher in the design of their study. This is done by selecting specific strategies or procedures to employ in the study's design. The goal of the quantitative researcher is to examine hypotheses, the relationship between variables, and the support of models that theorize the average experiences relative to a phenomenon (Glesne, 2016). Further, the quantitative researcher tests his or her hypothesis by using specific methods that are methodologically designed to remove the researcher from his or her subjects/participants, in an attempt to be objective in his or her approach, to avoid influencing the participants, data, and results of their study (Glesne, 2016). The quantitative researcher then analyzes his or her data statistically to generalize the information they gathered

throughout the course of the study (Glesne, 2016). Qualitative research differs from quantitative research as it seeks to understand the participant's personal and subjective experiences to generate a narrative so that the researcher can have a deeper understanding about the social phenomenon they are researching. This process prompts the researcher to ask questions, make direct observations, and directly interact with the participants (Glesne, 2016). Furthermore, the qualitative researcher looks for patterns but does not try to reduce these subjective interactions to a norm (Glesne, 2016).

There are four main uses of qualitative methodology: instrumental, enlightened, symbolic, and transformative/emancipatory (Rossman & Rallis, 2016). An *instrumental* study of a case (i.e., person or specific group) provides the qualitative researcher with insight into the specific phenomenon that they are studying and helps the researcher to redraw generalizations. Additionally, an *instrumental* study involves solving local or practical problems (Rossman & Rallis, 2016). Studies that seek to *enlighten* consist of contributions to general knowledge. They enhance understanding and offers heuristic insight (Rossman & Rallis, 2016). A qualitative researcher selects enlightenment as its focus when little is known about the social phenomenon. The goal of the researcher is to generate a theory and produce knowledge. Thus, the researcher sets out to obtain intricate details about the little-known phenomenological experiences. As the researcher's knowledge accumulates, the findings improve their phenomenological understanding and builds insight into the principles behind their procedures. *Symbolic* use of qualitative methodology seeks new ways of understanding phenomena, crystalizing the researcher's beliefs or values, and re-conceptualizes any existing etic or public perceptions of the phenomenon (Rossman & Rallis, 2016). When qualitative methodology is used *transformatively,* it is typically used to break or shift the existing scientific paradigm. Such studies are often linked

to critical ethics and social justice issues (Rossman & Rallis, 2016). The emancipatory use of qualitative methodology involves taking actions that empower participants and change oppressive structures and practices (Rossman & Rallis, 2016). For this current study, the two main uses of qualitative methodology that will be reflected are *symbolic* and *instrumental* use.

Specific Methodology

The phenomenological method of inquiry is based on the premise of the human consciousness (Moustakas, 1994), where reality and truth, although not directly "knowable," controls the way we individually respond to our personal experiences (Moustakas, 1994). This qualitative method is specifically used to explore the way participants understand their subjective experience, and relies on in-depth interviews (Moustakas, 1994). The transcendental phenomenological method heavily utilizes and relies upon the semi-structured interview to gather information in the postmodern approach of transcendental phenomenology (Moustakas, 1994). The semi-structured interviews prove to be valuable in the gathering of qualitative data as it allows the participant to give their subjective views about their interpersonal experiences of the phenomenon. Furthermore, this interviewing style will prove valuable to my present study as opposed to a more structured interview format that would be looking for subjective questions to be answered by the participant, rather than a more open-ended, grand-tour style of questioning that the semi-structured interview allows me to do.

Moustakas (1994) described a very specific phenomenological method, epoché. This process sets aside and manages any pre-judgements the researcher may have while conducting research. This process begins prior to a researcher launching the study and continues throughout the process of data collection, analysis, and the write-up (Moustakas, 1994). Ultimately, the researcher wants to be as far removed from any preconceptions, knowledge, or beliefs they have

of the phenomenon prior to the study (Moustakas, 1994). Epoché is important to the current study as it opens my ability to act on my intuition, be sensually aware, and to be open to the experiences of the participant. This process will assist me in understanding the participant's experience with MDMA and if the empathogenic substance promotes healing. Furthermore, eliminating any pre-judgements or biases allows me to experience epoché in the study, and will assist in establishing good rigor.

Throughout the process of this study, my goal is to objectively understand and gain insight into the literature, the participant's data, and to separate personal beliefs from the phenomenon that I am researching. Furthermore, in a qualitative study, it is of specific importance that I separate and differentiate what is important to the study and what is not. This occurs throughout the analytical process and is directly linked to the moral praxis of the study. In all forms of therapy, the focus is the good and well-being of the patient that we engage with, thus, it is my responsibility as a researcher and clinician to focus on how the study will be beneficial to patients and practitioners alike, in addition to the public.

Role of the Researcher

Intersubjectivity

Glesne (2016) stated that intersubjectivity the subjectivities that help shape the research since they are not those of the researcher alone. The more the participant and I interact in the study, the subjectivity will guide the research process and content. I will consider the subjectivity *of* and *how* it can assist me in the interpretation of my data (Glesne, 2016). One way I can address the subjectivity of the study is to be reflective while I monitor the study (Glesne, 2016). The author states that there are three ways to be reflexive in the study:

1. I inquire into and discuss any decisions that affect my research process;

2. Inquire and discuss any of the methods that I use; and
3. Inquire into and discuss with the participant any personal biases or perspectives that I have (Glesne, 2016).

Participant Observation

As a participant-observer, I will carefully observe the systematical experiences of the participant, recording in detail the many aspects of the MDMA experience (Glesne, 2016). This process affords me the opportunity to continuously analyze and observe the participant's experiences. As a qualitative researcher, I will observe for any potential biases in the study as it is instrumental to the research goals set forth (Glesne, 2016). I will be involved in the research setting and continuously observe as it allows me to make inferences related to any interpersonal experiences. As research is conducted, I will take notes of the participant, the events that occur, the setting, any behavioral or observational data, and any other information that may be gathered so that I can analyze and code it once I complete the study (Glesne, 2016). Furthermore, in the observation process, I will move on a continuum between being observational, to completely participant, but never being at either one of the end points on the pendulum (Glesne, 2016). By achieving this, I will have a better understanding of the participant's full experience.

Ethical Considerations

There are four categories of ethical theories that will inform my qualitative inquiry: theories of consequences, rules and responsibilities, ethics of justice, and care (Rossman & Rallis, 2016). Nonconsequentialist ethical issues recognize universal standards to guide all behaviors regardless of the consequences in a specific context, thus, Rossman and Rallis (2016) have outlined two nonconsequentialist ethical theories: ethics of individual rights and responsibilities, and ethics of justice.

The *ethics of individual rights and responsibilities* are set in place so that I can uphold the unconditional worth of and equal respect to which all human beings are entitled, in addition to the corresponding obligations and responsibilities bestowed upon me to protect the rights of the participant (Rossman & Rallis, 2016). The *ethic of justice* is described as working past individual privileges so resources and opportunities for socially and economically hindered people can realize fairness (Rossman & Rallis, 2016). I have put these two categories of ethical theory in place so that I can have an educated guidance in how I build and develop my relationship with the participant and the guidelines I will apply to these relationships (Rossman & Rallis, 2016).

The ethic of justice goes beyond individual rights. I will employ this ethic so that I can achieve equity above equality, most specifically when I am faced with circumstances of social and economic disadvantage (Rossman & Rallis, 2016). Further, I am encouraged to use these ethical considerations by Rossman and Rallis (2016) so that I can pay closer attention to the "voices" that have "previously been silenced." *Ethic of care* is a powerful way for me to conceptualize the moral and ethical aspects of the study and will assist me in spotting the relationships within the study (Rossman & Rallis, 2016).

Rules and responsibilities and *ethics of individual rights and responsibilities* are also important ethical theories in the study. Ethical responsibilities will entail informed consent, confidentiality, anonymity (including the limits), security data, voice and interpretive authority, ownership and proprietorship, and the rights of the participant (Rossman & Rallis, 2016). I must provide the participant with a promise to confidentiality, since the work I am conducing happens in the field. Thus, I need to assure the participant that I can deliver confidentiality (Rossman & Rallis, 2016). I will do this by protecting the privacy of the participant and keeping what they share with me confidential.

Informed consent is another ethical responsibility I have towards the participant. It lets the participant know about any possible purpose of the study and the audience. Informed consent allows the participant to understand what the agreement of being a participant is, gives them consent to willingly participant in the study, and allows them to understand that they may withdraw from the study at any time without prejudice (Glesne, 2016; Rossman & Rallis, 2016). The participant is a co-owner of any material that develops throughout the study (i.e., data, narratives, write-ups, taped interviews, transcriptions). They will be made aware that they have full access to any of the above-mentioned materials (Rossman & Rallis, 2016). The security of their taped interview is also assured to further protect their privacy and autonomy. Furthermore, the participant has the right to use a pseudo name to further ensure their autonomy.

Purposive Sampling and Bounding of the Study

Purposive sampling is a research method of sampling that benefits the research project due to the way it assists with the research questions (Glesne, 2016):

(*Descriptive*) How is MDMA used therapeutically?

(*Experiential*) How is MDMA therapeutically experienced?

(*Process*) How do consumers come to use MDMA? What is the therapeutic process as described by consumers?

(*Meaning*) What is the meaning of the MDMA experience? By using purposive sampling, I can rely on my own judgment during the selection process of the participants (Glesne, 2016). Since there are limited resources and participants, purposive sampling allows me to explore the meaning of the MDMA experience from an intuitive approach rather than an expert model (Glesne, 2016). Purposive sampling affords the opportunity to select participants with knowledge of MDMA, therefore allowing me to capture the breadth of the MDMA experience from a

therapist's perspective. For this reason, there was a small sample size. Furthermore, this method requires me to select participants and sites where I can gain information that is important to the research through in-depth interviewing (Glesne, 2016; Patton, 2002).

According to Rossman and Rallis (2016), there are various strategies that can be employed for purposeful selection of cases, participants, and processes: (a) case sampling, (b) critical case sampling, (c) snowball/chain sampling, (d) criterion sampling, (e) extreme or deviant case sampling, (f) maximum variation sampling, (g) stratified purposeful sampling, (h) homogenous sampling, (i) theory-based sampling, (j) politically important case sampling, and (k) convenience sampling.

For the study, I conducted an in-depth interview with one participant (e.g., case study) and used critical case sampling. This strategy fit the study for various reasons, including the population I was looking to study consisted of an individual who had an interpersonal understanding of MDMA, and I was looking for a participant who had an interpersonal relationship with to healing with an empathogenic substance. Furthermore, due to the time constraint of the study, having multiple participants made it difficult to complete this study in a timely manner.

