

The early use of MDMA ('Ecstasy') in psychotherapy (1977–1985)

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Abstract

3,4-Methylenedioxyamphetamine (MDMA), also known as ecstasy, was first synthesized in 1912 but first reached widespread popularity as a legal alternative after the much sought-after recreational drug 3,4-methylenedioxy-amphetamine (MDA) was made illegal in 1970. Because of its benign, feeling-enhancing, and nonhallucinatory properties, MDMA was used by a few dozen psychotherapists in the United States between 1977 and 1985, when it was still legal. This article looks into the contexts and practices of its psychotherapeutic use during these years. Some of the guidelines, recommendations, and precautions developed then are similar to those that apply to psychedelic drugs, but others are specific for MDMA. It is evident from this review that the therapists pioneering the use of MDMA were able to develop techniques (and indications/counterindications) for individual and group therapy that laid the groundwork for the use of MDMA in later scientific studies. In retrospect, it appears that the perceived beneficial effects of MDMA supported a revival of psycholytic/psychedelic therapy on an international scale.

Keywords

couple therapy, entactogens, group therapy, MDMA (3,4-methylenedioxyamphetamine), MDA (3,4-methylenedioxyamphetamine), psychotherapy, couple therapy

Introduction

This article provides an overview on the early use of 3,4-methylenedioxyamphetamine (MDMA) ("ecstasy") in psychotherapy in the United States from 1977 to 1985, when it became scheduled under the Controlled Substances Act (CSA). MDMA was considered a useful drug by some professional psychotherapists during this period (cf. Eisner, 1989). After its scheduling, efforts were made to conduct clinical studies, but most studies were denied regulatory approval. Placebo-controlled studies conducted beginning in the 2000s have provided preliminary safety and efficacy data on the use of MDMA in assisting psychotherapy for treatment-resistant post-traumatic stress disorder (PTSD) (Mithoefer et al., 2011; Oehen et al., 2013). Phase 3 trials will be started to establish MDMA as a prescription medicine for the use in psychotherapy for PTSD (Philipps, 2016). This article describes the historical context and the approaches, techniques, and precautions developed for the therapeutic use of MDMA in the early period of its use.

A prehistory of MDMA in psychotherapy

Mescaline and some of its derivatives were researched for their hallucinatory activity since the beginning of the 20th century (Passie, 1992/1993). It was the Californian pharmacologist Gordon A. Alles who first came across the specific psychopharmacological effects of the mescaline derivative Methylenedioxy-amphetamine or MDA, which induced a state of intensified emotions with less hallucinatory activity and cognitive alteration (Alles, 1959). For this reason, MDA was tested beginning in the early 1960s as an agent to facilitate psychotherapy by Chilean psychiatrist Claudio Naranjo (Naranjo, 1973; Naranjo et al., 1967). In their continuing search for a "psychotherapeutic drug," Naranjo and his associate, the American chemist Alexander T. Shulgin, studied derivatives of the

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essential oils of nutmeg (Shulgin et al., 1967, 1969). In 1962, Shulgin synthesized the derivative MMDA, which had lower hallucinogenic activity than MDA and appeared to be a promising therapeutic drug (Naranjo, 1973; Shulgin et al., 1973). MDA, but not MMDA, became the drug of choice of some underground psychotherapists from the mid-1960s onwards (e.g., Stolaroff, 2004). The psychologist Leo Zeff, a core figure of the psychedelic therapy underground, was a proselytizer of MDA (Sargent, 2013). MDA had less pronounced sensory and cognitive effects and its major effect was described by clinicians as to “open up the person” and to intensify emotions, give access to suppressed memories and insights. MDA was also used in studies of drug-assisted psychotherapy (Turek et al., 1974; Yensen et al., 1976). Nevertheless, in the mid-1970s, Zeff stumbled upon MDA’s toxicity, which has produced some medical complications and even deaths (cf. Naranjo, 1973; Richards, 1972). In 1977, Shulgin introduced Zeff to MDMA, which looked like a better and less toxic MDA (Benzenhöfer and Passie, 2010).

The “Boston group”

A circle of interested persons known as the “Boston Group” had a lasting influence on the therapeutic use of MDMA beginning in 1976. The group consisted of a chemist, a few persons interested in spiritual development and psychotherapy, and others associated with the MIT Artificial Intelligence Lab (Harlow, 2013). They periodically synthesized MDMA and distributed it in the Boston area. Beck and Rosenbaum (1994: 18, 19) write that . . .

this group had a “therapeutic” perspective.” They periodically made some MDMA and gave it to a few people. They cared about the experience and how people made use of it. (Harlow, 2013: 1)

It seems reasonable to presume that the Boston group had facilitated some early interest in the therapeutic use of MDMA. For example, the physician Rick Ingrasci, an early MDMA therapist, got his MDMA from the Boston group (Ingrasci, 2016).

Leo Zeff—The Secret Chief

The psychotherapist Leo Zeff became interested in the therapeutic use of psychedelics in 1961 (Zeff in Stolaroff, 2004: 37). After using LSD in psychotherapy, he became very much convinced of its therapeutic potential. In the mid-1960s, he came across MDA through Shulgin’s research associate Tony Sargent (Sargent, 2013). After LSD became illegal in 1966,

Zeff continued his work underground. During the 1970s, he became a major figure of an informal underground network of therapists using psychedelics. He developed many useful procedures and shared them with other acquainted therapists. For this role, he was later named “the Secret Chief” (Stolaroff, 2004).

After Shulgin introduced Zeff to MDMA in 1977, Zeff responded enthusiastically and started therapeutic work. During the next 12 years, Zeff administered MDMA to about 4000 people and trained more than 150 therapists (Stolaroff, 2004: 86).

Zeff conducted sessions for personal and spiritual development. His groups had a consistent format. Participants began a weekend session by sitting together in a talking-circle on a Friday night. One by one, they told the group what was going on in their lives. Following this, Zeff would review the instructions and agreements. These prohibited leaving the site without permission, doing anything harmful or aggressive, and having sexual contact. To conclude, all were required to pledge that “[i]f I should tell you to stop something that you are doing, you will” (Stolaroff, 2004: 137). Zeff found it most effective to focus the clients on their own inner experiences by using eye-shades and headphones, discouraging talking and other interaction. “Sometimes,” they wrote, “people like to get up and do some hugging and then we set them right back down” (Zeff in Stolaroff, 2004: 81).

Lay down and stay down. No wandering around, because as soon as you start to be functional you detract. You’ve got to get into your ego to be functional. Lay down and have your whole trip and when you’re all the way down, really coming down, then you can get up and walk around. (Zeff in Stolaroff, 2004: 92)

His instructions for the session itself were these: “If you don’t know what to do and your mind wanders, then listen to the music. If you go into heavy judgements against yourself, then listen to the music.” In the evenings, after the daytime drug sessions were finished, a meal was prepared. On Sunday morning a ritualized circle for integration of the experiences was conducted, where everyone shared their personal experiences and insights (Andrew, 2004: 138).

The Association for the Responsible Use of Psychedelic Agents (ARUPA)

The name ARUPA was coined by Richard Price, one of the founders of the famous Esalen Institute at Big Sur, California, which was a center for the development of new psychotherapeutic techniques during the 1970s and 1980s (Kripal, 2008). The term ARUPA originated from Sanskrit and denominates a “formless” network.

ARUPA had no formal structure. Its main activity between 1978 and 1984 was to organize invitation-only meetings at the institute in the style of conferences to discuss the therapeutic use of psychedelics (Forte, 2014). During the ARUPA meetings in the early to mid-1980s, MDMA became a major topic. Among the participants were most of the psychedelic luminaries at the time, including David Nichols, Rick Doblin, Jack Downing, Stan Grof, Oscar Janiger, Rick Ingrasci, Sasha Shulgin, Myron Stolaroff, Rick Strassman, Ralph Metzner, Leo Zeff, and George Greer (Greer, 2014).

In March, 1985, when it had become obvious that scheduling was inevitable, a conference was held on “MDMA in Psychotherapy” at Esalen. Among the 35 participants were veterans of psychedelic research (Grof, Naranjo, Yensen, Lynch, DiLeo) and psychotherapists using MDMA in their practices (Greer, Downing, Wolfson, Ingrasci). Greer (1985a: 58) noted in the conference report that MDMA . . .

reduced defensiveness and fear of emotional injury, thereby facilitating more direct expression of feelings and opinions, and enabling people to receive both praise and criticism with more acceptance than usual. . . . Many subjects experienced the classic retrieval of lost traumatic memories, followed by the relief of emotional symptoms.

