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Meetings at the Edge with Adam: A Man for All Seasons?

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Since becoming a psychotherapist in the late 1960's, this author has had a passionate involvement with people experiencing painful altered states of consciousness. While there has been a group of explorers who have consistently emphasized the possibilities for positive growth and development from within the psychotic process, success has remained practitioner relative and mostly anecdotal, with techniques and approaches that tend to be nonreplicable.

With an absence of valid statistical data, psychotherapeutic strategies of promise are marginalized by mainstream drug studies that are more easily formalized statistically and even occasionally double blind. Yet the political and theoretical ascendancy of biological psychiatry is confounded by the minions of treatment failures who inhabit county and state mental health systems, an ever-widening stream of misery.

In this author's search for new methods and resources to deal with limited success (and even in the hands of the best therapist, success is only limited), discovering MDMA opened the possibility for some new help in the complex and difficult process of psychotherapy. Using MDMA as an adjunctive agent within an overall psychotherapeutic approach with individuals and families in severe crises, a potentiality was revealed. Unfortunately, perhaps even tragically, this exploration was aborted by the sudden decision by the Drug Enforcement Administration to illegalize the substance.

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A CASE REPORT

Some months ago, a client (Lou) complained that MDMA had lied. He is a man in his early fifties who had embarked on a difficult exploration of this longstanding depression, a characterological tendency to see himself as an emotionally incompetent human being who delegated the work of the heart to his wife (Sara).

In the twists and turns of their life cycle they had graduated four sons, the third (Mel) having returned to haunt their middle years with a terrible unending siege of paranoid madness and a steadfast refusal to respond to the noblest, most heartfelt of ministrations—no matter what the source. The wife turned herself inside out searching for solutions to her son's affliction, saving him from one paranoid horror after another, transporting him to the best institutions from which he would inevitably flee, scouring herself for the secret to the mystery of his recalcitrance and distance. Psychiatrists of many persuasions were consulted. Rebirthing was attempted, with the mother bottle feeding her giant infant. Family therapy was initiated with siblings and husband, all dutifully flying in to do their share in the saving. Vast amounts of money, energy, loving, pleading and praying were expended. Regrettably, the more that was applied, the farther away he fled—in actual physical flight back and forth across the country or into sheer willful misbehavior. In fact, it might be said that what was retained in his massive regression was only the childish foot-stomping insistence on his way, no matter what the whim.

When an adult child has a break, the parental world

turns upside down. Roles that were in transformation toward equalization, friendship and independence lurch back to desperate modes of bonding and reparenting. A search for causality often leads to blame, splitting and wrangling between parents over responsibilities—past, present and future. The emptied nest turns into a pit with a giant, ungainly and insatiable pseudofledgling who occupies inordinate space.

PROBLEMS WITH PSYCHIATRY

In this crucible of concern, old patterns of communication are resurrected and a reciprocal disqualification of the other may take place. The specter of failure hovers and a sense of the possibility of endless dependence emerges. All of this may only delay the necessary task of regraduating the child despite wrenched hearts and protestations of incompetence.

To this internal family dilemma is added the confusion of the psychiatric profession: the strangeness of the diagnostic process; the disagreements between practitioners over labeling, treatment choices and prognosis; and a tendency to blame parents or to eliminate them from the treatment process—all contribute to a terrible muddle. One paradigm emphasizes chemical imbalance as etiologic, another stresses self-responsibility. Epistemologies clash with no clear guidance through the philosophical minefield. The inevitable cornucopia of medication pours its wares into the resisting child. All too often the results are negative and frightening. For example, a child may be reduced in a matter of days to a gray zombielike shell inhabiting a terrifying milieu in which no privacy exists for this terribly frightened person. A world of strange people—staff and patients—mill about in uncertain communion, with struggles for trust and relationship occurring under the most difficult conditions with the most distressed of humans.

If this picture is grim, it is all too representative of the experience. From the parental purview, the nightmare of this situation is bewildering, alienating and disempowering. From the child's purview, there is often unremitting traumatization and a terror of mental states that are all too often iatrogenic, deriving from both chemical and setting aspects.