During the participant selection process, the potential participant was given an overview of this study, including very specific details about the risks, benefits, time commitment, and a potential timeframe as to when the study would be completed. At that point, the participant had access to documents related to the study, as the participant was considered a co-owner of the materials that developed through this study. The participant was given the option to use any code name. The participant's name did not appear on any transcripts or in any of the provisional write-ups. The transcriptionist(s), peer debriefer(s), peer examiner(s), and research consultant(s) only

had access to the audio recordings and transcripts when performing duties related to the study. When these materials were not being used, they were in a locked filing cabinet or locked file box to which only I had the key/combination. I am required by law to inform an appropriate other person if there was reasonable suspicion that a child, elder, or dependent adult had been abused by the participant. My intent was to ensure that the participant's safety and the safety to others by networking the participant to resources that supported them through challenges. In such an instance, interviews were temporarily stopped until the participant had a chance to access these resources. The participant may ask questions regarding the study, and I will attempt to answer them fully. The participant were allowed to withdraw at any time without having to provide reason and without fear of negative consequences with me, the members of the team, or Chaminade University of Honolulu. The participant's participation was completely voluntary. If at any time the participant wanted to speak off the record, they were provided with the opportunity to do so without consequence. Anything that was discussed off the record was not entered into the data unless the participant discussed them on record at a later date. The participant could waive any questions they did not wish to answer and could defer and answer any question at a later date. The participant had the right to review the work at any point in the process. After I generated a narrative of what the participant had shared with me during our meeting, I gave the participant an opportunity to add, revise, and remove material the participant believed did not accurately represent their experiences.

The participant was made aware that I wanted to conduct two meetings. The first interview lasted an hour to an hour-and-a-half. During that meeting, I explored their experiences with them. With the participant's permission, I taped the conversations and I personally made transcriptions from the tapes that I attempted to represent the participant's perspectives with

greater accuracy. In our second meeting, I reviewed the transcripts with the participant, and my understanding of what the participant shared with me. This gave the participant an opportunity to make any necessary corrections, additions, and retractions to the interview transcripts, and to further review the narrative and/or analysis of their story for accuracy before I submitted the information.

After I transcribed the audio of the interviews, the next step was to engage in peer debriefing, meaning that I conducted peer debriefing before and during the process of collecting the participant's data. My peer debriefer, Dr. Patrick Kamakawiwo'ole, assisted with the study. His role was to provide support, assist in the analysis of the data and inquiry, provide feedback, discuss observations and challenges in the study and interview, understand any possible hypotheses, and assist in addressing the problems that may emerge throughout the process of conducting the study (Glesne, 2016; Lincoln & Guba, 1985; Shenton, 2004).

The final consent and release of information was discussed with the participant. The information collected through the course of their participation in the study was submitted by me, in partial fulfillment of my requirements for the Clinical Research Project (CRP), and the Doctor of Psychology degree in Clinical Psychology, through the Hawai'i School of Professional Psychology at Chaminade University of Honolulu. By authorizing the use of these materials as part of the CRP, the participant and I discussed the use of the highlighted quotes in the final write-up to illustrate the perspective/themes that were used. Further, the participant was made aware that the tapes, transcripts, and analysis for this project were maintained until the completion of the CRP requirements, or three years after the interview(s), whichever comes first.

The constant comparative method was used to generate a theory about the study through the analyzation of data. The participant was made aware of how constant comparative analysis assist in the analytical process of their experiences:

1. this method assists in identifying local concepts regarding the study;
2. it helps identify principles;
3. it assists in the identification of structural processes and processes of the participant's subjective experience in relation to the study; and
4. it assists in the decision-making process (i.e., initial data collection).

Further, the participant understood that there were four specific stages to the constant comparative analysis. In the first stage, I compared incidents that were applicable to each category I recognized. In the second stage, I integrated the categories and their properties into the study. In the third stage, the study's theory went through a delimitation process. Finally, in the fourth stage the theory was written.

CHAPTER III. EMERGENT FIELD METHOD

Pre-entry

The pre-entry phase in the qualitative study was the period prior to me entering the field, when I focused on gaining an understanding about the culture of the participant and their setting. This process helps to increase the sensitivity and respect for the cultural aspects in relation to the participant and the site (Glesne, 2016). One way, as a qualitative researcher, I can obtain assistance in the pre-entry process is by the help of informants and a gatekeeper (Glesne, 2016). As I begin to enter the field, I will begin to build rapport, and this continues throughout the process of conducting fieldwork (Glesne, 2016). Furthermore, the author Glesne (2016) stated that I must consider the relationship as a building and emergent process and means that the relationships between myself and the participant are not static.

Review of Biases

It was of importance that I began an initial identification and review of any theoretical, methodological, and personal biases during the pre-entry period. This will assist in facilitating greater openness to the participant's experience (Glesne, 2016).

Theoretical biases. In my qualitative study, a theoretical bias was one that was related to any assumptions or conceptualizations I learned as part of my training in clinical psychology (Glesne, 2016). Theoretical biases may come from specific frames and modalities of therapy that I have studied (e.g., Person-Centered, Cognitive Behavioral Therapy, Psychodynamic Psychotherapy). If I conceptualized within a specific psychotherapeutic modality, I may act in ways during the study that reflected theoretical biases, rather than remaining open to whichever frame the participant presented. I needed to be aware of my tendency to conceptualize in a specific frame as it may inhibit the ability to listen, to be present, and to objectively understand

the participant's story. If not, a methodological drift may occur, thus creating problems with role management.

There was a possibility that I entered with a theoretical bias in the study due to my belief in alternative and holistic approaches to interpersonal change, and how it related to our healing processes. These biases of mine may align me with the belief that MDMA-assisted psychotherapy is an effective therapeutic technique. After reviewing my biases, it might be difficult for me to hear that MDMA is a transformational form of healing, and if this occurred, I planned on speaking with my peer debriefer and examiner to make sure that I was attuning to the participant without any personal judgement or bias. Furthermore, during the interview, I asked the participant open-ended questions so that I could completely understand why the participant did not believe that MDMA can assist in the process of healing.

A bias I have is my interpersonal belief that through the process of being empathetic towards others, we can connect to parts of ourselves that are otherwise difficult to connect to, leading to self-actualization. I believe that our senses, intuition, feelings, and our thoughts allow us to reach higher levels of consciousness with the assistance of empathogenic substances (e.g., MDMA). Furthermore, I believe empathogenic substances attune us to a more empathetic self and is part of a holistic approach to therapy. The assumption is that MDMA allows us to feel levels of empathy that we would not be able to feel otherwise. I addressed these biases by creating space for listening and understanding the participant's interpersonal experiences. If my biases arose while I interviewed the participant, I asked the participant open-ended questions so that I was able to understand why the participant believed that MDMA is not an agent for healing. I used a peer debriefer and examiner to further understand my processes throughout the interview if the biases were to arise, and I conducted a member check with the participant to

make sure that the interpretations of the interview were true and accurate based on their own experiences.

Methodological biases. A methodological bias happens to qualitative researchers who have been exposed to and trained in different research paradigms. In the study, I checked with my clinical Research Project Committee and my peers to ensure that I was not engaging in a methodological bias due to my educational training in quantitative methods. As an undergraduate and graduate student, I have been educated in the expert model. I may experience a methodological drift, and experience problems with role management. Because of this I assumed the role as the expert. This would cause me to make decisions that are aligned with the positivist tradition/expert model.

The quantitative method I am accustomed to relies on correlational and casual relationships between variables and differs from the intersubjective understanding of the participant's subjective experiences that are important to the qualitative study. An example of this type of methodological drift is if I believe that the participant will construct their experiences and reality so that it correlates with the questions. I may ask the participant questions that are correlational or causal to support the hypotheses. As a qualitative researcher, it is important that I may also ask about aspects of the participant's experiences with MDMA to objectively understand the participant's personal narratives and experiences.

The purpose of the study was to gain an understanding of the participant's insights into the healing properties and effects of MDMA, rather than the research that supports the participant's experiences, or my own biases (Glesne, 2016). It was of importance that I attuned to the possibility that I may try to gather patterns that are common and explanations that are simple. Because of this, the potential consequence was that I may experience a methodological drift, and

problems with role management that would prevent me from attuning to the participant's personal stories and experiences as they are told (Glesne, 2016).

To assist me with any problems with methodological drift and role management, I used a peer debriefer and examiner. I was open about the way I interviewed by theoretically conceptualizing and analyzing data. My peer debriefer and examiner assisted me in identifying any possible problems that arose. At this point, I was able to address these potential issues prior to coding my data. Additionally, I engaged in a member checking process to assure that I gathered correct and objective information in the case that I made any correlational or casual inferences from the participant.

Personal biases. Personal biases may occur in the study if I predicate on my own experiences and allow my personal and subjective views effect my research as I engage with the participant (Glesne, 2016). An example of personal bias I have is I believe that people understand interpersonal healing at an intuitive level. A personal bias I have is my belief that empathogenic substances, such as MDMA, will allow a consumer to experience higher levels of consciousness, thus promoting a positive interpersonal psychological experience.

If I engaged in personal biases, there could be natural consequences as a result. Personal biases could potentially have a negative impact on my data collection and analysis. Data bias could occur when my selection process is subjective (Glesne, 2016). I may select a participant that aligns with my personal beliefs about the interpersonal healing process I associate with the consumption of MDMA. I may also over identify with the participant based on any personal biases I have. This would result in me acting in a way that is relatable to the participant (e.g., "impressing" them; Glesne, 2016). If this happened, it could have a potential impact on my data collection and analysis due to the lack of rigor the study had if personal biases interfered with the

ability to objectively attune to the information provided by the participant. My peer debriefer and peer examiner assisted in delimitating biases. Furthermore, I was also able to limit the effect of personal biases by having a within and in-between interview strategy. This process consisted of a peer reviews, debriefing, and a member check-post interview.

Entry

Immersion

The immersion process enables qualitative researchers to gain knowledge of and gain insight about a specific setting, the cultural aspects of the site, and the participant (Rossman & Rallis, 2016). This assists the researcher in the development of a comprehensive and emic understanding (Rossman & Rallis, 2016). The process of immersion encompasses full participation of the researcher while they participate in activities with the participant. Over an extended period of time, the amount of involvement the researcher has in the field will influence the design of the study through observation and interviews. Immersion allows the researcher to understand the data analysis (Rossman & Rallis, 2016), and Glesne (2016) stipulated that the researcher's role is to be present in the everyday setting to enhance the awareness of what takes place around them, further assisting the researcher in the analysis of the data. The more the researcher becomes immersed in their research setting, the more likely they will understand the issues from the participant's perspective (Glesne, 2016). Furthermore, the immersion process helps facilitate a connection between the researcher, the participant, the research site, and the phenomenon (Glesne, 2016).

