

# Open MDMA: An Open Source Framework and Practical Guide for the Therapeutic use of MDMA

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DRAFT Version 0.31 July 31, 2024. It's still a messy, unfinished draft in need of some corrections. SAFETY RECOMMENDATIONS ARE UNDERGOING MAJOR REVISIONS.

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Please send us comments at [mgroeneveld@protonmail.ch](mailto:mgroeneveld@protonmail.ch), especially if you spot an error! Please let us know what is helpful and what is not helpful, as well as general impressions. Considerate reviews will help us refine this work.

If you share this document, please use this link to ensure people have the latest version: [doi.org/10.31234/osf.io/aps5g](https://doi.org/10.31234/osf.io/aps5g). This site also keeps tallies downloads, informing us how many people are using the guide and how worthwhile it is to update it with new research.

If you feel inspired and want to help us continue this work, we accept donations sent to [mgroeneveld@protonmail.ch](mailto:mgroeneveld@protonmail.ch) on Zelle, Venmo, or Paypal. We spent about 600 hours on this project, not including most of the acquisition of relevant skills and knowledge.

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## Abstract

This paper presents a comprehensive, evidence-based framework for the therapeutic use of MDMA, addressing both professionally-guided and self-guided (not recommended, but may be the least-worst option in some circumstances) approaches. We synthesize current research on the neurobiology of trauma, focusing on maladaptive schemas and memory reconsolidation as key mechanisms of MDMA-assisted therapy. The efficacy of this treatment modality is reviewed, drawing on recent clinical trials demonstrating significant improvements in PTSD symptoms.

We provide detailed guidance on the practice of MDMA-assisted therapy, including safety considerations, dosing protocols, session preparation, therapeutic processes, and post-session integration. The paper addresses common challenges such as anxiety and dissociation during sessions, offering strategies for their management. Long-term therapeutic trends and complementary practices are also discussed.

While acknowledging the potential benefits of MDMA-assisted therapy for various mental health conditions, we emphasize the importance of careful risk assessment, particularly for self-guided approaches. The paper explores broader implications of this therapy, including its potential to expand compassion and cognitive flexibility.

This manual aims to enhance the accessibility, safety, and effectiveness of MDMA-assisted therapy by consolidating current scientific understanding and best practices in a practically-usable format.

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# META (Remove before publication)

Goals:

- Broad audience -> Avoid language or references that may unnecessarily activate challenging schemas for various large groups. Avoid unnecessarily technical language. Minimize length so people aren't scared away and can readily digest it. Conciseness and lack of useless wordiness for better readability. Audience feels guide is reputable, safe, and high quality.
- Achievable writing task (knowledge and time) -> Only attempt to write manual for an audience open to a neurological/egalitarian framing of trauma and healing. I can only write recommendations that I know are good within the culture I live in. It might also be appealing to the more diverse, spreading Modern Global Individualist culture? Probably less applicable to more different cultures.
- Maximize healing and minimize risk -> Comprehensive. Rigorous. Proper balance between risk-warning language and healing-hopeful language so we don't unnecessarily scare people away OR fail to adequately warn about real risks. Most people doing healing need a lot more than reconsolidation; include broadly useful resources on emotional skills.
- Avoid legal risk -> Disclaimer and wording.
- Improve authors' understanding of concepts -> Rigor. Comprehensiveness. Usefulness to broad audience.
- Improve authors' reputation -> Publish in a journal (J. Psychedelic Psychiatry looks like a good fit. If all else fails, can still put it on Psyarxiv.). Rigor. Comprehensiveness. Usefulness to broad audience. More care to not openly endorse solo use of illegal drugs.
- Want to be useful as FAQ or supplemental material for guides and therapists. Should consult one to see what they would want in such a document!
- Help Mark (and others who think like me) understand what is actually happening in trauma and healing. Psychologists, psychiatrists, and therapists rarely told me what was actually happening to me, and when they did, it was presented in baffling, ill-defined metaphors. -> Construct a rigorous, science-based explanation of trauma and therapy.

Known Issues, Uncertainties, and Missing Things:

- Chatbot review prompt (upload entire paper but specify which section you want it to review): This paper is intended as a scientifically rigorous framework for professionally-guided and self-guided MDMA-therapy for a variety of audiences. Help my copyedit it. Suggest improvements for ease of comprehension, logical flow, active voice, conciseness, avoidable stimuli for challenging schemas for a wide variety of groups, and technical accuracy and comprehensiveness. Identify any claims out-of-line with the

scientific literature. Don't assume citations back up my conclusions. Identify gaps in my coverage of a topic. Suggestions should especially include opportunities to reduce the length of sentences and paragraphs through more efficient phrasing and removal of unnecessary words. Suggest important additions, subtractions, or mergers of items in the lists in my paper. Deliver your responses in narrative format. List all suggestions. Tone down your recommendations to never do anything without a medical professional. We already know.

- Review bibliography for missing information like volume numbers. Write out full first names in bib then make bibtex only say first initial. Try to eliminate non-peer-reviewed sources.
- Change reconsolidation to MR?
- Discuss how to choose which things to work on? How do you feel in your body about the thing you want to work on? Pull it out by the roots.
- Some misc references have access date instead of publish date when a publish date wasn't available.
- I'm skeptical that dissociation can be adaptive when activated by maladaptive schemas. Dissociation is an ANS response to life-threats. So it's definitely adaptive when a lion caught you, probably adaptive when you're a neglected child, and unclearly adaptive when you're an adult facing overwhelming feelings? Overwhelming feelings might or might not be a life threat depending on context. So when can we assume dissociation in adults is adaptive or maladaptive? Not sure ANS is sophisticated enough to make sure its responses are always adaptive.
- Talk about making schemas explicit as a means for more effective reconsolidation and management?
- When/why do schemas deactivate?
- TRUST THE PROCESS OF RECONSOLIDATION as long as destabilization is manageable. Things may be distressing and confusing but AS LONG AS YOU ARE RECONSOLIDATING THEN YOU ARE MAKING PROGRESS TOWARD STABILITY.
- Maybe we should synchronize use of we, us, you, one, etc.
- Include risks of maladaptive schemas and extended defense cascade to balance tradeoffs
- Most of the citations need to be made more rigorous (the referenced material backs up the exact claim I make, referenced material is peer-reviewed if possible) and in APA style. Sections starting with \*\* have had this process completed.

# Preface

The process of therapy (fundamentally memory reconsolidation, though many techniques can activate this process) has the potential to heal not just mental illness, but a wide range of maladaptive patterns ranging from the implicit biases driving toxic politics, to insecurity, escapism, disconnection, and more. Traditional psychotherapy strongly relies on the client finding a practitioner they match well with, is expensive, has trouble making progress in the presence of strong resistance, dissociation, or panic, has significant drop-out rates, and frequently doesn't work. The psychedelic-therapy renaissance has emerged partly as a response to these challenges. While we believe a variety of psychedelics have positive roles to play in therapy, we focus on MDMA because of our personal experience and MDMA's relative ease of use for those with trauma.