A CASE REPORT—CONTINUED

For Lou and Sara, the experience of their son's sudden madness brought old unresolved differences to the surface. Symbolization of the father as soul murderer by the child raised feelings of anger and blame in the mother toward her husband. Role differentiation, which had been accepted on the surface by both parents, was called into question as a totality, while the inadequacies of both parties were thrown into stark relief. Polarization into the "angry bitch" and "withholding male" roles compromised the task of sharing the burden of assisting their extremely difficult child. Holding back from the fray, Lou once again left the emotional work to Sara, while she in turn punished Lou by withdrawing her pleasuring and maternal caring from her husband. As exhaustion and discontent sapped the couple, the child would further split them by shifting loyalties. In this desperation, acting out or divorce became more and more attractive for both parties.

Confronted with a disintegrating family situation, chronicity and inability to either seek help or bond except from a distance on the part of the identified patient, a choice to use MDMA in a series of sessions was made. The aim was to provide a context in which defensiveness and character armor would diminish in favor of frank communication and sensitivity to the other's perspectives and feelings. Diminution of negativity and reduction in paranoia and distrust were other important goals. Strengthening family bonds throughout the triadic matrix was viewed as essential to the recovery of the adult child, with independence—even with significant symptomatology—deemed as essential for long-term prospects of recovery. Equalization of parental responsibilities to provide mutual parental nurturance and reliability was viewed as necessary for the health of the marriage. Overall, these goals were compatible with structural family therapy approaches to this problem, with MDMA seen as potentially facilitating and shortening the time frame for accomplishment of the therapy.

There was an initial blush of excitement and change after Sara and her 24-year-old son had a session. It was her first experience with a mind-altering substance and the effect was profound. Despite a year and a half of awfulness and distrust, Mel experienced warmth and closeness that generated a sense of hopefulness, some calm in the storm and the possibility of sufficient closeness to allow for a therapeutic alliance and a positive relationship with his mother.

But in novel territory there are always (fortunately) surprises. In working with individuals who manifest extreme forms of borderline personality disorganization, it is common to experience a shattering withdrawal after sudden unexpected intimacy. Mel reacted within two days of his experience, fleeing into a hypomanic delusional state, then settling into a more comfortable distance from all. A second session, 10 days later, consolidated his sense of difference from other family members, increased his ability to cope with the delusions that he continued to experience and enabled him to view himself as a potentially redeemable human being from the ape image he carried

of himself. For the first time in over a year, the family returned home in a hopeful state of anticipation.

Unfortunately, timing was of the essence—a period of stagnant waiting occurred—and the therapeutic bond was not established before decompensation resulted. By the time Mel returned to the San Francisco Bay Area, he was in a moderate manic-paranoid state and hospitalization inevitably occurred. Now, a year later, with many months more of dark periods in locked units on neuroleptics, with intermittent odysseys based on delusions and hopeful exits from his psychosis, Mel has finally 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.

For Lou and Sara, Mel's ongoing struggles have contributed to distance, anger and blame—life's laundry lists of discontents and recriminations binding them into strife and fear for their future. Over a year's time, MDMA sessions with the couple together and separately as individuals were held. This was adjunctive to ongoing psychotherapy. Periods of growth and movement occurred, interspersed with difficulties. The initial glow of relaxation and hopefulness moved to an intense two-month-long episode of anxiety on Sara's part. Improvement in the sexual sphere was followed by mutual disappointment and withdrawal when a breakthrough into new, more satisfying patterns was not achieved.

Yet, with all the spasms, steps forward and back, change and development were occurring. Sharing of responsibility for Mel's welfare became more of a dual function, with Lou moving in to do some of the emotional tasks. Lou's depression began to have moments of relief, accompanied by a new sense of competency and self-appreciation. Meanwhile, Sara worked on untangling the web of bitterness at her own suppression and fixedness—voluntary and unconscious. Recognition of their need to create some independence and distance from Mel, despite his neediness and vulnerability, enabled an exit from the constant cliff-hanging anticipation of dreadful events. As of this writing, Sara and Lou are in a more respectful attitude toward self and each other. They are committed to an open exploration.

