UNIVERSITY OF SURREY

Faculty of Health and Medical Sciences (FHMS)

Practitioner Doctorate in Psychotherapeutic and Counselling Psychology (PsychD)

Research Dossier

A Portfolio of Research Work Including an interpretative phenomenological analysis of MDMA assisted psychotherapy for PTSD

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ABSTRACT

This portfolio comprises a culmination of research work spanning three years of full-time training on the Practitioner Doctorate course in Psychotherapeutic and Counselling Psychology (PsychD) at the University of Surrey. The research comprises three research reports: a literature review, and two qualitative studies. The literature review explores the psychedelic renaissance, focusing on the resurgence of studies into utility of psychedelic drugs as an adjunct to psychotherapy. The first empirical study is a Thematic Analysis of therapists who have worked with clients when they were under the influence of a psychedelic during a research trial. The study seeks to explore how they experienced the interplay between the drugs and psychotherapeutic practice. The analysis revealed three master themes: i) ‘The Facilitation of Process’ ii) ‘The Therapeutic Relationship’ iii) ‘The Power of a Transcendental Experience. The second empirical study used Interpretative Phenomenological Analysis (IPA) analysis to explore the lived experiences of having MDMA assisted psychotherapy to treat people with a diagnosis of PTSD. Analysis revealed three major themes: i) ‘Existential Freedom’, ii) ‘Beyond the Cartesian Split’, and iii) ‘A Journey Back in Time’.
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STATEMENT OF ANONYMITY

To ensure the confidentiality and anonymity of all clients, supervisors and research participants, any potential identifying information in this portfolio has been omitted or replaced with pseudonyms.
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Introduction

This dossier contains three pieces of research submitted during my four years of training on the PsychD course. The three pieces of work all explore how novel psychopharmacological interventions may impact on psychotherapy. I will introduce each piece in more detail below.

Project 1 – Is it time for Counselling Psychology to join the psychedelic revolution?

This review sought to explore the empirical literature that has emerged from what is commonly referred to as the ‘psychedelic renaissance’. The review highlights the promising potential of this novel treatment, pointing to a rapidly emerging body of randomised control trials that are demonstrating their utility. The review also indicates that there are several risk factors involved with this intervention, most prominent is perhaps the unpredictable nature of how they will impact on the client. Finally, the review considers how this research sits within CoP and argues that since it is presenting evidence to support its utility within the psychotherapeutic domain that it is important for CoP to begin...
engaging with this field. I became increasingly aware during the process that there was a dearth of qualitative studies in this field. This reinforced the critical stance that I have developed throughout my training regarding utility of objectivist epistemologies. Regularly during the process of reviewing studies I was left yearning for a richer more in depth understanding of the experience of working with and being on these substances.

Project 2 – How do psychedelics impact the psychotherapeutic process? A thematic analysis of qualitative interviews with practitioners who have delivered psychedelic assisted psychotherapy.

As outlined above, my literature review highlighted the significant dearth of qualitative studies in the area of psychedelic research. Whilst it demonstrated that utility of psychedelics alongside psychotherapy has promise it also indicated that there was much need to better understand the how of this process. Thus I embarked on this project as a starting point in attending to this gap. Using Thematic Analysis (TA) I explored the subjective experiences of therapists who had delivered therapy to clients when under the influence of a psychedelic. I was seeking to better understand how psychedelic consumption might interact with psychotherapeutic
processes during therapy. I thought that this might also draw out both how they could be helpful and also where they may be concerns about their utility given the risk factors highlighted in the literature review.

Project 3 – An Interpretative Phenomenological Analysis of MDMA assisted psychotherapy for PTSD.

This project was born out of the literature review and my second year project. Having denoted in the previous project that, therapists in the study thought that there was much psychotherapeutic potential for psychedelic substances to be used alongside psychotherapy, it seemed important to better understand the lived-experience of the clients who had been administered these substances. At the time when I was embarking on this piece of research the literature was becoming more focussed in terms of where the novel drugs were most likely to be used in the near future. Predictions and forecasts in the literature suggested that the most evidence based, and thus most likely to be administered as a treatment option soonest, was MDMA assisted psychotherapy for PTSD. Thus I felt that the most necessary and helpful place to explore would be in this narrower area. In light of this, this project used Interpretative Phenomenological Analysis to explore the
lived-experience of having psychotherapy whilst under the influence of MDMA.
Year 1 Literature Review:

Is it time for Counselling Psychology to join the psychedelic revolution?

Introduction

Recent empirical trials have demonstrated that psychedelic substances could be a safe and effective adjunct to psychotherapy in the treatment of many psychological problems such as obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), death anxiety and substance abuse (Winkelman, 2014; Mithoefer et al., 2011; Gasser et al., 2015; Johnson et al., 2017). Prior to the current prohibition status, psychedelics plants had been utilised as medicine by humanity for thousands of years (Winkelman, 2014). The large recreational consumption of psychedelics in the ‘sixties’, a time of radical societal and political change, resulted in the formation of a negative impression of the substances and consequently their prohibition in 1970 (Grinspoon and Bakalar, 1979). Such prohibition may have led to the field of Counselling Psychology (CoP) not hearing about their positive psychotherapeutic effects.
Past studies have shown that, alongside psychotherapy, psychedelic substances can intensify the change process in therapy, help individuals access difficult emotions and assist in the strengthening of trust in the therapeutic relationship (Grof, 1980). These findings may be of particular interest and relevance to CoP as the field emphasises the importance and benefits of the therapeutic relationship above all other components of psychotherapy (Clarkson, 2003). Moreover, stronger transference, and improved self-reflection are additional specific effects induced by psychedelic experiences during psychotherapy (Passie & D¨urst, 2009). Considering these positive findings, it is therefore surprising that there is no literature into how psychedelic psychotherapy may enhance the field of CoP. Hence, this review aims to provide an overview of topics within the literature regarding psychedelic psychotherapy, and the recent empirical findings, to evaluate how such research may impact CoP. To do so, it is important to acknowledge the current risks behind using psychedelics in therapy, such as the importance of taking psychedelics in a safe setting, at an appropriate dose and with an appropriate knowledge of the effects one may expect to feel.

Rationale
Many preliminary studies are suggesting that psychedelics may be of benefit to psychotherapeutic practice. These studies have suggested that using a psychedelic as an adjunct to psychotherapy can enable clients to access repressed memories, increase reflective capacity and introspection, and help strengthen the therapeutic relationship (Grof, 1980; Tupper et al., 2015). As well as these psychotherapeutic processes being routinely utilised by counselling psychologists, CoP is also a pluralistic profession that values a vast range of treatment and research (Milton, 2016; Woolfe et al., 2010). It therefore seems appropriate for CoP to engage and develop the field of psychedelic-assisted psychotherapy.

Current psychotropic medications are often considered to block many psychotherapeutic processes such as engagement with emotion in psychotherapy (Tschoner et al., 2007). The psychotherapeutic effects that psychedelics offer can be seen to attend to such a limitation and can enhance psychotherapy (Mithoefer et al., 2011). Such effects may offer a chance for psychiatry and psychotherapy to better complement each other’s practice. Currently, psychiatry is undertaking research into psychedelic assisted psychotherapy. Unlike psychiatry however, the discipline of CoP puts an emphasis on utilising psychotherapeutic treatments in mental health; it therefore seems
of importance for CoP to support psychiatry in evolving and enhancing psychotherapeutic treatments. Additionally, as current research suggests that psychedelic psychotherapy can be a short treatment model that could match, or even better, the current 12-week model used in IAPT services available on the NHS, there is further rationale for CoP to investigate psychedelic assisted psychotherapy.

Furthermore, Vera and Speight (2003) suggest that CoP should endeavour to have a responsibility beyond direct therapy to issues of social justice. They acknowledge dissatisfaction with CoP’s attention to social causes given CoP’s involvement in the development of feminist theories. As much of feminist practice involves recognition that individual struggles are often rooted in oppressive political social and cultural forces, they postulate that such struggles cannot be resolved in the absence of changing the structures and systems that they arise from. It can therefore be argued that CoP should explore whether there is a political agenda behind the prohibition of psychedelic drugs, which have been shown to have such profound positive implications for psychotherapy (Tupper et al., 2015; Cahart Harris et al., 2012). If an individual’s struggles can be alleviated with these substances, CoP could benefit psychotherapeutic practice significantly by
taking an interest in balancing out the dominant prohibitive discourses with the resistive discourses that refute this.

Indeed, the need for more social justice–oriented attitudes in counselling psychology has been strongly argued and supported by practitioners for a number of years (Vera & Speight, 2003). Social justice oriented counselling psychologist’s ideas are heavily influenced by feminist movements; they discuss the importance of sharing power and giving voice to marginalised individuals, allowing oppressed groups to emerge (Bond, Belenky, & Weinstock, 2000). It has long been argued that individuals who have used psychedelics as mind altering tools for psychological progression are a marginalised group (Letcher, 2006). Thus given the extensive supporting literature of the profound positive benefits of psychedelics to psychotherapy it could be argued that, in line with CoP’s strong social justice oriented aspirations, it may be appropriate for CoP to provide a voice for this group. This literature review will thus seek to understand and present such discourses in the hope of empowering them, noting their potential benefits for future therapeutic practice in CoP. In addition, giving voice to such marginalised groups has also been argued to allow those who traditionally hold power to re-examine their perceptions and opinions, and acknowledge the potential strengths of the
marginalised group’s ideas (Letcher, 2006). Again, in terms of psychedelic therapy, counselling psychology may be able to impact such a cause where the strengths are so often going unnoticed despite the compelling literature.

An additional motive for such a lit review to be conducted from a CoP perspective is in response to Van Duerzen’s (1990) powerful paper on the philosophical underpinnings of counselling psychology. She articulates her desire for counselling psychologists to remain open and accommodating of the notion that there is “a lot more to psychology than is written in the academic text books”. The author identifies counselling psychology as a place where “we can rediscover what has been so skilfully hidden elsewhere” (Van Duerzen, 1990). This quote invites attention to be drawn to the discourses that had potentially enabled psychedelic research to be “hidden”, by not only CoP but also psychology more broadly, despite the expansive positive findings. In this review I hope to shine light on such discourses in order for practitioners to move closer to engaging with the research in a more objective capacity, as opposed to within the tight confines of the current prohibitive discourses which dominate the field (Letcher, 2006). Here, attention is drawn to the ways in which, the attitudes that CoP has towards current psychotropic
drugs on the market, may impair the way that they approach the
literature on psychedelics, despite the profound differences in
effects between the two classes of substances (Carhart-Harris et al.,
2012; Carhart-Harris & Goodwin, 2017).

A brief history
Psychedelics have been used as sacramental tools by non-western
cultures for thousands of years (Nichols, 2004). Many religions
around today have been shaped by their use. For example “Soma”
often appears in Sanskrit texts that heavily influence the Hindu
religion. Anthropologists believe that Soma is derived from the
hallucinogenic Amanita Muscaria mushroom (Nichols, 2004).

Psychedelic research, in western cultures, was inspired by studies
on peyote in 1896 (Nichols, 1994). Ibogaine was studied in the
1920s prior to a large rise in psychedelic studies correlating with
the discovery of LSD during World War 2 (Grof, 1980). Returning
soldiers fuelled such research as psychedelics were used as
psychomimetics to further understand various psychoses. Freud’s
ideas of dreams being “royal roads” for studying the unconscious,
emphasised the power and importance of accessing the
unconscious in a conscious state (Grof, 1973).
From the 50’s onwards psychedelic research boomed (Carhart-Harris & Goodwin, 2017). In Gloucestershire, England, Dr Ronald Sandison pioneered psycholytic therapy with the aid of LSD in accessing repressed areas of his patient’s psyches. On the other side of the Atlantic Albert Hoffman, LSD’s founder, was collaborating with Timothy O’ Leary in investigating the power of administering LSD to overcome mental health difficulties (Grof, 1980). Word of their therapeutic capabilities spread and studies involving psychedelics such as mescaline, psilocybin and LSD were being conducted all over the world. Indeed, between 1950 and 1965 1,000 papers were published on LSD alone (Grof, 1980). The studies led to the treatments of 4,000 patients. Adverse incidents were remarkably low and psychiatrists began to evolve the best method for psychedelic exposure, often using the methods from Eastern cultures; the aim of which was to create a relaxed and facilitative environment (Grof, 1980).

Despite the success of psychedelic research, by 1966 LSD was made illegal in the USA. The seemingly miraculous effects of LSD were popularised by writers such as Aldous Huxley who stated “I was seeing what Adam has seen on the morning of his creation – the miracle, moment by moment of naked existence.’ Academics such as Dr Timothy Leary, a clinical psychologist from Harvard,
began to promote the use of psychedelic drugs to the public. Ironically the US government, the creators of psychedelic prohibition, also promoted the use of LSD in the public (Friedman, 2006). The project “MK-Ultra” was designed to develop LSD as a truth serum for military use. Random members of the public were unknowingly administered LSD and examined by a team of researchers in a famously unethical experiment. Upon illegalisation the US government blamed LSD for causing left-wing behaviours, opposition to the Vietnam War and negative social changes (Friedman, 2006). The funding for LSD research was soon cut by the government resulting in research coming to a dramatic halt (Friedman, 2006). Whilst research stopped, recreational use continued to increase often in impure and contaminated forms leading to public euphoria into the potential toxicity of a physically harmless compound (Gable, 1993). There are two clear dominant discourses regarding psychedelics since these events, the “pathological” and the “prohibition” discourses.

The 30-year hiatus in psychedelic research appeared to mark the demise of the discovery of a potentially remarkable tool for mental health practitioners. Once compared to be for psychology what the microscope was for Biology, it appeared that western cultures had missed a unique opportunity to understand the human psyche.
(Grof, 1980). In 1990 however the renaissance of psychedelic research was initiated at the University of New Mexico. A small study was approved to investigate the effect of N,N-Dimethyltryptamine (DMT) on human participants (Carhart-Harris & Goodwin, 2017). By investigating a relatively unknown psychedelic substance, public and media-driven sensationalism were minimalised allowing for uncompromised, responsible and reliable research (Tupper et al., 2015). In 2002 studies at the University of South Carolina began investigating the therapeutic effects of 3,4-methylenedioxymethamphetamine (MDMA) in treating PTSD following approval from the national institute of health and university’s institutional review board (Carhart-Harris & Goodwin, 2017). Research into the therapeutics of psychedelics has since grown extensively, similarly to the initial LSD research in the 1950s. In America, studies are underway at the universities of California, Arizona, Harvard, Duke and Purdue investigating a range of psychedelics including MDMA, psilocybin and LSD, on PTSD, addictions and anxiety disorders (Tupper et al., 2015; Carhart-Harris et al., 2012). In England, Imperial College have undertaken studies into LSD and psilocybin, neuroimaging the patient’s brain after consumption (Carhart- Harris et al., 2012).

Recent psychedelic psychotherapeutic studies
Recent research into the benefits of psychedelics as an adjunct to psychotherapy has begun investigating a wide selection of mental health difficulties, such as obsessive-compulsive disorder (OCD), depression, social anxiety and many more (Tupper et al., 2015). The majority of research historically has focused on their effects with, substance dependency, PTSD and death anxiety, in individuals who are terminally ill (Mangini, 1998). Due to the scope of this academic piece, this review will focus on the most recent studies involving these particular mental health conditions, as at present they have the most vast and substantiated literature base, thus they can provide readers with a deeper understanding of their benefits. The studies below were selected because unlike other research being conducted into psychedelics at the moment, they involved the use of psychotherapy in the trial, which is most relevant to the field of CoP. The majority of the studies are quantitative and at present there are few studies, which have looked at the individual’s experiences of psychotherapeutic treatments with psychedelics as an adjunct from a qualitative perspective. Moreover, since the renaissance in psychedelic research, there are no qualitative studies that investigate the effect of psychedelic-assisted psychotherapy on the therapeutic relationship.
Psilocybin and alcoholism

Bogenschutz et al. (2015) carried out a ‘proof of concept’ study investigating the effects of using psilocybin, the psychoactive compound found in psilocybin mushrooms, alongside therapy in the treatment of alcohol dependency. The research model used has been further outlined in a recent publication by Bogenschutz et al. (2017), the research involved ten participants with a DSM-IV diagnosis of alcohol dependence. Participants were given psilocybin once in a supervised session and partook in motivational enhancement therapy (MET) sessions before and after the dose. In the four weeks prior to the administering of psilocybin, there was no statistical difference between individuals who had received MET and those who hadn't. Following administration of psilocybin, the abstinence rates significantly increased. Furthermore, abstinence rates were maintained when investigated 36 weeks later. The strength of experience of the psilocybin effects were shown to strongly predict decline in drinking 5-6 weeks after the treatment. In addition, the intensity of the experience also significantly predicted decline in cravings and increases in abstinence self-efficacy. In terms of safety, no adverse events were reported. Although their study showed promise in using psilocybin as an adjunct to psychotherapy, the small sample size makes it hard to definitively say that it was the psilocybin-mediated...
psychotherapy that increased abstinence. The sampling of participants may also include potential biases, as it is possible that an individual who has previously had a favourable experience using psilocybin recreationally is more likely to participate in such a trial. Nonetheless, the authors suggest that such preliminary findings offer a strong rationale for further research into the effects of psilocybin as an adjunct to psychotherapy with large samples. From a CoP perspective, it would be interesting to understand how the psilocybin administration impacted the therapeutic relationship, as this is not documented. It would thus be useful to conduct qualitative research regarding the participants’ experiences. It would also be of benefit to understand how different traditional psychotherapeutic approaches may impact the findings, such as using a person-centred model as opposed to MET.

**Psilocybin and tobacco**

There have been many reports of successful abstention from various addictions after psilocybin psychotherapy (Johnson et al., 2017; Bogenschutz et al., 2016). Since the renaissance, a study into the treatment of tobacco addiction with psilocybin was conducted at John Hopkins University in Maryland. The study represented the first of its kind in investigating the power of psychedelic mediated
psychotherapy on smoking cessation (Johnson et al. 2014). The trial involved administering psilocybin to 15 patients, all of whom were heavy smokers. Each individual received 15 weeks smoking cessation treatment involving regular sessions of cognitive behavioural therapy (CBT). Psilocybin was administered at week 5, 7 and 13. Afterwards, the patients were encouraged to listen to music and have an introspective experience. During CBT the individuals were told that today would be their last day of smoking. Six months after the trial, 80% of the patients had remained abstinent from smoking; an impressive statistic considering that none had used nicotine replacement therapies. In contrast to this study current traditional psychotherapies, without psychedelics as an adjunct, is estimated to have a success rate of between 11 and 33%; a drastic reduction when compared to psilocybin treatment (Cahill et al., 2014; Garcia Romeu et al., 2015). These statistics further highlight how psychedelic psychotherapy could be revolutionary for the recovery of individuals who suffer from addiction. Whilst these findings are positive, it is important to take into account the lack of control group in the study. Although abstinence results are far higher than using traditional CBT, without a control group it is impossible to rule out other factors contributing to the high abstinence rates such as the competence of the therapists.
Interestingly, Johnson et al (2017) has recently published a long-term follow up on the trial. Sixteen months following the study, 60% of the participants had remained abstinent of smoking and nicotine suggesting that the effect of psychedelic mediated psychotherapy can be long term. Johnson et al. (2017) also asked the participants to rate their experience of the psychedelic mediated psychotherapy. 13 of the 15 individuals rated their experience as one of the most meaningful and spiritually significant experience of their lives. Even taking into account the small sample size and lack of control group, such resounding results certainly seem worthy of further study. It would be interesting to investigate the individual’s experiences following the psychedelic psychotherapy as historically psychedelic consumption has been linked with, intense transference, reduction in feelings of guilt, and an increased felt sense of trust in the therapeutic relationship (Grof, 1980).

**MDMA and PTSD**

PTSD is an anxiety disorder which is characterised by hyper arousal, intense re-experiencing of past events and avoidance symptoms. Currently the most utilised form of psychotherapy for PTSD is cognitive behavioural therapy (CBT). A review of CBT
and current pharmaco-therapeutic treatments being used in PTSD found that dropouts vary between 20-30% and response rates are between 50% and 75% (Cloitre, 2009; Hembree et al., 2003; Rothbaum et al., 2006). There is therefore a large subset of the PTSD population who are termed ‘treatment resistant’ (Watts et al. 2013).

Studies have shown that MDMA induces a 2-4 hour experience wherein participants experience feelings of euphoria, increased self-confidence and extroversion, sociability, improved well-being and a decreased fear response (Cloitre, 2009). Such findings informed the rationale for the potential uses of MDMA in the treatment of PTSD as it's often characterised by an uncontrolled fear response (Mithoefer et al. 2011). Many psychotherapeutic approaches with this client group involve inducing these autonomic responses by revisiting the traumatic experiences in the therapy sessions. However, treatment is often ineffective as clients find the feelings evoked in revisiting the trauma intolerable (Rothbaum et al., 2006).

Thus Mithoefer (2011) conducted a study that demonstrated that MDMA-assisted psychotherapy is effective in individuals with
chronic and treatment-resistant PTSD. The study had a between subjects design and involved a control group. The results demonstrated that MDMA-assisted psychotherapy, when compared with the same psychotherapy with an absence of MDMA, produced significant improvements in participant’s PTSD symptoms. 83% of participants in the MDMA group no longer held a diagnosis of PTSD as opposed to 25% in the placebo group. In addition, the results had been sustained at a follow-up of 2 years (Mithoefer, 2013). Furthermore, no adverse drug events were noted and there was no impairment of cognitive function. Moreover, this research showed that all individuals who received MDMA assisted-psychotherapy who were unable to work prior to the treatment had subsequently returned to work.

Although Mithoefer’s study showed considerable promise for utilising MDMA as an adjunct to psychotherapy, there were undoubtedly several weaknesses that could have confounding implications. Firstly, as the study was a phase 2 trial, the sample size was small which affects the reliability of the results. Secondly, the control group has a longer history of psychotherapy than the MDMA group which could suggest a more ‘treatment resistant’ sample; when statistically analysed however this covariate proved non-significant. Thirdly the majority of participants in the trial
were female and of Caucasian ethnicity suggesting that gender and/or ethnicity variations to MDMA-assisted psychotherapy may exist. Nonetheless the positive results of Mithoefer’s study has led to further phase two studies being carried out involving giving war veterans who have a diagnosis of treatment-resistant PTSD, MDMA-assisted psychotherapy (Sessa, 2017). Phase three studies are also expected to begin in the UK in 2018 (Sessa, 2017).

**LSD and death anxiety**

Individuals who are nearing the end of their life often don’t obtain satisfactory emotional relief with the current treatment options available (Gasser et al. 2014). Chronic pain, depression, anxiety and unresolved relationship issues are all problems that this client group struggle with (Gasser et al., 2014). As death anxiety is increasingly being recognised as a significant public health concern it seemed of additional importance to discuss here (Gasser et al., 2014).

Gasser et al. (2014) conducted a double-blind control trial to investigate the efficacy of LSD assisted psychotherapy. Twelve participants, all of whom were experiencing anxiety associated with their life-threatening diseases, were administered drug-free
psychotherapy supplemented with two LSD assisted sessions. The study demonstrated that at a 2-month follow up, the State-Trait Anxiety measure utilised showed positive trends for reduction in anxiety. The reductions in anxiety were sustained at a 6-month follow up. In addition, the study investigated the safety of LSD consumption and reported no chronic or acute adverse effects in relation to the treatment administered. A major limitation to the study however was the effectiveness of the double blinding; through altered behaviour, it is quite identifiable, both for therapists and participants, who has been given a dose of LSD. Although it is possible to use a low dose of LSD in the control group, this will undoubtedly raise efficacy of the comparator group and thus compromise effect size.