Our deepest desire in this work is aiding the wellbeing and cooperation of all beings through the unlearning of maladaptive emotional learnings and practicing compassion. However, we have our own maladaptive beliefs, and may have projected them into this work in unhelpful ways despite attempting to correct for that. We've tried to be critical of the things we're enthusiastic about, but inevitably our biases have pushed us to be overly critical of some things and credulous about others. We try to strike a balance between practical applicability and scientific robustness but recognize that that balance means this document is optimally adapted to neither case. In addition, the scope of this document presents some problems. We have expertise in some aspects of MDMA-therapy, but are not research experts on a majority of the individual pieces of this document. Hence, while we have done our best to critically evaluate the evidence and our references, we will certainly have missed some nuances only visible to certain subject matter experts. Our core assumptions and our confidence for them are laid out in the introduction. The core ideas of the guide are likely solid, however, some of our citations will inevitably not reproduce in further experiments. Reproducible science is difficult to do and hard to identify.

The length, information-density, and technicality of this guide may make it mostly appealing to those who are highly motivated and have higher levels of education or a strong ability to self-educate. We felt this "full strength" version of the guide was important to write before attempting to make a more accessible version, as the knowledge from writing the full version is a prerequisite. Not to mention the fact that we may not have the time for a more accessible version!

Multiple psychedelic-therapy training programs exist for mental health professionals. Typical therapist education often contains major oversights, and we strongly suspect psychedelic-therapy training programs do too. These programs are also locked behind paywalls. There are also various solo MDMA-therapy guides that, while offering some valuable advice, also contain poor-quality information and fail to adequately discuss safety risks. We attempt to fill the niche of accessible and practically applicable recommendations backed by rigorous scientific research, professional therapist experience, and strict ethical guidelines. Our experiences with the failure of the mental health treatment system help us tailor this document to the complex nuances of real situations.

**Mark Groeneveld:** During my own use of MDMA-therapy I realized a few things: Core knowledge essential for effective MDMA-therapy is dispersed across many sources, ranging from scientific literature to the wisdom of experienced therapists. Memory reconsolidation,

which MDMA is particularly good at facilitating, can address the some of root causes (particularly our tribalist predisposition, which we think is too strong to be adaptive in the modern world) of many of the world’s problems. Many people are desperate for healing, don’t know where to start, can’t access expert assistance, and don’t have the information to safely and effectively heal. I was also frustrated by not understanding how trauma and healing work, despite successful application of MDMA-therapy.

I thought a manual could help with these problems. My goal is for this document to be a comprehensive and self-contained starting point, including scientific descriptions of the core concepts and brief tutorials on a variety of related practices. Links to in-depth resources are provided for those wanting to dig deeper. This document aims to describe how the mind responds to trauma and how healing works, in a way that is hopefully clear, accurate, and directly applicable to healing. I also hope this will serve as a FAQ, manual, and general reference for MDMA-therapy. Maybe this document will also be helpful for those who didn’t understand why they felt the way they did or how to address it. I hope you find it of use.

MG would like to thank: MDMA-therapy, for giving me hope. The scientists and therapists who developed this body of knowledge and practice. My friend and guide, Jessica Sojorne Libere, for years of MDMA-therapy guidance. My partner for encouragement, support, and editing. [r/mdmaththerapy](#) for numerous case examples. We used Large Language Models for assistance with editing, research, and major contributions to the Appendices, Glossary, Defense Cascade, and Managing Anxiety and Panic. All sections written with these models have also gone through multiple rounds of thorough editing by both TH and MG.

**Thomas Harper:**

**Author Contributions:** MG developed the initial concept and first draft. TH and MG then shared writing, editing, concept development, and research.

**Biases, Conflicts of Interest, and Author Background:** MG has a strong pre-existing belief of the efficacy and safety of MDMA-therapy because it saved their life. MG and TH both have strong pre-existing beliefs of the benefits of treating mental illness and cultivating compassion. MG personally funded the project.

MG has extensive personal experience using solo MDMA therapy for self-treatment of severely disordered attachment, is thoroughly familiar with the MDMA research literature, but has no experience as a therapist. TH has experience as a therapist highly regarded by their clients, is familiar with the theory of psychotherapy, and has two decades of experience with community organizing around mental health, but has not used MDMA or guided MDMA-therapy sessions. MG and TH both have extensive experience with the failures of the mental health treatment industry. We think this combination of viewpoints helps us write a more thorough, nuanced, skeptical, and accessible guide.

## 1 \*\*Introduction

MDMA creates powerful feelings of compassion, connection, and safety [82]. When used with skill, these emotional states are highly effective tools for healing and adaption. However, there are no quick fixes for all but the most simple issues. In our experience, even



in optimal conditions, MDMA-therapy and the best cases of traditional psychotherapy can take multiple years to heal severe mental illness. Additionally, almost all models of MDMA-therapy currently under investigation emphasize the necessity of between-session therapy or at-home therapeutic exercises, sometimes termed integration, to fully treat complex mental illness [22]. We think MDMA can provide an on-ramp to these activities if they have traditionally been difficult or useless for you. Uncovering and healing the effects of trauma can be psychologically destabilizing until the newly-surfaced emotions have been processed [163]. Therapeutic destabilization can be intense for those with the severe trauma [145]. We believe MDMA-therapy presents a significant increase in the potential cost-quality curve of therapy and provides a much needed tool for cases that haven't responded well to other approaches [155]. Various fundamentally similar framings highlight the potential benefits of therapy to different audiences:

- Healing mental illness or addiction
- Connecting to yourself, those you love, and the world.
- Developing equanimity, patience, compassion, introspection, resilience, alignment of behavior with goals, and cognitive and emotional flexibility.
- Unburdening from hyper-vigilance, fear, chronic stress, loneliness, addiction, shame, guilt, etc.
- Helping you focus on the things that you can change and let go of the things you can't.

Put another way, we think the processes in this document (also achieved through the best cases of traditional psychotherapy) can help you achieve the following characteristics of securely attached adults, developed by Brown and Elliott [34]:

Seeks emotional closeness with others; Able to establish emotional intimacy; Comfortable with mutual dependence; Comfortable being alone; Positive self-image and other image; Warm and open with others; Accepts criticism without significant distress; Strong sense of self; Self-esteem; Self-observational skills; Self-reflective skills; Able to trust in relationship; Relationships tend to be stable, lasting; Open with others about feelings; Positive feelings about relationships; Balanced experience of emotions-neither too little nor too much; Values attachment

This manual addresses three audiences: mental health professionals seeking a thorough understanding of MDMA, mental health professionals seeking a supplementary resource to give to their clients, and people doing solo MDMA-therapy. Because of the complexities and risks of the practice, we generally recommend starting MDMA-therapy with professional assistance. However, availability, cost, or trust obstacles often make adequate professional assistance hard to access and many people have to make the best of non-optimal circumstances.

This guide doesn't offer personalized medical advice, guarantee healing, assure the prevention of negative outcomes, or prevent legal problems if used in a place where MDMA is illegal. Instead, this guide presents a framework for increasing the efficacy and safety of

MDMA-therapy, grounded in research, community insights, and author experiences. While this guide has universal aspects, it doesn't cover all frameworks for MDMA-therapy. Although MDMA-therapy has been practiced by underground therapists for decades, comprehensive scientific study is relatively recent, leaving some aspects unexplored [169]. Possessing psychedelics is a felony in many jurisdictions; this guide doesn't endorse illegal activities [9]. Licensed mental health professionals theoretically risk their licensure by offering psychedelic therapy in contexts where it isn't legal. In practice, we are only aware of two instances of this happening, both involving inappropriate therapist-client boundary crossing [206, 132].