Two-part Informed Consent Protocol

The entry process consists of a two-part informed consent protocol that I conducted. Because I conducted a study that involved human participants, a consent form was required to

protect my rights as a researcher and the rights of the participant(s). In the study, the consent forms stated that the participant had access to all transcriptions, writings, and audio recorded during the interview, data collection and analysis, and narrative processes (Glesne, 2016). The participant was given a consent form prior to the study, providing them with information about the study, how their identifying information was protected, who had access to their information, who was part of my research team, what I would do with the date (e.g., transcriptions, write-up), how they were protected under the law, and how I assured their anonymity (Glesne, 2016). Additionally, the participant was given a consent form about recording the interview and who transcribed the audio, if it was someone other than me. The participant was given a peer debriefer and examiner consent form so that I was able to consult with peers, in addition to a consent form about the release of their information and were all designed to protect the rights of the participant (Glesne, 2016). The final consent and release of information protocol allowed them an opportunity to check our work and to add, redact, or modify anything in the final write-up that they believed was too sensitive, poses risks to them, or did not capture their story with complete accuracy (Glesne, 2016). Furthermore, the participant was asked to review the transcripts, analysis, and write-ups of their personal narratives, including the exemplar quotes I used to illustrate the themes that emerged throughout the interview process (Glesne, 2016).

Constant Comparative Method

The authors Glaser and Strauss (1967) suggested that in a qualitative inquiry the constant comparative method is used by the researcher to generate a theory about their study the authors further suggest that the constant comparative method of analyzing data can be applied by the researcher to social units of any size. The constant comparative method allows the researcher to

identify phenomena of their study through the analyzation of data, and assists the researcher in the analytical process:

1. Helps the researcher identify local concepts regarding the study;
2. Helps the researcher identify principles;
3. Assists the researcher in the identification of structural processes and processes of the participant's subjective experience in relation to the study; and
4. Assists the researcher in their decision making process (e.g., initial data collection; Glaser, 2016; Glaser & Strauss, 1967; Glesne, 2016).

Furthermore, the author Glaser (2016) stated that the constant comparative method consists of four specific stages: (a) in the first stage, the researcher compares incidents that are applicable to each category that they recognize; (b) in the second stage, the researcher will integrate categories and their properties into the study; (c) in the third stage, the study's theory must go through a delimitation process; and (d) in the fourth stage, the researcher must write their theory.

Semi-structured Interview

In this transcendental phenomenological study, I used a semi-structured interview process to conduct my data collection. The interview was audiotaped and then transcribed so that I could readily code and find themes about the participant's experience with the phenomenon. As mentioned previously, qualitative researchers choose to use semi-structured interviews to objectively understand the subjective experiences of the participant's story. This differs from the positivist tradition and expert models of a structured interview that quantitative researchers use to find correlational and causational data (Glesne, 2016).

Data Management

The authors Rossman and Rallis (2016) suggested that the process of data analysis requires the researcher to organize their data accordingly: (a) organization, (b) familiarization with the date, (c) identifying categories, (d) generating themes, (e) interpretation, (f) searching for alternative understandings, (g) writing the report, and (h) coding the data.

Peer Debriefing

After transcribing the interview, the next step was to engage in peer debriefing. I conducted peer debriefing before and during the process of data collection (Glesne, 2016). The author Glesne (2016) further stated that it is not "absolutely necessary" for the debriefer to be familiar with the area of inquiry they are studying, though it is beneficial if the debriefer has some knowledge about the phenomenon, so they can assist the researcher with their study. The debriefer's role is to provide the researcher with support, assist the researcher in the analysis of the data and inquiry, provide feedback to the researcher, discuss observations and challenges in the study and interview, understand any possible hypotheses, and assist the researcher in addressing the problems that may emerge throughout the process of the conducting the study (Glesne, 2016; Lincoln & Guba, 1985; Shenton, 2004).

Transcription and Auditing

I personally transcribed and audited the recorded interview with the participant so that I could record and analyze, verbatim, the dialogue between us.

Coding

In a qualitative transcendental phenomenological study, there are three levels of coding: (a) Level I, *open coding*; (b) Level II, *axial coding*; and (c) Level III, *selective coding* (Glesne, 2016; Strauss & Corbin, 1998). The first level, *open coding*, also referred to as

"phenomenological reduction" by Moustakas (1994), is used to deconstruct data that the qualitative researcher collects. The researcher then transcribes the interview, then labeled by what the researcher believes was captured throughout the interview process (Glesne, 2016; Strauss & Corbin, 1998). Level II, *axial coding*, referred to by Moustakas (1994) as "imaginative variation," consists of the researcher clustering small units of categorical data, then again clustering it into larger categories and subcategories. Level III, *selective coding*, also referred to as "synthesis" (Strauss & Corbin, 1998), is a process where the qualitative researcher spots areas of code that emerges, likely revealing new data (Moustakas, 1994; Strauss & Corbin, 1998). Furthermore, according to Weiss (1995), the researcher develops a strategy for coding the interviews, and then integrates ("synthesizes") the codes across the interviews.

Peer Examination

In a qualitative study, LeCompte and Preissle (2003) suggested peer examining is used by the researcher to enhance their theoretical sensitivity. It consists of the researcher consulting with peers and other researchers who understand the type of research setting. This makes it easier to identify, discuss, and manage any personal or professional biases, methodological drifts, and discrepancies that may impact the data analysis. Furthermore, this process is valuable to a qualitative researcher because it assists them in refining any explanations of the previously mentioned issues that may arise in a quantitative inquiry (Glesne, 2016).

Generating the Narrative

According to Hammersley and Atkinson (2007), there are multipole ways for a qualitative researcher to present and organize their findings. Glesne (2016) suggested that the presentation of a qualitative study can be approached in various strategies, such as (a) the natural history approach, (b) the chronology technique, and (c) learning to labor. In addition to the

employment of presentation strategies that assist the researcher in narrowing and expanding the focus of their findings, it assists in the organization of the themes and/or topics. Glesne (2016) suggested that when a qualitative researcher analyzes their data they can do so by a process referred to as amalgamations (e.g., when the qualitative research and the author of the study analyze the interviews and observational data from their participants) then create categories that develop a descriptive portrait of them. For the study, I incorporated and utilized this approach as it best suited the data and the way that I coded, created categories, and finally, narrated the portrait of the participant's experience.

Member Checking

The member check process occurs when the researcher and participant discuss their interview (Glesne, 2016). The purpose of this process was to assure that the transcriptions, understandings, and views of the researcher were accurately reflected in the narrative that was generated by the researcher. Additionally, this typically occurs prior to the preliminary write-up and the final narrative of the findings (Glesne, 2016). Furthermore, throughout the coding process, the researcher typically finds themes and then codes them. This prompts the researcher to check in with the participant to further ensure the accuracy of the data, making this step a valuable part of the qualitative process (Glesne, 2016).

Methods of Verification

Validity

Rossman and Rallis (2016) suggested qualitative validity means that "the researcher checks for the accuracy of the findings by employing certain procedures." Validity and trustworthiness are one of three aspects of rigor assessed in a qualitative inquiry (Glesne, 2016). The researcher establishes trustworthiness by assessing the credibility and confirmability of a

study (Glesne, 2016; Rossman & Rallis, 2016), and consists of discovering if the study is based on emic accuracy (e.g., truth; Rossman & Rallis, 2016; Shenton, 2004). According to Shenton (2004), confirmability is the degree to which the subjectivity of the researcher is managed, and that the researcher does not have any biases affecting their findings. If the researcher has biases that negatively affect the findings of the study, the interpretation and narratives may be inaccurately reflected upon the participant's personal experiences (Glesne, 2016; Rossman & Rallis, 2016; Shenton, 2004).

Specific procedures and validity strategies for the researcher to incorporate into their proposal are outlined by Rossman and Rallis (2016):

1. The triangulation of data sources is utilized by qualitative researcher by examining the data so they can justify the themes coded from the data;
2. The researcher uses member checking after their interview has been completed to check the accuracy of their findings.
3. The researcher writes their narrative and takes their findings to their participant with the themes that have been found, and then checks to make sure that the participant feels they are accurate.
4. Rich, thick, description is a strategy employed by the researcher to convey their findings. Essentially, the purpose of this strategy is to provide a detailed description of the setting so that the readers have a clear and concise understanding; and
5. The qualitative researcher wants to ensure that they clarify the biases of their study, present negative or discrepant information, spend time in the field, use peer debriefing, and an external auditor.

These methods of verification assist the researcher in the enhancement to the validity and rigor of the study (Glesne, 2016; Rossman & Rallis, 2016). Further, the study did not use triangulation as a method of verification, however, I used member check, a description strategy, peer debriefing, and peer examination to ensure that I was able to clarify my personal and professional biases.

Reliability

The second aspect of rigor assessed in a qualitative study is the reliability (Glesne, 2016). Reliability is referred to as the analytical generalizability of emergent findings, and assesses for potential transferability and dependability (Glesne, 2016). The transferability of a study refers to whether the research findings are transferable to other sites and contexts (Glesne, 2016). The dependability of a study refers to where the findings will be comparable to those of similar studies (Glesne, 2016). To ensure the transferability of a study, the qualitative researcher will engage in peer debriefing to check for any personal and professional biases and will further ensure the reliability of the findings. I incorporated this in the study to assure transferability and dependability. I checked in with the peer reviewer, debriefer, and examiner, who assisted in the examination of my processes. Additionally, they checked for potential personal and professional biases, or any methodological drifts to further validate data, and ensure the repeatability of the study.

Utility

LeCompte and Preissle (1993) stated that the utility of a study is used to assess the rigor of and keeping with the conventional ethics of a study. The authors then presented some questions:

1. Does the study enhance or refine our current knowledge base with respect to a phenomenon?
2. Does it add to our understanding?
3. Do the findings address the statement of the problem?

Utility is used in a qualitative study to address the researcher's ethical commitments to the moral praxis and is comprised of specific criteria: (a) fairness, (b) ontological authenticity, (c) educative authenticity, (d) catalytic authenticity, (e) tactical authenticity, (f) catalytic authenticity, and (g) tactical authenticity (LeCompte & Preissle, 1993). Additionally, utility also encompasses fairness and educative authenticity. The authors LeCompte and Preissle (1993) state the fairness of a study provides the qualitative researcher with a balanced presentation of the multiple realities in a situation. Fairness reveals the multiple perspectives that are geld by group members, as it portrays the complexity and perspectives of the participants (LeCompte & Preissle, 1993). The ontological authenticity provides a fresh understanding of the phenomenon that is being studied and helps in uncovering a new way to conceptualize and understand the phenomenon (LeCompte & Preissle, 1993). The educative authenticity proves a new appreciation of current understandings, whereas catalytic authenticity is when the study has the capacity to support new courses of action (LeCompte & Preissle, 1993). Furthermore, tactical authenticity is when the study offers potential benefits to all concerned, enhancing the rigor and the utility of a qualitative inquiry (LeCompte & Preissle, 1993).

CHAPTER IV: RESULTS

The purpose of this research project was to understand and explore professional perceptions of the use of MDMA-assisted psychotherapy to treat long-standing trauma. This chapter of my Clinical Research Project (CRP) contains the results of the phenomenological methodology study I conducted to answer these research questions:

RQ1 (Descriptive): How is MDMA used therapeutically?

RQ2 (Experiential): How is MDMA therapeutically experienced?

RQ3 (Process): How do consumers come to use MDMA? What is the therapeutic process as described by a therapist?

RQ4 (Meaning): What is the meaning of the MDMA experience?