Recently, Gasser et al., (2015) has published a qualitative study on the experience of receiving LSD-assisted psychotherapy on the same cohort. Participants reported positive personality changes including increasing openness and a deeper awareness. 77.9% also reported a reduced fear of death and an improved quality of life following the LSD-assisted psychotherapy. When asked about the effects of LSD on therapy, clients reported faster progress, easier access to their emotions and an increased feeling of safety (Gasser et al., 2015). However, similarly to the studies discussed
previously, there was no mention of how the therapeutic relationship was impacted such as the felt experience between the client and therapist and the level of psychological connection. These elements of psychotherapy are widely regarded for being vital for positive change (Clarkson, 2003). Perhaps qualitative research would be useful, as the phenomenological underpinnings would capture the subjective experiences of participants.

Overall, the results of the studies detailed provide interesting findings for the use of psychedelics as an adjunct to psychotherapy. It is important to be cautious with the findings though due to the small sample sizes. Psychedelics offer such profoundly different and personal experiences, that it is important to conduct much larger studies to gain an understanding of their potential to be generalised to wider population (Tupper et al., 2015). There is also a current lack of qualitative research in the field, leaving a gap for CoP to attend to by exploring the phenomenological experience of both clients and therapists who undertake and practice psychedelic psychotherapy. Indeed, as CoP is underpinned by phenomenological philosophy and also puts an emphasis on the subjective lived experience of an individual in therapy, it may offer the perfect platform to perform such research (Clarkson, 2003). Furthermore the BPS (2013) guidelines state
that counselling psychologists, as reflective scientific practitioners, should seek to engage in research that could improve psychological treatments. As present research into psychedelic-assisted psychotherapy demonstrates that it could provide both a more efficient and more available option than current treatments for a range of client groups, it also seems important for CoP to engage and contribute to further research (Tupper et al., 2015).

**A critical evaluation of psychedelics and the therapeutic relationship**

Martin Buber (1937) proposed an understanding of the relation between the self and the other that is widely recognised in psychotherapy today. Buber denoted that people are ‘twofold’. He argued that we respond to the people who we encounter as either an “I-Thou” or an “I-It”. The “I-Thou” relationship refers to an authentic, holistic relationship between two people. This is the form of relationship that is mostly sought in humanistic psychotherapy. In contrast, Buber notes that “I-It” relationships are more in relation to one’s self and can be understood as a monologue as opposed to a dialogue. In addition, Buber (1937) states that an individual can only become an “I” in the mutual recognition with the other (Hudson, 2010). Thus, an individual’s
self-existence is dialogical in nature and is fundamentally comprised of encounters with others.

These interesting ideas that inform much of the emphasis on intersubjectivity in CoP are important to consider in relation to the psychedelic research that has been presented here. Much of the historical literature has suggested that a large proportion of the psychedelic experience is profoundly introspective and involves deep self-awareness (Grof, 1980). However, it does not comment on the way in which such substances impact the individual’s relationship with others and the wider world. Indeed to date, no study has placed particular emphasis on this part of psychotherapy in relation to psychedelic treatments. When considering Buber’s contribution to the field and its subsequent attitudes towards relationship, this seems of significant importance as an area of research in the future. It is important to explore what happens in the shared inter-subjective space of client and therapist if the client is in such an introspective mode of being.

In addition, most psychotherapeutic approaches now acknowledge the therapeutic relationship as fundamental to psychotherapy (Clarkson, 2003). An important aspect of this is considered to be
the shared empathic understanding between the therapist and client (Mearns & Thone, 2007). Empathy is typically conceptualised as the process in which therapists seek to enter their client’s unique phenomenological world. Arguably, this poses difficulties in relation to psychedelic assisted psychotherapy, as firstly, if the substances induce such a deep level of introspection that the client no longer experiences the intersubjective “I-Thou” nature of their relationship, they may not have a felt experience of the empathy that the therapist is communicating to them. Secondly, in terms of the therapist being able to provide empathy, if the client’s experience is of such a depth of introspection, and the ideas that are emerging are in such an abstract form (Grof, 1980), it may be difficult for the therapist to connect and empathise with the client, again inhibiting the therapeutic relationship. Thus this element of psychedelic therapy research needs to be explored in much greater detail (Tupper et al., 2015).

**Risks of psychedelic psychotherapy**

Despite the possibilities that psychedelic treatment offers, the uncontrolled use of such substances does undeniably have risks attached. It should be reiterated however that the proposition of this literature review is to evaluate whether psychedelics have
benefits in a controlled clinical setting, as opposed to recreational use. Indeed, there is a wealth of research regarding the importance of the setting, the expectancies of the user and the awareness of the dose administered; all of which are controlled in the therapeutic environment (Friedman, 2006). There are also several meta-analyses that have investigated the link of psychedelic and psycholytic therapies and adverse effects on over a thousand participants (Carhart-Harris & Goodwin, 2017). These analyses concluded that psychedelics are safe to administer in psychotherapy, investigating parameters such as suicidal rates, psychoses and hospital rates (Friedman, 2006). Moreover Nichols (2004) conducted an extensive search of various medical research databases such as medline on LSD induced psychoses finding only three incidents within the last 20 years.

Psychedelics may however have a negative effect upon individuals with a family history of psychotic disorders such as schizophrenia or on individuals who have pre-existing mental illness (Walsh, 2003). A study conducted by House (2007) compared the diagnoses of patients with LSD-induced psychoses and those with a diagnosis of schizophrenia with no psychedelic consumption. Both groups showed similar psychopathological symptoms as well as having a significantly high rate of psychoses within their family
history. In obtaining these results, it was concluded that the psychoses that were supposedly induced by LSD, may have occurred later in life by other triggers. Such a finding therefore indicates that the family history of psychoses is an important factor to consider on whether psychedelic psychotherapy is given. Grawe (1995) investigated the findings of several toxicologists who compared frequently used psychedelic compounds in the potential for harm, such as their potential for dependence. The findings concluded that none of the psychedelics used in research cause physiological toxicity or show any evidence of having an addictive potential (Gable et al., 1993). These findings along with the fact that no reputable researchers have found any direct toxic effect, are surprising when considering how widely touted their toxicity is (Carhart-Harris & Goodwin, 2017). Some research does exist however on the use of psychedelics causing accidents such as an individual developing hyperthermia due to overexertion and exhaustion under MDMA influence at a rave (Gowing et al., 2002). These incidents further outline the importance of an appropriate ‘set’ and ‘setting’ which is provided within the psychotherapeutic room.

The continued prohibition dilemma
Despite new studies being conducted in psychedelic research, funding still remains a major issue for the future. Since 1967, psychedelics were classified as schedule 1 drugs under the United Kingdom’s misuse of drugs regulations (Carhart-Harris & Goodwin, 2017). Psychedelic drugs have also been classified as Class A since the UK misuse of drugs act in 1971. In the same year, psychedelic drugs were also classified as schedule 1 of the United Nations Convention on psychotropic substances; a classification system required to be accepted to receive UN membership. The classification was decided due to the UN deeming psychedelic drugs as having no accepted medical use and a great potential to cause harm, despite the previous two decades of research contradicting this (Carhart-Harris & Goodwin, 2017). Indeed, John Ehlrichman, Richard Nixon’s former assistant, infamously admitted that the harmful effects of psychedelics had been greatly exaggerated and that media had been manipulated to exacerbate this for political advantage (Friedman, 2006). Despite Ehlrichman’s confession and the evidence that psychedelic drugs do not cause dependence or toxicity, they still remain classified as schedule 1 (Gable et al., 1993; Grawe, 1995). Considering that heroin and cocaine, two drugs that do cause dependence and toxicity, are classified as schedule 2, psychedelics classification in schedule 1 seems misleading to the public. Indeed organisations
are beginning to question such outdated restrictions (Tupper et al., 2015)

As well as the bureaucratic obstacles imposed by such strict classifications, the financial implications greatly limit future psychedelic research. For example UN’s schedule 1 classification has resulted in only one manufacturer offering psilocybin at a quality that is sufficient for research (Carhart-Harris & Goodwin, 2017). The Imperial College psychedelic group were quoted an extortionate £100,000 for 1g of psilocybin, the equivalent of 50 doses (Carhart-Harris & Goodwin, 2017). Furthermore, in the UK for a hospital to store a schedule 1 drug a license must be bought for £5,000. Regular police checks are also required and transport is extensively over regulated. Even for a schedule 1 drug to be prescribed, the prescriber must hold a license that costs £3,000. The theoretical cost of providing licenses for 100 volunteers in a field study is thus £305,000 for licenses alone (Carhart-Harris & Goodwin, 2017). The financial burden is increased by the negative burden of schedule 1 classification discouraging grant funders (Carhart-Harris & Goodwin, 2017). The difficulties in conducting research, which are outlined here, lend themselves to an exploration of the dominant discourses that might be maintaining them.
Discourse

Considering the strong bureaucratic, financial and political obstacles, that face researchers in conducting clinical investigations of a compound that could be revolutionary for psychotherapeutic use, it is helpful to understand the discourses behind such prohibition. As mentioned earlier, CoP seeks to give a voice to marginalised groups and ideas (Vera & Speight, 2003). By adopting such a social justice oriented attitude, repressed voices may be heard and thus result in positive change for the field of psychotherapy. This quest seems well applied to psychedelic discourses as the predominant prohibition discourses are proving extremely inhibiting of psychedelic research (Carhart-Harris & Goodwin, 2017).

Indeed, from a Foucauldian point of view, psychedelics appear to have suffered from “scientific classification”, meaning they have been socially constructed on the observation of how they appear to symptomatically and objectively affect an individual (Letcher, 2006). Discourse, meaning the way of understanding an object, therefore becomes relevant when talking about psychedelics (Phillips and Jörgensen, 2002). Such western discourses, such as
‘pathological’ and ‘prohibition’ discourses, which dictate that psychedelics have no therapeutic benefits, have arisen from the scientific classification. From these dominant discourses, resistive discourses have arisen in counteraction; these include ‘psychological’ and ‘psychedelic’, ‘entheogenic’.

Two functions related to discourses are relevant when referring to psychedelics. The first is how they function to divide individuals into set, boundaried and objectified subjects. The second is how they draw boundaries around how an individual can act and what they can say. A scientific classification results in not only objects becoming classified but also individuals (Letcher, 2006).

**Objectifying an object**

These dividing practices that occur from such categorisation are perfectly demonstrated in the predominant cultural discourse of the word “drugs”. “Drugs” can usually have two wide antithetical interpretations in western culture. The first is pharmaceutical drugs, which are produced by giant, regulated and thus reliable companies and are administered by well-trained health-care professionals for analgesic or pharmacological actions. The second, refers to a group of plants, chemicals and plant extracts
which are grown, extracted or synthesised illicitly and self-administered by an untrained hand for pleasure, escape, curiosity and introspection. Consequently however such substances are criminalised, usually due to a high toxicity to public health (Letcher, 2006). The different types of substance in the second category are wide and highly variable and have variations in their qualities, including psychophysical effects, chemical action, toxicity, ecstatic states and dependence. However these experiences are overridden by a shared delineation of potentially being abused (Letcher, 2006). Moreover, if an individual was to self-medicate such a substance they would be labelled the undesirable term of “drug abuser” and would be consigned to the boundaries of society, becoming a target in the much talked about “war on drugs” (Voase, 2003). The main negative connotation of “drug abuser” is thought to be mainly due to the constructed image of an individual injecting heroin and becoming a vector of disease or a “drugged up criminal” (Jay, 2000; Davenport-Hines, 2001). In contrast, using a drug from the first category results in less negative stigmas and the use of highly addictive drugs such as caffeine and alcohol are not even considered as a drug and are merely “drinks” (Letcher, 2006). Such attitudes in society seem important to draw practitioners awareness too as they may impact on the way that clinicians engage with research.
Discourses result in boundaries

In addition, the negative discourse behind “drug” also results in boundaries of what individuals can say and do. Foucault explains that discursive practices are virtually impossible to think outside of and that to do so would be mad, incomprehensible and out of reason (Voase, 2003). Therefore, to postulate the possible use of the “drug” psychedelics as a positive aid in psychotherapy is against the dominant scientific-materialist discourse. Letcher (2006) suggests that in counteracting such a discourse an individual could be labelled as mad, delusional or as a drug-consuming hippy. Such negative discourses appear to be why funding agencies are uncomfortable in providing funding for psychedelic psychotherapy investigations. In funding such a study the agency fears societal judgement and thus the agency becoming less reputable (Letcher, 2006). Again, it is likely that such discourses will have impacted the way that CoP practitioners engage with such research.

The pathological discourse
Literature has termed “pathological” and “prohibition” discourses as dominant when thinking about psychedelics in regard to Foucauldian scientific classification (Letcher, 2006).

The pathological discourse refers to the emphasis of psychedelics as drugs that induce physiological and mental toxicity (Letcher, 2006). The origins of this discourse can be split into the pathological discourses of mushroom based psychedelics and that of LSD. The former is a long-lasting delineation that originated from antiquity when mushrooms were either considered to be edible, or poisonous. Experiences ingesting psilocybin mushrooms were considered poisonous as opposed to psychedelic or transcendent, resulting in one’s recovery being regarded as a fortunate escape (Letcher 2006). In the 18\textsuperscript{th} and 19\textsuperscript{th} century this led to treatments including emetics, stomach pumping and the ingestion of leeches to treat such conditions. Indeed, Ford (1926) named a distinguished type of mushroom poisoning named \textit{mycetimus cerebralis}, based on the hallucinogenic symptoms. 30 years later psilocybin and mescaline were identified as causing these effects however as mentioned earlier, their toxicity is less than that of caffeine (Gable, 1993).
Around the same time, Lewin (1924) invented the term 'narcotic', classing drugs that cause hallucinations as “phantastica”. Lewin proposed that the effects induced by phantastica drugs were the same as psychosis, putting them down to the excitation of nerves causing a disruption to the function of the brain. This materialist neurological basis behind the hallucinations helped introduce the neuro-scientific discourse of hallucinations causing psychosis in western medicine (Letcher, 2006).

Indeed the link between hallucinogens and subsequent psychosis became further fixed in the 1960s and the 1970s after the US government made LSD illegal and described their properties as mind-altering and psychosis inducing (Grof, 1980). Moreover, as LSD became illegal the drug was synthesised in homemade labs resulting in toxic impurities that caused morbidity or mortality as opposed to the actual LSD itself. Such cases led to moral panic over the use of psychedelics and further confirmed the pathological discourse (Stevens 1989).

Lewin’s description of “phantastica” was a brief term that did not catch on following the 1940s, however the pathological discourse that was created by the term reveals various assumptions that are
now assumed of psychedelics (Letcher, 2006). These included the terms “schizogen” (mimicking or producing schizophrenia), “intoxicant” (inducing poisoning), “psychomimetic” (mimicking psychotic states) and “hallucinogen” (producing hallucinogenic states). The terms created assume that psychedelics cause alterations and aberrations to the “normal” human state via their poisonous mode of action. Such divergence, impairment, and interference of the normal physiological and mental state of the human body are assumed to be the reasons behind the production of visions and hallucinations, which therefore, although real at the time, lack ontological substance (Letcher, 2006). Therefore the phenomenological psychedelic experience is one of little value in this discourse, except perhaps to empathise with individuals who have psychosis. Indeed such assumptions led to many psychiatrists encouraging their colleagues and pupils to consume psychedelics in order to fully understand the nature of psychosis (Letcher, 2006).

**The prohibition discourse**

As previously mentioned, following the clinical application of psychedelic therapy, psychedelic use leaked out into the public creating a psychedelic counterculture (Letcher, 2006). As this
culture increased, western governments illegalised their use (Tupper et al., 2015). This was enforced in both clinical settings and recreationally, so as to supposedly protect public health (Letcher, 2006). Such an argument does hold power as taken in the wrong environment, state or dose psychedelic ingestion has been shown to trigger psychotic breakdowns (Letcher, 2006). However due to the rarity of these incidents and the much higher risk to public health with substances such as alcohol and tobacco this appears dubious (Carhart-Harris & Goodwin, 2017; Bogenscutz et al., 2017). Indeed, the admissions of Ehlirchman further cast doubt about whether the protection of public health was the reason for their prohibition.

Due to the prohibition discourse, psychedelics have thus become classed as toxic substances with no therapeutic value, of which physical and mental health are only negatively affected (Letcher, 2006). The mere presence of the new psychedelic studies in the renaissance provides evidence that the legal boundaries may have been reduced. However, the vast amount of time, resources and finance that are required in order to create a study that uses psychedelics is huge compared to that of other drugs such as antidepressants, despite the minimal toxicity levels that psychedelics present (Letcher, 2006).
It is thus important that we acknowledge and explore the prohibition and pathological resistive discourses, as a result of the promising empirical research that has been presented in the last 20 years. This is arguably especially important to CoP as the field aspires to highlight, examine and ultimately change social injustices (Vera and Speight, 2003). Arguably the cost imposed by the classification of psychedelic drugs, which is supported by the prohibition discourse, is a social injustice, considering the findings that demonstrate their potential benefits for psychotherapy and low safety risks.

**Entheogen**

Finally, the resistive discourse of “entheogen” was created by a group of academics that wished to further differentiate the psychedelic compounds from connotations with the medical model and also that of recreational use (Letcher, 2006). The term “entheogen”, originating from Greek etymology, means “inspired by god” and has religious and sacramental contexts (Letcher, 2006). By consuming psychedelics as entheogens, this discourse refutes the “prohibition” and “pathological” discourses by claiming that they are substances that are not illicit or dangerous, nor ones
of toxicity. Instead, the entheogenic discourse claims by affecting consciousness, religious and ontological experiences of significance are produced (Letcher, 2006). Indeed some individuals critique the term as too exclusionary, and awkward (Saunders 2000; Weil 1998). However, the term has become a popular discourse and is used by both new and old age academics (Letcher, 2006). Indeed the use of the term has helped in gaining funding for psychedelic research as its steers emphasis away from the negative connotations of psychedelic compounds (Carhart-Harris & Goodwin, 2017). This discourse is still not considered dominant within mainstream society and thus it seems important to continue to explore what the discourse is trying to expose and inform society of (Letcher, 2006). In doing so we might draw further light on how psychedelics may be of benefit to psychotherapeutic research, and furthermore what the current positivist psychedelic research is missing.

**Psychedelic research implications for psychological prescription privileges**

Having thought about the implications of the prevalent and resistive discourses for psychedelic research, it now seems important to consider how some of CoP’s common attitudes may
impact the way that the field engages with psychedelic-therapy literature. Counselling psychologists commonly negate over-reliance on psychotropic drugs in the treatment of psychological problems and disprove of the argument that mental health can be wholly conceptualised in the medical model (Hammersley & Beeley, 2006). Thus, the compelling research, which suggests that psychedelics have a transformative capacity poses potential problems for the field of CoP. To elaborate, it raises the question of how counselling psychologists can disapprove of overuse of drugs in mental health treatment and not reject psychedelics’ compelling potential to support and contribute to the humanistic aims. It may be helpful to consider the distinctions between the functions of psychedelics and psychopharmacological drugs on the market currently when reflecting on how such a question can be reconciled. Current psychopharmacological prescriptions can generally be seen as constrictive of feelings (McHugh et al., 2013). Moreover, in the constriction of emotions, for example sadness in relation to the intake of antidepressants, we may come up against a tension with regard to CoP’s conceptualisation of sadness as a potential stimulus for psychological growth during psychotherapy (Friedman, 2006). More problematic is their replacement of depressive feelings with numbness thus preventing the opportunity for individuals to experience happiness when under the influence.
Research has exposed that the biggest predictor of change in psychotherapy is the quality of the therapeutic relationship. Literature shows that without this component, change is much less likely to occur (Clarkson, 2003), therefore if antidepressants suppress emotions it could have negative implications on the development of feelings in regard to a client’s relationship with their therapist. Therein lays a profound difference between psychedelics and currently predominant psychopharmacological treatments. Psychedelics expand psychological processes. Therefore psychedelics could in this regard compliment CoP’s direction towards facilitating psychological growth through the exploration of emotions and experiences. Thus, they may act as a powerful adjunct to humanistic talking therapies. Indeed such discussions have occurred previously between psychiatrists over the past decade; Victor (1999) expressed sadness towards Western culture’s contradi distinction between humanistic and biological treatments. He contrasts this with other cultures around the world that more commonly understand biological and spiritual components of existence to be intrinsically connected to each other.
Conclusion

To conclude, there is a large evidence base that suggests psychedelics can be useful as an adjunct to psychotherapy for a variety of mental health disorders (Bogenschutz et al., 2017; Lawrenson et al., 2017; Mithoefer et al., 2013). Western mental health is experiencing a rapidly growing epidemic in mental health difficulties and thus financial resources are being stretched (WHO, 2003). There is an over reliance on pharmacological drug prescriptions, as health care professionals endeavour to manage the increasing demand on mental health services (WHO, 2003). Thus the research outlined here seems important and worthy of further investigation, as the literature presented suggests that combining psychotherapy and psychedelic substances can quicken and deepen the therapeutic process (Tupper et al., 2015). They may therefore help alleviate some of the issues that mental health professionals are grappling with.

However, despite the evidence of the therapeutic potential, and low risks with psychedelic-assisted psychotherapy, it is important to endeavour to be objective. In the past, psychedelic psychotherapy became marginalised and the benefits largely went unseen; clinicians became somewhat biased and thus at times oblivious to
the inevitable risks and dangers of the substances (Letcher, 2006). Thus it is important to continue to investigate the risks with as much depth as the therapeutic uses. Nonetheless, it seems important to ensure that we do not allow the strong prohibition and pathological discourses to impair our reception of the emerging research in to this field, which demonstrates expansive positive potential for psychotherapy. Indeed, it is important to look beyond the prejudices that are largely associated with recreational drug abuse to enable us to tentatively embrace the compelling research that is being presented in the current literature in relation to clinical uses.

Whilst psychedelic psychotherapy research is in its infancy, the evidence of psychedelic therapy from the past should be enough to power future research into the uses of these substances as an adjunct to psychotherapy (Grof, 1980). It has been strongly suggested that the anecdotal nature of some of these studies should not act as a deterrent, as this is often the way that medical trials begin (Carhart-Harris et al., 2012). Medicine, neuroscience and philosophy are increasingly contesting the scheduling of psychedelic substances as drugs with high abuse opportunity and few medical uses (Carhart-Harris et al., 2012; Carhart-Harris & Goodwin, 2017). However, there are few clinical trials being
conducted in the UK and thus it seems important to continue to endeavour to carry out such research in order to make a more informed conclusion about whether it can benefit CoP (Sessa et al., 2017).

Finally, it is important to pay further attention to the implications of psychedelic assisted psychotherapy for the therapeutic relationship. Since CoP has a particular interest in this element of psychotherapy (Clarkson, 2003) it seems reasonable to suggest that such research would benefit the field greatly. It can therefore be argued that as a profession we would benefit from undertaking qualitative research into this area. Furthermore, much of the research has focused on the experience of the client but it seems interesting to also acknowledge the experience of the therapist, who from a humanistic standpoint, is of paramount importance to the therapeutic process (Clarkson, 2003). Indeed, it would be interesting to explore their phenomenological experiences of conducting therapy with individuals in a different state of consciousness to that which we work with in traditional psychotherapeutic practices.
References


Year 2 Empirical Study:

How do Psychedelics Impact the Psychotherapeutic Process? A Thematic Analysis of Qualitative Interviews with Practitioners who have Delivered Psychedelic Assisted Psychotherapy.