The report included presentations by George Greer and Rick Ingrasci about MDMA therapy and by Richard Yensen outlining differences between MDMA and MDA. The evening was devoted to discussions about MDMA and procedures for facilitating MDMA experiences. On day 3, half of those interested in experiencing MDMA began their first MDMA session while the others assisted them. On day 5, discussions were held about scientifically valid research designs and the possible integration of MDMA into psychiatry (Greer, 1985a: 58).

Ann Shulgin’s therapeutic work with MDMA

Around 1980, Ann Shulgin, the wife of chemist Alexander Shulgin and a lay therapist, began to help friends “sort out” personal problems in MDMA sessions. In early cases, she took MDMA together with the patients, but she soon recognized that this was counterproductive (Shulgin and Shulgin, 2005: 75). During that time she was instructed by Leo Zeff and partnered with a licensed psychotherapist. The therapist would refer to Shulgin only those patients who had been in therapy for at least 6 months. For these patients, an MDMA session under the guidance of Ann Shulgin would be offered. In the beginning of

the MDMA session the patients had to consent to the following “four agreements”: no expression of hostile feelings in aggressive action, no sexual activity, “no allowing the consciousness to abandon the body in such a manner that would cause physical death,” and no exiting until after the end of the session. The therapist’s attitudes and actions are supposed to be directed toward activating the patient’s own internal healing abilities. An important prerequisite for this is a caring and trustful relationship in the therapeutic dyad. The usual dose was 125 mg MDMA orally, sometimes followed by a dose of 40 mg 90 minutes later (Shulgin, 2013).

Ann Shulgin extensively discusses one aspect of the therapeutic work that concerned her greatly. This is the “dark side of humans,” also called the “shadow” by prominent psychoanalyst Carl Gustav Jung (1875–1961). These forces are aspects of the psyche which are usually suppressed and excluded from consciousness—to protect the conscious self against “inacceptable” inner tendencies and/or fantasies. Before taking MDMA, clients should be prepared that they may encounter aspects of this darker side of themselves. She recommends that these issues should be discussed before starting a session, in relation to the patient’s biography and current issues.

One of the problems that most humans beings suffer from is the suspicion that the core essence of who they are deep down is a monster. There is terrible fear . . . when you get down to it. . . . MDMA removes that fear. . . . During psychedelic therapy, . . . what we do is we go into it and look through its eyes, so that we become it. But we’re all afraid that we got stuck with the demon. . . . Once you get inside the demon, the first thing you experience is a lack of fear, and then you begin to recognize that this is also the survivor aspect of yourself. There’s a part that takes care of you. Then it begins to transform, and you recognize its quality of total selfishness—it’s going to take care of you and nobody else, right? —but it’s your ally. And then you begin to recognize its positive aspects. (Shulgin and Shulgin, 1995: 131, 135–136)

In the end, the shadow aspects of the psyche can be integrated and the shadow will take its place as a devoted ally and protector. To confront and learn to know the shadow can take more than one session, but the transformative power of this encounter is claimed to be enormous. Ann Shulgin’s Jungian interpretation of MDMA psychotherapy was inspired by her first husband, John Perry, a psychiatrist trained by Jung (Perry, 1974).

Ann Shulgin’s active therapeutic work spans just a few years (Shulgin and Shulgin, 2005: 76), but she was influential for other psychotherapists and authored an

early guideline for the therapeutic use of MDMA (Anonymous, 1984; Greer, 1984). She also mentioned for the first time a therapeutic synergy of MDMA with the mescaline derivative 2-CB (4-bromo-2,5-dimethoxyphenethylamine, first synthesized by her husband) (Shulgin, 1984). Interestingly, Ann Shulgin mentions not only successes with her patients but also points out a few cases in which MDMA did not help (cf. Shulgin and Shulgin, 2005: 75–77).

Kueny's 1980 study

In 1979, Alexander Shulgin initiated an exploratory study about the psychotherapeutic use of MDMA at the Pacific Graduate School of Psychology (San Francisco, California). Psychologist Sallie Kueny (1980) administered MDMA to nine persons in a “nonclinical setting” (i.e., the subject’s living room) to evaluate its use in psychotherapy, especially in respect to the “therapeutic alliance” between patient and therapist. The report on the (unpublished) study includes a research protocol, a synopsis of the MDMA sessions and a follow-up after 9 months. Originally planned was the administration of MDMA at three occasions to each client, but the project was stopped for technical reasons after each client had received one MDMA session.

No negative effects were registered during or after the sessions. All subjects reported positive experiences free of usual anxieties. Kueny concluded:

this brief experiment yields enough provocative data to justify further research on that issue. . . . MDMA allows ordinary defenses against communication and closeness to relax, and permits those involved in its effects to deal with substantive issues. . . . The implications for using this agent in the therapeutic setting are enormous. (Kueny, 1980: 8, 16)

Claudio Naranjo—Early researcher in drug-assisted psychotherapy

Claudio Naranjo, MD, a Chilean psychiatrist, periodically visited the U.S. on scholarships during the 1960s. Naranjo describes his life as that of the “eternal student . . . wanting to reach beyond boundaries,” shaped “by the study of music, philosophy, and medicine, and by the pursuit of the philosopher’s stone. . . .” (Naranjo, 1973: XV). When he finished his education, he was a research psychiatrist at the Centro de Estudios de Antropología Médica in Santiago de Chile. In 1962, Naranjo became an associate of the American psychedelic chemist Alexander T. Shulgin (Naranjo, 2001: 209). Their cooperation led to testing of MDA and MDMA in 1965/66 at Naranjo’s research facility in

Chile (Naranjo et al., 1967; Shulgin et al., 1969, 1973). In 1973, Naranjo published a classic book on drug-assisted psychotherapy (Naranjo, 1973: 97–115).

In the late 1970s, when MDMA became known in psychotherapeutic circles, Naranjo was a major figure in spiritual teaching programs in California and became the most scientifically educated among the early MDMA therapists. Naranjo had known Zeff since the 1970s and inspired him to use ibogaine and MDA in his work (Naranjo, 2015). Naranjo participated in some ARUPA-meetings at Esalen. By 1984, he had used MDMA with more than 30 patients. To Naranjo, MDMA differs from MDA, being not hallucinogenic, less toxic, and having very mild side-effects (Naranjo in Eisner, 1989: 58). Because MDMA reduces natural defenses and opens the user to trust relationships, he calls MDMA experiences “artificial sanity, a temporary anesthesia of the neurotic self.” In respect to clinical practice, he reported using MDMA once or twice per patient in therapeutic settings: “I mostly use MDMA as an ‘opener’ at some point in psychotherapy, not only for the wealth of the material gained during the session but for how it facilitates therapeutic work in the aftermath” (Naranjo in Shafer, 1985: 69). Naranjo was eager to differentiate his approach from others in the field.

Most people I know have used MDMA with a model borrowed from the use of LSD—that of listening to music through headphones while blindfolded. Much can be gained from that alone, but essentially the feeling enhancers have to do with the world of relationship and with the enhancement of the sense of “I” and the sense of “you.” . . . I see verbal interaction as an invaluable vehicle for guiding people and helping them to go deeper. (Naranjo, 2001: 216)

Consequently, his main interest became the use of MDMA “within groups of people who had ongoing relationships with one another” for “‘clearing away the garbage’ so as to keep the relationship healthy” (Naranjo, 2001: 216). He described his approach as . . .

one in which I have intervened little, except in the preparation of the group and in the course of the session of retrospective sharing and group feedback. I not only coordinate and share my own perceptions but also assist toward further elaboration of the experience. (Naranjo, 2001: 216)

Especially in group therapy, he found a feeling-based intensification of interpersonal trust and empathy for others. This can be furthered by creating “an atmosphere of surrender and spontaneity within the boundaries of a simple structure that limits movement away from the group but allows for withdrawal, protecting everyone’s

experience from invasion” (Naranjo, 2001: 217). From his experiences, group therapy with MDMA does not produce confusion or chaos. “Again and again I have had the impression that as the result of the catalytic effects of MDMA upon the participants, the group becomes a spontaneously organizing system, for the good of all” (Naranjo, 2001: 217).