As of 2024, we are in a psychedelic hype bubble [243]. There are many reports and anecdotes of psychedelics treating a wide variety of health conditions. The hype bubble makes it difficult to figure out which are true and which are false. We recommend the Understanding Science 101 guide from UC Berkley [166]. There are also many claims of psychedelics solving a wide variety of issues including war and oppression [243]. We don't believe that just taking the medicine will necessarily change people's beliefs and actions related to these issues. However, we do think the fear partly driving these problems can be unlearned by explicitly activating these feelings during an MDMA session.

We start with an overview of how our minds and bodies respond to trauma, how healing works, and the efficacy of MDMA-therapy. Then we describe the practice of MDMA-therapy, including the trade-offs of professional guidance vs. self guidance, safety, preparation, how to conduct the session, how to process the session, troubleshooting, and how to minimize overwhelming symptoms. We also discuss a variety of complementary practices and tools. These are not essential to the practice of MDMA-therapy itself, but appropriate use will quicken and deepen your overall healing. There is a glossary in Section 8.

We base this guide on the following core assumptions:

- The emotional learnings/schema framework explains most, but not all mental illness (Sotala [213] and Ecker, Ticic, and Hulley [73]). It does not explain the genetic or environmental susceptibility to certain symptoms of schemas or stress, such as psychosis. Certainty - medium/high. This claim is quite large, but the model has a compelling mechanism and epistemological foundation in neuroscience research. We think the general model is true enough to work well. Some parts may turn out to be different than currently understood. It also aligns well with the realizations therapy clients have after successful therapy.
- Memory reconsolidation, or something similar, is the universal mechanism of unlearning maladaptive schemas (Sotala [213] and Ecker, Ticic, and Hulley [73]). Certainty - high. A variety of studies have established memory reconsolidation in simple cases. It also has an epistemological foundation in neuroscience research, unlike most therapy frameworks.
- MDMA facilitates memory reconsolidation when used appropriately (Feduccia and Mithoefer [82]). Certainty - medium/high. We see strong overlap between the effects of MDMA and the memory reconsolidation. MDMA is well-known to increase feelings of safety, empathy, and love. These naturally decrease avoidance and provide an emotional mismatch for a variety of negative-emotion based schemas. Personal experience also closely matches the described process of memory reconsolidation. Controlled trials

investigating this assumption are difficult because placebo-control doesn't work well with mind-altering substances.

- The subsection of the autonomic nervous system called the defense cascade governs many symptoms of mental illness and schemas, such as anxiety and dissociation (Kozłowska et al. [122]). Certainty - high. The general principals seem well-established.
- Therapeutic destabilization and consequent defense cascade activation explain the large majority of therapy-induced (including MDMA-therapy) adverse psychological effects (Olthof et al. [163]). Certainty - medium. Therapy-induced destabilization seems well established, though under theorized. Most adverse experiences appear compatible with destabilization and defense cascade activation, though we can't rule out other mechanisms.
- Further memory reconsolidation resolves therapeutic destabilization and consequent defense cascade activation (Olthof et al. [163]). Certainty - medium/high. A variety of research has shown that destabilization is associated with better therapeutic outcomes. We don't think a rigorous, comprehensive model of destabilization or temporary symptom worsening has been established. We think there are multiple mechanisms, some of which we later describe.

We frequently rely on several other, less critical assumptions:

- MDMA-therapy induces a period of neuroplasticity that makes memory reconsolidation easier (Nardou et al. [159]). Certainty - medium. This relies on a small set of studies by one lab group on mice and extrapolating the applicability of neuroplasticity from one context to another, but matches up with personal experience.
- Acute physical injury from MDMA is caused by mixing it with dangerous activities, certain other drugs, or certain pre-existing medical conditions, not MDMA itself (Rigg and Sharp [189]). Certainty - high. The primary causes of injury seem well-understood and we are not aware of a single acute injury in MDMA clinical trials, where dangerous activity and drug interactions are absent, and participants are screened for liver and cardiovascular problems. There could be rare exceptions that are poorly understood.
- MDMA does not cause long-term cognitive impairment when used in low-risk contexts (Halpern et al. [101] and Passie [169]). Certainty - medium/high. This largely relies on one observational study, but we think it was thorough and convincing.
- Limited MDMA use does not cause long-term physical problems when used in low-risk contexts (Nutt, King, and Phillips [161]). Certainty - medium. We're not aware of any research specifically investigating this. A panel of drug experts concluded that overall, MDMA has some risk of harm, though significantly lower than most drugs of abuse. We think a majority of that harm can be attributed to the known and avoidable risk factors mentioned in Section 5.1. In therapeutic contexts, MDMA is also used far less frequently than common drugs of abuse. The highest number of therapeutic doses we've heard of someone using is 32.

Without professional guidance, solo MDMA-therapy users need to acquire a greater degree of knowledge to reduce risks and increase effectiveness. We recommend reading Chapters 1, 4, and 5. However, if you find this document overwhelmingly long to read and are also determined to do solo MDMA-therapy, we suggest skimming the Safety (5.1), Dosing (5.3), Pre-Session Preparation (5.5), and The MDMA Therapy Session (5.6) at a bare-minimum. If you run into trouble, look at Troubleshooting (5.7). After the session, consider reading After the Session (5.8).

The writing process involved a back-and-forth combining of informal literature review with professional and personal experience. This was also informed by numerous self-reports of MDMA-induced adverse experiences. We resort to many "we suggest"s based on our personal and professional experience because the scientific literature on MDMA and psychotherapy is highly inadequate to the task of saying "this is the best way to do things based on rigorous evidence" for every detail of the process.

We avoid providing a simple list of instructions to follow because the practice of MDMA-therapy is sometimes complex, we are not able to provide individualized medical advice, and many uncertainties about the practice remain unresolved.

## 2 \*\*Background, Goals, and Rationale

Mental illness is one of the largest causes of suffering [233]. Besides being painful, difficult, and expensive for the people who experience it, it carries a heavy economic, emotional, and logistical cost for close companions of those who experience it. On top of all this, we hypothesize that the widespread prevalence of mental illness effects such as cognitive distortion, emotional rigidity, and emotions of deep insecurity and threat may be among the engines driving tribalism and political polarization across the globe. Even when mental illness isn't a factor in tribalism, we think that the learned maladaptive and false beliefs that are key components of humanity's tribalistic tendencies [119] can be unlearned by the same mechanism that mental illness can be unlearned. While a small number of individuals are able to access effective mental healthcare, both access and effectiveness are inadequate for most of the vast and growing population of individuals who experience mental illness.

We are developing an evidence based user guide to therapeutic MDMA use. Therapeutic use of MDMA is one of the most promising developments in psychopharmacology [155]. This guide has the potential to meaningfully reduce mental illness by addressing several of the most prevalent, highest impact barriers to effective care. By doing this, we hope to:

- Alleviate suffering
- Assist individuals in building their capacity to function effectively in the world.
- Increase the ability of individuals to feel and behave compassionately toward all beings.

Ultimately, we believe this has the potential to improve the capacity of entire communities to act collaboratively towards constructive ends. Although the usefulness of therapeutic MDMA for individuals who do not experience mental illness has not been established with the same research base, we are also hopeful that it could eventually become a resource for anyone who wishes to experience a greater sense of meaning, connection, and fulfillment in

We supplemented this with a review from a professional MDMA-guide. We used informal interview data from x other professional MDMA therapists and guides to inform key aspects.