Abstract

4-phosphorloxy-N,N-dimethyltryptamine (psilocybin), Lysergic acid diethylamide (LSD) and Methyleneoxymethamphetamine (MDMA), are demonstrating encouraging results as an adjunct to psychotherapeutic practice following a surge of empirical research over the last 10 years.

Method: Psychotherapists, who had worked as therapists on studies that involved delivering psychedelics to clients under the influence of a psychedelic, were interviewed to explore their experiences of working in this capacity.

Results: 3 clear superordinate themes emerged from the analysis: 1) Facilitation of Process 2) The Therapeutic Relationship and 3) The Power of a Transcendental Experience

Conclusions: Psychedelic substances were experienced as useful catalysts to psychotherapy. However participants shared concerns regarding the impact of the speed at which they accelerated the therapeutic process. Proposals are made for future research to be conducted into the subjective experience of clients who have had this treatment.
Introduction

Over the past sixty years, psychopharmacology has been used to treat millions of individuals with different mental health issues. Anxiolytics, antipsychotics and anti-depressants help to decrease symptoms however also show heavy side effects. Furthermore, these drugs often fail to attend to the underlying issues of clients, thus their problems perpetuate, leaving individuals dependant on the substance (Mithoefer, Grob & Brewton, 2016). Studies have shown that evidence-based psychotherapy can be more effective than medication at treating individuals who meet the criteria for a mental health diagnosis under the Diagnostic Statistical Manual (DSM) such as ‘post-traumatic stress disorder’ (PTSD) and ‘anxiety associated with terminal illness’ (Mithoefer, Grob & Brewton, 2016). Indeed, a recent meta-analysis showed that individuals experiencing death anxiety had a 3-fold preference for psychotherapeutic interventions as opposed to drugs (McHugh & Whitton, 2013). However, there remains a large subset of the population whose mental suffering is not alleviated by evidence-based psychotherapy and/or psychopharmacological treatment (Mithoefer, Grob & Brewton, 2016).
Indeed, previous publications document how individuals with a ‘psychiatric diagnosis’ often try successive medications in an effort to alleviate their symptoms, however many cannot find such relief or suffer severe side effects (Watts, Schnurr & Mayo, 2013). Furthermore, despite positive effects in psychotherapy, dropping out is common and progress is often slow (Mithoefer, Grob & Brewton, 2016). Clinicians practising psychotherapy report feelings of frustration around being ‘stuck’; clients frequently report feeling this ‘stuckness’ (Hammersley & Beeley, 2006). Hammersley and Beeley (2006) discuss the ‘stuckness’, commenting on how some clients appear unable to get in touch with feelings. Others seem to find the session very helpful and engaging, then fail to transfer this effectively into their daily lives.

The current limitations of pharmacotherapy and psychotherapy therefore fail to sufficiently attend to individuals suffering mental health distress. Indeed, these shortcomings are felt in the National Health Services (NHS), with long waiting lists topping 12 months for psychotherapeutic treatments, largely due to a ‘revolving door’ problem wherein clients frequently return as a result of unsatisfactory results of previous treatments (Beck, Burdett & Lewis, 2015). Improving Access to Psychological Therapies
(IAPT) services, delivering cognitive behavioural therapy (CBT), represents a new approach by the NHS to satisfy high demand. Despite short-term success however, these treatment outcomes have been shown to fail in terms of sustainability, with individuals often relapsing and returning to services a year later (Beck, Burdett & Lewis, 2015).

In line with these limitations of current mental health practices, Hammersley and Beeley (2006) comment how longstanding and frequently prescribed psychotropic medication might be accountable for limitations experienced in psychotherapy. They note how in the short-term psychotropic medications alleviate symptoms such as crying, distress and tension, however the authors assert these symptoms are the way in which we can access the underlying issues in psychotherapy. The authors express that a vital part of successful therapy often involves clients’ re-experiencing of emotional pain to work through their past traumas. In addition, they comment how clients need to be able to experience the relationship with the therapist, on an emotional level, and to be in touch with the subtleties of the interactions between them. This is in line with CoP’s emphasis on the therapeutic relationship in psychotherapy (Woolfe, Strawbridge &
Douglas, 2010). This notion is supported in research that conveys outcome of therapy to be attributed largely to the quality of the relationship between therapist and client (Ardito, 2011). Therefore, they suggest that given that the drugs prescribed often reduce the client’s capacity to feel and think, they can be incompatible with psychotherapy and contribute to the ‘stuckness’ experienced in the process. Finally, the authors suggest that it is too simplistic to take a position that medics and psychotherapists have separate areas of competence; doctors are embracing skills of counsellors and likewise psychotherapists should not disregard psychotropic medication. This seems aligned to CoP’s pluralistic and scientist-practitioner position (Woolfe, Strawbridge & Douglas, 2010). Therefore, there appears a need for such a gap in treatment to be investigated and attended to.

Over the last ten years, studies have begun investigating the potential of psychedelic compounds in mental health treatments with promising results (Mithoefer, Grob & Brewton, 2016). Of interest to CoP are emerging studies that seek to investigate the use of such compounds, as an adjunct to psychotherapy such research is outlined below.
Utilising psychedelic compounds as an adjunct to psychotherapy

4-Phosphorloxy-N,N-dimethyltryptamine (psilocybin), 3,4-methylenedioxy-methamphetamines (MDMA) and Lysergic acid diethylamide (LSD) are psychedelic compounds which have shown promise in treating mental health distress as an adjunct to psychotherapy (Mithoefer, Grob & Brewton, 2016). Indeed, a resurgence of clinical research over the past 10 years has provided promising results for populations considered to be suffering with a ‘treatment-resistant’ diagnosis, including anxiety associated with terminal illness, addiction, depression and, as illustrated below, PTSD (Bogenshutz, Forechims, Wilcos, & Strassman, 2015; Carhart-Harris, et al. (2012); Danforth, Struble, Yazar-Klosinski & Grob (2015). For a detailed account of such research, see Ruger (2015), literature review.

MDMA and PTSD

Mithoefer et al. (2011), conducted an investigation demonstrating that MDMA-assisted psychotherapy was effective in treating clients with chronic, treatment resistant PTSD. Using a between-subjects study design, with a control group, the study demonstrated
a reduction in PTSD symptoms using psychedelic assisted psychotherapy as opposed to psychotherapy alone. 20 individuals with treatment resistant PTSD were randomly assigned psychotherapy with MDMA (n=12) or an inactive placebo (n=8). Individuals were administered MDMA during two 8 hour sessions 3-5 weeks apart. A non-directive, person-centred approach was taken by the therapists in discussing trauma-related material. After a 2 month follow up, 85% of participants who were administered the active drug no longer held a DSM IV diagnosis of PTSD, compared to just 15% in the placebo group. The results were sustained upon a 3.5 year follow up. No adverse effects were noted from either group of participants. Impressively all clients who were previously unable to work due to their PTSD symptoms returned to full-time employment. In relation to the aspirations of IAPT services in the NHS, whereby short term therapy is utilised to help people with mental health difficulties return to work, such a finding could have positive implications for the NHS (Layard et al., 2006).

Whilst the research above should be commended for its progressive stance in challenging the effectiveness of conventional psychotherapy with regard to psychological distress, in taking a
positivist epistemological position and attending only to quantifiable outcome measures, this study as well as others, neither discuss the impact of MDMA administration to the psychotherapeutic process nor attends to the phenomenological experiences of both clients and therapists; ethical matters important to the field of CoP. Furthermore, As RCTs are often hailed as the ‘gold standard’ of research the issue arises surrounding a lack of critical evaluation regarding assumptions that researchers bring to their work.

The limited current understanding of how psychotherapy is facilitated by psychedelics

The way in which psychedelics act as a catalyst to psychotherapy remains elusive, with current theories speculative (Mithoefer et al. 2016). Such observations include, decreased “defensiveness and avoidance” and a clearer memory of historic events. Moreover, clients’ willingness to explore historic events is also increased, along with a better ability to process their experiences (Carhart-Harris, 2012). Additionally, participants are reported to have new awareness for unhealthy emotional and cognitive patterns in response to traumatic events and increased capacity to fearlessly
offer compassionate reappraisal. These have been hailed as being ‘ideal effects’ to augment psychotherapy (Mithoefer et al. 2016).

Such speculation is of interest to CoP as it suggests promise for the psychotherapeutic process. However, there are also potentially some concerns with increased ability to recall memories. Indeed, the capacity to maintain difficult memories beyond awareness is perhaps best understood in terms of a ‘tolerable’ mode of being, enabling the individual to function in the world. Indeed, whilst explanations are ontologically distinct, there is some agreement within the literature that the ‘removal’ of traumatic memories has a protective function. Goldberg (2013), discusses the importance of caution regarding therapists’ pace when working with clients’ exploration of erstwhile unavailable material, claiming that accessing memories rapidly may be traumatic for the client. This raises important questions regarding how distressing the therapeutic encounter may be for the client subsequently. Furthermore, an acceleration in accessing memories also poses potentially negative implications for therapists. In accompanying the client through the rapidly emerging affective experience, the therapist may be rendered insufficiently equipped to hold or contain the individual in their experiencing of traumatic material
(Goldberg, 2013). However, it remains that all therapeutic encounters involving traumatic material require an attendance to sufficient levels of self-care on the part of the therapist (Iqbal, 2015) and that ‘significant’ material may enter the therapeutic frame, unannounced, regardless of clinical orientation. Thus research that seeks to explore therapist’s experiences of delivering this form of psychotherapy seems important to understand the impact of psychedelics on the therapeutic process better.

Furthermore, in terms of the impact of using psychedelics on the psychotherapeutic process, Mithoefer et al. (2016) speculates that MDMA could improve the therapeutic alliance with those clients who find it particularly difficult to trust. Whilst this strengthening of the clients’ trust presents promise for psychotherapy, arguably using a psychedelic substance raises other issues for the therapeutic relationship. Indeed, most psychotherapeutic approaches acknowledge the therapeutic relationship as fundamental to psychotherapy, and a significant aspect of the utility of the relationship is the shared empathic understanding between the therapist and client, as conceptualised by the process in which therapists seek to enter their client’s unique phenomenological world (Woolfe, Strawbridge & Douglas, 2010).
Arguably, this process may be compromised when the client is under the influence of a substance, as the therapist may not be able to provide empathy if the client’s experience is of such a depth of introspection, and the ideas that are emerging are in such an abstract form (Grof, Goodman & Richards, 1973). Indeed, it may be difficult for the therapist to connect and empathise with the client, thus inhibiting the therapeutic relationship and obstructing the therapists’ ability to be with the client and meet them at their phenomenological experience. Research to date has not explored how therapists experience delivering psychotherapy under these conditions, thus the impact of the client being under the influence of a psychedelic on the therapists ability to enter their world and be with them remains largely unknown.

Possible adverse effects of using psychedelics as an adjunct to psychotherapy

Although there is an emergence of evidence supporting the use of psychedelics within psychotherapy, research is obliged to attend to risk potential for therapists and their clients. Indeed, popular discourse, as characterised by using psychedelics within recreational settings, has presented a less than positive interpretation of their use and studies have reported the harmful
effects associated with a range of factors such as delusional expectancies, inaccurate dosage and the appropriateness of setting (Carhart-Harris, 2012).

A recognised adverse affect of psychedelic use in the recreational setting is referred to as ‘Hallucinogen Persistent Perception Disorder (HPPD)’ or ‘The re-experiencing, after cessation of use of a hallucinogen, of one or more of the perceptual symptoms that were experienced during intoxication with the hallucinogen’ (DSM-V). With regard to recreational LSD use, HPPD has an incidence rate of 5% (Hermle et al. 2008). However, as reported by Carhart-Harris and Nutt (2010), unlike those who use specific psychedelic substances under controlled conditions, the majority of the recreational user population use a range of drugs. Accordingly, it is not possible to implicate psychedelics per se in the onset of such symptomology. Indeed, a recent meta-analysis (Carhartt-Harris et al., 2013) examining links between psychedelic psychotherapy and suicide rates, psychotic episode and rates of hospitalisation (Friedman, 2006) concluded that psychedelics are safe to administer in the therapeutic setting. However, it should be borne in mind the extent to which a paucity of studies involving small sample sizes raises issues of generalisability.
Interestingly, to elaborate in terms of safety of such substances, Grawe (1995) conducted a study on findings of toxicologists who had compared frequently ingested psychedelic compounds in their potential to cause harm, including factors like the potential to form dependence. His research concluded that none of the psychedelics used in research cause physiological toxicity and there was no evidence of psychedelics having any addictive potential. Such findings, alongside no reputable researchers having found any direct toxic effect to date (Carharrt-Harris et al, 2013) are perhaps surprising when considering how frequently their toxicity is touted. However, research does exist on the potential for psychedelics to cause accidents, such as individuals developing hyperthermia due to over exertion and exhaustion under MDMA influence Gowing et al., 2002). Such incidents further compound the importance of acknowledging the potential for these substances to be dangerous and the need for a much wider breadth of research to be conducted in this area prior to conclusions around their safety being drawn. Furthermore, it is important to be mindful of how research may filter into popular discourse and draw attention and attraction to recreational use, which could put the public at risk.
Rationale

Preliminary research is demonstrating the potential benefit that psychedelics can offer to psychotherapeutic practice. Whilst research conveys that psychedelics are useful, the impact they have on the psychotherapeutic process remains to be investigated. As a pluralistic profession, CoP endeavours to acknowledge and utilise, a wide range of research and treatment (Milton, 2016). As previously discussed, recent studies propose that administering a psychedelic can facilitate the strengthening of the therapeutic relationship, enhance reflective capacity and introspection, and enable patients to access their repressed memories more easily. These psychotherapeutic processes are referred to, researched and utilised in practice regularly within the field of CoP (Woolfe et al., 2010). Therefore, if administering a psychedelic may have the potential to facilitate such processes, and could provide useful opportunities for CoP practice, it is helpful for CoP to begin to investigate this model of treatment further. Indeed, if psychedelic psychotherapy may be able to offer a short-term treatment model, which is not dissimilar in terms of time to the current 12-week model offered in IAPT, but has shown more promising results in terms of sustainability, then it seems important to investigate this form of psychotherapy further, in order to attend to the current NHS challenges.
Additionally, current psychotropic medication prescriptions frequently act as an obstacle to psychotherapeutic processes and the use of the therapeutic relationship in psychotherapy (Hemmersley & Beeley, 2006). Therefore, since psychiatry is endeavouring to engage in research that is attending to this, it seems important for CoP to acknowledge, support and engage with psychedelic research also. Indeed, the field of psychiatry is reporting positive findings for psychedelic psychotherapy but recognises that there is still a need for further research before conclusions can be drawn regarding efficacy of psychedelics in psychotherapy. CoP, unlike psychiatry, is a discipline that emphasises psychotherapeutic treatments for mental health issues (Milton, 2016), and thus can arguably provide a better platform from which to explore the impact of psychedelics on the psychotherapeutic process. This could offer the opportunity for the two disciplines to complement each other better.

The above rationale is in line with BPS (2013) guidelines, as scientific-practitioners, CPs have a responsibility to respect, utilise and contribute to empirical research that seeks to develop and offer better psychological treatments (BPS, 2013). Since current
research has indicated that this form of psychotherapy may provide a more efficient treatment than currently available treatments for a range of client groups (Mitohefer, 2016), it seems important for CoP to consider and evolve the research further.

**Aims and research question**

The proposed study aims to expand on current literature’s understanding of the impact of psychedelics on the psychotherapeutic process. It will consider themes that emerge regarding how psychotherapeutic processes appear impacted because of using psychedelics. Thus, the research question, ‘How do psychedelics impact the psychotherapeutic process?’

**Method**

**Research philosophy and design**

The introduction pointed to an absence of qualitative research in psychedelic mediated psychotherapy. Qualitative methodology allows for individuals’ subjective experiences to be explored at
depth, creating a richer understanding of the phenomena, or argument, that participants hold. A qualitative methodology therefore seemed appropriate when attending to the present study’s research aims and questions (Willig, 2013).

Since the research question seeks to explore the impact psychedelics have on the psychotherapeutic process, thematic analysis seemed the most appropriate choice of methodology (TA). This is because TA is a flexible qualitative method that provides opportunity to explore why people think, feel or do particular things (Braun & Clarke, 2006).

Alternative methods such as IPA emphasise individual participant’s lived experience more, rather than concentrating the emphasis of the research on the themes that emerge across participants. In IPA, researchers code the data items individually, looking for themes within each data item first. However, in TA researchers develop their analysis across the whole dataset at every stage (Braun & Clarke, 2006).
Sampling and Participants

Braun and Clarke (2006) suggest a sample of between 7-20 participants when using TA, offering researchers the opportunity to see themes across the data set. Given the limited research in the field thus far, and the subsequent small population of therapists working in the field, the sample was kept small. In addition, it was felt that the scope of this research supported the need for a small sample to ensure that rich analysis could be conducted, with space to report the findings elaborately at depth. Therefore, it was decided that a sample of 10 and no less than 6 participants would be optimal.

Participants were selected purposively; inclusion criteria stipulated that individuals must be qualified practitioners of psychotherapy, who have provided therapy to patients whilst they had been under the influence of a prescribed psychedelic substance. In addition, it was stipulated that they had worked in a psychotherapeutic capacity in the absence of utilising psychedelics as an adjunct for a minimum of two years, in order to ensure that they could give a richer insight into how this experience is similar or different. Furthermore, inclusion criteria required individuals to have worked
in this capacity in a clinical trial, which has been run in the last 10 years of psychedelic psychotherapy research.

Regarding participant recruitment, the researcher made contact with a research fellow in the field at a highly regarded university in the U.K. This individual responded saying that he could not facilitate access to the population required however he advised that the researcher contact MAPS, an American charity directly involved in the funding of this research called the Multidisciplinary Association for Psychedelic Studies (MAPS). He suggested that they would have access to the contact information of the individuals whom had provided therapy to patients on the psychedelic assisted psychotherapy trials. Thus the researcher contacted this charity. From this point of contact a process of chain referral or ‘snowballing’ occurred, following the administrators at the charity sending out the email advertisement (Appendix 1). This process generated a list of individuals who met the criteria. 7 individuals contacted the researcher showing interest in the study, and all were responded to with information regarding what participation would involve and an invitation for them to participate (Appendix 2). They all replied and agreed to take part.
Description of participants

Seven individuals who were qualified to deliver psychotherapy took part. Two of the participants were primarily qualified as psychiatrists, but had been trained in, and used, psychotherapy in their practice frequently. All participants had delivered psychotherapy without the use of psychedelics in their practice for a minimum of three years prior to participation. Theoretical orientation and modality preferences were varied across participants, including humanistic, cognitive behavioural, psychoanalytic, somatic and transpersonal psychotherapy.

Data Collection

Semi-structured interviews were used to explore the topic flexibly, whilst remaining within the area of the study (Braun & Clarke, 2006) (Appendix 4).

The interviewer endeavoured to enter the personal frame of reference of the participant. (Willig, 2013). Thus questions were non-directive in order to maximise the potential to explore the individual’s experience without influencing the direction of the
material that emerged. The interpretative aspect of TA means that the influence of the researcher is ‘inescapable’ in the knowledge that is produced. Thus attention was placed upon reflection of my role as researcher in the interpretations that emerged at every stage of the research process (Larkin & Thompson, 2012; Yardley, 2000).

Interviews lasted between 45-60 minutes and were recorded and transcribed before analysis.

The interviews were conducted using video/phone technologies. This decision was made due to financial and time restraints within the scope of this study, given that all participants were based in America. This approach was further supported when taking into account how it contributed to minimising ecological dilemmas in terms of the researcher travelling to America. The researcher used Skype which is an internet telephony software which allows videoconferencing via a web cam. It was considered that the use of videoconferencing enabled an experience that was closer to an in-person encounter (Slade, Emery & Lieberman, 1997). Indeed an advantage of skype was that it enabled nonverbal communication
to be captured, which felt important in the context of an IPA study. In addition, Skype calls are recorded and transcribed in the same way as face-to-face interviews (Oliffe, 2010).

**Data analysis**

The inductive analysis procedure outlined by Braun and Clarke (2006) was employed. Data was initially read to identify and code important features of transcripts. Codes were sorted into possible themes and all data that was deemed relevant to the theme was collated. Finally, data was systematically reviewed to enable identification of an appropriate name and definition for each theme, and to ensure that themes corresponded to the codes that emerged from the participants’ transcripts.

Braun and Clarke (2006) express the need for researchers to make the theoretical framework of their study transparent. Different theoretical frameworks are underpinned by different assumptions about the data, and what it reflects in terms of ‘reality’. TA is not underpinned by a particular theoretical position, thus it can be used in conjunction with various theoretical frameworks. The present study’s question invites a ‘contextualist’ position, which Braun and
Clarke (2006) denote sits between realism and constructionism. Such a position, allows for the acknowledgement of individual experiences of participants and their personally ascribed meanings, recognising that the experience is “real” to the individual, whilst also acknowledging that experience is always the product of interpretation and thus constructed. Therefore, since one was looking at how practitioners make sense of their realities, but also acknowledged that their realities are inevitably socially constructed, this position was deemed appropriate.

**Ethical considerations**

Ethical approval was applied for and granted (Appendix 5) and steps were taken to ensure that the study met with both the BPS and HCPC codes of conduct.

Participants were informed of the risks and benefits of partaking and their right to withdraw at any point, as well as where they can seek help should they need support during or after the study. Participants were required to give informed consent and did so prior to partaking in the study (Appendix 2).
Following participation, individuals were debriefed on the aims of the study (Appendix 3) and their confidentiality was, and will continue to be, maintained. All names used in the analysis of this study are pseudonyms.

**Findings**

Three master themes and seven sub-themes emerged from analysis (See table 1). Further, an integrative theme was observed to emerge. Integrative themes have previously been used in TA research where the theme seems to thread across themes (see, King, Caroll, Newton & Dornan, 2002). Including this theme enabled the latent tone of participants accounts to be represented.

<table>
<thead>
<tr>
<th>Master Theme</th>
<th>Sub-Theme</th>
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<td>1. Facilitation of Process</td>
<td>1. Increased access to and engagement with memories.</td>
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2. Emotional Processing
3. Consolidation and Integration of experience

| 2. The Therapeutic Relationship | 1. Openness, Trust and Authenticity
|  | 2. Transference and Reparative relationships
| 3. The Power of a Transcendental Experience | 1. Changes in Narrative and ‘Meaning making’
|  | 2. Spiritual Connection

N.B The Integrative theme was ‘Therapists as advocates of psychedelics’

Overall the data appeared to reflect that participants considered their experiences to have led them to see psychedelics as a useful adjunct to their psychotherapeutic work. They all stated that psychedelics appeared to “speed up” a number of therapeutic processes and also to give their clients a sense of “safety” during the therapy. This is reflected frequently throughout this analysis.

**Integrative theme: Therapists as advocates of psychedelics**
The above theme was incorporated in order to capture how all participants seemed to use language, which suggested they hold strong positive attitudes towards psychedelics. Perhaps this indicates an underlying bias of positive attitude towards psychedelics within the sample. On the other hand, their strong expression of positivity may be a reflection of MDMA producing such strong benefits to the therapeutic process that this would be a common conclusion regardless. Such language can be seen in the majority of excerpts presented below. Whilst it has not been possible to elaborate and comment on each example, I have drawn attention to several occasions where this appears communicated in a strong way.