Naranjo usually worked with groups of 12–16 people. He conducted individual interviews with those group members whom he had not met before. A group session at the first day of a weekend workshop was devoted to personal information, for sharing the expression of interpersonal emotions and for the clarification of individual expectations. Three group rules and general indications for the therapists were given: seek a balance between spontaneity and noninterference, abstain from sexual intercourse during the psychedelic session and the night after, wait for the effects of MDMA in an attitude of self-observation and goal-less restful effortlessness, and seek no contact with other group members before devoting a sufficient time for “self-immersion” (Naranjo, 1989: 107, 108). An integrative session is conducted on the following day for sharing experiences, group feedback and therapeutic interventions. Naranjo points explicitly to the necessity of after-session work to integrate the emerged material. Not much is known about whether Naranjo continued his work during the 1980s and 1990s, but during the late 1990s he trained a Spanish team for a study using MDMA-assisted therapy for victims of rape and violence (Bouso et al., 2008; Doblin, 2012: 145).

Joseph Downing and the Exuma Island Institute

The psychiatrist Joseph J. “Jack” Downing became interested in the effects of drugs on the mind in 1954. As director of the Mental Health Division of San Mateo County he treated alcoholics with LSD therapy from 1961 until the mid-1960s (Downing, 1968; Seymour, 1986: 67). Downing was associate professor at Stanford University, a scholar-in-residence at the Esalen Institute, and president of the Gestalt Institute of San Francisco (Downing, 1985). Downing began using MDMA in psychotherapy around 1984 in eight patients (Downing, 1985). He describes its effects as different from the hallucinogens:

The site of action is primarily in heart and emotions. . . . It produces no images or hallucinations. It does produce a general sense of well-being. . . . Feelings of fear and anxiety lift. One feels that one can examine both one’s motives and actions, and those of others, calmly and objectively, with acceptance and compassion. . . . Depending on the material contained in the unconscious, the patient will deal with any situation, from

childhood traumas, to long-felt adult insecurities, to deeply repressed emotions. (Downing, 1985)

At the hearings on the scheduling of MDMA, he presented a case history of a patient who was a victim of a crime in which she was abducted, tied up, and tortured for several hours. The patient had undergone psychotherapy, but still suffered from terrible flashbacks, nightmares, and suicidal thoughts. Here are the patient’s conclusions from the MDMA sessions:

I’ve taken it several times, and each time I felt a little less fearful. For the first time I was able to face the experience, go back and piece together what had happened. By facing it, instead of always burying it, I was able to sort of slowly discharge a lot of horror. The drug helped me regain some measure of serenity and peace of mind and enabled me to begin living a more normal life again. (Tamm in Eisner, 1989: 59)

In 1986, after MDMA was scheduled, Downing founded the *Exuma Island Institute*. This offshore MDMA stress-relaxation clinic was situated in a scenic beach resort on Exuma Island in the Bahamas. The central therapeutic goal of the program was stress relief. The “psychocatalytic” program of the institute included MDMA sessions devoted to personal introspection and interpersonal communication. After some initial support, the government of the Bahamas suddenly became uncooperative, and after some months of activity the institute was forced to close.

A manual, written by Downing, elaborated on the intentions and activities of the Institute. It described candidate selection, the psychocatalytic experiences, follow-up, and advanced training. The participants were grouped into 10-person “Life Groups,” originally intended to be a month-long program with two MDMA sessions. During the initial period, participants were instructed on what to expect and how they would be supported when encountering negative emotions. They were encouraged to surrender to the experience. The preparation emphasized the incorporation of new insights into everyday life after the sessions. MDMA was understood as providing a powerful learning experience with life-changing benefits. Sessions were conducted in a comfortable setting under the supervision of two staff members. In order to integrate the experiences, the accompanying exercises emphasized mental concentration, proper breathing, and stretching yoga movements (Downing, 1986a).

George Greer’s work with MDMA in psychotherapy

The psychiatrist George Greer became interested in psychedelics during his college years in the early-1970s.

He attended a long workshop with former LSD-therapist Stan Grof at the Esalen Institute in 1975 and opened a private practice in San Francisco in 1979. In 1980, Greer heard that underground psychedelic therapist Leo Zeff gave MDMA for therapy. Greer asked Zeff to teach him about MDMA and had some training sessions with him (Greer, 2015). After some evaluations, Greer realized that the therapeutic use of MDMA by a physician was legal. "I read the regulations and found that if I synthesized it myself, I could prescribe and administer it to my own patients if I had peer review and informed consent" (Greer, 2001: 223). Consequently, he synthesized 80 g in Shulgin's lab and started to work with it in his office. During the 1980–1985 period, Greer, together with his wife Requa Tolbert, a registered psychiatric nurse, treated over 80 patients with MDMA-assisted psychotherapy (Greer, 2015). Patient referral was by word of mouth. "It wasn't secret, but we did not tell people, we didn't publicize it" (Greer, 2015). The subjects were typically referred by conventional psychotherapists for an MDMA session. After an examination and informed consent, the sessions were usually held in the subjects' homes. During individual sessions, the subject listened to instrumental music, usually with headphones and eyeshades, to facilitate internal exploration. During interpersonal sessions, music was played in the background.

Greer and Tolbert had some rules for their patients: remain on the premises until all agree that the session is over and it is safe to leave; no destructive activities toward self, others, or property; no sexual contact between facilitators and clients or between clients; and follow the facilitator's instructions (Greer and Tolbert, 1985: 192). They also recommend a final question-and-answer session prior to administering the dose (Seymour, 1986: 42).

Greer and Tolbert provided a short prayer to their clients to help them to adopt an attitude of surrender (Greer and Tolbert, 1986: 375). This poem was originally written by the French Catholic priest Francois Fenelon (1651–1715) and was given to them by a mentor.

Lord, I know not what ought to ask of thee; Thou only knowest what I need; Thou lovest me better than I know how to love myself. O father, give to Thy child that which he himself knows not how to ask. I dare not ask either for crosses or for consolations; I simply present myself before Thee, I open my heart to Thee. Behold my needs which I know not myself; see and do according to Thy tender mercy. Smite or heal; depress me or raise me up; I adore all Thy purposes without knowing them; I am silent; I offer myself in sacrifice; I yield myself to Thee; I would have no

other desire than to accomplish Thy will. Teach me to pray. Pray Thyself in me.

In 1982, Greer heard that MDMA was being used at parties in New York City and realized it would not take long for MDMA to be scheduled (Greer, 2001: 227). Therefore, he decided to write up his results. In 1983, a scientific paper about his work with MDMA was self-published (Greer, 1983). It was circulated only among interested psychotherapists to avoid the promotion of MDMA as a recreational drug.

The paper, which was later published in the *Journal of Psychoactive Drugs* (Greer and Tolbert, 1986), gives a follow-up of 29 patients treated with 75–150 mg MDMA, plus a 50 mg booster circa 2 hours after ingestion. Individual and group sessions were conducted. No serious side-effects or negative after-effects were found. The most common benefits were enhancement of communication and intimacy during the sessions, improvement in interpersonal relationships, self-esteem, mood, and a decrease of consumption of addicting substances. Twenty-three subjects reported positive changes in attitude lasting between 1 week and the study's follow-up time of 2 years. From clinical experience the authors conclude that . . .

the single best use of MDMA is to facilitate more direct communication between people involved in a significant relationship. Not only is communication enhanced during the session, but afterward as well. Once a therapeutically motivated person has experienced the lack of true risk involved in direct and open communication, it can be practiced without the assistance of MDMA. . . . Regardless of the mechanism, most subjects expressed a greater ease in relating to their partners, friends, and co-workers for days to months after their sessions. (Greer and Tolbert, 1986: 326)

In respect to the mechanism of action, Greer concluded that a blocking of activity in the neurophysiological fear network promoted inspection of traumatic memories, self-acceptance, and the development of trust. "The insights obtained during the MDMA induced state can be quite valid, but that therapeutic change and development require follow through with regular practice or therapy" (Greer, 1985b).