This chapter also includes a discussion of the analysis and coding including tables to complement the thematic findings, a description of the sample for this critical case study, I also described some of my processes, such as analyzing the interview transcript, my coding and themes will be detailed, including the levels of analysis (i.e., 1st cycle open coding, 2nd cycle axial coding, 3rd cycle thematic coding). Also included is a graph to present my coding of the thematic data used to present my findings.

In the section I talk about how I became interested in the topic of MDMA assisted psychotherapy and my personal stake in it. During my diagnostic year, I worked with a lot of clients who had experienced life debilitating trauma. It was not until then that I had an understanding of the effects, both short and long term, trauma has on individuals that we work with. I specifically remember a conversation I had with a few of my friends who had introduced me to that the research on MDMA assisted psychotherapy. At first, I was a little bit reluctant about the efficacy surrounding MDMA assisted psychotherapy. However, once I began doing

research on empathogenic substances such as MDMA, Psilocybin, marijuana, and other medicine such as Iowaska, I began to change my outlook on how the change process happens. Referring back to my diagnostic year, I saw how impacted the clients that worked with were because of the complex childhood trauma that for the most part, went untreated. It was then that I began to switch my focus to trauma as an area of interest that I would like to specialize in after I complete my generalist degree in clinical psychology.

Originally, I had a vision of working with individuals with specific eating disorder such as anorexia nervosa and bulimia nervosa. At some point in my graduate career I lost interest in this topic. I am actually very thankful for having this conversation with a few of my friends that had or have a lot of experience with empathogenic substances. One of my friends in particular, has a lot of personal experiences in the healing practices of using empathogens as the agent of change. When I began to listen to the stories and experiences of others who had transformative experiences while under the influence of an empathogen such as MDMA, my interest began to spike as it was combined with my newfound interest of complex trauma. Specifically, I really took notice of how complex trauma manifests into an array of pathological disorders. I worked with clients who had trauma that stem from childhood which resulted in psychosis, obsessive compulsive disorders, depression, and substance use. In my experiences, the most common was the trifecta of depression, PTSD, and illicit substance use.

This is my first true qualitative study, although I have taken a course in qualitative research methods twice. In recent days I have been questioning myself as to why I have chosen this methodology, but for whatever reason, it seems fitting to the study. As a person and a student studying to become a therapist, I align myself with the humanistic approach to therapy (i.e., client centered therapy by Carl Rogers) and apparently this aligns well with the qualitative

method. Therefore, I did not come in with a lot of experience or knowledge about qualitative research. However, my intent and hope are to gain a rich and thick description of a phenomenon that I intend to continue learning about in the future as a clinician.

In regard to MDMA, I have zero personal experience outside of research. The only outside experiences I have are the stories from acquaintances and people in my life. We have personal experiences using empathogenic substances. The way the world is working today, we can expect a big change in the future in regard to the use of substances. I hope that with this study I am able to provide some outlook about the phenomenology of MDMA, specifically that of MDMA assisted psychotherapy through the lens of a therapist.

Sample

For this critical case study, the sample size is of one person who is a female participant. Jessica was born and raised in California and is currently on her post-doctoral residency on the East Coast. Initially, I had planned to have more participants; however, due to the school closure of my academic institution, myself and my advisers had agreed on doing a smaller study as a result. Although Jessica is my only participant, she comes to this research project with a bevy of knowledge in both treating trauma and understanding the current body of literature in regard to MDMA assisted psychotherapy. Previously, I selected a participant who had a thick and rich personal and interpersonal experience with using in pathogens such as MDMA, Iowaska, and Psilocybin to help people be present in their experiences. However, due to restrictions of the IRB at Argosy University, I had to abandon that study for a smaller study such as this critical case sample. As I will mention in the limitations, the study would have benefited from having a larger pool of participants, in addition to participants who have personal experience of using MDMA, thus providing a deeper understanding of its healing qualities.

Data and Analysis

Glesne (2016) stated that it is not "absolutely necessary" for the debriefer to be familiar with the area of inquiry they are studying, although it is beneficial if the debriefer has some knowledge about the phenomenon, so they can assist the researcher with their study. The debriefer's role is to provide the researcher with support, assist the researcher in the analysis of the data and inquiry, provide feedback to the researcher, discuss observations and challenges in the study and interview, understand any possible hypotheses, and assist the researcher in addressing the problems that may emerge throughout the process of the conducting the study (Glesne, 2016; Lincoln & Guba, 1985; Shenton, 2004).

I had to undergo my coding process several times. At first, I went through my transcript while listening to the audio. During this stage of coding, I was again familiarizing myself with the interview as it had been eight months since I had conducted the interview, which I had completed a week or so prior to the abrupt school closure of my academic institution. I will further discuss this in the limitations section in Chapter V. While immersing myself in the interviewing process, I was listening for possible themes. After I completed my first round of coding, I realized that my approach was not consistent with the qualitative method. I was originally listening for 'spike' words rather than trying to understand the phenomenology of research topic.

I consulted with my peer-debriefer and peer examiner after going through the transcript 3 different times. By doing this I was able to approach my coding using more accurate qualitative approaches, such as open or initial coding. I used a book titled *The Coding Manual for Qualitative Researchers* (Saldaña, 2009). This book proved to be helpful in identifying the type of first cycle coding that would be appropriate for my single interview case study.

During my second cycle, I used axial coding as it helped me extend my first cycle and analytic work that I did during my initial or open coding process. I had to go through the coding several times to find the themes. I took the advice of my peer-debriefer to remove my thoughts about the coding, and just 'code' them. I put them in clusters without thinking too much. About halfway through this part of the coding, I began to see the emerging themes, and began to feel more comfortable with the process. This newfound confidence had me feeling able to complete the coding and continue with the rest of the process.

In my 'third' cycle of axial coding, I again removed 'spike' words and tried to look at the data objectively by removing things that I already know. For example, one cluster of codes was under a theme of trauma. I then removed the words from the trauma theme and tried to have a more emic approach to the codes. I looked to remove things that I already know, such as words that provided content (e.g., molestation, childhood, abuse). Afterwards, I now had a more complete set of thematic codes within the clusters.

In the earlier stages of my coding process, one word that stood out to me was the word 'trust.' It appeared that Jessica, my participant, kept using this work throughout our interview. Instinctively, I began paying attention to this word and what it possibly meant to the study and in understanding its importance to MDMA-AP. The purpose of a phenomenological study learns about a phenomenon that we are trying to understand. In working with clients, trust is important to the therapeutic process. This is what helps us establish rapport and build the therapeutic alliance. In client centered therapy, trust is the foundation to the belief that the client has the potential to actualize. It is a belief in the other person.

In the context of this study, why is trust so important? Is trust needed from the client to the therapist? The therapist to the client? Both? Is trust important when treating trauma? Is trust a

reason why a consumer will decide to participate in MDMA-assisted psychotherapy to treat their complex trauma? Do you need trust to take this drug? A lot of questions were coming up for me. I went back to the transcript to try and generate a new understanding of what Jessica meant by this. Using Epoché, I began to see trust as a barrier. In re-coding, 'barriers' began to emerge in the data. Specifically, time for the client, time for the therapist, stability, and uncertainty.

Barriers

Time. In working with clients, the component of time is usually a factor. For Cognitive Behavioral Therapy, for change to occur, it typically takes approximately three months. For other modalities, such as Psychodynamic (which is used by MAPS in MDMA-assisted psychotherapy), and Person-Centered Therapy (Client Centered), therapy typically takes approximately six months or is an ongoing process, depending on the therapist. Combining this with a long history of complex trauma, the change process is prolonged exponentially. The participant of this critical case study, Jessica, spoke extensively about a client that she had worked with on a regular basis for over a year:

> If a therapist is seeing six clients for an hour a day, six different people in a day, how's that different other than 10-minute breaks in between. So, it's almost, at least you can kind of settle in with the person, you're just real. I mean, how many times have you been in therapy with someone, and the minute hour is up, and you're like, 'Oh, we were just getting into the meat of it.'

Therapy takes time and commitment from both the client and the therapist(s) part. From listening to Jessica's story about working with clients that have a history of trauma, this process can be both frustrating and rewarding, albeit a lengthy process. But in this

journey of healing, Jessica talks about what it is like to be there with someone through difficult times:

> We're all still going to feel uncomfortable feelings at times and we're all still going to struggle at times. But to give someone the tools where they can get through those difficult times themselves, at least for the most part, or go back and into therapy and get through another difficult time and then go back out on their own. But certainly, the goal is not to have someone in therapy from eight years old until they die.

One step forward, two steps back. Jessica loves the work that she does with her clients, even though at times she feels frustrated because of the process. Again, it takes time for change to occur, and in order to change, there needs to be time. For Jessica, the barrier in working with a client who has a long history of trauma is the time component. It is difficult for her to get to the 'heart of things" without an ability for the client to trust themselves, but this takes time. In one experience, Jessica talks about her frustration about the process, and it shows that she genuinely cares about her client's health and ability to process trauma and emotions.

> I would say frustrating overall. It's kind of feels like two steps forward, one step back, one step forward, two steps back. And it's kind of always feels like we ultimately end up in the same place. Even if maybe she's doing better for a few weeks or a few months. It just kind of feels, it's frustrating. I can only imagine how frustrating it must be for her to also feel like she's never really making a whole lot of progress overall, and kind of ending up back in the same spot. Because again, if she's not really willing to address the emotions and address whatever is contributing to her depression, which we're all kind of under the assumption that there's some sort of trauma, but she's not able to get in touch with the emotions of it. She just sort of runs away from the emotions of it.

No matter how much she works with her client, Jessica feels that they return to where they started, which gives her the feeling that they are making no progress. After working with her client for over a year, this can be frustrating to Jessica because she genuinely cares about her client.

When asked what therapy would like for a client, and how it differs from typical therapy (e.g., one-hour sessions), Jessica stated:

> If a therapist is seeing six clients for an hour a day, six different people in a day, how's that different other than 10-minute breaks in between. So, it's almost, at least you can kind of settle in with the person, you're just real. I mean, how many times have you been in therapy with someone, and the minute the hour is up, and you're like, 'Oh, we were just getting into the meat of it.'

Trust. In Jessica's experience, the process of trust takes a long time and can be tough for both her as the therapist, and for her clients. She understands that trust is very important to the therapeutic process, while also understanding that the client would also need to trust in her as the therapist throughout the process in order for change to occur. Here is an excerpt from our interview where Jessica describes just this:

> It's tough that it takes her so long to build trust with someone because it's hard to make any progress or headway until the trust is there. I mean as you know, with any clinical relationship the trust is the foundation, the client has to feel safe and they have to feel comfortable sharing anything and everything. And if they think that the clinician is going to judge them or is going to, whatever they're afraid of, then it's going to take a year essentially of building enough trust start making headway. What feels like the number one barrier for her is the trust and feeling like she can disclose things to her therapists.