Narrative review? Strengths and weaknesses.

harm reduction ethics framework

their life. We believe this guide provides the foundational knowledge necessary to leverage MDMA to create transformative increases in compassion and connectedness, relevant to many positive social outcomes as well as to mental healthcare. This project aims to amplify the broad-scale effectiveness of therapeutic MDMA use by helping overcome three categories of barriers:

**Trust related barriers:** Feelings of trust towards the therapeutic process are an important resource for getting individuals into mental health treatment who need it, and feelings of trust between therapists and clients are an essential mechanism for the effectiveness of therapy [234]. One of the most exciting aspects of therapeutic MDMA usage is that it allows traumatized individuals to experience a sense of safety and connectedness that is otherwise physiologically and psychologically inaccessible to them, even in trustworthy circumstances [82]. Additionally, many cultures and subcultures experience a normalized hostility regarding even the acknowledgement of mental illness, creating a challenge for clients who are in need of care and for clinicians who attempt to provide effective care in these communities. It can also be extremely difficult for individuals of a particular identity group to feel trust towards a clinician who shares few of their identities and little of their direct experience. Because of this, the ability to achieve that trust more reliably with the support of MDMA may be an enormous asset in increasing the accessibility of effective care. Because of its emphasis on rigor and accessibility, the guide we are producing has the potential to increase the comfort of a wide variety of individuals who would not otherwise be willing to use MDMA, and the comfort of a wide variety of clinicians who would not otherwise be willing to support them.

**Financial and logistical barriers:** We believe MDMA is useful for increasing cost-effectiveness for many clients. This can happen through increased efficiency of therapy—it has already shown promise in clinical trials for treating cases resistant to conventional methods. It can also happen through gradually shifting a large amount of therapeutic work to at-home sessions the client conducts by themselves or with a “sitter” who needs far less training than a fully licensed clinician, if such a method is found to be safe and effective within certain parameters (as some underground practitioners we know have already anecdotally seen, and has been reported by Colbert and Hughes [50] and Hills [105]). We believe MDMA-assisted psychotherapy will make significant improvements to the cost/quality curve of psychotherapy.

**Clinician training barriers:** In our professional experience, many licensed clinicians lack access to the best and most up-to-date training on a variety of therapies because of financial barriers. Additionally, because MDMA usage is and has long been illegal, clinicians who ask their supervisors and senior colleagues about how to support this form of clinical work are often rebuffed. Many clinicians are unwilling to provide clinical support to individuals who embark on its therapeutic use on their own, due to this lack of training and support, as well as due to the legal ambiguities of such care. Depending on how flexible the FDA rules for clinical support are when and if MDMA is legalized, it is possible that providing a high quality open access manual at this early stage of the legalization process could have a positive impact on the culture of mental health providers around MDMA support. This has the potential to prevent rent-seeking experts from making an expensive certification the standard in clinical MDMA support before widespread access to therapeutic MDMA can even be established.

We are writing a rigorous, comprehensive, and accessible guide to therapeutic MDMA use. It starts with a clear exposition on the science of trauma and healing, articulating a

proposed mechanism by which MDMA therapy most likely achieves its effectiveness. It continues on to a thorough discussion of the practice of MDMA therapy, covering safety, dosage, what to expect physically and psychologically, the role of clinical support, and recommendations on making best use of the neuroplastic period that follows a dose. This includes discussion of complicating factors such as addiction, poly-drug use, and contraindications. We have included detailed, neuroscientifically grounded instructions on using MDMA to confront the painful and self-defeating feelings that underlie a wide range of implicit social biases. Finally, we include a discussion of therapies and therapeutic supports appropriate for augmenting MDMA therapy, as well as several appendices of supplementary resources to assist therapeutic MDMA users in getting the most out of their experience.

Many people are already doing professionally-guided or solo MDMA-therapy outside legal frameworks [105, 169]. The available information on the subject for these professionals, their clients, and DIY'ers is usually poor quality, locked behind expensive training programs, or both. Often the institutions providing training advocate for a mix of evidence based and non-evidence based practices, which requires that individuals who wish to take an evidence based approach must do extensive research on their own. Our manual will provide a much-needed source of high-quality, accessible information on this subject. This can increase the accessibility and quality of MDMA-therapy and decrease its risks.

### 3 \*Summary for Mental Health Professionals

We hope this section, and the whole paper, will provide a valuable review of MDMA-therapy. We have noticed many MDMA-therapy clients have questions or feel distressed or confused about parts of their professionally-guided MDMA-therapy sessions. We hope to remedy this by providing better information to both the professionals and clients. We think this manual may serve as a useful handout to clients.

Adding MDMA to a psychotherapy session essentially adds a source of profound safety and connection without the loss of control or hallucinations that LSD or mushrooms can create. This reduces dissociation and resistance, and provides a strong mismatch for reconsolidating maladaptive schemas. We based this manual on the schema/reconsolidation framework because of its epistemological foundation in lower-level neuroscience models and our belief that it is a major component of almost all therapeutic change.. Schemas are memory structures containing multiple integrated and co-activating components: emotional responses (e.g. fear at the sight of dogs), abstract beliefs (e.g. dogs are dangerous), and episodic memories (e.g. being bitten by a dog as a young child). Minds create schemas to guide us toward beneficial actions and away from harmful ones. Schemas change over time as situations change, or as we grow up and acquire increased capability to cope with challenges. A schema reconsolidates (updates) when relevant stimuli activate it, and your brain detects a mismatch between the emotional responses or beliefs of the activated schema and the current situation (or a second activated schema, as is often used in therapy). Schemas can become maladaptive when prevented from updating by avoidance, resistance, lack of resources, fight-or-flight, or dissociation. They are similar to the parts of Internal Family Systems. In therapy, mismatches are often constructed and held in focus for a duration of time to deliberately rewrite and re-store the schema in a new, durable, and adaptive form.



The safety and connection of MDMA create a strong, possibly universal, mismatch that easily reconsolidates most maladaptive schemas.

Unlike most therapeutic modalities, going beyond the therapeutic window into a panic response is rarely a barrier to reconsolidation during an MDMA session. MDMA is also effective at reducing dissociation, however when the dissociation is strong enough it can still be a barrier. It typically presents as sleepiness, feeling bored or sober, or feeling disconnected from emotions. When dissociation impedes the therapeutic process, practicing extended focus meditation toward the dissociation often resolves the issue. A different approach such as Psychedelic Somatic Interactional Psychotherapy (PSIP) may be needed first if dissociation is so intense that the client falls asleep. Resistance or avoidance may also still be present during an MDMA-therapy session and can be worked with by worked with through both standard and novel therapeutic practices. These may include asking the client to practice selective inhibition (see Section 5.4.2), prompting the client to focus on and stay present with their emotions instead of thinking or ruminating, or asking probing questions about feelings, beliefs, and the events that may have created them.

Reconsolidation and insight during MDMA-therapy is often so deep and rapid that with only non-directive support or occasional prompting, clients quickly come to their own accurate insights about how trauma shaped them and why their schemas didn't update. However, guidance may be necessary to deal with resistance or dissociation. This unusual depth of healing can prompt greater degrees of therapeutic destabilization as dissociation and avoidance rapidly decrease.

MDMA has a few serious medical and drug contraindications, but is generally safe and non-addictive in therapeutic contexts. We believe its popular reputation as inherently dangerous is not accurate when it's used carefully. Additional caution is warranted in clients with dangerous or difficult to manage symptoms such as a history of psychosis, mania, or strong suicidal ideation. See Section 5.1 for more information.