Revised versions of these early papers were later published in established scientific journals and became classics in the field (Greer and Tolbert, 1986, 1998). One of these describes "A method of conducting therapeutic sessions with MDMA" (Greer and Tolbert, 1985, 1998). The client's psychological preparation and goal-directed motivation were posited as the most important factors in determining productive outcome. To facilitate internal exploration, clients were encouraged to recline

and to wear eyeshades and headphones. It is recommended that the client should not have any obligations for at least the following day. It is necessary that facilitators should be trained by someone who has given many MDMA sessions and should ideally have had the MDMA experience themselves at different dosages. Follow-up contact with the patient is recommended as needed, and the facilitator should be available on a 24-hour basis for 3 days after treatment (Greer and Tolbert, 1985b: 193).

Greer's interest in the therapeutic use of psychedelics never subsided. In 1993, he was a co-founder of the Heffter Research Institute, an association of scientists to further studies with psychedelics, and later became the Medical Director.

Rick Ingrasci: MDMA in couples and patients with life-threatening illnesses

During the early 1980s, Rick Ingrasci had a psychotherapeutic practice in Watertown, Massachusetts, and was president of the Association for Humanistic Psychology (AHP). Ingrasci had been interested in psychedelic psychotherapy since the late 1960s. When LSD was banned, Ingrasci began looking for possible legal alternatives. He worked for some years with ketamine to treat people with anxiety associated with a life-threatening disease (Ingrasci, 2000: 2). In the late 1970s, he was enthused when he heard about MDMA as a benign and still legal psychedelic drug with therapeutic potential. After some treatment sessions, Ingrasci was pretty convinced about MDMA's therapeutic potential: "[I]f anything was going to redeem psychedelic psychotherapy then MDMA could do it because it wasn't a hallucinogen, and when used correctly it was remarkably predictable and safe" (Ingrasci, 2000: 2). Ingrasci treated 100 patients in about 150 sessions from 1980 to 1985. One-third of the sessions were with couples (Ingrasci, 1985: 1).

Using a careful medical examination (excluding patients with epilepsy and cardiovascular diseases), Ingrasci never encountered a physical complication. The usual dose was 135 mg orally.

After the onset of action of the drug (usually 45–60 minutes after ingestion), I encourage the patient or couple to talk about what they are thinking and feeling in the present moment. This gentle, non-directive process continues for the next two hours. . . . Following the formal therapeutic sessions with me, I have the patient spend the next two hours with their spouse and/or family members, or with a close friend, someone with whom the patient would like to talk in an open, intimate way. Please note I only use MDMA once or twice in the context of an ongoing individual or couple psychotherapeutic process. (Ingrasci, 1985: 2)

Ingrasci describes MDMA's effects:

It puts a person in an unbelievable open frame of mind . . . the expanded capacity for self-awareness, the expanded sensitivity, the increased ability to share feelings. All that's attributable . . . to the lowered fear and anxiety induced by this drug. (Ingrasci in Gertz, 1985: 56)

In couples therapy, MDMA worked as a catalyst for dissolving encrusted communication blocks.

To sit with a couple . . . as they kind of opened up and you facilitate the process a bit, but, quite frankly, once things get rolling, it's like, they just kind of go where they need to go. . . . What [MDMA] does is, actually remove the fear of being real, of being authentic with yourself and with other people. . . . Afterwards . . . you don't need to take MDMA in order to experience authenticity. (Ingrasci, 2000: 4)

In this state, in which neurotic fears are dissolved, the couples were able to communicate in very direct, honest, and compassionate ways. "I have seen MDMA help many couples break through long-standing communication blocks because of the safety that emerges in the session as a result of the drug" (Ingrasci, 1985: 3). And because of the very alert and well-functioning cognitive state there is a good chance that these insights can be transferred into everyday life. MDMA-assisted therapy can be also useful for . . .

a deeper bonding process to take place in relationships where for some reason the natural bonding process has been prevented from occurring. . . . MDMA holds promise of allowing a healing to take place on those primary feeling levels. (Ingrasci in Eisner, 1989: 41)

Ingrasci reports having given MDMA to eleven cancer patients. Ingrasci work was presented at the popular Phil Donahue TV show in 1985, when some of his patients were invited to speak for themselves. One of his patients was a 40-year-old lawyer with terminal liver cancer. At the beginning of the therapy she was very contained emotionally and it was virtually impossible for her to open up for her inner feelings about the situation. After months of psychotherapy, she had a session with MDMA. When the effects came on,

she became more relaxed than she had ever felt in her entire life. She opened up emotionally and was able to discuss her feelings about dying in a deeply-felt, meaningful way. Even more significant was the discussion that took place with her husband, mother and her daughter following the therapy session itself. . . .

Many unresolved feelings and family issues were dealt with openly and honestly in one evening. (Ingrasci in Seymour, 1986: 70, 71)

Ingrasci concludes that MDMA helped patients put their immanent death in perspective, relieved pain, and may have helped them communicate feelings and needs to loved ones (Seymour, 1986: 45).

In summary, Ingrasci believed there are many people who can benefit from the use of MDMA in psychotherapy, especially when their defense mechanism includes splitting, isolation, and projection of negative feelings. "MDMA helps people to reconnect with these split-off emotional parts of themselves" (Ingrasci, 1985: 4). Ingrasci reports little about his rules in therapy. However, as noted above, he typically used MDMA just once or twice in the context of an ongoing individual or couple psychotherapy, and he asked patients to write a follow-up report on their experiences.

Phil Wolfson's work with patients in psychotic crisis and their families

Phil Wolfson, a physician practicing in California, was the only physician using MDMA with individuals experiencing a psychotic crisis and their families. He graduated from New York University and ran an alternative psychiatric inpatient clinic that was family centered and used little or no medication in assisting people going through an experience with madness.

From the psychotic illness of a family member a family dilemma ensues. The strangeness of the disease, disagreement over labeling, treatment choices, and prognosis, and the tendency to blame parents or to eliminate them from the treatment process—all these contribute to complex interpersonal situations and significant suffering. A psychotherapeutically guided MDMA session in such a situation can provide a context in which defensiveness and character-armor is diminished in favor of frank communication and sensitivity to the other's perspectives and feelings. Diminution of negativity and reduction in paranoia and distrust are other important aspects.

Wolfson illustrated his technique with a case vignette of a 27-year-old male with a psychotic illness that had begun 2 years earlier. The psychosis was characterized by hallucinations, paranoia, delusions, and negativism. After being hospitalized a few times, he was under treatment on an outpatient basis. Unfortunately, his psychotic behavior prevented the development of positive, trusting relationships that could serve to reduce symptoms. To treat this condition, several MDMA sessions with various configurations of family members

were interspersed throughout a year of family therapy. The first MDMA session . . .

was profound in the change in this individual's sense of self. Connections of an affectional nature were made with his parents and myself and the openings of trust experience began. For the first time in two years, he experienced a glimpse of a positive self-image and loving feelings that did not panic him. The afterglow of this session lasted several days with intensity, but recognition of that positive self-image has lasted permanently. (Wolfson in Eisner, 1989: 66)

Despite short-term gains in intimacy and understanding, often periods of closeness were followed by painful rebounds into isolation and alienation. Wolfson clearly realized the limits of these deep-reaching interventions, because "growth and change occur over time with ebb and flow . . . and significant shifts in attitude and behavior require singular effort and understanding on everyone's part." Unfortunately, the patient had another decompensation with a "manic-paranoid state," and many months of hospitalizations followed. A year later, he was "settled in a nondemanding, gentle residential program on the East Coast. He is now offering the beginnings of acknowledgment that he has to learn anew to love and care for himself and those around him" (Wolfson, 1986: 331).

Despite the lack of clear success in this case, Wolfson saw the potential of the approach. "In the warm afterglow of an MDMA session, new possibilities for love, relationships and self-appreciation emerge. To achieve these possibilities, the forgiving, less judgmental, reduced defensive state that MDMA provides has to be learned, at least partially, as an everyday way of life" (Wolfson, 1986: 331).