As she states, trust is the foundation to the therapeutic relationship. First, the client needs to feel safe both in their experiences and in with sharing their experiences with the therapist. For Jessica, she views this process as essential to the change process and understands how tough it can be for her to build this relationship with a client that is guarded and suppressing their emotional and traumatic experiences.

The theme of time as a barrier appeared throughout. Jessica expressed the challenges clients she has worked with face and how it is difficult for her as the therapist. She wants to help the client but is met with the barriers faced by the client in accessing their trauma. But what would happen if she were to be treated with MDMA-assisted psychotherapy? Would this change any part of the 'time' component that is a barrier for both the client and the therapist? Would the client then be able to trust? Would this ultimately change the barrier to healing that is time? Below, Jessica expresses her thoughts:

> I feel like she would be able to fully interact with her emotions and be able to feel what's really going on for her, instead of kind of continually pushing down, pushing away, somaticizing and all of that, but to really get the core emotions that are driving her illness essentially, and her inability to function if she could trust someone enough to really trust herself enough to really say what's going on underneath and to really look inward and feel everything without fear that she's going to be stuck there forever. Because I think that's kind of what it is. Is she just gets so scared that any feeling is going to last forever? Any feeling feels like forever to her as opposed to being like, "Okay, this is the feeling that all of the sudden is defusing.

Specifically, Jessica talked about how the length of time is important in the content of therapy. By being able to introduce to her client a new method to treat the trauma, the time to "cure" the

symptoms are significantly shorter. Through her own research, she came to a realization by simply stating: “People come out being like, ‘Oh, my God, I got more out of those six hours than I have in the past, however, many years of therapy.’” Because of this, Jessica views MDMA-assisted psychotherapy as a significant step in the treatment of trauma.

Jessica’s empathy reaches beyond her client’s and extends to those who are associated to the client she works with. Healing takes a substantial amount of time and support. Processing for the therapist can be challenging and frustrating, as it is for the friends and family members of the clients she has treated. Specifically, the client she focused on in her interview had a lot of support from friends, family members, and additional therapists. Jessica highlighted that she worked in conjunction with members of her client’s support group. However, she also empathizes with her client’s community, knowing first-hand how difficult the overall process can be, especially since it takes so long:

> It's very frustrating and it's very sad. And her parents, I mean gosh, they've had to hospitalize their daughter just so many times for so many years and they're just trying to keep their kid alive and they just want their kid to be healthy. But at this point, everyone's just kind of doing what they can to maintain, but nothing seems to really help.

For Jessica, therapy reaches beyond the work she does with her clients. It extends to those in the community that are in place to assist the clients that she works with. Thus, the amount of time it takes for everyone involved to get to a place of stability and maintenance can be frustrating and highly challenging. In her understanding of the MDMA-experience, if her client would be allowed to participate in MDMA-assisted psychotherapy, the time component changes drastically.

Uncertainty. Jessica views the MDMA-experience as very promising, although she expressed that many people may feel uncertain about it, even individuals who have experienced a long history of complex trauma that has gone untreated. Uncertainty is theme related to barriers of treatment. Because trauma hangs around for so long, even after efforts by her, the client's family members and friends, and other therapists, Jessica wonders if some of that uncertainty would disappear if they were given access to the MDMA-assisted trials and discusses the results of this auxiliary treatment:

> If you tell someone, 'Hey, there's this thing that you can take once a month for six months, and it's going to last for six hours. And we're going to have a six-hour therapy session those days. And then we're going to have one-hour weekly therapy sessions in between. And then after six months, there's a 60 to 80 percent chance you'll be cured after trying everything for so many years.' I think people are willing to try that. And I mean, clearly, they are because they've done all of these phases of the studies and now, they're moving into open access trials.

Although the results of MDMA-assisted psychotherapy are promising, even if some of the uncertainty were to be removed regarding its efficacy, according to Jessica there are some caveats:

> I think it's also important to remember that this particular treatment is not for everyone and it's not going to work for everyone. But I think just looking at the statistics so far, it's the most promising treatment that has been written about and tested in a very long time, as far as I know. The success rates are really promising.

Jessica spent time talking about the reasons why people may feel uncomfortable about using MDMA in a therapeutic setting:

> So much of the stigma around this medicine and the common knowledge of people having a crash, that's an array of doses. So, people who are taking ecstasy or Rave are not taking pure MDMA, in a controlled setting, are taking much higher doses than the therapeutic dose. They're likely taking substance that is not your, it's not pure MDMA. It's possibly laced with amphetamines, or any other number of drugs. When something is made illegal, and it's not regulated, people who are making it and selling it are going to potentially take advantage or they're going to do; take shortcuts, and they're not. It's being made by above board chemist, in a lab.

Jessica feels that through time, like most stigmas and things we are uncertain about, the stigma will eventually lift, and our perceptions may change.

If the change about the stigma of using MDMA occurs, Jessica sees the world embracing the medicine. She recognizes that there are dangers in taking a banned substance if it were to be consumed outside of a clinical setting. She also recognizes the possibilities if the uncertainties were to be removed, both around the stigma of using MDMA and the uncertainty if the trauma will be successfully treated:

> For one thing, it's safer. So, they're in a controlled setting, they're not, they know exactly what they're taking, and how much they're taking, and that they're not overheating that they're staying properly hydrated. And all of that just sort of the basics, physical safety precautions are a big part of it. Also, in the studies, they're always continually measuring the person's heart rate and blood pressure and making sure that they're not having any kind of adverse reactions physically to the medicine. So that's a big part of it. And then yeah, also just to be able to actually have the space to properly explore the experiences

and memories and emotions and thoughts and everything that are connected to the trauma.

The therapist processes for both themselves and their client. In speaking with Jessica, it was apparent that she truly believes in the power of healing through therapy. As a therapist with clinical experiences, she has personally witnessed the transformation of her clients. Becoming a therapist is a journey that begins with the self in order to help others. In the treatment of trauma, especially coming from an experiential modality or one that uses mindfulness in its approach, it is highly important to process your own experiences. For Jessica, it is just that: you have to processes for yourself so that you can help the other process their experiences. Here is a quote from Jessica talking about doing your own internal work as a therapist and how it relates back to doing therapy with clients, especially in working with trauma and MDMA-assisted psychotherapy:

> I think doing any therapy, you have to be able to work on yourself, because you got to be aware of the—I mean, even being from more of a CBT angle, we still think about transference, and counter transference and those sorts of things. And I think if you're not aware of your own issues, and haven't put your own work in, then you're going to have a lot more blind spots and potentially be doing a lot more projecting, or other things come up in therapy that is your stuff and not your client stuff. So, I think in any form of therapy, it's important to do your own work. But I think in this form of therapy, yeah, it's definitely important to have done your own work and especially, I mean, doing any sort of heavy trauma work requires a lot of preventative self-care.

Jessica recognizes that as a therapist, it can be easy to bring your "own issues" into the room, experience transferences and counter-transferences (regardless of your theoretical orientation),

which may affect the outcome of therapy. When doing heavy trauma work, she suggests that it takes a lot of self-care as the therapist, and recommends doing your own internal work, such as the therapists that conduct MDMA-assisted psychotherapy:

> Both preventative and afterwards as well, requires a lot of self-care and going through your own stuff. And I think that another thing that's really interesting that they're doing is for all therapists going through the training program to provide MDMA-assisted therapy, they've also gotten approval to have the therapists go through their own MDMA-assisted therapy session.

For MDMA-assisted psychotherapy, Jessica pointed out that it is important for the therapist to participate in this type of treatment to process their own experiences so that they can be more attune to their clients when facilitating:

> I think for the therapist, to be able to say, 'I've done this.' In a clinical setting, helps the client feel safer, and helps them feel less judged throughout the process. Because if you feel kind of silly, or like things are coming up for you, it's easy, I think, to feel like the other person could be judging you. But one of the things they want all therapists who are providing this treatment, who have actually tried it themselves to know what it feels like to be on the other end and I think, again, that's important for all forms of therapy. I think all psychologists should have their own therapy at some point in their life. But for this therapy in particular, I think that it's really important to know what it feels like to be on to be on the couch or not in the therapist chair.

So, what does this mean in the context of MDMA-assisted psychotherapy? For Jessica, going inside helps those on the outside.

In another instance, Jessica spoke in length about why it is important for the therapist to do their own work prior to working with trauma and using MDMA as an auxiliary treatment in psychotherapy:

> And then also someone who can help them sort of make sense of what they're thinking or feeling, because a lot of it is also just making sense of stuff. And then in addition to having someone there to sort of hold the space and help you feel comfortable and help you indeed, again, with memories and whatever else coming up. There's also the integration sessions in between. So, it's not just, 'You take this once a month.' And it's not even just, 'You take this once a month with a therapist.' But you're also continuing to do therapy in between, but it's a way to enhance and deepen the therapy so that the person is able to, I mean, what I've heard people say is, it's like a year of therapy, and six hours.

If the therapist successfully does their own work, some of the barriers are able to be removed, such as any transferences interfering with the therapeutic process, being able to attune to the client's experiences in a truly non-judgmental way, being able to create and hold space for them, and possibly, the time component may be affected which as she alluded to before, is a major barrier in treating posttraumatic stress.

Surfacing. During the interview and review of the transcripts, a coding theme of 'surfacing' appeared throughout. Jessica shares a story about an individual whom underwent MDMA-assisted psychotherapy:

> Things that someone just hadn't thought about for so many years. I mean, I've heard of another case also where someone had also been through therapy their entire life. And then their first MDMA-therapy session was something like, 'Oh, I was molested as a kid.

> And all these years, I just thought that that didn't affect me. And it wasn't worth mentioning to any of the therapists that I went to.' And just never mentioned it to anyone.

With time and therapy, deep rooted memories appear to surface and as Jessica said, it can take many years for someone to realize their experiences to have them surface during this process.

In describing what it would be like for a client to be in MDMA-assisted psychotherapy, Jessica stated:

> Being in that state kind of brings up exactly what you need to talk about. And so, memories and thoughts and feelings just sort of come up naturally, and the person feels safe enough, and naturally inclined to talk about it. And then to have a therapist who is trained in kind of dealing with those challenging situations, and challenging emotions and, and hearing and being an active listener, and empathic and all of that.

Natural qualities of some therapists are the ability to listen and be empathic. Jessica talks about combining this with the 'drug' MDMA:

> If they have even a little bit of time to sit down and process feelings and memories with a close friend, that even that can be a little bit healing, I think, speaks to how powerful this medicine can be, when used in conjunction with actual therapy. If that can be healing, and if therapy can be, if that can be a little bit healing and therapy can be a little bit healing, imagine what they can do together.

Working with trauma is challenging. Jessica focuses on engaging fully with the client and using exposure. She talks about how hard it is to engage through those times when memories surface so that they can be reprocessed:

> So many of the barriers for many people with PTSD is just engaging fully in exposure because it's scary and it's really hard and you have to have a lot of trust with the person guiding you through the experience and you have to stay through it, through the times, that is going to be really scary and feel really horrible. But to move through those uncomfortable, even horrible feelings and fully reprocess the memory can take a little bit of time. But there has to be full engagement in it, there has to be follow through. And if someone jumps back into that avoidance pattern or is just kind of not fully engaging in it, they're not really going to be able to get through it. She talks about really being able to actually have moved through the trauma and be able to trust people again, and be able to form relationships again, and move through the world in a way that she hadn't been able to for such a long time.