An example of such positive language is demonstrated in Ben’s discussion of his transition from being perhaps hesitant about the benefits of psychedelics to feeling very convinced about their uses:

“\textit{I think I was really converted, I remember being really sceptical, and then in the first session that I was in it was really clear to me how powerful the acceleration of the therapeutic process is.”} 

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The word “really” is used twice in the above quote, perhaps this reflects Ben’s need to communicate the strength of positivity that he feels towards psychedelic and may also serve as a means of convincing the interviewer of this position. Moreover, the use of the word ‘converted’ may imply a sense of powerful change in his opinion and highlights his firm position regarding their uses.

Another example of such a positive transition of position to perhaps advocate of psychedelics can be seen in the following extract from Natalia:

“Well when you see it work, and it was the part of a double blind design so we supposedly did not know who was getting the real medicine, you could see the effects and you know when you just see something work. So, really I suppose that I see them as another useful tool to bring into the therapy room, not dissimilar to tools like mindfulness.”

Natalia repeats himself in the above quote, regarding his experience of observing the substance to “work”. Perhaps the
function of this reiteration is his endeavour to advocate for their utility. Additionally, he compares them to a well-regarded and utilised contemporary therapeutic technique (mindfulness) (Cigolla & Brown, 2011) perhaps in order to further support and advocate for their utility therapeutically.

The analysis will now be presented below, demonstrating the three master themes and 7 of the 8 sub-themes. Unfortunately, due to word-limit not all themes can be discussed here. All master themes will be presented but sub-theme 2, of master theme 3, will not be presented. A pragmatic decision was made to focus on themes which most closely answered the research question, and were particular areas of interest for CoP practice e.g psychotherapeutic processes and the therapeutic relationship.

**Master Theme: Facilitation of process**

The use of the psychedelic substances appeared to enable many of the internal processes, associated with psychotherapy, to occur. All participants commented that they had observed a reduction in their
client’s fear and anxiety levels as a result of the psychedelic, and suggested that this facilitated necessary internal processes to occur more easily and safely.

Sub-theme 1. Increased access to, and engagement with, memories

Participants spoke about how their client’s had appeared more able and willing to get in touch with memories associated with their trauma, as a result of a reduction in feelings of fear around the memory content following psychedelic administration. This is conveyed in the following excerpt from Josh:

“Yes, so I think that MDMA seems to be like an ideal drug for people for PTSD, just because of the way that it seems to give people access to parts of their memories, that are very like anxiety provoking, and fear inducing. And because it's able to seemingly reduce that level of fear and anxiety, they can then go and approach those traumatic memories and process them with a feeling of safety.”
Here Josh explains how individuals may feel safer to engage with difficult memories and as a result are more able to work through the trauma. In terms of the integrative theme, the use of the word ‘ideal’ perhaps suggests a strong bias. Again, perhaps such language implicates a position of advocacy for the drug. Matt appears to have had a similar experience when working with individuals under the influence of a psychedelic substance, this is reflected in the following statements:

“There is some percentage of people where CBT does not achieve the desired effects and usually for reasons to do with not engaging with the full memory. I think that MDMA facilitates that further. If we believe that people who are treatment resistant to PTSD are not really allowing themselves to touch on the traumatic memory, that they are doing so only in a very superficial way, then the way I understand MDMA is that it seems to relax the person and this helps you to touch the things which felt quite threatening to look at before. If you are enabled to touch those memories you can then do the processing. So it's the MDMA which allows access to the memory material which then can be processed.”
Again Matt comments on the psychedelic enabling the individual to engage with their traumatic experiences without feeling too afraid, and as a result processing them with more ease. He explains that he feels that often individuals, who have not been successful in his therapy, where he uses CBT alone, were not able or prepared to approach such memories because of feelings of fear. His comparison of CBT with and without psychedelics supports one’s understanding that he deems the psychedelic to be the mediating factor. Helen refers to a similar experience of working with trauma:

“And you know sometimes when you are working with trauma; the main issue is that the person is hyper-vigilant. It is really difficult to even work on trauma because you are just having to regulate people to stay out of that hyper-aroused state. And what I saw with the MDMA is, that it helps to decrease activity, so it seems to decrease the fear response. And then people are so much more able to access trauma and talk about it from a place, rather than going into a state of dissociation, and so it is almost too good to be true. But what we are finding is that years after the study results are still holding.”
Again, in line with the integrative theme, in the above example the term “almost too good to be true” perhaps implies a sense that Helen feels slightly sceptical about her own powerfully positive experience. However, perhaps what follows this comment is a defence of her own questioning. Indeed her discussing later “study results” gives the sense that it is important for her to corroborate her experience of them as very positive. Such defending may implicate a desire for Helen to convince or advocate for psychedelic uses, despite her acknowledgment of the positive effects she observed seeming somewhat unbelievable to her.

Josh appears to share a similar experience to Helen with regards to his observation of access to memories being facilitated as a result of a decrease in dissociation:

“During the experience she was constantly having waves of memory sort of coming to her, and very often with this patient it would be new memories, things that she hadn't experienced or remembered in the past. She had a very strong predisposition to dissociation and so I think that was what usually happened to her,
any time she would approach some of this information she would dissociate and not deal with it, and then under the MDMA and that lessening in the fear, like she wasn't dissociating, and so all of a sudden all these memories are coming back.”

In the below example, Ben acknowledges how he found the MDMA to enable the individual to engage with the emotions that are associated with their memory. He reports that as a result his clients seemed more able to process their experiences. Indeed, in Ben’s experience the particular utility of the psychedelic was that it enabled individuals to connect the memory with the corresponding emotion.

“The MDMA shifts people to the emotional quality of a memory that they can do much better than they can do without it.”

In the above example Ben’s use of the words “much better” to discuss what can be achieved with and without MDMA perhaps reflects a strong positive attitude towards the drug and again may aligns to a sense of advocacy in participants’ narratives.
Sub-theme 2. Emotional processing

Participants discussed how their client’s seemed to become more ‘in touch’ with their emotions when under the influence of the psychedelic substance, and in the sessions that followed. For example, this is reflected in the following two excerpts from Dan:

“Generally speaking one of the things that I saw a lot of, especially in men but also women, is increased emotional openness. That is one thing that people talk a lot about, during and after their experience, that they feel more sensitive to their emotions and the people around them”

Dan goes on to say:

“...I think mostly psychotherapy is done when people are at their cognitive, or intellectual level, people are talking about and thinking about things. Sometimes you may get someone, you know,
to slow down and feel or be emotional. But basically, the emotional part can be very challenging to reach when we are sitting and talking to someone, because often when we sit and talk it's an intellectual exercise. But I think when they have the psychedelic they are more able and allowing of their feelings and emotions and even afterwards the person is more open to you and more able to sometimes go back to those kinds of emotional or other known difficult places and revisit them.”

In the above statements Dan suggests that clients were more emotionally available during their psychedelic sessions, he finds this to enable the psychotherapeutic process not only during the session but afterwards in following sessions as well, commenting that the individual appeared more able to return to such states. He notes this as a marked difference in his experience of psychotherapy without the use of a psychedelic and with.

In line with the integrative theme, there appears a difference in the language surrounding how Dan talks of psychotherapy in the absence of psychedelics when compared with. Indeed he uses the word “sometimes” and “very challenging” when talking about
psychotherapy alone, perhaps implying a negativity or frustration towards this practice. In contrast, Dan repeatedly uses the term “more” in a positive manner when discussing psychotherapy with psychedelics. Again his distinct difference in tone when discussing the two forms of therapy may indicate a desire to advocate for psychedelic psychotherapy above other therapies.

Matt appears to have observed similar responses in his clients when using the psychedelic, as reflected in the following:

“There is a big difference in my understanding between the use of SSRIs and the use of MDMA, SSRIS are all about reducing the symptoms, and that's it nothing changes. MDMA actually facilitates healing and recovery through the experiencing and processing of emotions.”

Here he explains how in his experience, in contrast with medication such as SSRIS, the psychedelic appeared to enable his clients to get in touch with their feelings allowing emotional processing.
Helen’s experiences seem to support these observations:

“The things I was surprised about were the speed, you know, at which people progressed and the access that they had to their vulnerability and emotions.”

Here we possibly see again the overarching observation of participants, in terms of ‘speed’. Helen appears to have found that the psychedelic substances accelerated her clients’ ability to be in touch with their feelings and vulnerability.

Sub-theme 3. Consolidation and integration of the experience

Whilst all participants appeared to speak positively of the speed at which individuals were able to connect with their memories and emotions, there was also a lot of acknowledgement of the
difficulties that it could cause for the integration process of the experience. Indeed, participants seemed to talk about how it could be difficult for clients to continue to hold their experiences of the psychedelic sessions in mind, and use the experience to positive affect moving forwards. Also, participants discussed how it appeared difficult for individuals to make sense of, and manage, the material that emerged from their psychedelic sessions as a result of the speed at which it was accessed. This appears to be reflected in the following statement from Ben:

“I think the most difficult thing for people is to integrate changes that happen so quickly, because the change happens so fast that the brain has to catch up.”

A very similar statement was made by Mary:

“The downside is that, because it is so fast, it is also pretty shocking, and so it can be a little difficult to integrate. And there's a sense of feeling like “oh no I'm going to lose the connection I made, I'm going to lose it because now I don't have the influence of
M.D.M.A...I think that it is hard you know when you do something so fast and there is such drastic change that happens, it can be pretty difficult to integrate so fast. So, like in regular session because things move so slowly, so that’s the drawback. So it goes so slowly that the integration process is really just kind of like automatically there because it’s just such small steps, you know, so it can take years to do the same thing.”

In the above excerpt Mary seems to talk about individuals struggling to deal with the speed at which the experience occurs, referring to how it can be ‘shocking’. We also see here that she appears to note the difficulties that clients experience, in terms of consolidation, as a result of speed, due to expressing feeling anxious about losing the positive benefits that they had reaped from the psychedelic session.

Mary compares the differences between psychotherapy with and without the use of the psychedelic, commenting that in psychotherapy without the psychedelic, difficulties with integration do not present themselves as such a problem. She
appears to recognise this to be due to the pace being slower and therefore happening more naturally.

In addition, Josh seemed to talk about the importance of the individual being offered the opportunity to process the experience during personal therapy, following the psychedelic experience. Earlier in this report we saw him speak positively of the way in which he felt psychedelics enabled individuals to access elements of their minds, however below he appears to think that there are difficulties in doing so and suggests that psychotherapy is particularly important after the experience:

“If people don’t have their own therapist to go back to they may be left high and dry with a lot of new stuff to process. I think that the hope was that the processing part of it all would go quickly, just like the other parts, like building quick relationships, trust and openness you know, but processing the trauma seems to take a long time.”
**Master theme: The Therapeutic Relationship**

All participants appeared to speak of the psychedelic psychotherapy sessions as enhancing their therapeutic alliance with clients. This is reflected in a number of statements, for example Matt said:

“In most cases it certainly added to the therapeutic alliance”

In Matt’s example perhaps the use of the word “certainly” reflects the strength of his positive attitude towards using psychedelics and may serve to persuade others of their benefits.

Dan reports observing similar responses to the psychedelic assisted sessions, explaining that the therapeutic relationship felt stronger during and following those sessions.

“So, it enhances the therapeutic alliance. Well, I mean that's what I noticed, when the drug is administered and after those sessions usually people feel closer to the therapist.”
Sub-theme 1. Trust, openness and authenticity

All participants appeared to recall experiencing trust and openness to have been enhanced within their relationship with clients both during the psychedelic assisted session and in the sessions that followed. This is perhaps reflected in the following comment from Helen:

“Sometimes it can take forever for the clients to really open up to the therapist. The rapport is so important in the healing process. In the beginning there was sort of a questioning or a discomfort, just like how it is normally in any therapeutic situation really. And then after MDMA sessions, just more and more increased comfort, more eye contact, more revealing of themselves, more able to ask for support. People with trauma often experience difficulties in asking outside people for support because of the lack of trust, even simple things like ‘could you get me a tissue, or can u get me some water’.”
Here Helen seems to explain how she observed clients being more able and comfortable to speak openly and honestly about their needs from others and her as the therapist. She compares how prior to the MDMA sessions clients seemed to be similar in their ability to trust the therapist to that which she had experienced during her therapy practice in the absence of psychedelics, but that there was a significant difference in their style of relating after the psychedelic.

Similar to the example given of the integrative theme above, Helen appears to use strong language to distinguish between her experiences of psychotherapy with and without psychedelics. She explains how she has experienced it to take “forever” at times for clients to open up. Whereas after the administering of the MDMA she talks about how this is starkly different using the words like “more” repeatedly to describe clients’ abilities to interact. Again perhaps this reflects a need to advocate for their uses and suggests a powerful positive attitude.

Josh seems to go on to support this observation of perhaps more authenticity and openness in clients as a result of the MDMA
session. Like Helen, he talks of observing a distinct difference between his experiences of working psychotherapeutically with individuals in the absence of the psychedelic and with it:

“I worked with one patient for so many months, and at the end of so many months she would still tell me “actually, I wasn't honest and open with you last week or at our last session”, and it's hard because you've worked together for months, you are hoping that at that stage you've shown yourself to be trustworthy as a therapist. And still you are hearing from the patient that they’re telling you part truth or lies. And with the MDMA therapy people would sometimes opt not to tell you things but they would usually say “I am experiencing something and am just not ready to talk about it”. But then in that case you know something is happening, and there is usually a good chance that they would want to go back and explore it with you later. Yes, it was very dramatic the difference in being able to interact and relate with people on MDMA.”

In the above exchange, Josh appears to articulate his frustrations about the pace at which individuals are able to trust him as a therapist during psychotherapy without the psychedelic. He reports
a different experience when working with individuals under the influence of a psychedelic, stating that they were more open, particularly in terms of what they were not saying during sessions.

Similarly, Mary appeared to observe a reduction in clients’ fear surrounding what they should talk about and how they should act. This again perhaps marks an example of the increased sense of safety that is seen throughout all participant’s experiences. Mary observed that her clients seemed less concerned with their therapist’s opinions of them, and therefore were more able to be authentic. Also of note in the following excerpt is Mary’s observation that this positive change in style of relating, to a large extent, continues in the sessions that follow:

“They are not... there isn’t that questioning so much about what to say, what to do, what is my therapists going to think about me, should I say this, should I not say this. They become much more comfortable with asking for what they need. They are able to ask you for things that normally they would not ask you like if they... even simple things when they're in preparatory session if they want a glass of water, they might not ask... whereas the treatment
session, they are actually pretty needy. And that change is usually very sustained in the sessions that follow.”

Interestingly, in the excerpts of Mary and Helen above, they both use the same example of the “glass of water”, perhaps this reflects a dominant group narrative amongst therapists and may further imply a positive bias or sense of need for advocacy across the sample.

Participants appeared to feel that the psychedelics facilitated the Trust, openness and honesty of clients during the psychotherapy. Ben talks about this in terms of increased ‘trust’:

“I sense the MDMA really does accelerate the development of trust. I'm kind of basing it on the fact that we have three preliminary sessions. In those 3 sessions it feels like the first three sessions of any psychotherapy and then the next 3 sessions after the first MDMA session are really different on the level of trust. It’s just really clear to me how the psychotherapy and the relationship are essential to the MDMA process.”
Here, Ben explains how he observed distinct differences in the way clients engaged with the therapeutic relationship before and after the psychedelic session, in terms of their trust for the therapist. He discusses how he feels that the drug and the psychotherapy are an important combination. Josh’s experience may support what Ben suggests about the importance of the combination of the psychedelic in conjunction with the psychotherapy:

*Josh:.* well I think it was both the MDMA and the psychotherapy together, but I do think that it was the MDMA that allowed us to discuss those things openly. ”

**Sub theme 2. Transference and ‘reparative’ experiences**

Four participants talked in terms of ‘transference’ with regards to what they witnessed when individuals were under the influence of the psychedelic substance. Transference is most widely recognised in a psychodynamic theoretical context and was first coined by Freud when describing clients experiencing their therapist as
having qualities that reflect those of prominent people in their childhood (Freud, 1905).

Here participants discussed how they felt that the psychedelic facilitated insight into, and processing of, transference relationships. For example, in the next example Ben discusses how he felt that the MDMA facilitated the processing of transference as a result of the client noticing the way in which their early experiences influenced how they approached their present life.

“I felt like it was really important for people, especially with an early trauma, to be able to see, with the support of MDMA, that the lenses that they see people through are coloured by earlier experiences of their relationships with their parents.”

In the following excerpt Josh is talking about an example where one of his clients was experiencing transference of him as her father, due to some unavoidable incidences of lateness on his part during the therapy. He notes how what felt enabling about the
psychedelic was the individual’s ability to raise the issue with him and talk about the feelings that were aroused for her as a result:

“My schedule was extremely busy while I was participating in the study, and so with one of the subjects there was an occasion where I ran late, you know like very unavoidably, but it did bother the patient a lot and I think she found that she was reacting to me very negatively because of that. I think that part of it is she had felt that her trust was betrayed, and that she was let down by her Dad growing up, so that’s who I was representing to her, and what I think the MDMA did was it allowed her to bring it up, what I suspect is that if she hadn’t taken the MDMA she wouldn’t have mentioned it and would've just kind of ignored it even though she was feeling emotions based on that...”

Mary’s words support Josh’s experience of the substance being useful in assisting clients in processing of transference.

“You know they were really able to have corrective experiences. The treatment really lends itself to have transference of mother and
father. Even if the therapists are younger, there is that sense of like you are his mum and dad, and because of how the MDMA helps with the trust from there you see the person really heal and process that transference stuff, so in that way it offers a corrective experience. For instance, like they often have a transference with me as a mother, and like because of the increased sense of safety one guy, who was really shy and reserved, like he felt a lot of shame, actually asked if I could give him a hug and stroke his head. And so we could then talk about that. And in the somatic style of therapy that I was working with then they can actually have that experience. And so this corrective experience allows them to trust a bit more and move beyond those old stuck ways of interacting with their world.”

Here Mary articulates that she feels that where clients are experiencing the therapist as a parental figure the psychedelic can facilitate the processing of this. She explains that she understands this to be a result again of the substance enabling the individual to feel trusting and safe enough to do so. Mary suggests that, similarly to Josh’s observations, in her experience the client was more able to express when they were having a transference experience and furthermore to make their needs known to her.
Major Theme: The power of a ‘transcendental’ experience

Here, the theme refers to the impact that the psychedelic experience has on the client’s relationship to their wider context. Participants appear to consider that clients experience a connection with something ‘larger than themselves’ and that this enables them to broaden or change their perspective. One gets the impression that, in a metaphorical sense, the client’s horizons are widened from the experience.

It is of note that some participants commented that it is difficult for them to describe or articulate what they observed, regarding this matter, as a result of the limitations of language. For example, in the following statement Josh is discussing his observations of the client experiencing what he terms a “transcendental” experience, and he explains the limitations of language regarding this subject:

“It is such an interesting area of English because I don't think we really have the vocabulary for it.”
Sub-theme 1. Changing of narrative

Some of the participants reported noticing individuals shift in the way that they made sense of themselves, in relation to their experiences of trauma, as result of the psychedelic enabling them to perhaps ‘zoom out’ on their experiences. They discuss how there appeared to be a change in their clients’ narratives as a result.

In Ben’s comment below he talks about how individuals are able to engage with their trauma during the psychedelic session, and to make sense of how it impacted their development and growth in a meaningful way. He explains how they reach this position of, acceptance, perhaps as a result of them meeting themselves with more compassion. He comments that clients experience a “moment of enlightenment” and explains how it appears to have a “spiritual” context. This supports participants’ sense that individuals have a useful transcendental experience during the psychedelic sessions. He notes how he feels the positive function of this experience for the client is that they move from a position of seeing themselves as a “victim”, suggesting a change or movement in their personal narrative around their life experiences. Finally, he also distinguishes between how this shift often appears
to occur with ease during the psychedelic sessions, contrasting with just psychotherapy:

“Inside the session people go to the scene of the crime, they speak of the trauma and they really can see it from a much broader perspective, a lot of times it is being more compassionate to themselves and understanding that they needed to go through what they went through in order to grow up and change. Like they have this, this kind of moment of enlightenment, where they realise it was something that they needed to experience to learn what they needed to. So this like spiritual dimension of understanding comes through pretty easily, it really moves them from their victim perspective of “something was taken from me and I’ll never be the same” that kind of perspective changes with the MDMA session. So people work in years of therapy to come to a place of acceptance about what happened to them and a lot of people I have worked with never get there after too many years of therapy.”

Helen again comments on this observation of an expansion of awareness and a “spiritual” experience, suggesting a transcendental component to the psychedelic experience.
Moreover, she gives the impression that the function of this expansion of awareness is to facilitate the clients’ ‘meaning making’, and relationship to the wider context of their life. This is implicated in the types of questions that Helen suggests come up for individuals under the influence of MDMA. They appear to have an existential context to them, and to encourage the individual to think about the greater meaning to their existence. Moreover, this excerpt supports much of Ben’s observations, in terms of the client making sense of their trauma and inviting it to be a part of themselves that they can tolerate and show gratitude for. She again, like Ben, talks about how she noticed clients reach a place where they no longer engage with the world from a position of feeling a “victim” but instead recognise the trauma as an experience that is valuable to them.

“Psychedelics can really expand our awareness people have like a, sort of a, spiritual experience. Sometimes the questions that come up for people in MDMA sessions can be like ‘What is my purpose in life and how can I get that back?’, like really, “What is the point of my life”. Somehow they move from seeing their trauma story as this horrible, terrible thing that they will never get over, to
Discussion

Research findings

Here, the therapists’ experiences of the impact of psychedelics on the psychotherapeutic process are explored. Overall therapists acknowledged that using psychedelic substances enabled the psychotherapeutic process. The accounts supported the notion that psychedelic-substance-mediated-psychotherapy occurs at an accelerated pace whilst offering clients a sense of “safety” in the process. Such experiences support Mithoefer et al.’s. (2016) review into psychedelic psychotherapy, where it is speculated that psychedelics facilitate psychotherapy in various ways, including a “decrease in avoidance and defensiveness accompanied by clearer memory of past events”. This theme emerged in sub-theme ‘Increased access to, and engagement with, memories’. Indeed, therapists reported that individuals no longer dissociated when approaching difficult memories.
However, therapists’ accounts also reflect that acceleration creates difficulties in the therapeutic process, including consolidation and integration of the experience. Indeed, the accounts convey the importance of sufficient psychotherapy being offered to clients so that adequate time for processing material evoked is ensured. These reports support the literature presented earlier regarding concerns about the impact of expediting the accessing of difficult memories. It raises concerns regarding unprocessed material remaining with clients beyond this therapeutic experience. Perhaps the therapists’ accounts imply a need for further research to develop a more specialised therapeutic model when utilising psychedelics in psychotherapy.

A limitation of the current study is highlighted in terms of the range of psychotherapeutic approaches deployed by therapists. Conversely, whilst only a preliminary study with a small sample size, one must consider the study where MDMA was administered to individuals who met the criteria for a diagnosis of ‘treatment-resistant’ PTSD. This study, demonstrating symptom reduction at a 3.5 year follow up, suggests that treatment does enable some form of experiential integration. However, this study, positivist in its epistemology, did not allow for participants’ experiences to be
explored and it is difficult to conclude whether, despite the quantifiable reduction in their symptoms, participants found it to be a therapeutic experience. This point exemplifies an important distinction between symptom reduction and qualitative experience and needs further exploration in research.