To Wolfson, MDMA offers the possibility for a rapid and significant break with defensive structures that are a product of cumulative trauma and communicational disqualification. In many patients, he saw a shift from a kind of personal isolation to interpersonal contact and intimacy. From this experience, he gives a glimpse into a possible future of such an approach:

Imagine a setting in which individuals and their families would . . . be in psychotherapy for a psychotic crisis and in which MDMA might be used. It would be in a secure outpatient environment or in the home. . . . MDMA would be used on a once per five-day basis, with psychotherapy continuing daily. There would be space and time for dedifferentiation and privacy. Exploration of anger, distance and negativity would be possible. . . . A family focus would enable exploration of the communication matrix and embedded injustice in the structure. (Wolfson, 1986: 333)

Wolfson thinks that embedded in an overall program of skilled psychotherapy, MDMA could be a new means to help those in torment (Wolfson, 1985: 13–14). Wolfson’s approach was not followed up on until 2014, when Wolfson became the principal investigator of a study using MDMA in psychotherapy with end-stage cancer patients (Wolfson, 2014).

Ralph Metzner: An academic psychotherapist

Ralph Metzner, a psychologist, was part of the Harvard-based research team that came across psilocybin and LSD in their search for creativity and personality change during the early 1960s. Another member of this team, psychologist Timothy Leary, later became a prominent figure in the 1960s psychedelic drug movement (Dass et al., 2010). By the late 1960s, Leary was in prison and Metzner, reluctant about psychedelics, turned to Yoga and eastern spiritual traditions. In 1983, Metzner first heard about the new drug MDMA. At an ARUPA meeting in Esalen he met Leo Zeff, who guided him in some MDMA sessions (Metzner, 1998a, 2013). Metzner also had sessions with Jack Downing, and they treated some patients together. Zeff used a very permissive approach with minimal therapeutic intervention (“I just give it to them and they do the therapy themselves”) (Metzner, 2013), but Metzner preferred to be more directive. During the years 1983–1985, Metzner became an expert in MDMA-assisted psychotherapy. In 1985, together with psychologist Padma Catell, he published a collection of first-hand descriptions of MDMA experiences (Adamson, 1985a). The book included the first comprehensive guide for the use of MDMA in psychotherapy and spiritual exploration. The guidelines were distilled from the work of two dozen therapists (Adamson, 1985b). They assert that intention or purpose is the most important factor for effective, beneficial use of MDMA in psychotherapy. Questions about self, personal life, and others should be put in writing in advance. Because MDMA induces a “state of extraordinarily heightened emotional intimacy” it is not advisable to initiate an ordinary sexual encounter when barriers to “to fears, concerns, and frustrations in the area of intimacy” are lowered. But it may be important to “agree that the physical touch of a hand on the heart, the shoulder, the head or the hand can be an important source of support and encouragement” (Adamson, 1985b: 183). Meditation or relaxation practices during the time immediately before a session were recommended. Like Ann Shulgin, they also mention the combination of MDMA with the mescaline derivative 2-CB, (4-bromo-2,5-dimethoxyphenethylamine) which they administered 2 hours after MDMA (Adamson, 1985b: 186). Mentioned as contraindications were

severe heart disease, high blood pressure, history of psychosis, diabetes, epilepsy, and pregnancy (Adamson, 1985b: 187). As the preferred mode for therapeutic sessions, a serene and comfortable room was recommended. In respect to music, he found “fast or highly complex music irritating and too difficult to follow.” He preferred serene, peaceful, and meditative music. Metzner was of the opinion that therapists should have used personally any substance they employ in therapy (Adamson, 1985b: 189). Further, the therapist should . . .

suggest to the voyager to go first as far and deeply within as they can, to the core or ground of being. . . . From this place of total centeredness, compassion and insight, one can review and analyze the usual problems and questions of one’s life. (Adamson, 1985b: 190)

They felt that “during the state of heightened, though balanced, emotional awareness, one can think clearly about the various options available, without the usual distortions caused by our emotional attractions and aversions” (Adamson, 1985b: 190). In respect to group sessions, Metzner characterizes two kinds. One kind is without group interaction, in which participants are expected to concentrate and follow their intrapsychic processes. Another approach is to allow some interaction and communication during the drug action (Adamson, 1985b: 192). In most cases, one to five sessions are recommended.

In respect to the mechanisms by which MDMA is thought to function, they write that MDMA helps in “facilitating a significant opening of relationship communication and . . . in the healing of disabling trauma” (Metzner, 1997/1998: 287). The case of a traumatized Vietnam veteran, treated by Metzner in 1984, provides an impressive example (Metzner, 2011). In a 1988 publication on MDMA-assisted psychotherapy, Metzner and Catell described as their primary thesis “that the empathogenic substances induce an experience that has the potential for dissolving the defensive intrapsychic separation between spirit, mind, and body, and that therefore physical healing, psychological problem solving and spiritual awareness . . . usually do co-occur in the same experience. . . . Thus, instinctual awareness, as well as mental, emotional, and sensory awareness, can all function together, rather than [one] being the focus at the expense of the other” (Adamson and Metzner, 1988: 59, 60). The most important therapeutic implications of the MDMA induced state is that “[p]atients have empathy and compassion for themselves, for their ordinary, neurotic, childish, struggling persona or ego” (Adamson and Metzner, 1988: 60). In addition, “the psychological problem-solving that occurs is also most frequently a shift in perspective, a reframing of

the belief that may also be healing.” And “individuals are able, if their intention in taking the substance is serious and therapeutic, to use the state to resolve long-standing intrapsychic conflicts of interpersonal problems in relationships” (Adamson and Metzner, 1988: 59).

Since 1985, Metzner has been instrumental in bringing the knowledge of therapeutic MDMA use to Europe (Styk, 2012, personal communication). Based on his extensive knowledge, Metzner later developed “hybrid shamanic therapeutic rituals,” combining features of shamanism and western psychotherapy for therapeutic sessions with MDMA and other psychedelics (Metzner, 1998b).

The Earth Metabolic Design Laboratories, Inc. (EMDL)

EMDL was set up in 1984 as a formal organization to support and coordinate the opposition against the proposed scheduling of MDMA. It was “a group of self-described physicians, researchers and lawyers” participating in the preparation of data and providing funding for the hearing and to initiate studies in humans and toxicological animal studies (Earth Metabolic Design Laboratories, 1984a: 2). Directors were Rick Doblin, Alise Agar, and Deborah Harlow. The Board of Advisors included James Bakalar, Francesco Di Leo, Jack Downing, George Greer, Stanislav Grof, Stanley Krippner, Richard Price, Tom Roberts, Alexander and Ann Shulgin, Richard Yensen, and Leo Zeff (Earth Metabolic Design Laboratories, 1984b). EMDL set out to gather more than \$100,000 to fund six human studies with MDMA. These studies were to include an investigation of the routes of metabolism and physiological effects of MDMA in humans, a survey of physicians and therapists who administer MDMA, a pilot study to evaluate the use of MDMA as a training tool for the education of mental health professionals, a study designed to evaluate the use of MDMA in the treatment of psychological distress in cancer patients, an evaluation of the effects of MDMA in a controlled double-blind study, and a study investigating the effects of MDMA on insight and empathy within a psychotherapeutic context (Earth Metabolic Design Laboratories, 1984b: 9). EMDL played a significant role in the successful preparation of the hearings and the organization of some meetings promoting the use of MDMA in psychotherapy. It dissolved in 1986, shortly after the hearings. Following this, Doblin founded the *Multidisciplinary Association for Psychedelic Studies (MAPS)* in 1986 (Emerson et al., 2014) to fund, which has served successfully up to today to gather funding for clinical studies with involving MDMA (Emerson et al., 2014). It still operates today.

A survey of MDMA therapists

The therapist Deborah Harlow conducted MDMA-assisted psychotherapy with more than 200 clients before 1985 (Harlow, 1994). In 1984, Harlow conducted an exploratory survey for ARUPA of 16 therapists “who have either worked with MDMA or are well acquainted with its therapeutic use through colleagues’ research” (Association for the Responsible Use of Psychedelic Agents, 1984: 362). The therapists were asked to evaluate their experiences with MDMA with different kinds of mental disorders. They saw improvement in most of their patients, with especially good results in depression, phobias, alexithymia, and PTSD. Fifteen of sixteen therapists said that MDMA was valuable and effective in augmenting psychotherapy. Asked about specific psychodynamic changes, therapists mentioned less projection and rigidity, being less defensive and more accepting, and increased ego-strength. Indeed, one therapist reported that the significance of his guidance in therapy was reduced by “the work MDMA does with the patient” on its own (Harlow, 1997: 173). Harlow concluded that MDMA served especially to “re-structure early object relationships,” for example, to transform early imprints on later behavioral patterns. She also thought that MDMA could be a good “introduction” to other psychedelics, because it enables people to place trust in themselves in an altered state (Harlow, 1994: 220).