Going inside. Throughout the interviewing process, I recognized that Jessica would continuously talk about internal and external processes. In many ways, she was tying in how the internal process and the emotional surfacing that occurs during therapy when treating a client with trauma. In the coding process, what stood out to me was her saying, “it’ll just keep coming out.” Below is an excerpt of Jessica talking about the internal process for clients.

> These things affect you in ways. But if you're not willing to look at the memory, and the experience and the emotions that it causes, then it's going to manifest in all of these other mysterious ways. Whether it's depression, or whether it's self-loathing, or whether it's sleep issues, or food issues, or other addiction kind of issues. These things find ways to manifest. And if you don't look at them, it'll just keep coming out in other ways.

By going deeper inside, Jessica talks about being present when the client’s defenses come down to help them reshape their coping:

> When the client is able to be fully present and engaged, kind of not on their own, but it's easier to keep them present and focused on what you're working on. Because their defenses are down, I mean, that's another part of what the medicine does, is it really tears down any sort of defense mechanisms, because the person feels safe, they don't need those defense mechanisms. So, when you're not constantly trying to circumvent the defense mechanisms, and you're able to actually get to the heart of things.

Normalizing. By the time I got to the final stages of coding, I had taken notice how often the theme of normalizing surfaced in the transcripts. She talked about 'curing' symptoms associated with trauma, not meeting diagnostic criteria, clients being able to live more 'normal' or typical lives, especially after living with trauma for a lifetime:

> Well, so I mean what is cured? Right? If someone doesn't meet the diagnostic criteria anymore. Does that mean they're cured? Is it if they don't need it for a certain period of time if they are 'in-remission' for what is it? Six months? A year? I don't know what other people's definition of cured is, but I feel like if someone no longer meets diagnostic criteria for a disorder and if they're able to maintain that for a long time, I think that sounds like a cure to me.

Jessica understands that trauma may stay around for long after the client has received successful treatment, although she believes that there is a way to help clients in living a more typical life:

> And then it will still come up sometimes, and you might feel like you're circling back to it. But, at least for people to be able to get back to their normal lives or even back to better than what was normal for them before, in cases of people who've had these issues their whole life, to just be able to again get to a point where they're not experiencing the symptoms anymore, or at least to the extent that it's diagnosable.

Although Jessica expressed that it can be frustrating when her client is not making progress, which includes help from the client's personal circle and other therapists, she sees MDMA-assisted psychotherapy as a different option to achieving the goal of living a more normal life, post-treatment:

> And then also someone who can help them sort of make sense of what they're thinking or feeling, because a lot of it is also just making sense of stuff. And then in addition to having someone there to sort of hold the space and help you feel comfortable and help you indeed, again, with memories and whatever else coming up. There's also the integration sessions in between. So, it's not just, 'You take this once a month.' And it's not even just, 'You take this once a month with a therapist.' But you're also continuing to do therapy in between, but it's a way to enhance and deepen the therapy so that the person is able to, I mean, what I've heard people say is, it's like a year of therapy, and six hours.

CHAPTER V: DISCUSSION

For this study, my identification questions were:

RQ1 (Descriptive): How is MDMA used therapeutically?

RQ2 (Experiential): How is MDMA therapeutically experienced

RQ3 (Process): How do consumers come to use MDMA? What is the therapeutic process as described by its consumers?

RQ4 (Meaning): What is the meaning of the MDMA experience?

Discussion

The meaning of MDMA-AP is to help the client normalize and so they are able to walk through life without the daunting psychological and physiological effects of trauma. My participant Jessica feels that some clients can be cured by combining the medicine with psychotherapy. However, before they are able to get to a more stable state, the relationship must be built, trust must be established, and a space for safety must be created. It is known that psychedelics have a drug effect that creates an inner safe space that helps the client and therapist to foster feelings of togetherness and safety and is important to understanding the MDMA experience through the lens of a therapist.

In answering the research question, “what is the meaning of MDMA-AP?” I was drawn to Jessica’s depiction of trust, safety, being cured of the symptoms, and normalizing (e.g., living a normal life post treatment). I was drawn to one of Jessica’s quotes:

> For people to be able to get back to their normal lives or even back to better than what was normal for them before, in cases of people who've had these issues their whole life, to just be able to again get to a point where they're not experiencing the symptoms anymore, or at least to the extent that it's diagnosable.

Through analyzing the data and reading some extant literature, I truly believe that the meaning of MDMA-AP is getting to a place where our clients can live their lives with safety and trust.

Before safety and trust is established, the therapist must help the client break down some of the barriers mentioned. The first of the barriers is getting through what appears to be a "time" component. What is meant by this is that clients who have a long history of trauma must get to a point in which they are willing to get treatment. A lot of times, trauma can go untreated for decades, especially if it is complex trauma that dates back to childhood. When clients are willing to seek help, it is after they have been self-medicating or have been prescribed prescription medications from a psychiatrist or their general practitioner. If they seek psychotherapy, such as CBT, TF-CBT, EMDR, amongst many others forms of treatment, they are not able to as Jessica said, "get to the core" or build a trusting foundation in the therapeutic relationship. This is partly due to their inability to build trust with others, which plays out in the therapy due to their social limitations. It is just one of the pitfalls of treating individuals with PTSD.

Once the client is able to break down some of their barriers, enter therapy, trust in their relationship with their therapist, and develop some coping strategies to help them stabilize, they can then deepen their therapeutic experience. Part of this process is exposure which is substantiated by the current body of literature as one of the most effective ways to treat traumatic stress. The challenging part for clients with complex trauma is that the exposure to the event(s) carries the possibility to retraumatize, and results in dropping out of therapy all together. However, the exposure component to treatment allows the client to explore within and make sense of their experiences, which is invaluable to the MDMA experience.

The MDMA-AP experience can be intense yet liberating for clients. However, because of the way the medicine interacts at a neurocognitive level, the overall experience is in essence

transformational. When working with difficult memories and past traumatic experiences, they can feel intense, present, and real. While using this medicine, these same experiences are met with empathy, which may allow the client to experience a massive reduction in overall symptomatology. The reduction of defensiveness about their past experiences, their memories of their past experiences and the contents surrounding them is met with forgiveness because of the medicine. With both the therapist and the MDMA acting in conjunction to treat the client, the therapist and the MDMA are both the change agents.

How is MDMA Used Therapeutically?

Through collecting and analyzing my data, I found that MDMA is used therapeutically to decrease the amount of time a client is in therapy, while also reducing the chances of symptoms returning after treatment. MDMA-AP decreases the amount of time clients are in therapy, is used to speed up the healing process of trauma and helps in building trust and tears down defensive mechanisms while working in a safe and controlled therapeutic environment. The results of the Multidisciplinary Association of Psychedelic Studies (MAPS) showed in their Stage 2 phase that in treating severe treatment resistant clients, they would show no symptoms of PTSD within two months after 2-3 sessions of MDMA-AP. By this, MDMA reduces the amount of time and challenges the client's support system goes through, including their psychotherapists. Thus, the barrier of time is unequivocally dire to how MDMA is used therapeutically.

Oehen et al. (2013) offered insight on the retention rates of clients receiving treatment for PTSD using evidenced base therapies such as Cognitive Processing Therapy (CPT), Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing Therapy (EMDR). According to the authors, CBT has a high drop-out rate of approximately 20%. In addition to this, the symptoms associated with PTSD for these clients (re-experiencing,

avoidance, negative cognitions, mood, and arousal) still return and will meet diagnostic criteria for PTSD (58%; Hepp et al., 2006). While we already know through past and current studies that MDMA decreases activity in the left amygdala where the fight-or-flight system becomes activated (e.g., arousal and fear response), it also affects the ventral medial pre-frontal cortex (vmPFC) which helps in reversing symptoms associated with trauma. Because of this chemical interaction, the amount of time required to be in treatment is subsequently decreased. By reducing fear in the client's left amygdala, a sort of cognitive diffusion occurs within the client's cognitive process. This allows for them to remove some of their defensive mechanism that have been in place to cope with their symptoms, and to protect them from the trauma.

According to Oehen et al. (2013), MDMA is used therapeutically to increase affect tolerance, contemplativeness, ability to recall and tolerate traumatic memories, increase social behavior with empathy, increase openness and trust/feeling connected to others, a need for touch, increase in self-esteem, self-acceptance, and sensuality. The MDMA-induced state also decreases anxiety and fear, in addition to social fears and defensiveness. But what are the psychotherapeutic implications of these MDMA-induced states? By reducing anxiety and fear in the client, the therapist can experience their client is a positive and fearless emotional state of well-being (Oehen et al., 2013). The increase in contemplativeness results in prolonged spontaneous exposure to traumatic memories during psychotherapy. When the client's social approach to behavior is met with empathy, they develop an ability to rebuild or build trusting relationships, which ties in directly to developing trust within themselves, and with the therapist. The recall and tolerance of traumatic memories while in MDMA-assisted psychotherapy allows for the client develop healthier coping mechanisms and a reduction in their defensive mechanisms. By helping the client increase their self-esteem, they develop the ability to become

grounded and centered, which is valuable in the therapeutic process both in and outside of the sessions. The MDMA-induced component of self-acceptance allows for the consolidation of self, while an increase in sensuality's psychotherapeutic implication results in positive body image (Oehen et al., 2013). Without using MDMA in therapy, the aforementioned MDMA-induced states are in fact barriers to change. Furthermore, by combining these MDMA-induced states and their psychotherapeutic implications, the effectiveness of therapy increases and decrease the amount of time needed to be in therapy for it to be successful long-term.

In using MDMA as a medicine for treatment, the typical treatment course is 1-3 sessions that last approximately eight hours each. After these sessions have been completed, the client then continues to go to therapy that does not include the medicine in order to continue the healing process (Amoroso & Workman, 2016). In contrast to another very successful form of treatment, Prolonged Exposure (PE) therapy, which consists of more typical sessions that last approximately 60 minutes, but the number of sessions range from six to 20 sessions (Amoroso & Workman, 2016).

Amoroso and Workman (2016) conducted a study that reflected the difference in time of treatment with effectiveness between MDMA-AP and PE. The results of his analysis suggested that the outcomes of MDMA-AP are comparative to PE. However, one major difference between the two forms of treatment is that PE puts the client in a heightened state of arousal which can be counterproductive to treatment trauma, especially long-standing complex trauma. However, the overall length of sessions (one hour each for 9-20 weeks) is comparatively different than that of MDMA-AP (6-8 hours each session for three sessions). This finding is consistent with the data of my study to which my participant spoke extensively about the amount of time in therapy that is a potential barrier. Thus, although the sessions are lengthy (6-8 hours), the amount of overall

time spent in therapy is significantly less in comparison to other treatment, while also increasing the effectiveness of therapy and reducing the likelihood of posttraumatic symptoms returning (Mithoefer et al., 2013).