The acceleration of psychedelic-mediated-psychotherapy creates potential opportunities for attending to important issues such as lengthy waiting lists in mental health services. However, issues relating to consolidation and integration of this powerful experience, under condensed treatment conditions, necessarily brings into question issues of ethically ‘best practice’ for clients. Whilst, in line with IAPT, it might support clients going back to work and symptom reduction, in line with IAPT’s motivation, it does not necessarily implicate that clients’ sense of ‘well-being’ is improved. Further exploration of the phenomenological experience of individuals undergoing this treatment would invite more understanding of how more intensive therapies impact individuals. This may assist in attending to overall efficacy of such treatments, and perhaps wider discourses regarding what one hopes to achieve with psychotherapy and associated need socio-economically for speed of recovery.
Implications for psychotherapy

The analysis suggests that participants believe psychedelics can enhance psychotherapy. Hammersely and Beeley (2006) note how, due to the client's unwillingness to revisit traumatic memories, or experience difficult emotions, clients and therapists may become ‘stuck’ during a course of psychotherapy. Due to a reduction in feelings of fear and anxiety and consequential experiences of “safety” during therapy, clients appear more able to revisit, and engage with, traumatic memories and to process associated emotions accordingly. Psychedelic psychotherapy may therefore help to mitigate the feelings of being ‘stuck’.

Perhaps the above raises interesting questions regarding the purpose of psychotherapy in relation to whether feelings of ‘unsafety’ and ‘stuckness’ invoked in therapy are worthwhile and/or beneficial. On the one hand, perhaps important interpersonal skills develop during the slow process of forming a relationship and moving from feeling unsafe towards a sense of safety in the psychotherapy. Psychedelic mediated inhibition of such processes may not necessarily represent long term benefit for
the client. Conversely, it should be remembered that the therapists here were working with individuals considered as ‘treatment-resistant’ prior to engaging with the psychedelic psychotherapy, thus suggesting that it was very challenging for them to make use of the psychotherapy when feeling unsafe, thus perhaps the facilitation of safety is necessary in enabling them to use the space optimally. Accordingly, further research looking at which client groups may benefit most from psychedelic psychotherapy is warranted.

In line with the speculative remarks in Mithoefer et al.’s (2016) review, all participants here supported the notion that psychedelics may enable the psychodynamic concepts of ‘transference’ and ‘reparative experiences’ to occur. Working with, understanding and processing transference in the therapeutic relationship is accepted as a fundamental aspect of psychoanalytic practice. Fonagy (1991) explains that the way in which therapists experience clients through the transferenceal relationship enables them to gain useful insight into their internal working models and to work with clients to understand and process earliest experiences. Here, work was acknowledged to be achieved more readily following individuals having been administered the substance.
Therefore, this study supports that, in terms of psychodynamic practice, the psychedelic substance facilitates a key area of the work.

Continuing with the participants’ comments that transference processes were supported in their experience, an absence of discussion of ‘negative transference’ is noteworthy in participants’ accounts. Negative transference, or ‘rupture in relationship’ from a humanistic perspective, is accepted to be an important aspect of the psychotherapeutic process. It is interesting to consider whether the sense of connection, warmth and safety that participants reported their clients experiencing inhibits the opportunity for important feelings of anger and hostility to be evoked and processed. Moreover, perhaps this reflects participants’ agenda to present positive experiences as a means of promoting the benefits of psychedelics. Indeed, the integrative theme of “Psychotherapists as advocates of psychedelics” gives the impression that it is perhaps important for participants to report positive aspects of psychedelics and, thus potentially overlook parts of therapy that are more challenging, but arguably of equal benefit in the psychotherapeutic process, such as tension in the relationship.
In terms of the theme ‘The power of a ‘transcendental’ experience’, participants imply that this element of the psychotherapy is very introspective and that insight is perhaps gained through the psychedelic facilitating an expansion of the client’s consciousness and subsequent changes in the way that they relate to, or see themselves. Such introspection raises questions about what is facilitating change in the client; i.e. perhaps introspection occurs as a function of the psychedelic, even in the absence of the psychotherapy. Nonetheless, participants’ accounts indicate the importance of the combination: “It’s just really clear to me how the psychotherapy and the relationship are essential to the MDMA process.” and “well I think it was both the MDMA and the psychotherapy together, but I do think that it was the MDMA that allowed us to discuss those things openly.” It may be difficult to disentangle with precision the cause of shift for the client. Further research looking at the seemingly powerful phenomenology of such experiences may further shed light on such matters.

_A treatment where psychiatry and psychotherapy complement each other further?_
Overall, participants’ accounts suggest that they find psychedelics to offer an effective adjunct to psychotherapy. Furthermore, the findings provide a contribution to an existing dialogue surrounding the limitations of currently available psychotropic prescriptions, which have been said to create obstacles for psychotherapy (Hammersley & Beeley, 2006). In contrast to current prescriptions, which have been considered by psychotherapists to inhibit the therapeutic process, participants here report experiencing psychedelics to enhance their psychotherapeutic practice. This is reflected in the master themes ‘Facilitation of process’ and ‘The therapeutic relationship’. In contrast to how Hammersley & Beeley's (2006) discussion of how anti-depressants often create problems in terms of individuals being unable to get in touch with their emotions - an essential part of psychotherapy - the current analysis suggests that participants experienced psychedelics as complementary to their clients’ getting in touch with their emotions. Indeed participants suggest that perhaps this is achieved even more readily than when clients are not under the influence of any substances at all. Furthermore, the present analysis suggests that therapists experienced psychedelics to facilitate the therapeutic relationship and enable individuals to feel more comfortable with their therapists. Extensive research demonstrates the therapeutic relationship to be the main indicator of successful psychotherapy,
above any particular treatment model (Ardito, 2011). Given CoP’s commitment to the therapeutic relationship, this is an area of psychedelic research that warrants further research.

**Limitations**

Given the personal and professional investment demonstrated by the therapist here it may be argued that the participants had a positive bias towards the use of psychedelics as an adjunct to psychotherapy. However, I formed the impression that this was mitigated somewhat by the depth of participants’ accounts. Indeed, participants shared both the strengths and the weaknesses that they perceived of this treatment model. This is particularly apparent in the instance of the theme of ‘Consolidation and integration of the experience’ wherein participants reported problems that they felt were associated with the way psychedelics accelerate psychotherapeutic process to occur.

A further limitation is in the lack of parity across therapist orientations. For example, some therapists reported using ‘somatic’ techniques in their work, whereas others did not. A lack of commonality creates complications in terms of determining the
positive impacts attributable to the psychedelic and the outcome of specific therapeutic technique. To some extent this was compensated for in the interview schedule seeking to tap into therapists’ personal comparisons of their own practice with and without the psychedelic. In addition, questions relating to how the participants responded in therapy before, during and after the psychedelic session attended to this. Future research attending more specifically to psychedelic use as an adjunct to particular therapeutic modalities may further elucidate which processes are facilitated by each model and whether psychedelics lend themselves to particular therapeutic models or clients above others. Indeed, the present findings’ themes seem to align to a range of modalities. To give brief examples, one can see benefits to CBT in terms of exposure work for PTSD, with regard to the theme of ‘increased access to and engagement with memories’. Moreover, with regards to psychodynamic therapy, reference is made to psychedelics supporting working with ‘transference’ and ‘reparative experiences’ of early experiences, and finally there is reference to components of existential practice with regard to discussions of ‘meaning making’ and ‘broadening of perspectives/horizons’ which can be seen in the theme of ‘The power of a ‘transcendental’ experience’.
Conclusion

Participants’ accounts in the present study support and strengthen research that has illuminated psychedelics as a promising adjunct to psychotherapy. Research to date is at the preliminary stage and further studies are needed prior to reaching strong conclusions. This requirement acquires salience in relation to therapists’ difficult experiences of the rapid acceleration of the psychotherapeutic processes. It therefore seems important to carry out further qualitative research exploring the lived experience of clients who have undergone psychedelic psychotherapy. In doing so, a better understanding of the experience of the treatment and how such acceleration of processes feel for the individual may emerge. This is particularly important given the current socio-economic needs within the mental health sector.
References


Appendix 1.

Information Sheet

Full study title: *What is the rationale for using psychedelics as an adjunct to psychotherapy: A thematic analysis of qualitative interviews with practitioners who have delivered psychedelic assisted psychotherapy.*

Dear participant,

I am a trainee counselling psychologist at the University of Surrey and I would like to invite you to take part in a study that I am conducting.

**What is the purpose of the study?**

The study I am conducting aims to explore what practitioners rationales are for using psychedelics to assist in psychotherapy. I would be grateful if you would read the information sheet provided in order for you to be informed about what participation would involve.

**Taking part**

Taking part in the study will involve being asked to attend a 45-60 minute interview that will be recorded. In this interview you will be asked a number of open questions about your views on using psychedelics as an adjunct to psychotherapy, and your experience of working with individuals when they are under the influence of a psychedelic.

**Are there possible disadvantages to taking part?**

During or after participating in this study it is possible that you may feel upset as a result of the material that is discussed. If the interview does upset you in some way you are encouraged to seek help from… You will also be given breaks during the interview if you should wish to.
What if there is a problem?

If you would like to complain about any area of the study you may contact the researcher. You can also contact Dr Stelios Gkouskos, the supervisor of the project (s.gkouskos@surrey.ac.uk).

Who has reviewed the study?

The University of Surrey Faculty of health and medical sciences ethics committee has ethically approved this study.

Will all information shared be confidential and secure?

Interview are to be recorded using a Dictaphone and then transcribed onto a password secure document. The information you share will be kept strictly confidential. Only the researcher and the researcher’s supervisor Dr. Stelios Gkouskos will have access to the information. When the project is complete all data and personal information collected will be destroyed. In the write up of the research all identifiable information will be changed in order to protect participant confidentiality.

Decision regarding whether to take part in the study

If you were to take part in this study you would be invited to set up a date and time that was convenient for you and the researcher to complete the interview. The interview would take place in a safe, quiet and neutral location that invites you to talk freely about your experience. Please note that participation in this study is voluntary and you are free to decline to participate. In addition should you partake in the study you are free to leave the study at any time.

Yours sincerely,

Michelle Ruger

Counselling Psychologist in training
Researcher contact details:

Michelle Ruger, email: m.ruger@surrey.ac.uk

Supervisor

Dr. Stelios Gkouskos, s.gkouskos@surrey.ac.uk
Appendix 2.

Consent Form

Study Title: *What is the rationale for using psychedelics as an adjunct to psychotherapy: A thematic analysis of qualitative interviews with practitioners who have delivered psychedelic assisted psychotherapy*

- I confirm that I have read and understood the information sheet/letter of invitation for this study.

- I have been informed of the purpose, risks, and benefits of taking part.

- I understand what my involvement will entail and any questions have been answered to my satisfaction.

- I understand that my participation is entirely voluntary, and that I can withdraw at any time without prejudice.

- I understand that all information obtained will be confidential.

- I agree that research data gathered for the study may be published provided that I cannot be identified as a subject.

- Contact information has been provided should I (a) wish to seek further information from the investigator at any time for purposes of clarification (b) wish to make a complaint.
Participant’s Signature

Date
Appendix 3

Debrief Form

Study Title: *What is the rationale for using psychedelics as an adjunct to psychotherapy: A thematic analysis of qualitative interviews with practitioners who have delivered psychedelic psychotherapy*

Dear participant,

Thank you for participating in this research.

This study looked to what practitioners rationales are for working with individuals when they are under the influence of a psychedelic substance. In addition, it hoped to elucidate more understanding of the types of psychological processes which can be facilitated when using psychedelic as an adjunct to psychotherapy. The rationale for this study was that recent research has shown that psychedelics can act as a beneficial adjunct to psychotherapy and so it is possible that practitioners may be required to practice under these conditions in the future. To date no research has explored what practitioners rationales are and furthermore what psychological processes are facilitated in psychedelic assisted psychotherapy. Therefore this study is seeking to understand this better. It is hoped that the research will enable a better understanding of the rationale behind psychedelic assisted psychotherapy and the psychological processes that are facilitated by the substances. If you have any further questions regarding this study please do not hesitate to contact the researcher.

As previously mentioned it is possible that partaking in this research may have evoked some difficult feelings or left you feeling in some way negatively effected. If you feel that you would like psychological support please contact

Yours sincerely,

Michelle Ruger
Researcher contact details:

Michelle Ruger, email: m.ruger@surrey.ac.uk

Supervisor

Dr. Stelios Gkouskos, email: s.gkouskos@surrey.ac.uk
Appendix 4

Project Title: What is the rationale for using psychedelics as an adjunct to psychotherapy: A thematic analysis of qualitative interviews with practitioners who have delivered psychedelic assisted psychotherapy

Interview Schedule

1. Can you explain your rationale for using psychedelics as an adjunct to psychotherapy?

Prompts: personal clinical experience, research evidence base, what mode of psychotherapy

2. In your experience do you think psychedelics facilitate the psychotherapeutic process and how?

Prompts: Strengthening therapeutic alliance, increased self-reflective capacity, reduced anxiety, types of psychological processes that are facilitated

3. Can you describe your experience of working with an individual when they are under the influence of a psychedelic?

Prompts: different from psychotherapy without psychedelics, relationship between you and the client.

4. Can you describe the differences that you observed in the same patient in sessions before, during and after they had been administered a psychedelics?

Prompts: More open, increased self awareness, motivated, spirituality, increased cognitive flexibility
Year 3 Empirical Study:

An Interpretative Phenomenological Analysis of MDMA assisted psychotherapy for PTSD.

Abstract

Methylenedioxymethamfetamine (MDMA), is demonstrating encouraging results as an adjunct to psychotherapeutic practice in the treatment of PTSD, following a surge of empirical research over the last 10 years.

Method: Individuals who had participated in a clinical trial wherein they were administered MDMA for treatment resistant PTSD were interviewed to explore the lived experience of MDMA assisted psychotherapy.

Results: 3 clear superordinate themes emerged from the analysis: 1) Existential freedom 2) Beyond the Cartesian-split and 3) A journey through time

Conclusions: Participants conveyed that they found the experience to be powerful and transformative in terms of their relationship to themselves, others and the world. Proposals are made for future research to be conducted into the psychological models that might be best suited for this treatment.
INTRODUCTION

Antipsychotics, anxiolytics and antidepressants are widely prescribed to treat mental health conditions despite severe side effects and limited efficacy (Tshoner et al. 2007; Watts et al. 2013; Beesley & Hammersly, 2006). By attending only to the symptoms of mental health, instead of the underlying problems, individuals may become dependent on taking such psychotropic medications. Furthermore, people often report feeling “numb” or “disconnected” when under the influence of such drugs (Beesley & Hammersly, 2006). Many studies have shown that psychotherapy is both a more effective and preferred treatment for individuals who have been diagnosed with Post Traumatic Stress Disorder (PTSD) and other anxiety disorders. Indeed, a meta-analysis carried out by McHugh & Whitton (2013) showed a 3fold preference for psychotherapeutic interventions over psychopharmacological treatments (Van Schaik, 2004). Despite psychotherapy being a more preferred treatment, many individuals who are diagnosed with a psychiatric disorder still do not experience an alleviation of their mental suffering with this line of treatment (Tupper et al. 2015; Watts et al. 2013; Cahill et al. 2014). A large proportion of individuals experiencing mental suffering are therefore left in need.
Such limitations in alleviating mental health suffering, has led to novel therapeutic treatments whereby MDMA is administered alongside psychotherapy (Tupper et al. 2015). Many studies utilising MDMA as an adjunct to psychotherapy have had encouraging results with high rates of remission. These studies suggest that MDMA can help improve self-awareness, increase access to repressed memories and facilitate psychological processes (Mithoefer et al. 2011; Tupper et al., 2015; Ruger, 2016; Sessa, 2017; Thal & Lommen, 2018). Furthermore, unlike current psychotropic medications that are often taken for a lifetime and in the absence of psychotherapy, MDMA treatment is only administered a few times and in conjunction with a course of psychotherapy (Mithoefer et al. 2011; Oehen et al. 2013). The most predominant area of research for MDMA assisted psychotherapy is with individuals who have a diagnosis of treatment-resistant PTSD (Thal & Lommen, 2018).

**Trauma, development and PTSD**

Characterised as a trauma and stress related disorder, Post Traumatic Stress Disorder (PTSD) has similarities to anxiety and dissociative disorders. The exposure of an individual to a traumatic event, such as one that could cause serious injury or loss of life,
contributes to the symptoms of the disorder. These symptoms include flashbacks, nightmares and profound psychological distress. Furthermore, aspects of life that may remind the sufferer of a traumatic event can cause extreme distress as well as a negative physiological response. These traumatic reminders, and the thoughts and feelings that surround them, are often avoided by the individual. A sufferer of PTSD may also experience a negative change in mood and increased arousal and reactivity (Thal & Lommen, 2018).

It is estimated that 50-90% of people suffer a traumatic life event, however the estimated risk of developing PTSD is 6-10% (Wittchen et al. 2009; Kessla et al. 2005). This difference has been explained with regards to the early years of a child’s attachment relationship with their primary caregiver, which it is proposed becomes a basis for emotional containment and the development of intimate relationships in adulthood (Van der Kolk, 2015). Damage to a child’s early attachment relationship can lead to the person being vulnerable to anxiety based disorders such as PTSD, reducing the capacity to form interpersonal relationships and cause feelings of low self-esteem. Furthermore, growing up in a chaotic and fearful environment leads to the release of stress hormones such as cortisol which in turn, condition the amygdala towards an
exaggerated sense of fear as well as inhibiting fear extinction responses exercised by the prefrontal cortex (PFC) (Lee & Hankin, 2009). The imbalance between the amygdala and the PFC is what characterises PTSD and can lead to many patients seeking an escape from their fear through addiction, self-harm and suicide (Sessa, 2017).

The shortfalls in current PTSD treatment

Currently, CBT is the most common form of psychotherapy used for individuals diagnosed with PTSD. As well as CBT, other trauma-based therapies are often utilised including cognitive processing therapy (CPT) and eye movement desensitisation and reprocessing (EMDR)(Benedeck et al. 2009). A meta-analysis conducted by Bradley et al. (2005), concluded that trauma-focused therapies showed a similar efficacy for individuals suffering with PTSD, with improvement of symptoms in 44% of individuals. Indeed, trauma focused therapies have been found to be more effective than other treatments. (Flatten et al., 2011).

Treatment of PTSD can involve revisiting traumatic experiences, which often the client finds intolerable rendering psychotherapy ineffective, thus leading to response rates of 44% (Rothbaum et al.,
Dropout rates are also high and range from between 20-30% (Cloitre, 2009; Hembree et al., 2003; Rothbaum et al., 2006). These can be attributed to the effect of the trauma leading to a negative impact on the individual’s capacity to form trusting interpersonal relationship such as the therapeutic relationship (Doukas et al. 2014).

Around 20-30% of individuals diagnosed with PTSD respond to pharmacotherapy with the selective serotonin reuptake inhibitors (SSRI) sertraline and paroxetine, which are recommended as secondary treatment options (Jeffreys 2009). Hammersley and Beesley (2006) discuss how reducing symptoms such as distress, crying and tension, may prevent the underlying cause being accessed, thus hindering the therapeutic process and long term recovery.

PTSD is estimated to cost the NHS £5.6 billion per year and has a cost to industry of £3.7 billion (NICE, 2005). There is therefore a critical need to improve the current treatment options for PTSD. One such psychopharmacological treatment 3,4-Methylenedioxymethamphetamine (MMDA), has demonstrated exciting potential to offer a solution.
**What is MDMA?**

MDMA, a ring substituted amphetamine, has been researched as an adjunct to psychotherapy for sufferers of PTSD. The compound was utilised in many psychotherapy studies between 1978 and 1985 following the prohibition of LSD (Sessa and Nutt 2007). Due to the illegalisation of MDMA, there had been little research into utilising MDMA’s psychotherapeutic potential. The last decade however has seen the re-approval of therapeutic trials that use MDMA as an adjunct to psychotherapy for a range of mental health disorders (Mithoefer et al. 2011; Oehen et al. 2013).

Administered in a controlled clinical setting, MDMA typically induces a 2-4 hour experience promoting feelings of increased extroversion, sociability, self-confidence and a decreased fear response. An uncontrolled fear response being common in sufferers of PTSD formed the target of the treatment for utilising MDMA in the treatment of PTSD (Mithoefer et al. 2011). MDMA also offers anxiolytic effects which, instead of merely diluting the feeling of anxiety, creates a detachment between the patient and the feeling of immediate threat. This may allow a therapist to help the patient reflect on difficult memories from a different emotional perspective. (Thal & Lommen, 2018).
Current MDMA and PTSD studies

In 2008, the first clinical trial investigating the use of MDMA as an adjunct to psychotherapy with PTSD sufferers began. When compared to placebo, the administration of MDMA assisted psychotherapy reduced PTSD symptoms, however, the sample was too small for conclusions to be made (Bouso et al. 2008).

Mithoefer et al. (2011) thus, undertook a study with an increased number of participants (n=20), demonstrating the effectiveness of MDMA alongside psychotherapy to treat sufferers of treatment-resistant PTSD. The study had a randomized, double blind design and utilised an inactive placebo. During the first stage of the study, participants were either assigned a placebo or a 125mg MDMA dose alongside two 8-hour sessions of psychotherapy. Scores on the clinician administered PTSD scale (CAPS) were reduced by 83% in the group that received MDMA assisted psychotherapy and 25% in the placebo group. Unfortunately, the double blind aspect of the study failed as both the participants and the coordinators could tell who had been administered MDMA (Mithoefer et al. 2011). Mithoefer et al. (2013), conducted a follow up study on 16 of the original participants. Fourteen out of the sixteen participants maintained significantly lower CAPS scores than before the
MDMA assisted psychotherapy. Additionally, none of the participants reported any harm from participating in the study.

Following the success of Mithoefer’s (2011) study, phase two studies utilising MDMA-assisted psychotherapy for army veterans diagnosed with PTSD are underway. Additionally, further phase two studies are underway in Canada, Australia and Israel. Finally, phase three studies will begin in the UK in 2018 (Sessa, 2017).

Possible reasons for how MDMA improves therapeutic outcomes.
Current positive outcomes of psychotherapeutic practice in treating PTSD correlate with a strong therapeutic relationship between client and therapist (Charuvastra and Cloitre 2008). As a symptoms of PTSD is a decreased ability to trust, it is harder to form a strong therapeutic alliance and thus is likely to be very conducive to the therapeutic process. Additionally, it’s common to observe a very small window of ‘optimal threshold’, within which clients can do the necessary psychological work for PTSD (Foa and Kozak 1986). It is thought that these challenges can be overcome by administering MDMA due to the compound’s upregulation of oxytocin, dopamine, noradrenaline and serotonin (Grob et al. 1996; Harris et al. 2002)
Oxytocin is thought to help in the understanding of emotion and increase trust in relationships and emotional empathy (Zak et al. 2005). In addition, during psychotherapy for PTSD, individuals often experience ‘negative’ emotional states, which leaves them feeling scared, mistrusting and threatened. Such feelings of fear inevitably colour their relationship to the therapist and the therapeutic work. An increase in serotonin may diminish such an effect by decreasing anxiety and depression and increasing self-confidence. Whilst it is claimed that this is conducive to psychotherapeutic work, one might wonder whether this also inhibits some of the useful psychotherapeutic work that can occurs when clients come into contact with their barriers to relationship and grapple with the struggle of that. Additionally serotonin alters an individual’s perceptions and facilitates a new way of thinking about old memories, which is considered to be useful in PTSD treatment (Matthews 2006). Dopamine and noradrenaline also raise levels of awareness that improves the individual’s ability to recall state dependant memories. At the same time, and paradoxically, activation of alpha 2 receptors increases relaxation that may counter hypervigilance seen in PTSD and support clients to revisit the traumatic memories in a manner that feels more tolerable. (Thal & Lommen, 2018).
MDMA also lessens activity in the amygdala reducing the fear response and increases activity in reward pathways, causing increased sociability and a smaller reaction to anger (Kirsch et al. 2005). In a clinically controlled environment, alongside a psychotherapist, these combined effects of MDMA allow the individual to stay with their memories of trauma without finding the experience unbearable. They are also argued to help improve the therapeutic relationship as the patient finds it easier to form interpersonal relationships in this state (Thal & Lommen, 2018).