All of the interviewed therapists claimed that complications with the clinical use of MDMA were negligible and that its potential for abuse was not high because “(a) it is not physiologically addictive, (b) it produces very little effect if taken frequently, and (c) it lacks the hallucinatory or narcotic effects sought by escape-seekers” (Association for the Responsible Use of Psychedelic Agents, 1984: 363). Harlow’s survey was used as evidence during the hearings held about a possible prohibition of MDMA in late 1985.

The first psychophysiological study of MDMA in humans

In October 1984, a clinical study on the psychological and physiological effects of MDMA began in secrecy at a private house in Stinson Beach, California, initiated by EMDL and associated MDMA therapists. It was intended to gain objective data on the clinical effects of MDMA before it was scheduled. The study had neither Food and Drug Administration (FDA) approval (which was not necessary) nor the approval of an institutional review board, which some of the researchers involved thought would be appropriate but which was not sought so as to avert publicity.

The study was conducted under the direction of Leo Zeff at the home of Jack Downing, who was also the study’s clinical coordinator (Doblin, 2001: 374). Phil

Wolfson directed the neurobehavioral substudy. All 21 participants had previous personal experience with MDMA and underwent a physical examination.

The oral dose was in the range of 0.8–1.9 mg per kg bodyweight. Blood samples and cardiovascular parameter measures were taken from every subject. ECG's were taken from a subgroup. With 10 participants, neurological and neuropsychological tests were performed during the 24 hours after ingestion. All participants were asked to write a narrative about their experiences. The dose-dependent rise of blood pressure ranged between 20 and 40 mm Hg. Blood analyses and neurobehavioral tests showed only very small changes. Many participants reported euphoria and a subjective increase of physical and psychic energy. There were no grave sensory alterations, for example, pseudohallucinations. Some participants reported mild to moderate mood lifting for up to 24 hours. No complications or negative after-effects were found. Neuropsychological testing showed no alterations in memory, but deficits with mathematical performance occurred during the acute effects. The authors concluded that MDMA "has remarkably consistent and predictable psychological effects that are transient and free of clinically apparent major toxicity" (Downing, 1986b: 339). But they appropriately mentioned that

any drug that causes ataxia, elevates blood pressure and pulse is potentially unsafe. . . . Safety must exclude long-term toxicity. Not enough is known about MDMA's long-range effects. (Downing, 1986b: 339)

Results of the study were used to support the therapeutic viewpoint during the hearings on the scheduling of MDMA and published in 1986 (Downing, 1986b).

Conference at Esalen

The first publication on the therapeutic use of MDMA appeared under the title "Using MDMA in Psychotherapy" in the journal *Advances* in 1985. The paper reports on a conference held at the Esalen Institute on 13–15 March 1985 under the auspices of EMDL and ARUPA. According to Greer, many of the participants were experienced in treating patients with MDMA and "the combined clinical experience in using MDMA during the past several years totaled over a thousand sessions" (Greer, 1985a: 58).

Among the 35 participants were five veteran psychedelic researchers from the 1960s (Francisco DiLeo, Stanislav Grof, Robert Lynch, Claudio Naranjo, and Richard Yensen) and four psychiatrists. Lectures showed that compared to LSD, MDMA was much easier to handle clinically because it induced virtually no hallucinations or other forms of cognitive and sensory

alterations and left self-control intact. Beside some mild sympathomimetic effects, side-effects were limited to temporary anxiety in some cases, which were easy to manage. All participants agreed that "the drug reduced defensiveness and fear of emotional injury, thereby facilitating more direct expression of feelings and opinions and enabling people to receive both praise and criticism with more acceptance than usual" (Greer, 1985a: 58). From their experience, it appeared obvious that severely traumatized patients especially could profit enormously by enabling them to open up for positive communication and relationship experiences. Psychotherapy, family support, or conjoint therapy with use of MDMA were judged to be "essential components of the healing process" (Greer, 1985a: 58).

Physical abuse in MDMA-assisted psychotherapy

Having sexual contact with patients is a violation of professional ethics. In Massachusetts and other states in the 1980s, sexual contact was a crime only if it involved rape, sexual assault, or unlawful drug use. Medical experts, however, argued that any sexual contact during therapy should be considered a crime because people in therapy or under a doctor's care are too vulnerable and dependent to give informed consent. Kathleen Mogul, a psychiatrist of the American Psychiatric Association's ethics board, notes that the patient may even suffer from a sense of guilt because, unlike the rape victim, he or she may not have protested vehemently. Nevertheless, in a national survey of psychiatrists, more than 5% admitted that they had had sexual relations with patients (Diesenhouse, 1989). With respect to the early therapeutic use of MDMA, two cases became known. Rick Ingrassi, from Massachusetts, and Francesco DiLeo, a psychologist and psychotherapist practicing in Baltimore, administered MDMA to patients already in therapy with the intention of overcoming therapeutic blockages. In both cases, the therapists initiated intimate body contact, sexual touch, and intercourse during the MDMA sessions. Both therapists were sued and lost their licenses.

The case of Francesco DiLeo serves to illustrate both. He began twice-weekly psychotherapy sessions with the patient in 1981. In summer of 1985, "a therapeutic impasse" was reached because the patient was "unable to verbalize feelings she has for her therapist." DiLeo asked her if a MDMA session would be beneficial to her. In late 1985, he initiated the session and they "lay down on a mat together, and [DiLeo] began caressing and fondling her." In the third drug session, the therapist initiated sexual intercourse. After the sessions, the patient immediately terminated treatment. Shortly thereafter, she suffered from panic attacks and had difficulties functioning. Her physician diagnosed PTSD and anxiety neuroses. The court involved

later found this treatment “totally unacceptable, counter-therapeutic, and forbidden by the American Psychiatric Association” and awarded the patient \$200,000 for medical expenses and \$500,000 for other damages (Court of Special Appeals of Maryland, 1991).

The possibility of intimate physical relationships between therapist and patient occasionally occurs in standard psychotherapy, but its risk may be higher in drug-assisted psychotherapy, where the client has lower defenses and altered emotions and cognition. Clients may be less able to form and assert their will.

Deborah Harlow interviewed 20 psychotherapists who administered MDMA between 1980 and 1985. She called the Ingrasci case “a huge wake-up call” to be countered by the antidote of “really stringent rules” (Harlow, 2013: 33). Of special interest is what one therapist told her about the risk involved: “You know the person you’re sitting with . . . and they’ve suffered so much and they’ve been very closed down and then you see that person open up [on MDMA] and for the first time it’s like they become really beautiful to you and it’s like you see them in a sense like they’re the best they can be and in some cases you may actually fall in love with that person” (Harlow, 2013: 35). In another interpretation, patients given MDMA may project their good feelings onto the therapists in the sense of “this is about you, you gave me this, oh you are a goddess” (Harlow, 2013: 35). She also found that some people may feel tempted to use MDMA because they are not very well prepared to work with conventional psychotherapeutic methods (Harlow, 2013: 35). According to Harlow (2013), the case of Ingrasci led to the installation of a male and female co-therapist team as a rule in later scientific studies (Mithoefer et al., 2011; Oehen et al., 2013). The male–female dyad was later found to have other advantages, such as safety in case of emergencies, coverage if one therapist has to take a break, and an enhancement of the ability to cope with transference/counter-transference issues.