This case is presented as an indication of the complexities of the psychotherapeutic process. Growth and change occur over time with ebb and flow. Success is far from guaranteed and significant shifts in attitude and behavior require singular effort and understanding on everyone's part. In this therapeutic crucible, MDMA can and has played a unique adjunctive role. Lou had made the remarkable comment that MDMA lies. This author's response was that MDMA promises. 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. An integration needs to occur for this remarkable attitude to take root as a guide to life. This is a multifactorial problem that requires the same diligence as any other discipline. In this lies the art of psychotherapy and the wisdom hopefully to absorb MDMA's offer of training.

THE TRUTH OF MDMA

The fundamental truth is that MDMA provides in its totality an unprecedented access to an experience that human beings value and may wish to have an opportunity to repeat at a future date. The second part of this truth is the almost uniform observation that those who have had the MDMA experience wish to share it with others and believe it has the power to alter lives, and even societies, positively. Nor has anyone been able to say otherwise after hundreds of thousands of experiences with MDMA. This is the completion of the fundamental truth: There are almost no critics of the experience itself. The stories told are of compassionate evaluation of the self and others with a shift to a more positive outlook and behavior.

Are there hazards and difficulties possible? Absolutely! The limited clinical experience (cut short by arbitrary emergency scheduling) has yielded the following information:

1. Idiopathic, severe and potentially fatal reactions can occur, seemingly similar to experience with MDA. MDMA is a chemical that has powerful central nervous system effects, and as with all chemicals, singular responses may unpredictably occur (Hayner & McKinney 1986).
2. There are anecdotal reports of seizures occurring. Whether or not there is a lowering of the seizure threshold is an open question.
3. MDMA may reduce resistance to infection. An increase in viral respiratory infections seems related to use in some individuals.
4. MDMA has significant cardiovascular effects, including tachycardia and a transitory increase in blood pressure. There is no established record of safety in those who have cardiovascular disease (Downing 1986).
5. A variety of short-term neurological and psychological phenomena occur and may persist or recur for several months. These manifestations include periods of significant anxiety, as well as anorexia, insomnia and flashbacks. Jaw tension may persist

for several days. A heightened sense of excitement and energy may interfere with judgment. Headaches as well as a sense of inertia and fatigue may persist for 24 to 48 hours after use. With respect to this latter problem, there appear to be two groups of individuals who display different responses: those who have normal or increased levels of energy and those who experience the dissipated state.

6. There is no established record of safety. The work just has not been done. On the other hand, MDMA users are not dropping like flies. Adequate animal and human experiments need to be conducted to establish safety margins. Cross-reactivity with other substances is also unknown.
7. There is absolutely no basis for causation of dependence or escalating use. Individuals are anecdotally reported to have injected MDMA in high doses, to have taken megadoses of the substance orally and to have combined MDMA with innumerable other substances. This is far from the general pattern of infrequent episodic use (Young 1986).

What makes MDMA a unique and special substance? The following statements are offered, which are based on the limited clinical experience available:

1. MDMA offers the possibility for a rapid and significant break with defensive structures that are a product of cumulative traumata and communicational disqualification.[1] Psychic integration and new identity structures are possible with the psychotherapeutic use of MDMA.
2. An MDMA experience offers the possibility of a shift from a negativistic self-hating state of being to one in which heartfelt feelings and love of self and others are possible (Greer 1983).
3. There is the encouragement of a shift from autism and isolation to interpersonal contact and intimacy; from withholding to giving.
4. In shifting affect to the positive side, facilitation of decision making may occur.
5. In making necessary a three- to five-hour contact between therapist and client, the process of psychotherapy is revolutionized. Imagine the effect on humankind if the 50-minute hour became the three-hour session.