We suggest guided MDMA sessions, possibly combined with certain safe activities, may also be particularly useful for creating new schemas. These may include bonds with nature or recognition of the inherent moral worth of all beings.

In Appendix A.9 we list some suggested readings for mental health professionals.

## 4 The Science of Trauma and Healing [Section is mostly right, but needs to be reframed around prediction error. Exact mechanism of MDMA mismatch is also poorly understood.]

Break up sentences. Too dense

### 4.1 What is Trauma and Why do its Effects Stick Around?

\*Traumas are distressing events or chronic conditions that overwhelm our ability to cope [126]. Our ability to cope depends on our capabilities and resources. Children are easily traumatized because they have very little ability to protect themselves, but a variety of other circumstances also lessen our ability to cope with adversity. These include deficits of:

reword

mental health, physical health, socio-economic status, healthy support from other people, physical activity, education, self-worth, emotional capacity to process distressing feelings, and cognitive flexibility [200, 219, 225]. Common traumas include:

- Different forms of unintentional or occasionally intentional neglect or abuse.
- Lack of emotional attunement from parents [34].
- Disasters, accidents, or war
- Chronic poverty, dehumanization, or dysfunctional social-cultural systems [192]
- Loss of health, home, family, or culture
- A wide variety of other difficult situations

Our minds continually create and update a network of unconscious memory structures called schemas [73]. Schemas are composed of detailed memories, abstract beliefs, and emotional responses. They form in response to emotionally positive or negative experiences to help guide our behavior when we encounter similar situations in the future. Our schemas usually update when our ability to handle adversity increases, like when we become adults, or when the situation changes. The updating process involves staying present with the distressing feelings of the traumatic memory. A variety of mechanisms can inhibit this presentness and updating, causing our schemas to keep operating in the same way as when we were less capable:

finish

- **Resistance:** Conscious or unconscious avoidance schemas like drinking alcohol when distressed, escapist habits, addictions, believing "feeling emotions is weakness", believing that shame is proper, fear that healing a schema will hurt you in some way, denial, projection, rationalization, etc [73]. This does not include healthy avoidance, which is temporary and helps you cope in non-destructive ways until you have the space to process.
- **Lack of Resources or Skills:** Not having a quiet moment or space to reflect and deal with emotions. Being unsure about the reasons for your emotions or how to handle them. Or you may not have skill in noticing and labeling feelings, sometimes called Alexithymia.
- **Fight-or-Flight or Dissociation:** These autonomic defense cascade states inhibit engagement with emotions [186].

\*When these prevent processing of a maladaptive schema, the schema becomes 'stuck', and keeps replaying in the presence of relevant stimuli, without adapting [182, 73]. This emotional response and the associated episodic memory (a narrative of how events unfolded during a specific event or "episode") then form and combine with abstract beliefs about the world to form durable, unconscious or partly unconscious structures called schemas, or 'parts' (from the Internal Family Systems framework) [126, 213]. The emotional, episodic, and belief components interact with each other and activating one activates the others. Schemas



are originally protective or adaptive (enhances your ability to cope with your environment; see Figure 1), but sometimes become maladaptive (inhibits your ability to cope with your environment; see Figure 2) when they don't adapt to changing conditions due to the above reasons.

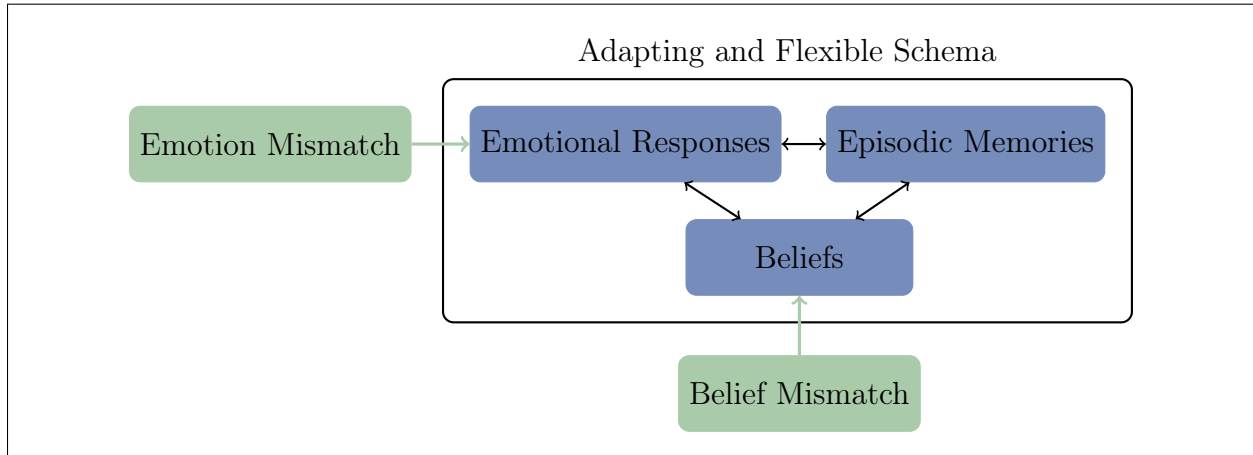


Figure 1: The whole schema updates when either its belief or emotion components experiences a prolonged mismatch with a contradictory experience. Avoidance behaviors are temporary and healthy.