**MDMA assisted psychotherapy through a counselling psychology lens**

The positive results of the studies above therefore show a strong rationale for building upon the research into using MDMA as an adjunct to psychotherapy for PTSD. As MDMA psychotherapy appears to offer profoundly different, personal experiences, larger studies are required to generalise their potential to the wider population (Tupper et al. 2015). Furthermore, there is no qualitative research into the lived experience of the client who experiences MAP, with the majority of research having been carried out from a positivist epistemological position. Such studies have underlying epistemologies and ontologies that may overlook
the idiosyncratic, nuanced nature of the phenomenon. As CoP adopts a phenomenological philosophical position, as opposed to the current research base, which adopts a medical model, and positivist position, and emphasises the therapeutic relationship (Strawbridge & Woolfe, 2012), arguably CoP offers a useful platform from which to carry out such a study.

Possible risks of MDMA
As well as having properties that make it useful as an adjunct to psychotherapy, MDMA also has problematic effects. For example, MDMA upregulates cortisol levels which may increase stress and negative feelings. MDMA is an ‘enactogen’ and increases feelings of love and warmth however the drug also has no selectivity in releasing thoughts and emotions and thus it can be unpredictable. Furthermore, following MDMA administration the body goes through neurochemical recovery whereby serotonin levels are low causing lethargy and depression (Baylen & Rosenberg, 2006). However, in the clinical trials to date there has been no report of any persisting MDMA-related harm in over 850 participants.

Method
Research philosophy and design
The introduction illuminated that to date there are no qualitative studies exploring the experience of MAP for PTSD. Quantitative research is limited in what it can explore of the individual’s experience. In contrast, qualitative methods enable a depth of exploration of individuals’ subjective experiences, facilitating a richer understanding of the phenomena. Thus, qualitative methodology seemed appropriate when attending to the research aims and questions of the present study (Willig, 2013).

Since the research question seeks to explore the lived experience of MAP for treatment-resistant PTSD, interpretative phenomenological analysis (IPA) seemed the most appropriate choice of methodology, as it is understood to be a type of phenomenological inquiry that seeks to explore participants’ personal experiences and life-world at depth (Smith & Osborn, 2003).

To elaborate, when choosing which qualitative approach to use the researcher considered a number of options before determining that IPA was the most appropriate method. This is in line with Smith’s (2004) understanding of the process by which one chooses the correct method for analysis in qualitative work. Smith (2004) proposes that when deciding which method to choose the process
is not concerned with choosing a “tool for the job” as might be seen in quantitative research, instead the work is to identify “what the job is” (p.43). Thus, in keeping with this, in terms of the present study, the fundamental rationale for choosing IPA over other approaches was because it was deemed consistent with the research question’s epistemological position.

To demonstrate the rationale for choosing IPA for the present study further I will now compare it with grounded theory (GT), another common approach. GT is also considered to be an inductivist approach however, in contrast to IPA, it is argued that GT seeks to develop a theoretical-level account of the phenomenon. Thus since the interpretative phenomenological experience of the demographic in the present study has not been explored at all to date it was thought that the divide between analysis and generating a theoretical framework would be too wide. Rather the endeavour of the current study was to carry out an in depth analysis of the lived experienced of participants, placing emphasis on the similarities and differences between their idiosyncratic experiences of MAP, focussing on capturing the rich and nuanced individual experience of each participant.

Sampling and Participants
IPA is characterised by purposive homogeneous sampling whereby small numbers of participants (between 4 - 11) are selected for their capacity to illuminate specific research questions (Smith & Osborn, 2003). Given the limited research in the field thus far, and the subsequent small population of individuals who have partaken in MAP to treat PTSD, the sample was kept small. In addition, it was felt that the scope of this research supported the need for a small sample to ensure that rich analysis could be conducted, with space to report the findings elaborately at depth. It was decided that a sample of 7 participants would be optimal.

Inclusion criteria stipulated that individuals must have participated in a recent (the last 5 years) MAP for treatment resistant PTSD trial. Regarding participant recruitment, the researcher made contact with a charity directly involved in the funding of this research in America called the Multidisciplinary Association for Psychedelic Studies (MAPS). The administrators of this charity agreed to send out an email advertisement to the individuals whom had participated in MAP trials (Appendix 1). From this point of contact a process of chain referral or ‘snowballing’ occurred generating a list of individuals who met the criteria. 7 individuals contacted the researcher showing interest in the study, and all were
responded to with information regarding what participation in the study involved and an invitation for them to participate (Appendix 2). 6 out of 7 of these individuals replied and agreed to take part. Since all of the studies that have been conducted thus far in this area have been located in North America all of the participants who responded resided in America.

**Data Collection**

Given that the material being collected was personal and intimate in nature, semi-structured interviews seemed the most appropriate form of data collection (Brocki & Wearden 2006). The interview schedule was devised in line with Smith and Osborne’s (2003) guidelines.

The interviewer set out to enter the personal frame of reference of the participant. (Willig, 2013). Hence questions were non-directive with the aim of maximising the potential to explore the participant’s experience, without influencing direction. The interpretative element of IPA determines that the influence of the researcher is ‘inescapable’ in the knowledge that is produced. With this in mind, attention was placed upon reflection of my role as researcher in the interpretations that emerged at every stage of the research process (Larkin & Thompson, 2012; Yardley, 2000).
Interviews lasted between 45-60 minutes and were recorded and transcribed before analysis.

The interviews were conducted using video/phone technologies. This decision was made due to financial and time restraints within the scope of this study, given that all participants were based in America. This approach was further supported when taking into account how it contributed to minimising ecological dilemmas in terms of the researcher travelling to America. The researcher used Skype which is an internet telephony software which allows videoconferencing via a web cam. It was considered that the use of videoconferencing enabled an experience that was closer to an in-person encounter (Slade, Emery & Lieberman, 1997). Indeed an advantage of skype was that it enabled nonverbal communication to be captured which felt important in the context of an IPA study. In addition, Skype calls are recorded and transcribed in the same way as face-to-face interviews (Oliffe, 2010).

**Data Analysis**
The first stage of analysis was to undertake a detailed reading and rereading of participant’s transcripts, alongside listening to their audiotapes. This generated an understanding of ideas and feelings
the participants were expressing. During this initial stage, salient topics, feelings, possible labels of themes and general ideas were generated and jotted down on each transcript (see appendix 5). The stage that followed involved the clustering of similar topics, feelings and ideas together under themes, which in turn facilitated a list of themes for each individual transcript to be produced.

The next step of analysis involved comparing across the corpus of participant’s transcripts; enabling a generation of consolidated themes for the entire sample. A smaller number of ‘superordinate’ themes emerged following a process of making connections between themes; these were a reflection of overarching ideas which appeared common within all subsets of themes. This process was iterative in nature as emerging superordinate themes were continuously checked and cross-linked against participants’ transcripts to allow each individual’s experience to be clearly maintained and represented in the data.

**Ethical considerations**

Ethical approval was granted and steps were taken to ensure that the study met with the BPS (BPS, 2010) and HCPC (HCPC, 2012) codes of conduct.
Participants were informed of the risks and benefits of partaking and their right to withdraw at any point, as well as where to seek help should they need support during or after the study. Participants gave informed consent prior to partaking in the study (Appendix 2).

Following participation, individuals were debriefed on the aims of the study (Appendix 3) and their confidentiality was, and will continue to be, maintained. All names used in the analysis of this study are pseudonyms.

Analysis

Analysis revealed three superordinate themes which are presented here. These are as follows: 1) Existential Freedom 2) Beyond the Cartesian-split 3) A journey back in time. Please see Table 1. below for an illustration of the superordinate themes with their respective subordinate themes. All of the themes have been presented here due to their value in attending to the research question. However due to the scope of the present study the third superordinate theme was restricted in terms of the extent to which it could be represented thus

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Superordinate Theme One: Existential Freedom

“I saw my soul out in the universe, it was beautiful. I saw what I had been enduring for all of those years and I knew I didn’t want to die like that”

Participants used evocative, ethereal, language to describe the cosmos and to illustrate the shift they'd experienced during MAP. Such connection seemed to support them to have an altered perspective regarding the trauma they had endured. They spoke about becoming connected with their own agency, autonomy and choice. Overall, they described an experience of being opened up to new opportunities and possibilities, where previously there had been only fear and inhibition, Thus, the three sub themes are: Living authentically: truth vs. denial, Released from fear’s captivity and Making meaning in the tragedy.

Subordinate Theme One: Living Authentically: Truth v.s Denial

“Oh MDMA it’s just the truth that you see. You can’t hide, so it’s being willing to be shown what is in front of you and accept, versus deny it”
This theme explores how participants become more ‘authentic’ with themselves and others. Participants talked about coming from a place of internal denial and shifting to a place of truth. This theme also captured participants’ reflections on the experience enabling them to move out of a ‘passive’ mode of living, into a mode wherein they were able to be take responsibility for their lives and recognise that inherent in human existence there is always a degree of choice.

Arguably, this is exemplified in Hannah’s explanation of how during the MAP experience, she could take ‘charge’ of her life and see her part in the traumatic incident:

“it puts you back in the driver’s seat, showing you that you were a participant, you were there and there were options and you chose certain options over others”

By using the metaphor of “the driver’s seat” Hannah emphasises how the MDMA facilitated her to move back into a position of actively engaging with her life. To elaborate, the metaphor perhaps implies that she had been living in the ‘passenger seat’ prior to MAP, moving through life in a passive mode and allowing others
to navigate her journey. This metaphor aligns with Yalom’s (1991) idea of authentic living being about ‘actively choosing’ as opposed to living by ‘happenstance’.

Furthermore, her description of how the experience illuminated a different way of looking at her part in the trauma, suggests she is now more honest in relation to herself. Indeed, she explains how she became more aware of her choice and responsibility. This aligns with Sartre's acknowledgment of responsibility as a given of existence, since we always have some degree of choice in any given situation (1997). It seems as if Hannah moves away from living in bad faith as she no longer needs to lie to herself and can thus live more authentically (Deurzen, 2010).

Lucy explains how during MAP she noticed that she previously allowed others to make choices for her thus avoiding responsibility:

“The responsibility part was the wakeup call for me to take charge of my life, until then I was existing and allowing things to continue to happen.”
By using the metaphor of a “wakeup call” Lucy demonstrates the extent to which MAP had a transforming impact on her awareness and existential experience. The excerpt evokes an image of her being asleep; again, like Hannah, she explains how her approach to life had been one of happenstance. Thus, one could argue that, for Lucy, this experience was comparable to an ‘awakening’. Yalom talks about how awareness of death can act as a reminder of the significance of life and spark motivation for living (Yalom, 1991).

Two other participants spoke about how they felt more able to express themselves authentically in the intersubjective space during and after MAP:

“I always felt like I was wearing masks,”

Historically masks served a number of functions, protection, disguise, performance and ritual practices. Thus, Daisy’s analogy of “wearing masks” could be taken in a number of ways, it evokes an image of her hiding her authentic self. Whilst this experience seems to have been one where she felt she was showing herself more authentically, I wondered whether it is also one of feeling exposed and in the exposure, somehow ‘seen’.
Similarly, Lucy talks about being more authentic with her children:

“I’m so much closer to my kids now. I feel like I’m real, they’re real.”

Lucy expresses a shift in proximity to her children, developing a capacity to be authentic with them. Indeed, Lucy’s use of the word “real” three times perhaps implies that previously she had been somehow ‘superficial’ or fake (like a mask). Yalom (1991) suggests that human connectedness enables us to live a meaningful life. Perhaps Charlotte and Lucy are describing a process of finding this connection.

Subordinate Theme Two: Released from fear’s captivity

“The treatment was a true birth of who I really was and what I really wanted, I was actually alive and excited for the future.”
This theme seeks to capture participant’s descriptions of being freed from the imprisonment of their fear. The accounts appear to indicate how they were unable to partake in life because of a deep-seated fear of future uncertainty and a sense of overwhelming futility. Their journeys depict how they progressed to a place of excitement and enthusiasm for their future. For example, Daisy says:

“My hopes in the beginning were “I hope I can survive for Sarah’s [pseudonym] sake.” But by the end of this my hopes and dreams skyrocketed”

Daisy captures this sense of a drastic shift from hopelessness to infinite freedom in relation to her possibilities and opportunities for the future. Indeed, her use of the word “skyrocketed” reflects being catapulted into the infinity of space. The sense of going ‘up’ in the rocket further supports an impression of growth at an accelerated speed.

In the following excerpt Charlotte explains how she was freed of fear.
“I can call people. I can hug my husband, I don’t hate being in the shower. All things I could not do. You just keep getting brighter and more alive”

Charlotte’s comparison of her inability to do normal things, to her sense of fearlessness captures the grandness of the shift. Her reference to becoming “more alive” arguably invites an impression of a resurrection as does the reference to ‘brightness’ which has an essence of her rising up from nothing to a radiant and powerful individual.

Charlotte goes on to describe feeling freed from her inhibitions and finding relationship with her children:

“I used to feel wrong about holding their (her children’s) hands, I think that was because there were so many boundaries crossed when I was younger. I remember being home and holding my daughters hand and noticing “wait this isn’t terrible, this is my little person.”
She describes an embodied shift in her expression of relationality and physical intimacy. Her intersubjective world is opened up, such that she can allow herself to physically connect with her daughter. The poetic referral to her child as “my little person” gives a sense of her capacity to see her daughter with maternal affection.

**Subordinate Theme Three: A Hero’s journey**

“I went from a strike on a box of matches to a star”

The narratives appear to illustrate a journey from a meaningless existence laden with a sense of being ‘stuck’ and a ‘victim’ in the world, to a discovery of a new found meaning in the trauma. Embedded in their experiences, was a sense of how participants were creative with regards to conceptualization of their trauma. Indeed, I found accounts to be reminiscent of Frankl’s notion of “tragic optimism” which depicts the human capacity to find meaning in the most horrific of circumstances (Frankl, 2004).

“I was looking at the setbacks in my life a lot differently. It made me feel like I’d been on a hero’s journey because I’d got to face death.”
In the above excerpt, Matt is discussing how he was able to re-conceptualise his trauma. The reference to “hero’s journey”, conveys his experience as a ‘mythological tale’, where he was heroic and triumphant in the face of tragedy. Myths are defined as timeless tales that seek to understand, portray and sculpt the human experience. They capture the realm of human fear and desire in order to offer narratives that better understand what it means to be human (Armstrong, 2006). Perhaps, Matt has drawn upon myth to make sense of his experience and construct a meaning that enables him to re-engage with life. Ernesto Spinelli proposes that we humans seek to find meaning in our experience such that we can see it with value and purpose (Spinelli, 2005). This echoes Matt’s portrayal; he encountered a violent near-death experience and yet still sees the value of the experience.

In the following excerpt Daisy recalls a profound moment in her experience where she visually hallucinated and communed with her husband, whom she had witnessed being murdered:

“I noticed the stars and they began to connect with each other. They became an image of my husband. he had grown
these wings, he threw his winged hands, up over his head and they shot up into the darkness, he was bringing me up to the scale of where he was. I got the feeling that what that meant was he’s not only still here, he’s everywhere and I might have him more than I had him before”

Daisy describes an experience of connecting with the infinite size and grandeur of the universe. Her sense of the vast presence of her late husband in relation to herself, appears to put her existence into perspective, allowing her to feel held and connected to the universe. There is also arguably a religious, or spiritual essence. Her final comment is suggestive of her finding meaning in the tragedy. The essence of magic and the supernatural suggests that she has, like Matt, previously found solace in denial and avoidance of the tragedy.

Beth also describes a powerful visual experience that supported a shift in the way she viewed her traumatic history:

“I would see myself at age five, this strong little girl dancing. It was, wonderful because I saw the strength of my own self and my ability to get through some horrific
experiences [...] and then it projected out to the end of my life and I remember seeing all my coping mechanisms not working for me anymore, and that they lead me to a very lonely end of life. And I remember saying no.”

Beth’s reference to seeing herself “dancing” gives a sense of connecting with a part of herself that is able to be free spirited in adversity. During MAP she appears to have learnt of her own capacity to find joy and value even in a world where she is being hurt.

In addition, Beth’s experience suggests a sense of temporality being brought into focus, which Heidegger proposes is inherent to existence (Landridge, 2007). Stolorow suggests that in trauma temporal unity is lost in terms of the flow between past and future (Stolorow, 2007). Here, Beth appears to find a way to have cohesion between her past, present and future.

Superordinate Theme Two: Beyond the Cartesian split:

“There was this connection that was made between what my brain was saying and what my body and my heart were feeling, where that understanding actually physically happened.”
All participants expressed a sense of ‘turning on’ to their embodied experience during the therapy. The narratives conveyed a sense of them having existed in a Cartesian-split where they talked about psychological and therapeutic language intellectually but were unable to connect with it on an embodied level. In addition, they described powerful experiences of being wholly immersed in feeling states and re-engaging with feelings that they had previously disconnected from as seen in Charlotte’s comment:

“Well I felt sad, I felt scared, I felt everything I felt everything I’d pushed away”.

In light of the above, two themes were identified: An intellectual understanding vs. an embodied knowing and Basking in novel felt experiences.

Subordinate Theme One: From an intellectual understanding to an embodied knowing

“There’s not a whole lot of, you know, logic-ing and working yourself through something that can happen when you don’t feel it”
This theme captures how participants find it very difficult to engage with an embodied understanding of many ‘feeling based’ concepts. The theme reflects how they experienced a powerful shift to feeling what was talked about rather than remaining at a cognisant level. Hannah says:

“My experience without MDMA and having just talk therapy, it was so cerebral and I don’t really think you can get at the deepest core issues with traumatic experience because so much, in my opinion, gets stored in the body through tissues and I couldn’t feel it before”

Hannah differentiates her experience with MDMA and without, in terms of how it moved from an intellectual experience to a felt experience. Her use of the word “cerebral” gives the impression that she had been engaging in therapy from a cognitive place, with an absence of experiencing on an embodied level. Further, her connection to the trauma being situated in her body gives the impression that through the MAP experience the trauma was somehow unlocked from deep within her and enabled to be processed.
Daisy describes how her body became almost channelled by the MDMA and began moving intuitively into different positions:

“I was stretching trying to get comfortable and then I felt the compulsion to bend over and sit cross legged in a ball and I could move but it felt really good not to move. It was a profound feeling... imagine if someone’s being electrocuted and their body moves independently of them because energy’s going through it, I felt really tight and rigid at one point like I was frozen, it felt like I had been that tight and rigid for years and I just had let go of it in that moment.”

Daisy’s description of feeling ‘rigid’ and ‘tight’ may refer to how she carried the trauma in her body. It sounds as if her movements were a way of her body going through a process of ‘undoing’ past events. The sense of being ‘overtaken’ by something physically is reminiscent of a religious or spiritual experience where people describe a ‘divine intervention’. Finally, like Hannah, it appears that something unpleasant had been unleashed and expelled from deep within her body through physical movement.
In the following excerpts participants appear to be describing a shift in their experience of the intersubjective space.

Lucy talks about how she had always felt as if she were “behind bars” perhaps due to being unable to feel and connect with the world:

“I had always felt kind of behind, like as if you were behind all of these walls, and then all of a sudden you start to feel almost like there’s this thread, that links you and everyone and everything around you together. Like you’re not floating in nothing anymore”

Lucy’s reference to “walls” and “floating in nothing” perhaps reflects how she existed largely in a dissociative state. She describes how it had always been this way. Thus ideas of infant attachment theory are possibly evoked, in terms of how she learnt to cope in her early environment. Indeed, Kohut (1984) describes how in relational trauma infants will “wall themselves off” from relationship.

In the following excerpt Charlotte comments on the shift in her relationship with the therapists:
“They were both so compassionate and caring...during the session it was a very physical and emotional and psychological understanding that these people are there for me with full love and acceptance”

Charlotte appears to physically experience the therapists deeply felt intersubjective understanding of her pain for the first time.

Finally, Matt describes how he noticed a change in his voice, as if he was talking from his “chest”:

“like my voice, I wasn’t talking from my throat anymore, I was talking from my chest [...]”

I wondered whether when he said chest he was describing talking from a more ‘heartfelt’ and thus embodied place.

**Subordinate Theme Two: Basking in novel felt experiences**

“You just go from happy to sad and, you’re just completely in it, really into just feeling the experience you know and enjoying it.”
Participants’ narratives described moments where they felt fully immersed in a range of feelings during their MDMA-assisted psychotherapy. It was as if they were completely in an "experiencing" mode. Perhaps we are seeing them move into a place of, in Sartre’s terms, authentic living whereby they are emphasising experiencing over knowledge (Sartre, 2003).

Charlotte describes how the MDMA-assisted psychotherapy, involved many emotional experiences, both positive and negative:

“*I felt the whole range of everything you could ever want and not want to feel. ... one of my goals was to feel happy at some point and I did, it did. I felt loved, it’s like you are starving for it and I felt it. We stopped and I snuggled into it. It was like the first time I’d felt peace, happiness and love ever.*”

The term “snuggled” gives the impression that she is leaning into the emotion and indulging in it. Similarly, her statement of holding onto the “moment” gives the impression that she allowed herself to be bathed in this positive effect and perhaps entered a mindful state of experiencing and awareness. There is a powerful communication of a rich, wholesome tone in Daisy’s language,
drawing on words such as “peace” and “love”. Indeed, the language and phrasing evokes an image of a resurrection of her humanity and sense of ‘aliveness’. This could perhaps be likened to coming alive as in a baptism experience.

Similarly, Charlotte describes an experience of crying from a place of compassion for the pain she had endured.

“It was more like a cry that you feel and not necessarily a cry where you just feel terror. It was like I started mourning, and it was really freeing. I would just bawl, I swear I felt like my chest hurt. I was crying because it was terribly sad that this happened, how terribly sad that you never really got to truly exist as a child”

Charlotte’s emphasis of the intensity of her crying with the world “bawl” portrays a deeply cathartic experience of expressing and expelling the pain that she had been carrying. Indeed her acknowledgement of the experience as “freeing” gives the impression of a release.
Superordinate Theme Three: A journey through time

Participants talked in vivid detail about their experience of going back through time and being with their trauma and pain. They spoke about reclaiming parts of themselves that they had betrayed, lost or previously submerged because of the trauma. In addition, they spoke about their capacity to tolerate difficult memories. Finally, participants appeared to talk about the MDMA as an externalised ‘thing’ which acted as a pillar of love and support. Thus the three subordinate themes are: Reclaiming lost parts of the self, Being there and not being there and “The maternal container”: A personification of MDMA.

Subordinate Theme One: Reclaiming the lost self

“I’m going to pat right here and take care of little me for however long is needed and just cry for real.”

Participants described how during MAP the traumatised aspects of themselves were brought into awareness with love and compassion. I formed the impression that they were describing how they had betrayed and abandoned vulnerable aspects of their being and these were reclaimed during MAP. They also noted how
desirable parts of themselves had also been discovered. In the following excerpt, Katy explains how she was able to reclaim a traumatised part of herself:

“They had this small doll and her hair was all over the place and it was kind of ugly. It was all messed up this doll, it was kind of that part of myself that I really hated and I just threw the doll over to the other side of the room. I said “I don’t want anything to do with that” and by the end of the experience it was so beautiful and I was just holding her to my heart and it makes me cry just thinking of it, I was like “oh sweetie you’ve just had it so hard, I’m so sorry I hated you.”