Therapists opposed to the scheduling of MDMA in 1985

On 27 July 1984, the DEA recommended that MDMA be placed in Schedule 1 of the Controlled Substances Act. On August 27, EMDL and a group of physicians, researchers, and therapists requested that the DEA grant a hearing on the proposed scheduling of MDMA. The intention of this action was to have MDMA unscheduled or placed in another schedule so that research could continue (Cotton, 1985). This request astonished the DEA. Their top chemist, Frank Sapienza, said “we had no idea psychiatrists were using it” (Sapienza in Adler, 1985: 96). Such hearings have to be held if there is resistance against a proposed scheduling of a substance, which might also

be a prescription drug. The hearings were held in 1985. After he heard witnesses from the DEA side as well as from the opponent’s side, the DEA’s administrative law judge who led the hearings concluded that MDMA does not have to be put in Schedule 1. He argued that MDMA had proven its therapeutic potential, can be handled without grave dangers in medically supervised settings, has no high potential for abuse and had not been proven toxic in humans. Nevertheless, the DEA decided to overrule the judge’s decision. EMDL and Lester Grinspoon, a Harvard professor of psychiatry and psychedelic drug expert, filed an appeal with the Boston Court of Appeals that ultimately failed but opened the so-called “Grinspoon window,” from 22 December 1987 to 22 March 1988, during which the DEA’s placement of MDMA in Schedule 1 was suspended as Grinspoon’s appeal was heard. The court ordered the DEA to reconsider its decision because the issue of a potential medical use had not been appropriately considered. The DEA did so and decided that “accepted medical use in the United States” requires FDA approval.

MDMA therapy goes underground

Beginning in the late 1970s, a few individuals with experience in MDMA-assisted therapy came from the United States to Germany and other European countries to continue their work. Ann Shulgin continued to be at the center of an international network of psychedelic therapists by virtue of her husband Alexander Shulgin, claimed that. . .

there were some psychotherapists and psychologists who used MDMA in the seventies, and when MDMA became illegal . . . many of them didn’t stop using it; its use went underground. . . . In both Europe and the United States, there has been a great deal of continuing work. (Shulgin and Shulgin, 2001)

Some evidence for this can be found in the books of British MDMA researcher Nicholas Saunders, who interviewed some underground therapists (cf. Saunders, 1997). One, known under the pseudonym “Andrew,” was a psychotherapist from California interested in LSD. He got to know Leo Zeff and MDMA in the late 1970s and hosted his first MDMA group session in 1980. Closely connected to a network of Gestalt therapists in Europe, he came into contact with therapists throughout Europe interested in learning how to conduct therapeutic MDMA sessions. Andrew and a few associates . . .

were doing this regularly, primarily in Germany, but also Austria, Switzerland, Holland, Hungary, and Czechoslovakia. We started gradually in 1981. By the

next year it really got going. . . . We sat for about twenty groups of twenty people per year. . . . Psychologists from different cities became interested in starting their own groups. (Andrew, 2004: 141)

In early 1985, the American MDMA therapist George Greer published his short “MDMA Users Manual” in the first German booklet on MDMA, which gave instructions and precautions for its use (Greer, 1985c). In mid-1985, when MDMA was still legal in Europe, a major “new age consciousness” conference with more than 500 participants was held in Todtmoos, a remote location in the Black Forest of Germany. At this time, MDMA became known to a broader public. For example, American MDMA therapist Ralph Metzner held a day-long workshop, including a MDMA session. This workshop ignited further interest among German psychotherapists, who were inspired to start psycholytic work again with MDMA, which was much easier to manage clinically than LSD. A year later, some of those therapists founded two now legendary entities. One was the “European College for the Study of Consciousness (ECSC)” lead by Professor Hanscarl Leuner, a leading European authority on psychedelics, and Albert Hofmann, the discoverer of LSD. The ECSC worked successfully to bring together scientists interested in the therapeutic use of psychoactive substances and altered states of consciousness (Scharfetter, 1994). The other entity was the “Swiss Physicians Society for Psycholytic Therapy (SAEPT),” with five of their members given permission to use MDMA and LSD in psychotherapy during the 1988–1993 period (Gasser, 1996; Styk, 1994). It is worth mentioning that until the mid-1990s MDMA wasn’t used as broadly as it would be later in the context of the rave dance movement (cf. Collin, 1998).

Obviously, it can’t reliably be estimated how much MDMA was used in underground psychotherapeutic work. My more than 10 knowledgeable informants gave evidence that it is likely that a few hundred therapists worldwide have ever used it underground. A realistic estimate would assume that in Europe alone, five to ten underground therapists which use MDMA-assisted therapy were active in the ten largest European countries. If these therapists are each giving 10 MDMA-assisted weekend group therapy sessions per year, with 12 to 15 patients each (the usual format), this results in approximately 10,000 therapeutic applications of MDMA per year. If the average number of sessions per patient is assumed to be five, this (probably conservative) estimate suggests that more than 2,000 people have been treated each year. If this is true, more than 60,000 patients may have been treated underground with MDMA-assisted therapy during the 1985–2017 timespan.

Discussion

When MDMA became known as a useful adjunct to psychotherapy in 1978, many psychotherapists were inspired by its power and efficacy. But not many were working with MDMA when it was still legal. An estimate from the relatively poor data available in the literature, supported by information provided personally to the author, is that a few dozen therapists used MDMA in a psychotherapeutic setting between 1978 and 1985. The majority of these therapists worked in California and other sites on the West Coast.

During this time, MDMA was neither an FDA-approved prescription drug nor a controlled substance. In California and some other states, it was completely legal to use MDMA in a physician’s practice if the substance was synthesized by the physician, informed consent was provided by the patient, and the treatment protocol was based on scientific literature and peer reviewed (Greer, 1985b: 190). It was documented that Alexander Shulgin helped Zeff, Greer, and Wolfson to synthesize MDMA (Greer, 2015; Wolfson, 1985).

It appears that MDMA was synthesized beginning in 1970 by underground chemists as a “legal MDA alternative” to circumvent the prohibition of MDA (Passie and Benzenhoefer, 2016). However, MDMA was not distributed widely in the 1970–1982 period. The DEA reviewed 751 illegal labs discovered during the 1978–1981 period. Sixteen had produced MDA, but none had produced MDMA (Frank, 1983: 29). This corroborates information from the US Drug Abuse Warning Network (DAWN) that there were only eight MDMA-related emergency room visits from 1977 to 1981 and none between 1982 and 1984. Thus, it is reasonable to assume that MDMA was not widely distributed before 1983 (Passie and Benzenhoefer, 2016).

Because MDMA was rather unknown until 1983, therapists were eager to avoid media attention, which had already led to the prohibition of the psychedelics like LSD and psilocybin. Therapists “were reluctant to publish any preliminary findings, fearing that such efforts would only hasten the criminalization of this still-legal ‘psychedelic’ and block further research” (Beck and Rosenbaum, 1994: 15). Shulgin obviously was following this strategy by not mentioning MDMA in his publications of 1978 through 1983 (cf. Shulgin, 1981; Shulgin, 1983). Doblin attributes some success to this strategy, claiming that for several years “Sasha [Shulgin] and others had been able to dissuade the media from reporting on MDMA” (Doblin, 2001: 376). Also for this reason, results of the study conducted by Greer and Tolbert were not published until 1983, when they were self-published and distributed only to “seriously interested psychotherapists” (Seymour, 1986: 40).

In 1984, when the DEA became aware that Michael Clegg, a theology student, had been distributing MDMA since 1983 in some Texas cities, it initiated the scheduling of MDMA. Some physicians opposed the scheduling. They were ultimately unsuccessful, but they were able to make their views on the potential of MDMA-assisted psychotherapy known to the public. In 1985, some positive articles on the therapeutic use of MDMA appeared in the mainstream press. For example, a *Newsweek* magazine article documented the therapeutic work of Greer and Tolbert (Adler, 1985). After publicity efforts such as informing individual members of the committee about MDMA's psychotherapeutic uses, proponents won some support in a statement of the World Health Organization's *Expert Committee on Drug Dependence*, which scheduled MDMA internationally in late 1985:

It should be noted that the Expert Committee held extensive discussions concerning the reported therapeutic usefulness of 3,4-methylenedioxymethamphetamine. While the Expert Committee found the reports intriguing, it felt that the studies lacked the appropriate methodological design necessary to ascertain the reliability of the observations. There was, however, sufficient interest expressed to recommend that investigations be encouraged to follow up these preliminary findings. To that end, the Expert Committee urged countries to use the provisions of article 7 of the Convention on Psychotropic Substances to facilitate research on this interesting substance. (World Health Organization, 1985: 25)

As reflected in the statement of the WHO's expert committee, the question of methodologically sound research was critical. As Sidney Cohen, a former LSD researcher, suggested, "[i]f scientists want to study it, let them file an Investigational New Drug application with the Food and Drug Administration" (Cohen in Shafer, 1985: 69). This sounds easy, but the therapists feared that if MDMA was being scheduled, all therapeutic research would be stopped. In retrospect, this skepticism was realistic. However, there was no way to deny the necessity of appropriate scientific research.