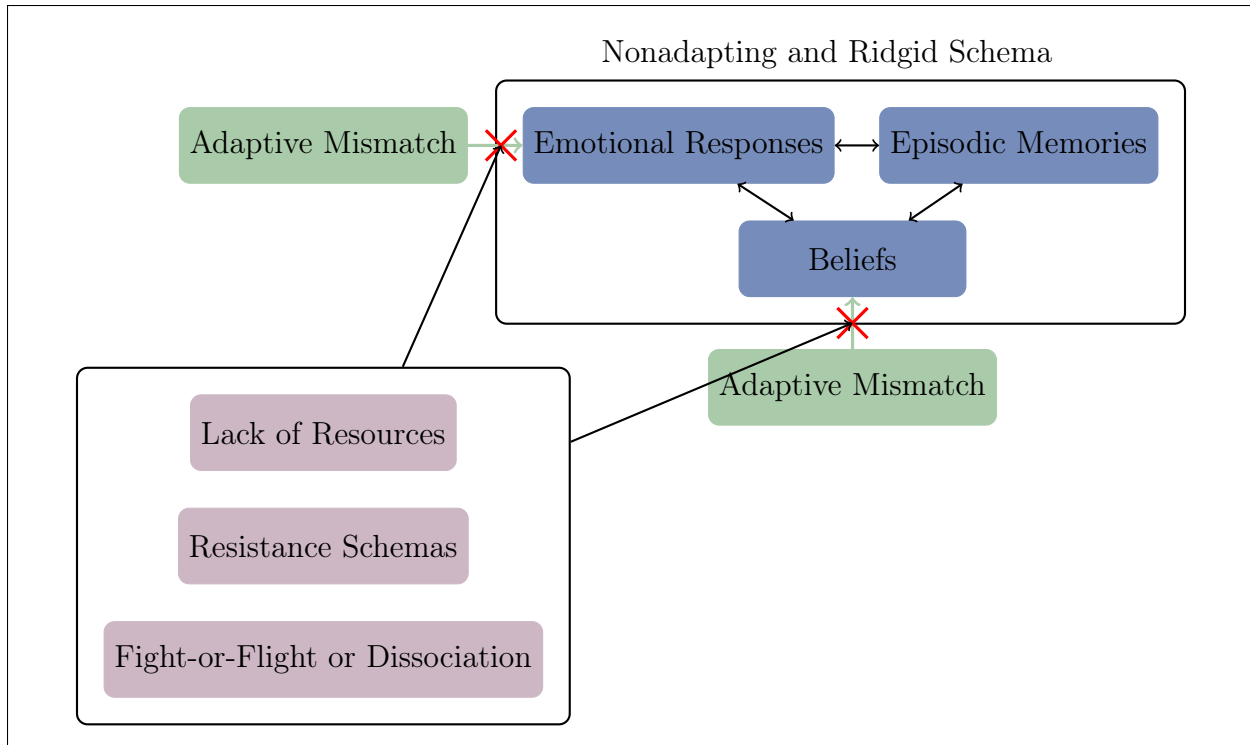


Figure 2: The schema doesn't update and becomes maladaptive when mismatches are avoided or another schema reinforces it. The maladaptive schema may be a stimulus for the reinforcing schema, or they may share a common activating stimulus. The emotional response of the reinforcing schema is intense and outweighs the adaptive mismatch.

Here's an example of a schema that became maladaptive:

- Situation: As a young child, Amy was frequently ridiculed by her peers whenever she spoke up in class or shared her opinions (episodic memory).
- Initial Schema: "If I voice my opinions or stand out, I will be ridiculed and rejected (belief). Ridicule and rejection hurt (emotional memory)."
- Resulting Behaviors and Beliefs: Amy grows up avoiding speaking in group settings and tends to keep her thoughts to herself (behavior). She might decline leadership positions or avoid roles where she'd be in the spotlight (behavior). In discussions, even if she disagrees or has a valuable perspective, she might not voice it (behavior). Amy might believe she's not as smart or valuable as others, even if evidence suggests otherwise (belief).

This schema operates in the background, guiding Amy's behaviors and beliefs without her necessarily being consciously aware of it. Over time, the schema may reinforce itself if Amy experiences further instances that align with it, making it deeply ingrained and automatic in her responses.

\*Schemas are stored as networks of neural connections spread across brain regions [73]. Some networks are complex, composed of multiple traumatic events and activated by a wide variety of stimuli. The stimuli may be singular and obvious like seeing a wasp of the same kind that once stung you, or diffuse and difficult to understand like a mood, thought, or time of day. We are often unaware of our activating stimuli.

Schemas may not contain an episodic memory if you were too young to form long-term episodic memories, or the experience overwhelmed you to the extent that your mind prevented episodic memory formation [120, 34]. These emotions can be especially confusing compared to emotions we clearly see a cause for. In addition to possibly lacking an episodic component, schemas may contain and sustain other signals in the brain, such as chronic pain or feelings in your chest or abdomen. The mind may interpret particularly strong collections of schemas as separate personalities.

Maladaptive schemas and the defense cascade activations they cause can manifest as: depression, anxiety, resentment, anger, low self-worth, an overactive fight-or-flight mode, hypervigilance, detachment, flashbacks, avoidance, numbness, self-harm, psychosomatic illnesses, shame, guilt, denial, isolation, impulsivity, trust issues, perfectionism, hopelessness, obsessions, disconnection, muddled thinking, etc.

We suspect schemas can sometimes activate physical sensations or altered states of mind.

Schemas that outlast their usefulness often harm us and those around us. They may push us to overreact, deny the truth, misjudge important trade-offs, say hurtful things, etc. We may also seek out the connection and safety we desperately need in dysfunctional ways. The stress of chronically activated distressing feelings or chronic defense cascade activation also significantly increases risk for a wide variety of physical diseases and problems [84]. The fear and defense cascade activation of emotional memories can also have a variety of negative consequences, such as being too distracted by our own pain to pay attention to the needs of those we love. These maladaptive patterns and their with sustained defense cascade activations also predispose individuals to conditions recognized as mental illnesses. About 10% of the population might meet the somewhat arbitrary criteria for mental illness at any given time [164], but almost everyone has some amount of maladaptive schemas that negatively effect them and those around them.

\*Schemas and mental illness can also be accurately analyzed through the lens of the biopsychosocial model, where a phenomenon arises through biological predispositions and functions, social models of how one should respond, and an individual's psychology [232].

categories  
(cognitive,  
emotional, so-  
cial, identity)  
in chart form?

## 4.2 \*Defense Cascade

The Autonomic Nervous System (ANS) governs a wide variety of involuntary bodily functions, such as heart rate and digestion [122]. While mainly operating unconsciously, the ANS also activates a defense cascade—a sequence of responses—to shield us from threats. Increasing levels of perceived threat activate these responses, though the order of activation depends on individual variability and experience:

- **Arousal** The most common initial reaction to a potential threat. Think of how a deer becomes alert when they see something moving far away. Vigilance, muscle tension,

respiratory rate, and heart rate all increase, allowing us to quickly assess and respond to possible dangers.

- **Flight or Fight** When an imminent danger is identified, like when a deer notices a wolf nearby, this response prepares the body to either confront (fight) or escape (flight) the threat. The adaptations of the arousal stage intensify and are augmented by an adrenaline surge, further suppression of pain, and an urge to fight or run.
- **Freeze** When the danger is imminent, but you might go unnoticed, such as when the wolf has not yet noticed the deer, the freeze response temporarily pauses a fight or flight response. If the predator notices you, freezing quickly reverts to fight or flight. While most physiological responses from fight or flight remain, muscles become immobilized.
- **Dissociation: Tonic/Collapsed Immobility** Tonic immobility (playing dead) may dissuade a predator from eating you when you have been caught. Fight or flight responses are deactivated, the body is paralyzed, and the brain produces opioids to numb and disconnect you from reality. Muscles remain tense in case the predator gets distracted, and you have to run again. This state may transition to collapsed immobility (fainting; muscle tension and consciousness partially to fully lost) when the threat further increases, or dissociation may continue increasing without a loss of consciousness. These dissociative states often become chronic in humans, and may not involve paralysis or sleep [186]. Extreme threats such as lack of attunement from parents, may cause extreme dissociation from bodily sensations, emotional memories, and current feelings, even while the person appears to be functioning and conversing normally. Chronic dissociation is association with trauma in situations of powerlessness [136].
- **Quiescent Immobility** Tonic/Collapsed Immobility may extend into a lethargic rest and recuperation phase after the threat has gone. Occasionally, this may persist beyond its period of usefulness and become maladaptive.

resolve whether fight or flight is deactivated during dissociation; explain how fight or flight can co-exist with dissociation

The defense cascade originally evolved to address immediate physical threats like predators, but is also activated by a wide variety of other situations [186]. Children are especially prone to these reactions because their threshold of what constitutes a threat to their life is much lower than it is for adults. Lack of parental support, attention, or attunement (see Appendix A.2) can easily activate defense cascade states in children. When this lack is chronic, durable schemas often form and activate the defense cascade whenever the memory is activated. This lasts a lifetime if the stuck schema doesn't reconsolidate.