Katy describes how she was able to recognise, through the doll, a part of herself she had discarded and been disgusted by, referring to the doll as “ugly”. She appeared to have accessed a loving maternal adult inside of herself that can now take care of the wounded child.

Similarly, in the following excerpt, Daisy explains the feelings that she had previously held towards herself in terms of how a mother relates to her baby:
“I think it lets you see yourself like a mother sees her baby. It seemed so overly simple but to be able to look at myself with love and compassion instead of fear, shame and dread.”

Daisy notes how she came to look at herself with newfound “love and compassion”. Her description of the feelings being akin to a mother and baby reinforces the impression of a true element of self-care. Taken together with her comparison of looking at herself with “dread”, there is a sense that she is reclaiming her traumatised and abandoned self with love and maternal nurture.

Charlotte talks in terms of how she had deserted the younger part of herself:

“I had this wounded little child and she’s sitting, she’s a part of me and I left and I said, I’m going to become an adult, do well and there might have been a thousand foot concrete wall between me and reaching her and in one day we knocked that whole barrier down. And it wasn’t reachable before I could just tell you, I could not have reached there.”
Possibly Charlotte is describing a process whereby she betrayed her younger self, leaving her vulnerable and wounded parts behind in pursuit of security and a better life. She describes how this formed a “concrete wall” between herself and that part. Her notion of knocking it down is perhaps reflecting how she experienced an unlocking of the hurt and trauma during MAP that had been deeply suppressed.

In contrast, below participants describe discovering the good parts of themselves. Katy describes her experience using a story where a “golden buddha” was uncovered:

“there was a golden Buddha discovered somewhere near Thailand. It was back in very old times and they had covered this golden Buddha with mounds and mounds of dirt so that during war times it wouldn’t get stolen. Many, many years later someone saw a glint of gold shining through and they dug through all of the dirt and found the golden Buddha. I thought that was a perfect metaphor for my experience. It had all this dirt. It was covering up this golden place inside me, I was for the first time able to, connect on all levels.”
Katy explains how the Buddha had been hidden under “mounds of dirt”. The colour of the Buddha was meaningful to me, “Golden” resembles treasure and richness, which indicates that she found something valuable underneath all of her trauma. I also find the reference to time in her analogy interesting. She explains how the golden buddha was revealed “many, many years later”. I wondered whether she was describing her sense of how many years she lived in a disconnected mode where her essence was submerged and unavailable to her.

Hannah also describes an experience of discovering herself:

“It was almost like you had been there, asleep, like it always had been autumn inside and then all of a sudden there you were.”

Here I form the impression that Hannah’s reference to the seasons is like her essence had been submerged. Indeed, in Autumn the leaves are falling rapidly and covering everything, furthermore we are waiting for the cold, bitterness of winter with no sight of summer. Hannah appears to uncover the warmth of summer inside of herself and allow it to emerge.
Subordinate Theme Two: “Being there and not being there”

“I wasn’t dissociating like I used to so I was able to stay more present”.

Participants explained how during MAP their capacity to tolerate the memory was far stronger. For example, Matt compares it to watching the memory on a “TV screen”. The impression is that they were able to be in the memory whilst simultaneously observing the memory. This experience is eloquently captured in the following excerpt from Daisy:

“whenever I would have flashbacks my body thought I was going to die. With the drug, it was more like watching a movie, It magically makes it to where you’re there but not there.”

Daisy’s reference to the ‘magical’ quality of the experience perhaps reflects how unimaginable it would have been to her previously to be with the memory. Moreover, perhaps she is describing a mindful way of being with the memory. Indeed, there
is a sense of maybe an ‘observer self’ that allows here to take a metacognitive approach to being with the trauma, thus part of her can have ‘one foot out’ such that she is not literally relieving the memory with the same terror.

Similarly, in the following excerpt Charlotte appears to be articulating an experience of revisiting the trauma memories, whilst at the same time having a degree of distance from them, which made doing so tolerable:

“It was painful but it wasn’t as impossible. I mean pain is... pain isn’t a big deal if you’re not terrified during it. I guess it was less scary... see it was scary too, I just felt removed from it.”

Charlotte’s reference to it not being “impossible” perhaps reflects the power of the drug to enable her to tolerate the experience of revisiting memories. She appears to be struggling to articulate how the MAP enabled this, as she at first says it was “less scary” and then retracts this statement. This gives an indication of how the experience somehow creates a situation where you are present with the memory whilst also not being simultaneously which appears, in Charlotte’s case, hard to describe.
Subordinate theme three: The “maternal container”: A personification of MDMA (Bion, 1959)

“I wanted to heal and it felt ok to go there [the memories] because I knew I was so well taken care of and like I said, within this container of such love that I could do anything”

Participants appear to be aware of their capacity to revisit memories and tolerate the intense effect that emerged with MAP. There is a sense that at times MDMA becomes personified as a ‘maternal figure’ for them. I formed the impression that perhaps MDMA was experienced as, in psychodynamic terms, a ‘holding’ and ‘containing’ figure that allowed them to revisit memories in the knowledge that they would be safe.

In the following excerpt Charlotte describes how she felt supported by the MAP. She uses the placebo experience to illustrate what the MAP experience provided:

“In the placebo I described it to them like I was having to drag the help along with me and I felt so hurt and wounded, I really needed to be picked up and carried a little by the medicine because that’s how it feels.”
Charlotte appears to personify the drug by acknowledging how it gave her the feeling of being “picked up and carried” as if she is a baby being cradled by the caregiver. Possibly, in this instance, the drug is experienced as a ‘maternal figure’ that provides her with a sense of ‘holding’, to use Winnicott’s words (Winnicott, 1954), as she journeys back to her trauma.

In the following excerpt, unlike Charlotte, Hannah does not describe the MDMA as a ‘mother’ however she refers to the experiences as enabling her to access a maternal aspect of herself, which then allows her to attend to an internal child part:

“It let’s you see yourself like a mother sees a child, you know? I don’t know why it does that, I mean it just takes away whatever chemically give you fear and allows you all the loving, you know mommy/baby hormones”

Hannah’s reference to parenting implies that she is experiencing the MAP as facilitating an experience of accessing an internal maternal figure. Furthermore her suggestion that it takes away “fear” and instead offers a loving parental relationship perhaps reflects how the MAP is experienced as a comforting, maternal
figure. Further, her reference to “baby” may reflect a vulnerability that she could access because she felt she could respond with love as opposed to fear in this mode.

**Discussion**

The results of this study have explored the lived experience of MAP. The researcher identified three superordinate themes from the analysis; ‘Existential Freedom’, ‘Beyond the Cartesian-split’ and ‘Journey through time’. The results from the presented themes appear to highlight how valuable and important participants found the experience in supporting them to engage with psychotherapy and process the pain of their individual traumas. In this way the study can be said to support the rapidly emerging literature of randomised control trials which have conveyed a relationship between MDMA and recovery on the CAPS scale for PTSD (see review, Mitohoefer 2016). Overall, the narratives appeared to present an image of participants having been on a powerful journey which was heavily related to their experience of time. Indeed participants’ experiences could be said to involve them being transported back in time to their past, being fully immersed in the present and finding a way to be engage with the uncertainty of a future.
In the following discussion, I will investigate the most significant findings in relation to the research/literature highlighted in chapter 1. However, due to the nature of IPA, and its non-assumptive stance, many unexpected findings emerged from the data. These will be explored from different perspectives to reflect the apparent nature of these findings. These include, existentialism, neuroscience, mindfulness and attachment theory. Despite the potential epistemological/ontological conflict between IPA and the latter in particular, it was deemed an appropriate lens for the discussion, as it was led and evidenced by the data.

‘Existential Freedom’: A new relationship to uncertainty

Arguably the above theme lends itself to exploration from an existential perspective. Indeed, this theme is characterised by discussions of choice, authenticity, opportunity, possibility, freedom and meaning.

With regards to subthemes ‘Living authentically’ and ‘Released from fear’s captivity’ one could be drawn to think of how participants are describing a shift in their relationship to uncertainty. In existential terms uncertainty is considered an
ontological given of our existence, coming increasingly into focus in the face of ‘ultimate concerns’ (van Deurzen, 2010) that characterise human existence such as isolation, meaninglessness, death and freedom. Participants’ experiences of trauma appear to bring all of these facets of existence into their awareness in a powerful way.

Van Duerzen (2010 p.153) explains how uncertainty manifests significantly in terms of choice, as we are never able to know what the outcome of our decisions will be. Thus, everyday living involves being presented with a vast amount of choice and possibilities. This is seen in the theme of ‘Living authentically’ where participants appear to describe having lived for many years in a mode of happenstance, whereby they negate responsibility for their actions and choices because of fear of the outcome. Such a response to choice is recognised by Yalom (1980), he purports that avoiding choice can be a strategy to defend against the anxiety that arises with regards to the outcome of making decisions elaborated on below. This offers a description of strategies that people appear to employ as a way of defending against the inescapable uncertainty that is inherent in our freedom. He suggests how one may choose to avoid making choices and wherever possible delegate choice and responsibility for their life unto others. In this
theme participants describe exploring the experience of a transformation in regards to their capacity to actively engage with their agency and choice.

In the theme ‘Freed from fear’s captivity’ we see a shift in participants’ from a place of fear regarding uncertainty about the future, to an excitement and enthusiasm about what it may hold. Such a shift is consistent with literature that suggests uncertainty can also be experienced as motivating (Gilbert, 2009). Qualitative research suggests that differences in one’s relationship to uncertainty may be a product of their dispositional stance towards it, in terms of whether they deem uncertainty to be constructive or destructive (Gilbert, 2009). The author elaborates, explaining how our responses to uncertainty can either serve to immobilise or intrigue regarding the possibilities that may emerge. Arguably, we see in both “Living authentically” and “Released from fear’s captivity” participants shifting from a place of ontically appraising uncertainty and freedom as destructive to finding that it is constructive and filled with possibility and opportunity.

‘Making meaning in the tragedy’: Is denial a necessary component of human existence?
In the theme of ‘Making meaning in the tragedy’ participants describe being able to conceptualise their trauma in a way that supported them to be able to attribute meaning and purpose. Spinelli (2005) proposes that humans have evolved systems that seek to creatively make meaning and find purpose in our experience. He suggests that reaching acceptable or reasonable explanations for events supports individuals to reduce their anxiety, implying that anxiety can be seen as a response to things that appear inexplicable. Arguably we see this in the example of Daisy, and her visualisation of her late husband. Indeed, Daisy now understands his death to have left her with closeness to him that is greater than it was when he was alive. Similarly, in the case of Matt, he is now able to understand his near-death experience to have provided him with a ‘hero’s journey’, supporting the idea that he is able to find a suitable and satisfying meaning in the experience.

The suggestion of participants having found ‘Existential Freedom’, through new meanings around their trauma narratives, can be further supported in Frankl’s work. Frankl (2004) emphasises meaning making as a primary motivator for living. He considers that we are driven through life by an urge to discover meaning in the face of what he terms the “tragic triad” (Frankl, 2004 p.139);
human suffering, guilt and death. He postulates that humans have the capacity to reconceptualise suffering as achievement, coining this “tragic optimism” (Frankl, 2004 p.139). Again, perhaps this occurs in the MAP experience for the participants. For example, Lucy visualises herself as a child and sees the strength of her being, noting how she was moved by her capacity to endure the trauma that she experienced. She then therefore understands her trauma to be a reflection of her strength and her capacity to endure challenging experiences.

On the other hand, I wonder to what extent ‘Making meaning in the tragedy’ reflects participants reinstating some denial about their trauma into their narratives. In contrast to the previous state of denial they lived with, this appears to help them to emerge as more able to lead a fulfilling life. Indeed, Heidegger’s being-towards-death, suggests that humans seek to hide from the inevitable finite nature of our existence. He proposed that when we are faced with the concept of death, either personally or through bereavement, we are forced to acknowledge the lack of meaning and purpose in life that subsequently induces experiences of anxiety (Heidegger, 2010). Thus, maybe MAP enabled participants to reinstate a healthy, or necessary, level of denial in order to function. To elaborate, one could argue that this invites us to think about
whether meaning making serves to function as a facilitator of denial.

For example, in the case of Daisy her visualisation of her husband may in fact represent a denial of death and offer a belief in immortality. Referring to her husband as being “more there” for her than he was before arguably gives an impression of her now seeing him as a God like, omnipotent and benevolent figure that she can depend on. This is consistent with Yalom’s suggestion that a common strategy people draw upon to deny death is an irrational belief in an ‘ultimate rescuer’ or god-like entity that can somehow protect them from the inevitability of death (Yalom, 1991).

‘Beyond the Cartesian Split’: A matter of the right hemisphere and left hemisphere of the brain working in harmony?

Beyond the Cartesian-split, illustrates participants’ to have lived in a mode of dissociation whereby they experience a disconnection both intra and inter subjectively. The theme presents participants’ experiences of shifting to a state of embodied experiencing wherein they describe moving from a place of connecting on a purely cognisant level with themselves and others, to powerful connections with their bodies and feelings on an embodied level.
Contemporary trauma literature has investigated the phenomena of dissociation, with regards to sufferers of PTSD, extensively from a neuroscientific perspective (Van der Kolk, 2014). Thus it seems important to understand how the present study contributes to this literature base. Below is a brief description of this evidence base followed by an explanation of how this connects with the theme.

Extensive neuroscientific research supports that the right hemisphere of the brain is understood to be active in regulating both negative and positive affective states, coping with novelty, stress and interpersonal relationships. Whereas, the left hemisphere is understood to be responsible for rational thought, speech, thinking, analysing and organising our experiences in a way that makes sense to us. The complex right brain system allows individuals to switch internal bodily based affective states in response to perceived changes in the external environment thus maintaining a cohesive sense of self both in the autonomous and interconnected context (Fonagy, 2018; Schore, 2015; Van der Kolk, 2014).

In PTSD sufferers research has indicated that often the function of the right hemisphere of the brain is maladaptive whereby they
experience prolonged frequent and intense episodes of affect
dysregulation and poor emotional communication both intra and
inter subjectively (Schore, 2003). During the MAP experience as
emphasised in ‘Beyond the Cartesian-split’, participants arguably
find a way to utilise their right brain, moving from a place of
dissociation to enhanced emotional connection with themselves
and the therapist. They note how they were now able to feel
previously unavailable emotional experiences. Thus, perhaps
MDMA facilitated the regulation of the autonomic nervous system,
responsible for fight, flight, freeze (the dissociated state) and in
turn enabled them to access embodied feelings.

Moreover, participants potentially demonstrate how they were also
engaging their left brain simultaneously, in terms of thinking and
making sense of their emotional experience. Van der Kolk (2014)
has written extensively on trauma and claims that, in the full
recovery of trauma it is necessary for both sides of the brain to be
alert and actively engaged, harmoniously working alongside each
other to process the trauma. Indeed, such a theory perhaps
resonates with participant Matt’s experience of attempting to work
through his trauma prior to MAP, he comments “there is not a
whole lot of logic-ing and working yourself through something that
can happen when you don’t feel it”. Perhaps Matt is describing the
limitations of trying to process trauma when only the left brain is available to you. In contrast, an example of where the left brain and right brain are functioning in harmony is illustrated in Daisy’s comment of her experience during MAP “it was more like a cry that you feel and not necessarily a cry where you just feel terror [...] I was crying because it was terribly sad that this happened”. Here perhaps Daisy is describing how she was functioning from a place of high arousal when crying prior to MAP, however it appears that during MAP she moved to a place of being able to feel the underlying pain and make sense of why she was crying. Thus she was thinking and feeling in unison ergo we can hypothesise that perhaps her left and right brain were working collaboratively.

In summary, perhaps what we can deduce about the participants experiences with regards to ‘Beyond the Cartesian-split’ is that MAP is facilitating participants to engage with their whole self as a result of supporting access and collaboration between the right and left hemispheres of the brain.

‘Uncovering the golden buddha’: An act of mindfulness?

Research and practice has recently yielded a vast body of evidence to suggest that mindfulness can be a powerful approach for working with trauma. Mindfulness has been defined as
“...an act of hospitality. A way of learning to treat ourselves with kindness and care that slowly begins to percolate into the deepest recesses of our being. The process has everything to do with self-compassion when facing the rough, shadowy, difficult, aspects of our lives....” (Santorelli, 2014, p. 1)

Santorelli (2014) captures the essence of what underlies the experience that participants report in ‘Uncovering the Golden Buddha’. Indeed, here we see participants opening up their hearts to the parts of themselves that they find less desirable and greeting them with love and compassion. Thus, perhaps the MAP experience reflects the MDMA fostering a mindful and compassionate mode when relating to their entire self.

‘Being there and not being there’: Could this be a process of dual awareness?

Mindfulness theory is particularly relevant with regards to the theme of “Being there and not being there”, Mindfulness is thought to facilitate “dual awareness” and "parallel processing”
allowing the individual to analyse their past whilst also being in the present. Mindfulness is therefore essential to trauma work as it minimises the risk of traumatisation (Ogden, 2006). Such dual awareness allows individuals to connect to their child self's painful emotions whilst in parallel being aware and managing to hold a loving and supporting side of themselves enabling them to tolerate such intense emotions.

It may suggest that this is what participants were experiencing differently when they describe revisiting the memory and “being there” whilst simultaneously “not being there”. Indeed, Fisher (2017) explains that when a client identifies the lens through which they look, they begin to notice their feelings, reactions and actions from a “meta-awareness perspective”. In doing so, they learn to separate themselves from painful, intense reactions and see them as their child self's difficult experiences, referring to these as “his” or “her distress”. Perhaps for the first time, in this theme participants are able to have a relationship to a distressing feeling rather than being consumed by it.

‘Reclaiming the lost self’: Is it all about the internal attachment bonds?
Here we see a shift in participants from a place of self-alienation to a place of welcoming the whole self. Fisher (2017, pp 79), who worked closely both academically and clinically with professor Van Der Kolk in the field of trauma, explains that individuals suffering with severe trauma often experience a yearning to “like” themselves and seek to disown the traumatic experiences. Such processes are said to result in a profound alienation from self: For individuals to feel safe in relationship, they are required to show compassion to both themselves and the other. Indeed Siegel, (1999 p.21) states that “earned secure attachment” leads to emotional resilience. By internalising secure attachment, people can tolerate emotions such as anxiety, frustration and hurt. However, to earn the resilience ourselves we have to fully accept every part of us, to the parts we hate, to the vulnerable parts, to the hostile parts, to the parts we love Fisher (2017). In the method of most psychotherapeutic models is the belief that healing is achieved as an outcome from relational processes. If an individual is hurt in an unsafe relationship then their wound must be healed in a relational safety.

However, Fisher (2017) proposes that it is the quality of internal attachment bonds, rather than interpersonal attachments, that are determinant of our ability to feel safe in relationship to the world
and ourselves. She postulates that it is the attachment to ourselves that contributes most strongly to our sense of well being as opposed to the attachment we feel to and from others. Fisher (2017 p.213) posed the questions “What if being witnessed as we recall painful events does not heal the injuries caused by those experiences? And what if compassion for the child who lived through these events is more important than knowing the details of what happened?” She proposes that when each part of our person can feel lovingly held we gain a feeling of internal safety and worthiness, often for the first time. She suggests that the first part of the work involves having a curiosity towards this “other” whom we carry internally but with whom we are not very well acquainted.

Arguably the presented analysis supports this theory. ‘Uncovering the golden buddha’, appears to demonstrate a shift in the quality of the participants ‘internal attachment bonds’. Perhaps this seemingly internal shift is what enables them to revisit their trauma and tolerate the affect associated with it. In “reclaiming the lost self” we see participants go through a process of meeting their traumatised parts, with compassion. Furthermore, we see them finding the loving and wholesome parts of themselves, which equally appear to have been estranged from them prior to their
MAP experience. Finally, we see how they seemingly draw on this new-found compassion and self-love internally to meet their trauma memories in a way that feels holding and containing.

‘The “maternal container” (Bion, 1962 p.17): A personification of MDMA’: Is MDMA the good enough mother?

Finally, with regards to the theme ‘The “maternal container” (Bion, 1962 p.17): A personification of MDMA’, in contrast, to the aforementioned experience of a shift in one’s internal attachment system, the theme explores how participants appeared to externalise the support that they felt during MAP in the form of personifying the MDMA. They appear to see the MDMA as a literal mother figure, which serves to support their capacity to engage with therapy. Whilst a psychodynamic lense is arguably incongruent with the phenomenological lense of IPA, CoP is pluralistic in nature and thus I have drawn upon psychodynamic theory here as the discourses in the final theme felt closely akin to that of this therapeutic model (Strawbridge & Woolfe, 2010).

To a large extent, the psychodynamic model understands one of the fundamental needs of therapy to be the following experience:
“What is needed is a form of holding, such as a mother gives to her distressed child. [...] It can be crucial for a patient to be thus held in order to recover, or to discover maybe for the first time, a capacity for managing life and life’s difficulties without continued avoidance or suppression” (Casement, 1985 p.133).

This view is largely founded on the work of Bion (1962) and Winnicott (1954), which I will expand on briefly here. Bion postulates that an infant becomes overwhelmed by their experience as they have not developed sufficient internal controls. The role of the mother therefore is to provide a containing function helping the baby develop self-regulation. The infant internalises such containment, experiencing the mother’s emotional availability, allowing for the development of their own capacity to contain.

‘Holding environment’ is the term Winnicott (1953 p.10) used to describe the best conditions for ‘good enough’ parenting. Winnicott postulated that emotional problems could be the outcome of an individual who had been deprived of such holding environments as an infant. He therefore concluded that it is essential to have a level of holding for the therapeutic environment. Thus, perhaps the participants experience of MDMA
is as a holding figure. Such a view is consistent with qualitative literature on individuals who have explored their experiences of other entheogenic substances such as the popular psychedelic ‘ayahuasca’. Indeed Loiziage Velders (2014) study reflected how people referred to ayahuasca as “mother ayahuasca”.

**Future research**

This study has contributed towards greater understanding and clarification of the lived experience of MAP. It supports the current emerging literature base that MDMA is a potentially fruitful adjunct to psychotherapy in the treatment of PTSD.

Here it has been suggested that MAP appears to support an integration of ideas, such as existentialism, psychodynamic theory and third wave mindfulness based therapies. However, at this stage there is no distinct understanding of which psychotherapeutic model is being engaged during MAP. Thus, it is of importance to better understand how best to work psychotherapeutically with this drug. It is possible that a grounded theory exploration could offer a useful platform from which to explore this.

Furthermore, perhaps neuroscientific advances can be made in the exploration of what is occurring in the right hemisphere of the
brain during MAP. It would be interesting to understand the interaction that occurs between the left and right hemispheres.

**Limitations**

Despite efforts to homogenise the study sample, there was only one male participant. Research shows that males may be more reluctant to get in touch with, and talk about, their feelings and so tend to be less likely to access therapy (Holmes, 2015). Thus perhaps this study's findings may have been different if more men had been recruited.

In addition, types of trauma differed and again the sample was arguably not as homogenous as it could have been. However, given the relatively small number of people who have undergone MAP thus far, it would not be possible to narrow this any further at this stage.