How is MDMA Therapeutically Experienced?

The data analysis found that MDMA is experienced as fully interacting with emotions, being able to cope with and handle difficult memories regarding past traumatic experiences and being able to get to the core of the experience. The client is able to explore in a safe environment so that they can examine their memories, emotions, and thoughts connected to their traumatic experience. In MDMA-AP, the client is able to feel safe from judgement, harm and unconditionally regarded through the therapeutic process. This allows the client to get to know themselves in ways they had not been able to prior to MDMA-AP. Within the MDMA-AP sessions, the clients have the space to make sense of what they think and feel, which allows them to reprocess their experiences while being guided by two trained therapists whom have also underwent MDMA-AP.

In MDMA-AP, it is experienced as an empathogenic and holistic approach to healing. According to Parrott (2007), the usage of MDMA provides benefits in its experience. Similar to the study done by Oehem et al. (2013), Parrott (2007) compiled a list of potential beneficial experiences of MDMA-AP:

1. Creating a deeper understanding of the self,
2. The client develops the ability to recognize positive parts of the self,
3. Because of the medicine, the client develops an ability to trust in others and build better relationships,

4. The indications of the medicine and increased levels of serotonin, which battles affect, and moods associated with depression,
5. Increased levels of empathy (love) towards the self and others,
6. New worldviews regarding the self and others,
7. It allows for past traumatic experiences and memories to surface for reprocessing during MDMA-AP,
8. The medicine allows for the client to tap into deeper levels of consciousness,
9. Reduction of fear due to suppression of the amygdala,
10. Deeper connection with the self and trust with both the self and with the therapist, and
11. Importantly, fewer therapy sessions than other forms of therapy.

Parrott (2007) also provided a collection of possible disadvantages found by multiple researchers. There is a chance that the MDMA-AP client will experience negative moods and cognitions which may cause acute psychological distress (Cohen, 1998; Greer & Tolbert, 1986; Grinspoon & Bakalar, 1986; Parrott, 2007). When administered MDMA, there is the potential of a rebound phenomenon (Parrott, 2007). This is characterized by a depletion of serotonin which can cause symptoms similar to those found in clinical levels of depression, such as fatigue, irritability, depressed mood, and psychological distress (Curran, Rees, Hoare, Hoshi, & Bond, 2004; Greer & Tolbert, 1986; Parrott, 2007; Parrott & Lasky, 1998). One of MDMA's larges disadvantages is that it is an acute metabolic and psychobiological stressor (Parrot, 2007). As a result, the rebound phenomenon that is caused by a rapid depletion of serotonin is unpredictable and can also affect the client's psychobiological functions (Baylen & Rosenberg, 2006; Darvesh & Gudelsky, 2005; Parrot, 2007). Notably, Doblin (2002) suggested that using MDMA with clients who have clinically elevated levels of depression may be dangerous. Other possible

negative experiences include somatic aspects such as nausea, jaw clenching, teeth grinding, headache, changes in body temperature, increased heart rate, muscle aches, tiredness, dizzy spells, vertigo, dry mouth, shifts in energy, sweating, numbness, tingling, tics, restlessness, and agitation (Parrot, 2007). Although there are some negative aspects of the MDMA experience that are not therapeutic, the positive aspects, such as trust and safety, are important components to the MDMA-AP experience.

Through my collection of data and analysis, the theme of trust continued to surface throughout. Jessica spoke many times frequently about the relationship between the client and the therapist, and how trust is an important element of the therapeutic experience of MDMA-assisted psychotherapy, and pivotal in treating trauma in clinical settings. In the literature, Thal and Lommen (2018) suggested that the reason there is a high dropout rate while working with clients through other treatment methods (e.g., CBT, TFCBT, CPT, EMDR) is that the client has difficulty building trusting relationships with others, which in turn complicates their ability to develop a trusting and working alliance with their psychologist. As we know through the literature, the relationship builds through time and typically takes 3-5 sessions before the client truly begins to trust the therapist. Conversely, in MDMA-AP, there are only 2-3 sessions in total, however, each session lasts between six and eight hours, which likely increases the levels of trust from the client, not to mention the increases in trust by taking the medicine.

SSRIs are effective in conjunction with psychotherapy, such as the combination of an SSRI with CBT to treat depression. As for post-traumatic stress, Hoskins et al. (2015) found that a small effect size in regard to the reduction of psychological symptoms associated to posttraumatic stress. Again, the amount of time clients is using SSRIs and also going to therapy to treat their symptoms are small in effect size in comparison to the MDMA-AP trials. Likely,

even though clients are taking SSRIs in conjunction with psychotherapy, they are not able to build a strong base or foundation for trust with others, themselves, and consequently, their therapist (Thal & Lommen, 2018). Furthermore, when engaged in MDMA-AP, the medicine allows for the client to engage in positive emotional engagement (Mithoefer et al., 2011).

Limitations

A major limitation of this study is the sample size. Although I had chosen a critical case study, this study would have benefited greatly from being able to interview multiple participants that have experiences with not just treating trauma as therapists, but with MDMA experience both personally and academically. However, as I had mentioned earlier in Chapter V, the reason why I chose a very small sample size was due to the abrupt closure of my academic institution. Because of this, it made the most sense to find one participant that would be able to give me rich and thick data for my study.

A second limitation of this study is that this research project is that MDMA is currently a federally controlled illicit substance. If the study would have been able to include participants that have personally used MDMA in a controlled setting or in a setting that is meant for healing practices, or even other recreational experiences, I may been able to get a lot more information about the use of MDMA and its experience.

In regard to coding and interpreting the data, a limitation for me in the study was that I am not an experienced qualitative or quantitative researcher. Because qualitative research is time consuming and also requires an in-depth understanding of a phenomenon or an in-depth understanding of how to use epoché and framing in an emic perspective, I feel that this was a weakness for me personally which results in a limitation to my study.

Another limitation for my study is my personal conceptualizations of the data and possibly some methodological drift. I found myself continuously trying to find causal data. Because of this, it was difficult for me to be completely immersed as a qualitative researcher. Part of this methodological drift is that in my early training in research as an undergraduate student at the University of Hawaii Mānoa, I was a research assistant in laboratories that focused on quantitative design and results. Because of the possibility of me having a methodological drift, I may have been interpreting data trying to find cause and effect (causal data) versus looking at it at in from an emic perspective. Again, I believe that this limitation is mostly due to my experience rather than my ability as a qualitative researcher. This in turn affects my ability to be creative in the quality the process of interpreting the data coding the data analyzing the data and presenting the results of the data.

A qualitative research study is typically very time consuming. This aspect of time is notable in the analytic process of coding the data and translating the data into a narrative form. For example, if this were to be a quantitative study with a survey which would provide the data, the amount of time it would take to collect the data interpret the data analyze the data to present the data are much shorter. Writing up these results is a longer writing process which in my personal opinion became a limitation of the project because of my lack of experience in qualitative research.

Future Research

For future research it would be really incredible to be able to interview participants that have a really in-depth knowledge and understanding of, and personal experiences with MDMA as consumers. By doing this, and also including interviews with multiple participants, the generation of knowledge for stakeholders would be significant. For example, if someone is

interviewed that has participated in healing practices around the use of MDMA for the past 20 to 30 years, their breath of knowledge and understanding of the healing experience that is brought on by the use of MDMA in conjunction with other healing methods (e.g., psychotherapy) would be significant information for us to understand as clinicians in practice.

MAPS is currently in the final phase of the clinical trials (phase 3). Because of this, we are now starting to understand the clinical implications of MDMA assisted psychotherapy. It would be really fascinating to be able to interview the therapists that participate in the MDMA assisted psychotherapy trials. Moreover, interviewing the therapists that began in phase 1 all the way through the final phase. Additionally, the participants that are involved in their clinical trials also possess lots of very valuable information that would be invaluable to understanding the healing qualities in effectiveness of MDMA assisted psychotherapy. I would imagine interviewing some of the military veterans that participated in the clinical trials and gaining their experience of the MDMA assisted psychotherapy would be highly valuable as well.

As noted in the literature, the success rate of curing the symptoms related to posttraumatic stress are between 60 and 80%. But why? What was their experience like? I understand that we can go on YouTube and hear about some clients who have undergone MDMA assisted psychotherapy, but we do not have a full clinical picture in the sense of qualitative data to interpret the themes that surface. It is important to have the quantitative portion of the clinical trials as it is required by the FDA in order to get approval as a therapeutic medicine, but to be able to interview the participants and get a understanding of what their experiences are, what happened in there, what transformed them, what surfaced during the process, and how did the surfacing change their perspective? This would all be valuable information that would significantly contribute to the academic literature.

For future research, I would imagine that we would want to compare the efficacy of MDMA assisted psychotherapy with other very notable and affective forms of psychotherapy such as EMDR, TF-CBT, PET, in addition to how these effective forms of treatment are when combined with psychotropic medication in comparison to MDMA-AP.

As noted in Chapter IV, the theme of 'time' is an important component to healing. What I mean by this is that some participants in the clinical trials, for example, have had long-standing trauma for an average of approximately 18 years. What if they would have been treated with MDMA within the first year, the first five years, or the first 10 years of their traumatic experience with this medicine in conjunction with psychotherapy as an auxiliary treatment? Would this of change the developmental process and course of their psychopathology? Is it more or less effective depending on when you intervene with this medicine?

MDMA is currently being used to treat individuals with a long history of complex trauma that has previous gone either untreated or the treatment is been unsuccessful. Outside of the population of military veterans, what other populations would benefit from this type of therapy? Clients with more severe pathology, such as those that experience psychosis and other more severe pathological experiences, is that MDMA most likely would not benefit them, in fact, it may be harmful to them. However, there is a growing body of literature regarding MDMA therapy for autistic adults with social anxiety, and there are cases of individuals with schizophrenia diagnosis developing social strengths. But what about other individuals that have not experienced a significant trauma? What if the trauma is not complex, is treatable and happen recently? A perfect example of this would be a breakup with a partner, the loss of a job, and more common experiences that our clients tend to have that stem from anxiety related

symptoms? This leads naturally to work with couples: would MDMA assisted psychotherapy be just as impactful as it is with long-standing, untreated trauma?

I also wonder who will benefit from this type of treatment once we have a better understanding of the biological and chemical qualities of MDMA. This form of therapy can possibly be extended to other populations such as teenagers, and the geriatric clients. Therefore, the limitation within the future implications of research is that we are limited to certain specific populations and that is the reason why it is important to continue doing research to understand client's experiences with MDMA, whether it be in a clinical setting or recreational.