Recurrent activation of these states contributes to conditions such as anxiety, depression, PTSD, and dissociative disorders [186]. PTSD sufferers, for instance, might frequently switch between heightened aroused and dissociative states. Dissociative and panic states can also simultaneously coexist in many cases of depression and anxiety. We suggest understanding the defense cascade enables safer and more effective healing:

- **Awareness and Insight** Recognizing where you might be within the defense cascade can clarify your reactions and behaviors.

- **Self-Regulation** With awareness, employ techniques like deep breathing or mindfulness to transition from heightened arousal to a calmer state.
- **Pacing** Observing your shifts between hyper-arousal (fight/flight) and hypo-arousal (freeze/collapse) can inform the rhythm therapy, indicating when to proceed or pause.

not quite right

- **Empathy Towards Self** Acknowledge these reactions as once protective, fostering self-understanding and compassion.
- **Creating a Safe Environment** Prioritize crafting a secure physical and emotional space, potentially setting boundaries in scenarios prone to activating stimuli.

Refer to *The PSIP model. An introduction to a novel method of therapy: Psychedelic Somatic Interactional Psychotherapy* for a comprehensive understanding of the defense cascade in psychedelic therapy [186].

### 4.3 Mechanism of Healing

too dense

MDMA primarily creates feelings of safety, love, and connectedness. In this state your resistance schemas naturally relax and allow processing of avoided or dissociated schemas. MDMA-therapy proceeds similarly for most types of trauma, with minor variations to accommodate individual needs [165].

Long-term healing of stuck schemas hinges on memory reconsolidation [82]. When memories/schemas are activated, they become plastic and amenable to change. Introducing a mismatch between the activated emotion/belief and a separate, contradictory emotion or belief rewrites and re-stores the schema in a healed state [126]. The mismatch can arise from MDMA-induced feelings of safety and connectedness, a feeling of safety from an attuned therapist, or the contradictory experience of a second activated memory as done in Coherence Therapy [73]. The experiences of everyday life often provide a small mismatch, slowly reconsolidating surfaced and non-reinforced schemas. Only the part of the memory network that is activated during therapy gets reconsolidated. Complex memory networks, arising from repeated traumas, may require multiple sessions activating different activating stimuli. A schema may also not fully reconsolidate if, during the session, a different schema came into focus before the first reconsolidation was completed. While reconsolidated schemas are stable, it's uncertain how prone they are to reverting to their original state after experiencing new trauma. Increased caution against future re-traumatization may be necessary.

The more conceptually related the positive experience is to the stuck schema, the more effective the mismatch. This may be due to a variety of mechanisms : a related feeling activates some of the same neural circuits as the schema, the mind may label related experiences as more significant, or related feelings/beliefs may activate each other and strengthen the process. MDMA may provide a universal mismatch that works for most if not all schemas. This may be because most maladaptive schemas are fundamentally a fear of disconnection or pain, and MDMA creates exceptionally intense feelings of connection and safety [32].

Reconsolidation often reduces the intensity of distressing feelings of a memory. It also commonly presents as more complex changes in self-conception, alterations in the narrative

or context of the memory, shifts in associated beliefs or values, expansion of emotional perspectives, integration of previously separated aspects of the experience, or the development of greater cognitive flexibility in relation to the event. Because many schemas contain indistinct beliefs about the self, healing experiences may not necessarily be subjectively conceptualized as activation and reconsolidation of a maladaptive schema.

Ecker, Ticic, and Hulley [73] describe the following signs of a completely reconsolidated schema:

A specific emotional reaction abruptly can no longer be reactivated by cues and triggers that formerly did so or by other stressful situations.

Symptoms of behavior, emotion, somatics, or thought that were expressions of that emotional reaction also disappear permanently.

Non-recurrence of the emotional reaction and symptoms continues effortlessly and without counteractive or preventive measures of any kind.”

---

Reconsolidation is the core mechanism of healing maladaptive schemas, but it is not the only part of healing. Learning healthy habits and emotional skills are also critical, as is insight into how trauma affected you and those around you.

Healing also depends on staying within the therapeutic window, where schemas are activated but not overwhelming, and defense cascade activation remains below the threshold of distraction.

A track record of successful treatment is also vital. Repeated unproductive attempts at MDMA-therapy, or even a single exceptionally distressing session, may push someone to unfairly discount the possibility that MDMA-therapy can be effective. This guide aims to put distressing sessions into a larger context where the distress or adverse outcome might be an okay part of a long-term healing process, an unnecessary outcome that can be avoided with proper technique, or sign that MDMA isn’t the right tool. Another goal is providing best-practices, risk-factors, and troubleshooting information to reduce the likelihood of unproductive sessions.

Trauma-therapy presents challenges in addition to its profound benefits. Distressing, previously hidden or avoided emotions are brought to the surface for processing. These emotions may be destabilizing until they have been fully processed. You can think of it as standing up. Sitting and standing are both stable positions. The transition positions between the two are unstable, but must be passed through if you want to walk anywhere. Therapeutic destabilization is a sign of progress, however, it can negatively impact your life if it is severe enough and not managed well [163]. We think destabilization is composed of the following components:

- In the Internal Family Systems framework, some schemas termed "protectors" facilitate emotional stability by pushing us to avoid stimuli that activate feelings of distress [203]. Protectors can increase in intensity when the overwhelming feelings they sometimes push us to avoid are engaged with during therapy. This is termed protector backlash. Some of these protectors may be old and unremembered.
- The targeted schema itself is also often overwhelming, and now that we are aware of it, we may no longer be able to avoid its presence.

Talk more about disconfirming experiences and how they can prompt unconscious daily reconsolidation

- Decreased dissociation or avoidance exposes distressing schemas to consciousness.
- Disturbing insights about one’s past, behavior, or beliefs may provide additional emotions.
- As inner stability increases, or as a result of insight, coping behaviors or beliefs may fall away. This change is usually healthy in the long term, but the lack of a familiar coping pattern may be hard to deal with in the short term.
- A transition from one stable point to another that involves passing through unstable territory [163].

Our schemas form complex networks of adaptive responses that unconsciously guide us through life. Occasionally, this network can be fragile, like a house of cards, in those with extensive early childhood trauma. Therapy can produce functionality collapse and dysfunction if a foundational schema (even if maladaptive) is reconsolidated before you have developed alternate coping strategies.

We propose a description of the healing mechanisms of MDMA in Figure 3.

Schema structure is addressed by happen chance of triggers, modulated by complex interconnectedness of schemas. Some schemas may need to be reconsolidated before others become apparent or reconsolidatable.