Immediately after its scheduling, MDMA proponent Rick Doblin was eager to initiate animal toxicological studies, a necessary requirement for any further studies in humans. These were completed in 1985 (Frith et al., 1987), and a FDA master file for MDMA, still in use today, was established from these data (Emerson et al., 2014).

Five different IND applications to conduct research with MDMA (on groups of volunteers or single patients) were submitted to the FDA between 1986 and 1988. All five were routed for review but placed

on clinical hold, effectively blocking them. The FDA based its rationale for rejection on the hypothetical risks of MDMA neurotoxicity (Doblin, 2000: 65). A later protocol by Charles Grob (Harbor-UCLA Medical Center) to assess MDMA's effects in terminal cancer patients with anxiety was reviewed and rejected by the FDA in 1992. The FDA recommended performing a study in healthy volunteers for gaining safety data. Grob applied for such a study and was able to start the first FDA-approved MDMA study in humans in 1992 (Grob et al., 1996).

Group therapy favored by MDMA

While MDMA was used at first mainly in individual sessions, as was LSD, it quickly became obvious to most therapists that it can easily be used in group settings. This is in contrast to conventional psychedelic and psycholytic work, where individual settings were more common (e.g., Caldwell, 1968; Grof, 1980). MDMA appears to have advantages for group settings because of its capacity to help people free themselves from interpersonal distrust and communication blocks without interfering with cognition. Two approaches to group therapy were established. One involved instructing the participants to focus on themselves and to engage in inward-directed reflection as the major purpose of the session. The other approach, represented by Naranjo and Metzner, sees interpersonal contact during the session as a central part of the therapeutic process. It is noteworthy that members of the Swiss SÄPT Society, given individual permission for MDMA-assisted psychotherapy in 1988, used a communicative group-therapy approach (Gasser, 1996; Passie, 2007).

Indications, precautions, and session guidelines

Virtually all therapists mentioned that facilitators should only use substances they had taken themselves (Adamson, 1985b: 189). Taking MDMA together with the patient was found to be counterproductive and was soon abandoned (e.g., Ann Shulgin).

The contraindications noted consistently by early therapists were disease affecting any internal organ, high blood pressure, diabetes, epilepsy, pregnancy, and history of psychosis. These address the sympathomimetic effects of MDMA, which are higher compared to LSD or psilocybin. However, the safety profile was very good overall, and the side effects of MDMA, all mild, included nausea, dizziness, increased heart rate, and transient anxiety. No allergic reactions are known.

The preparation of the patients was usually done in a few (minimal) individual psychotherapeutic sessions before the MDMA session to establish "a confident and trusting relationship" (Greer, 1985b). When

people did sessions primarily for personal growth, one to three preparatory sessions were found to be sufficient (Greer, 2017). Naranjo did one preparatory individual interview with those group members he had not met before. In addition, a group session at the first day of a weekend workshop was “devoted to personal information, for sharing the expression of interpersonal emotions and for the clarification of individual expectations” (Naranjo, 1989b: 187).

A quiet, comfortable, and protected environment with a living-room atmosphere was recommended. The wearing of eyeshades and headphones with instrumental music during the acute effects was recommended. The usual dose was 125 mg MDMA orally, optionally followed by a 40 mg dose approximately 90 minutes later. Some therapists recommended overnight fasting previous to session days for fuller absorption and to prevent nausea or vomiting. In the course of, for example, a year-long psychodynamic psychotherapy, one to five MDMA sessions were thought to be sufficient (e.g., Ingrasci, 1985). With respect to group size, 12–16 was considered ideal (Adamson and Metzner, 1988; Naranjo, 1989: 107/108; Zeff in Stolaroff, 2004). If group therapy is conducted, more than one therapist should be on-site. All of the indications explored by early MDMA therapists—including trauma, anxiety associated with terminal cancer, psychoneuroses, and couples—were also mentioned in later research.

Session agreements and instructions

The “agreements” and instructions for conducting a session as given by the different therapists (Adamson, 1985b; Greer, 1985a: 192; Naranjo, 1989: 107/108) can be summarized as follows.

Advance agreements

1. Everyone will remain on the premises until all agree that the session is over.
2. No one leaves the session site before all have agreed to allow it.
3. No sexual activity during the MDMA session.
4. No aggressive/destructive activities toward self, others, or property.
5. Follow any explicit instructions given by a facilitator.

Session instructions

1. Intention and purpose are important factors for a beneficial experience.
2. Questions about self, personal life, and others should be put forward in advance.

3. Seek a balance between spontaneity and noninterference.
4. Perceive MDMA’s effects with an attitude of self-observation and goal-less effortlessness.
5. Establish contact with other group members after a sufficient time of “self-immersion.”
6. Participate in an integrative session afterwards.

According to some early therapists, immediately before the taking the drug, patients should center themselves by speaking about their actual situation, where they are at this point in his life and how that relates to their individual biographical dispositions. Possibly acute and chronic issues, as well as questions about them, should be articulated. When the session starts, the therapist should “suggest to the voyager to first go as far and deeply within as they can, to the core or ground of being.” From this place of total centeredness, compassion, and insight, one can review and analyze the usual problems and questions of one’s life. It was found that “during the state of heightened, though balanced, emotional awareness, one can think clearly about the various options available, without the usual distortions caused by our emotional attractions and aversions” (Adamson, 1985b: 190). After the acute effects are over, the patient still needs (and can make use of) a quiet and protected place. He usually stays where the session was conducted for the following night. On the next day an “integration session” can be conducted, with the possibility for participants to discuss in retrospect their experience. Interestingly, this general format was also established as a typical format by many other underground therapists (Passie, 2007).

In respect to the therapist’s attitude and actions, the purpose is to activate patient self-healing. An important requirement for this is a caring and trusting relationship in the therapeutic dyad. In general, a modulated and nondirective attitude is recommended. “The facilitators should be available for contact and interaction, but should not initiate such contact” (Greer, 1985b: 192–193).

In respect to body contact, because of the “state of extraordinarily heightened emotional intimacy” induced by MDMA, sexual contact is not advisable. However, some body contact was allowed if agreed on before. “The physical touch of a hand on the heart, the shoulder, the head or the hand can be an important source of support and encouragement” (Adamson, 1985b: 183). Part of MDMA’s effect is the enhanced trust in one’s own body and feelings. Therefore, the body becomes an integral part of the therapeutic process (Adamson, 1988; Passie, 2012). The issue of body contact is somewhat specific to MDMA therapy, in contrast to psychedelics like LSD and psilocybin, because these do not engender as much

added interpersonal openness and longing for body contact (cf. Grof, 1980). This issue may be also relevant in respect to possible physical abuse of patients.

MDMA and the revival of psychoactive psychedelic therapy

In retrospect, it appears that since the 1980s MDMA has been at the forefront of another wave of psychoactive substance-augmented therapy. This follows the abandonment of therapeutic work with LSD and psilocybin after much research with these substances in the 1960s (cf. Passie, 1997). Interestingly, the last official studies with hallucinogen-assisted psychotherapy, which ended in the 1970s, used MDA (Yensen et al., 1976), a substance closely related to MDMA. MDA was also a favorite drug of underground therapy. It makes sense that a MDA-related substance with less cognitive and sensory distortion would be the “next step” for psychedelic-assisted psychotherapy, and its benign effects made MDMA the drug of choice for many therapists. A timeline can be drawn from the MDMA hearings in 1985 to the work of the Swiss SÄPT therapists in 1988–1993, through the research and congresses initiated by the ECSC (1986–2000). It currently ends at the placebo-controlled studies with MDMA therapy in the United States after 2004 (Mithoefer et al. 2011), including the currently anticipated Phase 3 trials to establish MDMA as a prescription medicine for the use in psychotherapy for PTSD, and a possible future FDA approval of MDMA for the treatment of PTSD (Philipps, 2016).

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