This then is the substrate, the potential that the substance offers in engagement with the set of participants and the setting of the session. Because some of this author's work has focused uniquely on the use of MDMA with psychotic persons and their families, some comments on this area of exploration will be offered.

It remains to be established that MDMA is an effective adjunctive agent in the treatment of psychosis. There is a volume of experience indicating that MDMA is effective in the treatment of depression (including melancholia), marital discord and couple's therapy as well as perhaps in the treatment of psychogenic pain disorders. This author's work suggests that MDMA used in the appropriate setting over time, with ongoing psychotherapy and the possible concordant use of traditional psychoactive agents, offers unique possibilities for the treatment of psychosis.

This is not an issue of small consequence. Consider the following:

1. Two to three million individuals in this country are to varying degrees living lives of chronicity: asexual, broke, unproductive and stripped of hope, family and aspiration. There is a process in moving toward this way of life and it occurs in engagement with psychiatry and its drugs and institutions. The obligation of progressive psychiatry/psychology is the prevention of such misery. Given the terrible toll, it is also a social obligation of far greater consequence than almost any other.
2. Biologically oriented psychiatry appears in the ascendant position relative to the humanist camps impact on the psychiatric process. Electroconvulsive therapy is back and more popular than ever, and while the clinical practice of biological psychiatry has remained virtually the same over a 20-year period, there is evermore esoteric information on neurotransmitters, and uses for new potent drugs when their use in psychosis is at an equilibrium with respect to effectiveness. No new chemical agent of importance has been placed in psychiatry's hands since the introduction of haloperidol almost 20 years ago.
3. Despite claims to the contrary, the number of treatment failures remains extraordinarily excessive and the development of effective new substances for the treatment of psychosis is boxed in by the specter of abuse. That is to say, if a substance is desired by human beings, it is taboo to the psychiatric and governmental bureaucrats. The consequence is that antipsychotic agents demonstrate poor compliance with prescription. Few patients take them without significant struggle and distaste, persuaded only by new episodes of hospitalization and constant badgering.
4. Research into new agents is constrained by the necessary absence-of-pleasurable or energy-giving properties. Is this not a total dead end, or

the height of human folly?

An ideal antipsychotic agent would probably have the following properties: (1) It would maintain or increase the sense of nonpsychotic identity; (2) It would reduce agitation and paranoia as well as pathological defenses, such as splitting and severe negativism; (3) It would enhance communication and affection; (4) It would facilitate meaningful goal-directed action to reduce environmental stress and to enhance decision making; (5) It would have a rapid onset of action and rapid elimination; and (6) It would have a low incidence of short-term and long-term adverse effects.

Consider then the neuroleptics (e.g., chlorpromazine, haloperidol). They create a dissociative zombielike effect, depending on dosage, and there is a profound loss of identity. Their effectiveness is based on sedation without sleep, the so-called antipsychotic action. They are effective in reducing agitation, but paranoia often remains as an internal experience. There is marked flattening of affect, and often depression. Some psychiatrists prescribe amphetamines conjointly to provide some feeling of energy to counteract the awful sluggishness. Furthermore, most patients ingest huge amounts of caffeine and tobacco (nicotine) as an antidote. They often create a profound amotivational syndrome. They have a slow onset and long halflife. There are a multitude of adverse effects (e.g., the Neuroleptic Malignant Syndrome), including the possibility of permanent brain damage and death.

Compare then the properties of MDMA and the exciting potential for future substances of this new class of drugs. Is there any question that the experience amassed thus far is grounds for the most serious investigation?

Imagine a setting in which individuals and their families would on a voluntary basis 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. There would be ongoing support for the duration of the crisis. 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 and such states accepted rather than condemned. A family focus would enable exploration of the communication matrix and embedded injustice in the structure. Long-term availability for programs that would enable vocational and personal growth would be component parts.

This is a possibility that MDMA's availability would facilitate. Is there any doubt that this is an opportunity to be explored with the utmost seriousness?

NOTES

1. In the Laingian sense, communication is either agreed with, disagreed with or disqualified in myriad ways. Disqualification is the source category for most works on interactive psychotherapy.

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