This research invited participants to recall an experience that occurred 4 years ago. Thus, memory recall may have been variable, subject to significant interpretation and potentially have missed some of the experience entirely. Thus one could argue that IPA explores the memory of experience as opposed to the
experience itself. However, Smith (2003) argues that the narratives are valid if they represent participants’ experiences in the absence of an inference with their truth and reality.

As aforementioned, interviews were conducted using Skype video technology due to the distance of the participants from the researcher. Thus it could be that some of the detailed, intricate, sensitive aspects of their lived experience were missed when using this interview forum. Perhaps participants felt less able to open up entirely due to the sense of physical distance between them and the researcher. However, during my reflective process regarding this aspect of the research, I did not experience the process as distance or lacking intimacy. Rather I found myself being surprised by the level of intimacy that appeared present between the participants and myself over Skype. When considering this in the context of the current literature on the topic the interview experience appears aligned with Hanna’s (2012) proposal that one of the benefits of video call based interviews is that the researcher and the participant can remain in an environment which feels ‘safe’ and familiar to them whilst not imposing on one another’s personal space. He explains how offering the participant the option of staying in their own home when being interviewed, without the physical presence of the researcher encroaching on their space,
may facilitate them to open up and feel more comfortable. He comments how this might also be the case for the researcher who may be able to be more present and attuned in the comfort of their own personal space.

Conclusion

Participants offered bright and enlightening accounts of their experience of MAP. They seemed to be powerfully moved by the experience and communicated a strong sense of living without crippling fear following MAP. Whilst this research has explored the lived experience of this small sample and does not seek to make generalisable claims, the participants passionate and detailed accounts arguably propose a strong argument for future research into the field of MAP both for PTSD and potentially for other manifestations of human distress. Furthermore, given the current socio-economic climate of the NHS and its subsequent emphasis on time-limited/solution-focussed evidence based practices (Rafalin, 2010), perhaps this treatment could be an adjunct to the strains of services offered at present.
References


Appendix 1.

Information Sheet

Full study title: *An Interpretative Phenomenological Analysis of MDMA Assisted Psychotherapy for PTSD.*

Dear participant,

I am a trainee counselling psychologist at the University of Surrey and I would like to invite you to take part in a study that I am conducting.

**What is the purpose of the study?**
The study I am conducting aims to explore what individuals’ experiences are of having psychotherapy which is assisted by MDMA. I would be grateful if you would read the information sheet provided in order for you to be informed about what participation would involve.

**Taking part**
Taking part in the study will involve being asked to attend a 60-90 minute interview that will be recorded. In this interview you will be asked a number of open questions about your experiences of MDMA assisted psychotherapy treatment. In order to be eligible to take part you will of needed to have been a participant in a trial within the last 10 years which involved you having psychotherapy when you had been administered a MDMA substance.

**Are there possible disadvantages to taking part?**
During or after participating in this study it is possible that you may feel upset as a result of the material that is discussed. If the interview does upset you in some way you are encouraged to seek help from counselling services such as the Samaritans who are contactable via the following number ‘1800283-TALK’ or website http://www.samaritans.org/how-we-can-help-you/contact-us. Further information and support regarding psychedelic use can also be sought from [http://www.maps.org/](http://www.maps.org/), a multidisciplinary association that are conducting research in the area of psychedelics and supporting individuals who have experienced them. You will also be given breaks during the interview if you should wish to.

**What if there is a problem?**
If you would like to complain about any area of the study you may contact the researcher. You can also contact Dr Stelios Gkouskos, the supervisor of the project (s.gkouskos@surrey.ac.uk).

**Who has reviewed the study?**
The University of Surrey Faculty of health and medical sciences ethics committee has ethically approved this study.
**Will all information shared be confidential and secure?**
Interview are to be recorded using a Dictaphone and then transcribed onto a password secure document. The information you share will be kept strictly confidential. Only the researcher and the researcher’s supervisor Dr. Stelios Gkouskos will have access to the information. When the project is complete all data and personal information collected will be destroyed. In the write up of the research all identifiable information will be changed in order to protect participant confidentiality.

**Decision regarding whether to take part in the study**
If you were to take part in this study you would be invited to set up a date and time that was convenient for you and the researcher to complete the interview. The interview would take place in a safe, quiet and neutral location that invites you to talk freely about your experience. Please note that participation in this study is voluntary and you are free to decline to participate. In addition should you partake in the study you are free to leave the study at any time.

Yours sincerely,

Michelle Ruger  
Counselling Psychologist in training

**Researcher contact details:**
Michelle Ruger, email: m.ruger@surrey.ac.uk

**Supervisor**
Dr. Stelios Gkouskos, s.gkouskos@surrey.ac.uk
Appendix 2.

Consent Form

Study Title: *An Interpretative Phenomenological Analysis of MDMA Assisted Psychotherapy for PTSD*

- I confirm that I have read and understood the information sheet/letter of invitation for this study.

- I have been informed of the purpose, risks, and benefits of taking part.

- I understand what my involvement will entail and any questions have been answered to my satisfaction.

- I understand that my participation is entirely voluntary, and that I can withdraw at any time without prejudice.

- I understand that all information obtained will be confidential.

- I agree that research data gathered for the study may be published provided that I cannot be identified as a subject.

- Contact information has been provided should I (a) wish to seek further information from the investigator at any time for purposes of clarification (b) wish to make a complaint.

Participant’s Signature

Date
Appendix 3.

Debrief Form

Study Title: *An Interpretative Phenomenological Analysis of MDMA Assisted Psychotherapy for PTSD*

Dear participant,

Thank you for participating in this research.

This study looked to better understand how individuals experienced MDMA assisted psychotherapy for PTSD treatment. The rationale for this study was that recent research has shown that psychedelics can act as a beneficial adjunct to psychotherapy and so it is possible that such treatment may become available in the future. To date no research has explored how people who have received this treatment experienced it leaving a gap in knowledge of the utility of the treatment. Therefore this study is seeking to understand this better. If you have any further questions regarding this study please do not hesitate to contact the researcher.

As previously mentioned it is possible that partaking in this research may have evoked some difficult feelings or left you feeling in some way negatively effected. If you feel that you would like psychological support please contact the Samaritans on 1800273-TALK or alternatively you can visit their website [http://www.samaritans.org/how-we-can-help-you/contact-us](http://www.samaritans.org/how-we-can-help-you/contact-us). Further information and support regarding MDMA use can also be sought from [http://www.maps.org/](http://www.maps.org/), a multidisciplinary association that are conducting research in the area of psychedelics and supporting individuals who have experienced them.

Yours sincerely,

Michelle Ruger

**Researcher contact details:**
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**Supervisor**
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Appendix 4.

Interview Schedule

*Project Title: An Interpretative Phenomenological Analysis of MDMA Assisted Psychotherapy for PTSD*

**Preliminary Questions:**
1. What trial were you involved with?
2. What was your presenting issue at the time when you received the treatment?
3. Had you received any psychopharmacology or psychotherapeutic interventions prior to engaging with this treatment?

**Exploratory Questions:**
1. How did you feel prior to being administered the MDMA?
   - Thoughts and feelings in psychotherapy sessions before the psychedelic session
   - Apprehension/Hope/Excitement/Fear
   - Therapeutic relationship experience
   - Feelings/thoughts immediately before being administered the substance

2. Can you describe how you felt during the session where you were administered the MDMA?
   - Bodily sensations/Feelings/Thoughts/Memories/Imagery/Spirituality
   - The how of the therapeutic relationship
   - Relationship to self
   - Relationship to Other

3. Can you talk about how you experienced the psychotherapy sessions that you attended after the MDMA session?
   - Any differences relationally?
   - Explore integration and consolidation of the process/adjustment

4. How has the experience impacted your life beyond the treatment?
   - What comes up now as you look back on your experience?
   - Relationships
   - Overall well being
   - Adjustment

5. Is there anything else that you feel you would like to talk about in relation to this topic?
Appendix 5.

Excerpt of clean transcript (Charlotte)
It’s quite hard even to remember it now, I can see. Thank you for sharing that.

Yeah, I spent the next 10 years and years before, you know, in every therapy you can imagine on every medication you can imagine until at 29 years they said “here there’s a study it might help you a little”. I said “sure, it’s something let’s try it”.

So can you tell me about what therapies and things you had tried before and your experience of those? How they’d been?

So I did traditional talk therapy and I mean honestly it doesn’t really help anybody I don’t think. I didn’t me. Like I said every medication out there. I did EMDR therapy and I felt like that went, really just brought stuff up to the surface that was painful and didn’t give you a way to work through it or to cope with it being there at all, like it just made things worse. I did a somatic therapy and that was right around the time that I found out about the study and that actually, I felt was helpful and actually use that during the study. When I started that therapy I was 79 lbs and during that we were able to get me up to a healthy weight to be able to even be in the study. That was probably the only one I felt like; I can’t even remember what they’re all called. I mean there’s cognitive behavioural therapy; I mean the whole… nothing. There’s not a whole lot of, you know, logic-ing and working yourself through something that can happen if you feel it.

Thank you that’s really helpful to kind of hear about those experiences. So, you’ve touched on it a little bit, but can you describe to me how you felt prior to being administered the MDMA?

How much prior like?

Let’s talk about kind of when you found out about the study and yeah that kind of period initially.

Ok, so like around the time I found out about the study that’s when I had been doing the semantic therapy and it had helped me to kind of put some physical mask back on and be ok with putting food in my mouth. But that’s kind of where I’d gotten too. That’s about it. I had also gained the ability to, at times, be able to tell my therapist “no”. Which was good, especially going into the study and later, but I think that my therapist was kind of at a point where he was thinking “this is going to take forever. If we can get you into this study it might take a year or two off of what we have to do” and he had told me we’ve got at least 10 more years before we can really get anywhere and I mean, you know, I was still a complete mess, like if you can imagine you crumble a paper, that’s what I felt like. I could not nothing. I spent my day just crying and waiting for my husband to come home. It was terrible, honestly it was terrible. Everything… it never stopped. Everything I thought about was just everything from then, everything from back then, it just kept replaying.
Ok my next question is how did you feel right before you were administered the MDMA?

I was terrified. I was terrified, I kept thinking I’m not going to be able to do this, I can’t take this pill. My husband came in with me and he went to work that day, but he stayed with me and went in late and he’s a teacher and I was like “if you don’t stay, I can’t do this, I can’t take this pill” and I thought “ok I’m either going to just sit here, I’m just gonna throw it back” and that’s how I kind of got through that moment because I was just like “ok here we go”.

If we could just describe, talk about how you felt during the sessions before you were administered the MDMA, because as I understand it you kind of have… is it three sessions before with Bruce and Marcella?

Yeah.

What were those… how did you find those? What came up?

You know very difficult. Looking back I’m really grateful for them. It’s a lot of kind of talking about how you are in the moment, it’s not just like a whole lot of dragging up what happened, you know, and not necessarily you can but that’s not what it’s intended for. It’s a lot of kind of intention and goal setting like “what do we want get out this? What’s actually going to be helpful, what do we want from this? How do we think that we can go about getting there?” and I think in a way also it kind of gives the therapists kind of an insight into how you work and they kind of catch on to things that might be helpful when they work with you. So I think they were really good, they were really good. I pretty much always left crying and I mean everybody was super nice and [deals with dog]

How was it with the therapists?

But I think for me, getting to the point where it was like “ok can I work with Marcella? How is this going to be?” I didn’t completely have like the fully like “I trust you with everything” at that point. That did not happen until the MDMA sessions for me.

Right, I see what you mean. So now I’d like to move onto the MDMA sessions. So if we start with the first one, I just wanted you to kind of describe that and talk me through how it was for you.

I was actually one of those, I don’t know if you’d say lucky or unlucky people who got placebo first. So I had two sessions of full on like minimal minimal dose MDMA and then I had three of the full MDMA. Placebo is terrible I will tell you. It is hellacious, it was eight hours of just mostly on your own, being pushed through it, I mean by the little
tiny bit of MDMA. It’s kind of like the EMDR, it was enough to just bring up a bunch of stuff to the surface but you don’t feel the support that you do in the full MDMA sessions.

**Right I see what you mean.**

So during the full MDMA sessions… so I guess where did you want me to start again?

**Well actually it's very interesting to hear about those initial sessions with the placebo because you were given enough, if I understand you correctly, of the drug to feel a very subtle effect but not enough to feel what you describe as kind of being supported, I think that was the word you used. Can you talk to me about those experiences and then we’ll go onto…**

Like I said… go ahead.

**Then we will go on to the MDMA full dose as well.**

In the placebo I described it to them like I was having to drag the help along with me and I felt so hurt and wounded, I really needed to be picked up and carried a little by the medicine because that’s how it feels in the full dose. So in the placebo yeah It kind of, it’s like it opens this doorway and you know I had gone in here and you don’t know if it's placebo. So I’m in this mindset where it’s like, “ok I’m just going to squeeze everything I can out of the opportunity” and thinking “if this is the MDMA oh god, this is terrible and if there’s something here for me to help I’m going to try and get it”. So you just keep going and you keep trying to work through things which really just end up incredibly painful because you don’t have like the feeling that it’s holding you and supporting you as much. It’s like poking holes through everything.

**It’s just bringing it up without the kind of support that you thought you needed.**

Right, it was more of a practice in feeling it for me at the two placebo sessions than really working through it completely. But again I honestly, I’m glad that I had it. It...I think that those two extra sessions gave me kind of the opportunity to be like, “ok here’s all this terrible stuff that I really do want to work through later” because I just felt all of this and I don’t want to do that again every day, forever.

**When you said it brought things up, what sort of things?**

I guess lots memories that I didn’t want to think about, lots of them and in vivid detail. As though you can really just see it, you can feel it, it's right there and you’re in it, a part of it. Yeah, it’s really and there’s not a whole lot of getting away. I mean you could, you could say “no I don’t want to do this” and just pull back from it but not knowing whether or not you’ve got MDMA or placebo, doing that I had to have had MDMA kind of shuts down your chance of getting anything good out of this, you know,
opportunities so I just kept going. It was horrendous, honestly it was some of the hardest stuff I’ve ever had to do.

**How did you find you were after those sessions?**

I didn’t stop crying, I didn’t not stop crying between there and the next one. It just kept coming.

**Just really really painful.**

Yeah.

**So then you went from those two placebos straight to the full MDMA dose?**

Yes, yes.

**How was that one? Can you describe kind of how that went for you?**

So different, so different. Let’s see I think after it was like 15 or 20 minutes you start, I started to kind of feel like “oh my gosh I’m alive” and you start to feel parts of yourself that you didn’t know you could ever recognise, like internally, it was, it was incredible. I can remember sitting up and saying “oh wait, hey guys” and I remember waving at the therapists and saying “I’m here, hi”. All of a sudden you just start noticing all these parts of yourself. There are also plenty of hours where you are just working through things. There was plenty of time where it all just felt so real again, you know, the memories were there, the trauma was there. it was all there, but I also felt a million times stronger, a million times more prepared, so supported, you know, just internally. It gave me this feeling like “ok, ok there’s going to be another side, I don’t what it is, I’ve never seen it but it’s over there and I’m going there”. I think that it was incredible too because I felt like this sudden connection to the therapist as well, so that was super helpful you know, when you don’t feel like you’re in the room alone. I remember at one point looking at them and saying… I think this was actually my last session “oh my gosh I know why you guys are doing this, you’ve been here, you’ve hurt, I’m sorry” and I was just like “come here let me hold onto you”. It’s like you just have this outpouring of empathy for yourself and for everybody else you can imagine. Everything just, it lit up and it was… let me see, my first MDMA session was the one where I felt like, and it was incredible, I felt like a moment of actual peace and it was for four minutes. I had these headphones on and you know they have the blindfold on you and I was listening to the music they played and there was this one song that came on and for four minutes I was just quiet and I just fell into, I was like “oh my gosh” and afterwards “What was that? Will it come back? Is this over?” So we kind of got to work with that but that was, that was amazing.

You’ve talked about so much I just wanted to come back to kind of what you described in the initial, if we just for a moment go to the first thing that you talked
about was this coming up and being like “hello” can you tell me more about that? What was that for you? How was that?

It was like meeting yourself at the same time as introducing yourself to someone. It was almost like you had been there, asleep, like it always had been autumn inside and then there you were and I just felt so much joy and wanted to let all of me out. I was the most excited thing on the planet at that moment, I really was. It was… I wanted to find it all, I wanted to share it all and I did for a good 15 minutes or so.

How did that look sort of, do you remember how it kind of looked?

Well I honestly remember kind of like popping up and sitting up and you know, seeing that and then for 15, 20 however long I sat and I talked so much, so fast and so big I think that we danced slightly. I think I hugged everyone, yeah, yeah.

Can you describe how that was different from how you’d been before?

Oh wow, it was like a different me. Before it’s amazing because I’ve seen some of the tapes, but before I was just small and snuggled up and quiet and kind of “don’t look at me”, you could kind of barely hear me, always ready to cry. Then afterward I was so big. It was like I suddenly had permission to take up so much space. If you could feel like you were growing, that’s what it felt like. it was amazing.

How do you feel though that session allowed that to happen? How do you understand that?

I think that the same way that it felt like in the placebo sessions, it was poking holes. Instead of just poking holes and letting all that terribleness through suddenly I had this bunch of cheesecloth where all of like everything good came through, you know, it’s like “wait, wait there’s more here” and it kind of floods you with more and you’re like “ok wait, there that is inside of me” and it just comes out, you can’t hold it in.

You say, talk more about, what’s that for you? What was the good feeling?

A lot, real, I used say that I was nothing, not nothing but the nothing. I had felt like I honesty was the worst thing to have ever existed. If there was evil it was me and in that moment it was gone like I felt like I was not the bad thing.

You talked about the, sort of the times in the sessions where you would go back into kind of the more difficult stuff, can you talk me through that a bit more please?

Well there would be times, you know, you have your blindfold, mind shades on, whatever they all them and your headphones, or you wouldn’t and you’d be sitting there talking and something. Almost like it kind of rose up from inside you it’s like “hey I’m here, do you want to talk? Do you want to deal with me right now?” and I was really
glad because beforehand they had given me the analogy that it’s kind of like a dance partner “do you want to dance?” and you can say “yes or no, go away” you know and there were times where I was like “no go away I can’t do this one yet” but then there were times when it just came up and you just fell into it and everything felt really pretty terrible but I also felt like I could look at it, like I could see it better, I could see things clearer, I didn’t have to hide from it so much. There was a lot of like actually… like it was a physical replay of things that had happened, it was like if you watched it and watched what I did it was like you could just see everything that had gone on. It was right there, but it was almost like you got to complete it better. Like having gone through it that way at that moment with that kind of internal/external support gave you almost like a better resolution, if that makes sense. Then afterwards you’re able to kind of see clearly a little better. Kind of like, “oh wait, no I didn’t invite that upon myself” you know, the whole like “that’s not just what happens to girls”. I remember saying “that’s just what happens to girls” and my therapist caught it and she said “What did you just say?” and I repeated it and I thought “oh my gosh, no, no, no, no, no, no, no” and so you like you just start this whole experience of feeling and then just healing it yourself as well. It hurts so bad and then you just kind of like hold your little self and apologise to your little self like that that had even happened.

You talked about kind of being there and it being there, do you mean like literally, you could see it in front of you and that was when the mask was on or without the mask?

So it was kind of… yeah, describe that in more detail if you can?

It really was like what was in front of you or what had been in front of you before was not, like it was gone. Like if you can remember back and you kind of think of how you imagined things or how you dreams things. It was like you’re sitting there and you’re seeing those things though, it’s all honest to god right there in front of you. Your hands are smaller, you are smaller, you don’t look the same. I remember looking in the mirror to make sure I was the same and I was not. I saw like you know little six year old me and it all just kind of right now vanished and everything was there. you just saw it all and I mean it sucked. That sucks, you don’t want to see, but I guess being able to see it, like I said with more of the support and kind of more of an idea that they maybe that wasn’t right kind of helps you to see it better then through six year old eyes.

How did you find that kind of being that six year old?

I mean it’s rough, it’s painful, it’s tragic but then when you remember for the first time of having one of these experiences that “wait I’m really not, you know, it all looks this way, I’m not looking the same, I look like this six year old but wait I know more, I do, I really do” and you start telling yourself this. So then you’re able to guide yourself better and like as you wish someone would have done, you know. I remember at one point going through that whole thing and like having it and seeing it all and then having Marcella come and just hold me like should have happened and I just snuggled in and felt it. It did it kind of reset what should have been there.
Appendix 6.
Excerpt of transcript analysis (Charlotte)
TRUST IN THE FUTURE.

F 1.

FEELING SAFE AS

A RHTY TURNs ON.

G.7.

DO LEAVING.

A RHTY TURNs OFF.

MIND.

I EXPERIENCE

DEEP BREATHE.

DO TIME REND

STILL HERE?

LEAVING IN FEELING.

RELIGIOUS CULTURAL

LITURGICAL/BAPTISM.

SELF HAD BEEN

TURD IN RELATIONSHIP

BY HERSELF.

ALSO TOOK TO

BEHAVIOR.

GETTING TO KNOW

HERSELF OR LOST

SELF.

A HUGE TRANSFORMATION

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ALLOW HERSELF TO

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CHANGE IN

ME.

FINDING SOMETHING

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Appendix 7.
<table>
<thead>
<tr>
<th>Exploratory comments</th>
<th>Original Transcript</th>
<th>Emergent Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>She seems to be describing a shift to being more authentic with herself.</td>
<td><strong>Can you elaborate more on the new perspective that you mentioned?</strong></td>
<td>Authentic living</td>
</tr>
<tr>
<td>Her reference to Woody Allen refers to a sense of living in a mode of denial that is not a choice. Despite her best efforts to be honest with herself she is too frightened to look at it.</td>
<td>Yeah, I mean I was totally hiding so many things from myself and I didn’t know anybody, as far as I knew, that was trying so hard to see myself. I was really actively working on it and it was impossible and you know you hear like Woody Allen saying “I’ve been in therapy 50 years”, whatever like it’s a joke. People really want to see themselves, it’s not like they’re not trying, it’s not like the help isn’t trying to help them, it is impossible. I’ll tell you why I think it’s impossible because I really thought I would die if I knew the things about myself that saved me. Because I was able to have compassion for myself and that is so different than fear. It’s the opposite of fear and I don’t know any other experience that would give that to someone because you can’t force yourself to have compassion for yourself, you can’t do it.</td>
<td>Seeing the truth</td>
</tr>
<tr>
<td>There is a fear of annihilation if she is to see reality but in fact it is the truth that rescues her from death.</td>
<td><strong>What do you think it is about the MDMA that enabled that experience to happen? How do you understand that to have happened?</strong></td>
<td>Fear of truth, a preference for denial</td>
</tr>
<tr>
<td>talking about how you cannot force feelings despite really wanting to. Unable to have compassion/love for herself just through thinking she should.</td>
<td>I think it just lets you see yourself like a mother to a child sees, you know. I don’t know why it does that, I mean except for brain chemistry maybe there’s something that just takes away whatever chemically gives you fear and allows you all the loving, you know mommy/baby hormones or whatever all of a sudden. I have no idea but that’s all it took. It seemed so overly simple but to be able to look at myself with love</td>
<td>The truth as a rescuer</td>
</tr>
<tr>
<td>Reference to herself as a mother figure. Conjures up feelings of internal attachment bonds. Her way of relating to herself has significantly changed on an embodied level</td>
<td></td>
<td>The power of self compassion</td>
</tr>
</tbody>
</table>

**Authentic living**

**Seeing the truth**

**Fear of truth, a preference for denial**

**The truth as a rescuer**

**The power of self compassion**

**Being Mum to yourself**

**The power of self love**

**A maternal love**