For future research it is important to have an understanding of the differences in effectiveness of how different modalities such a psychodynamic therapy, CBT, person centered therapy works in conjunction with MDMA. The reason for this is that therapists that work within these different frameworks approach therapy in their own unique ways. It seems that although MAPS technically use the psychodynamic approach in addition to cognitive reprocessing, it appears that they are using more of a person-centered client, non-directive approach to in their approach. In all actuality, I am not certain about how psychodynamic therapist truly works in their sessions, which may be a personal limitation, but it would be beneficial to understand how the different modalities can contribute to the clinical effectiveness of MDMA assisted psychotherapy.

Another interesting implication a future research would be to compare MDMA with its in pathogenic counterpart such as Psilocybin, marijuana, and LSD. From what we currently know about Psilocybin, which has been legalized in certain states for medical purposes, it is highly effective in treating smoking cessation and is also used in conjunction with psychodynamic therapy. Marijuana, for example, is also getting a lot of attention recreationally, but is being used

medically to treat physiological symptoms such as pain, but I wonder if using this through the course of treating trauma, would it have a similar or different affect in comparison to MDMA?

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Appendices

Appendix A. Copy of IRB Certification Letter

Chaminade University

Institutional Review Board.
Chair: Helen Turner, Ph.D.
Vice-Chair: Claire Wright, Ph.D.
Vice Chair: Darren Iwamoto, Ph.D.
irb@chaminade.edu

June 5th, 2019

Pedro Benach, MA.
Psy.D. Program
Chaminade University

Dear Mr. Benach

This letter is to confirm receipt of your Argosy University Institutional Review Board (IRB) approval for " A clinical perspective on MDMA assisted psychotherapy".

The CUH IRB IRB00007927 reviewed the above IRB external approval.

The Chaminade University IRB will accept your current approval and will not require reapproval at this time. Your Chaminade IRB protocol number is CUH 105-2019. You will now be entered into our annual report cycle (due date below). Please use the attached Form IV to complete your annual reporting.

Your external approval was dated February 22nd 2019. The final date for your CUH approval is February 22nd 2020. Continuation of research after this date will require:

1. Submission of Form IV Final Report; and
2. Request for an extension letter to be submitted to irb@chaminade.edu 30-days prior to the expiration date of your Argosy approval. The Board may require a new protocol submission, so please do this as early as possible.

Effective proposal approval date: February 22nd 2019

Date of annual or final report due to Chaminade IRB: February 22nd 2020

Please submit a copy of your current CITI training certificate by email to irb@chaminade.edu. Please be advised that if you submit future protocols to our IRB we will require updated CITI certification aligned with Chaminade's requirements.

Please feel free to contact the IRB above with any questions or concerns.

Kind Regards,

Helen Turner, PhD
Chair, Chaminade IRB Committee

3140 Waialae Avenue Honolulu HI 96816

ARGOSY UNIVERSITY

February 22, 2019

Pedro Benach
1916 Manoa Rd.
Honolulu, HI 96822

pbenach@hawaii.edu

Dear Mr. Benach,

Your Level 3 application, "A Clinical Perspective on 3,4 Methylenedioxy-methamphetamine-Assisted Psychotherapy," is fully certified by the Institutional Review Board as of 2-22-2019.

You need to abide by the requirements in any letters of permission you have obtained.

Please note that research must be conducted according to this application that was certified by the IRB. Your proposal should have been revised to be consistent with your application. Please note that you also need to abide by any requirements specified in your letter of permission. Any changes you make to your study need to be reported to and certified by the IRB.

Any adverse events or reactions need to be reported to the IRB immediately.

Your full application is certified for one year from 2-22-2019. Please be aware that if your study is not likely to be completed one year from 2-22-2019, you will need to file a **Continuing Review for IRB or Continuing Certification of Compliance** form with the IRB at least two months before that date to obtain recertification. If your proposal is not recertified within the year specified (365 days), your IRB certification expires and you must immediately cease data collection.

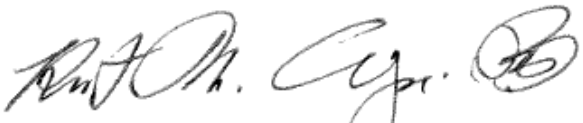
When you have completed your research you will also need to inform the IRB of this in writing and complete the required forms. You may use the **Project Completion Report** form for this purpose. Records must be retained for at least three years.

Good Luck with your research!

Please be careful not to lose this letter.

If you have questions, please feel free to contact me.

Sincerely,



Robert M. Anderson Jr., Ph.D., Co-Chair
Institutional Review Board

cc: Dr. Lianne Philhower

Appendix B. Coding Samples

Coding/Chart

Barriers to Change: Time, Uncertainty, and Stability

Time for Client

- *Takes long*
- *All these years*
- *Long time*
- *End up in same place*
- *Anymore symptoms*
- *No longer*
- *Continuing*
- *Barriers*
- *Progress*
- *Terminate*
- *Start all over*
- *Trust*

Time for Therapist

- *Hard to make progress*
- *Have to move on*
- *How much*
- *Moving on*
- *Done with that*
- *Space*
- *Battling to get to the heart*
- *Two steps forward, one step back*
- *So much effort*
- *Terminate*

Stability

- *Coping skills*
- *Nothing helps*
- *Start all over*
- *Help*
- *Settle*
- *Bad trip*
- *Crash*
- *Walk her through*
- *Call me*
- *Need us*
- *Get to a point*

- *Amygdala*
- *Emotion regulation*
- *Helpful*
- *Preventative*
- *Washes over them*

Uncertainty and the Unknown
- *What happened?*
- *What to do*
- *Nothing helps*
- *Does MDMA*
- *Have no idea*
- *No one knows*
- *Something happened*
- *Underneath*
- *Chance*
- *What happens*
- *Everyone*

The Therapist has to process

Their own
- *Own work*
- *One step forward, two steps back*
- *Burden*
- *Never feel she's*
- *Transference*
- *Affect me*
- *Hard to watch*
- *Constant effort*
- *Know the issue*
- *Focus*
- *At wits end*
- *Tried everything*
- *Hear about it*
- *battling*

The Other (client's experiences)
- *Listening*
- *Other*
- *It's tough*
- *Feeling*
- *Hard time trusting*
- *New person*

- *Never feel she's engaged*
- *Knowledge*
- *Burden*
- *Reprocessing*
- *Tried everything*
- *desensitize*
- *defusing*

Connection between the client and the therapist's experiences/therapist-client relationship

- *Easier*
- *Better than before*
- *Enhance*
- *Allow*
- *Interact*
- *Separate*
- *Shared*
- *Engage*
- *Allows*
- *Corralling able to call me*
- *Validation*
- *Fuse*
- *Guiding*
- *Important*
- *Hold*
- *Sitting*
- *Engaged*
- *Trying*
- *Walk her through*

Surfacing (This occurs when there is trust and a relationship is formed)

- *Letting something out*
- *Healing*
- *Resurfacing suppress entirely*
- *Person*
- *Come up*
- *Re-experiencing*
- *Needs to come out*
- *Experiencing*
- *All of a sudden*
- *Engage*
- *Pops up*
- *Disclose*
- *In those states*

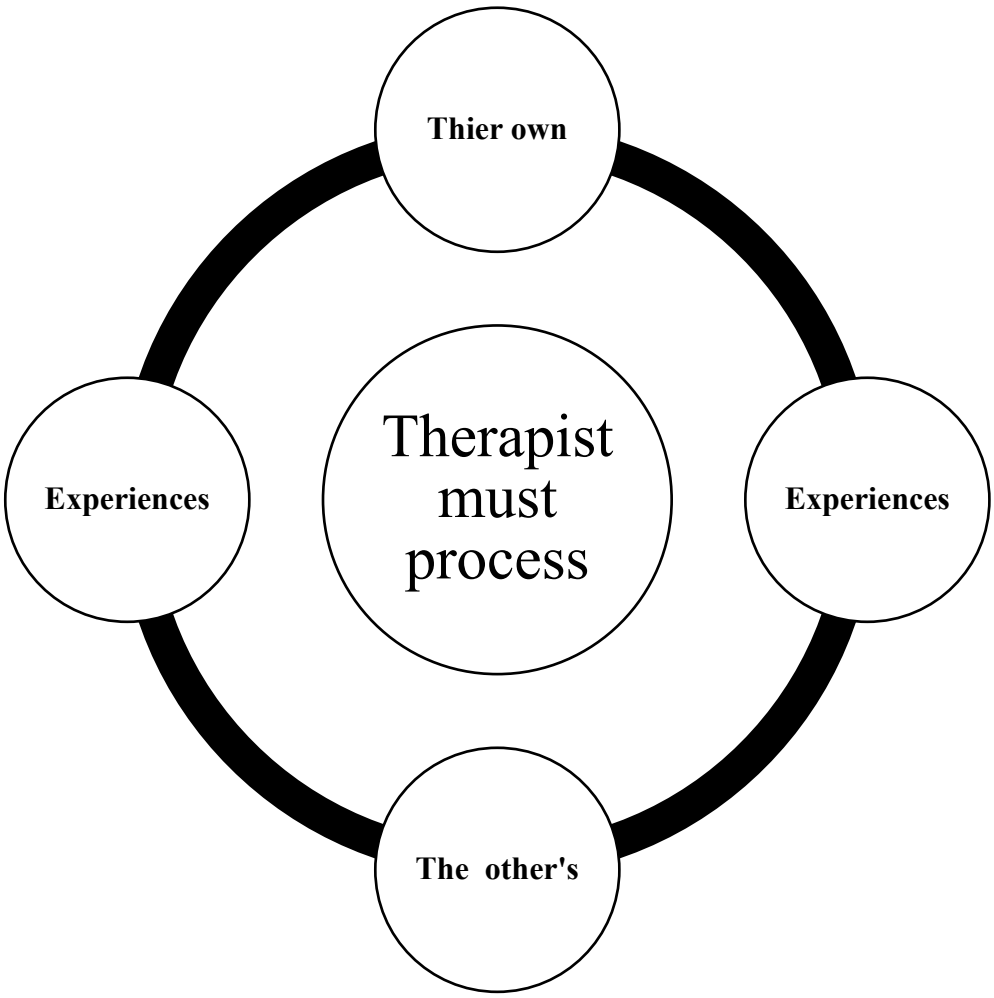
- *Real*
- *Significant*
- *Fear*
- *Come up naturally*
- *Exposure*
- *Comfortable*

Going inside and moving through the internal processes (go inside to let out; inside out—internal to surface)

- *Stay grounded*
- *In your body*
- *Feels like fully there*
- *Deepen*
- *Know*
- *Drill down*
- *See*
- *Healing*
- *Root of problem*
- *Disconnected from body*
- *Goal*
- *Get to heart of things*
- *Willing*
- *Senses*
- *Don't need defensive mechanisms*
- *Sense*
- *naturally*

Normalizing: Working towards change

- *normal lives*
- *promising*
- *through the world*
- *symptoms*
- *cured*
- *better than normal*
- *not experiencing*
- *people back to normal*
- *control over herself*
- *the other end*
- *results*
- *really struggles*
- *hasn't been able to*
- *soothing*
- *experiencing*


Thier own
Experiences
Therapist must process
Experiences
The other's