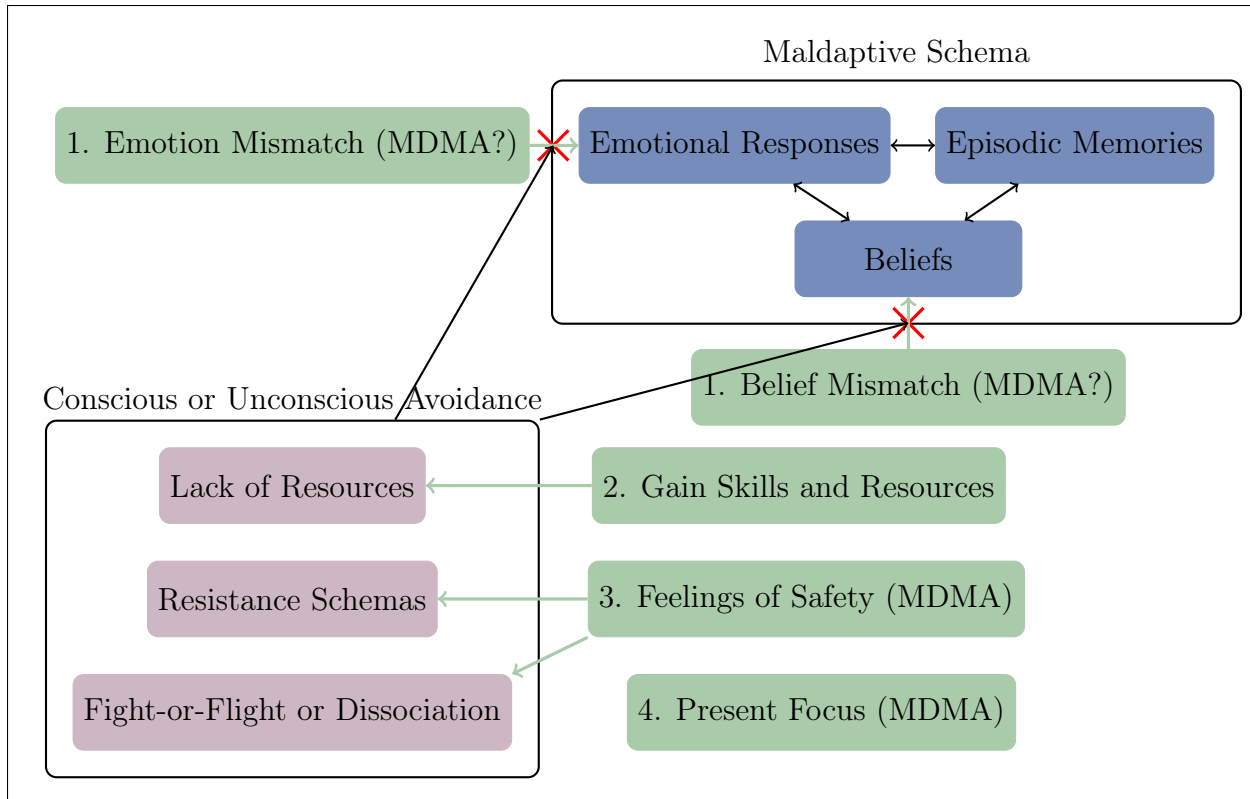


Figure 3: Reconsolidation is achieved through multiple interventions, some of which MDMA directly assists with: 1. MDMA introduces an emotion mismatch. 2. Learn emotional skills and develop resources 3. Feelings of safety lower resistance and deactivate the defense cascade. The feelings of safety from MDMA are sometimes insufficient by themselves when facing extreme dissociation. 4. Reconsolidation requires focus and is exhausting in extended sessions. The stimulant effect of MDMA assists with this.

#### 4.4 \*\*Efficacy of MDMA-Therapy

The MDMA phase 3 clinical trials (the final round of clinical trials that test efficacy and safety on a large sample size) reported that MDMA-assisted non-directive psychotherapy highly outperformed placebo-with-therapy treatments for PTSD, as Table 1 shows [156, 155]. Each subsequent dose (the trials included 3 doses) improved outcomes further, likely indicating further doses would further increase healing. The reported outcomes persisted when the data was reanalyzed by an independent, blinded programmer. Only 5% of participants in the MDMA groups discontinued treatment (half for reasons unrelated to the study), compared to 16% in the placebo groups. MDMA-therapy worked across severity of symptoms, presence of mental illness comorbidities (including substance addictions), and history of ineffective treatment. The phase 2 long term follow-up study shows the effects are durable [113]. While rigorous and highly promising, these studies were organized by a single organization, and

Talk about integrating disparate schema networks. Rebus? <https://slatestarcodex.com/2018/04/12/journal-club-relaxed-beliefs-under-psychedelics-and-the-anarchic-brain/>

Maladaptive isolation of beliefs causes particularly acute problems in mental illness. However, it is also pervasive in the non-mentally ill. Just think of emotionally charged arguments on social media involving two conflicting worldviews. It is rare for someone on either side to acknowledge the validity of any part of their own



a different methodology may show different results. MDMA-therapy with therapists less familiar with MDMA may be less effective. See meta-analyses from Green et al. [96] and Smith et al. [212] for a more thorough discussion of efficacy.

Psychedelic-assisted-therapy and psychotherapy trials frequently suffer from methodological problems such as poor blinding and high researcher bias [3]. Because phase 3 trial participants (and their therapists) accurately deduced whether or not they had been given MDMA or placebo, the trials effectively were not blinded. While this is a major limitation of these types of studies, it doesn't totally disqualify them as useful sources of evidence. Psychedelic blinding is inherently difficult to account for. Additionally, some trial participants reported intense expectations of good results [56]. This expectancy effect likely exacerbates the consequences of poor blinding. We suggest Elk and Fried [76] for a thorough discussion of these problems. We note that placebo treatments can still be useful if the placebo-induced safety and compassion are strong enough to achieve memory reconsolidation. We also suspect MDMA-therapy is more effective than placebo due to its close alignment with the memory reconsolidation mechanism of action. There are also numerous anecdotal reports of inadvertent profound and durable therapeutic improvement in situations where the user was intending a recreational, rather than therapeutic experience.

Table 1: Mean (Own work derived from Fig. 3 in Mitchell et al. [156] and Fig. 3 in Mitchell, Ot'alora, Kolk, et al. [155]) outcomes from the first and second phase 3 clinical trials (174 total participants). These numbers represent therapeutic progress on the single maladaptive schema that participants chose as their therapeutic target [56]. Those with many maladaptive schemas, as is typical for early-life trauma, will need a much longer time frame and number of sessions to reconsolidate all the schemas they want to address.

	<b>MDMA w/ Therapy</b>	<b>Placebo w/ Therapy</b>
<b>No Response</b>	13 %	35 %
<b>Clinically Meaningful Response</b>	87 %	65 %
<b>Loss of Diagnosis</b>	69 %	40 %
<b>Remission</b>	40 %	13 %

Based on the memory reconsolidation model, we think MDMA-therapy can potentially treat all the mental illnesses that are dependent on maladaptive schemas and consequent defense-cascade activation [38, 73]. Coherence Psychology Institute [49] has a list of symptoms they have found treatable with memory reconsolidation practices. While we think they are reputable, take the list with a grain of salt because it mostly consists of case studies involving single examples. We think most emotional problems and unhelpful reactivity that don't rise to the level of mental-illness are also schema-based. ADHD is a heterogeneous collection of symptoms with multiple causes, not a single well-defined disorder [138]. Because of this, it is difficult to say whether some subtypes of ADHD might be schema-based and amenable to treatment with MDMA-therapy. The symptoms of certain types of attachment disorders (which are schema-based) also overlap with ADHD symptoms, making the two difficult to distinguish [87]. Therefore, we suggest MDMA-therapy may be worth trying for those with ADHD, given the possibility of misdiagnosis or a schema-based subtype of ADHD. MDMA-therapy cannot cure autism, which is genetically- and environmentally-determined,

but it can treat the anxieties that autistic people often have [220, 58]. MDMA-therapy is effective for durably improving alexithymia and reconsolidating maladaptive schemas in the presence of strong alexithymia, which is often a barrier to reconsolidation [121].

Many mental illness have some degree of genetic susceptibility [173]. For, instance, psychosis and mania have strong genetic links, but episodes are often triggered or exacerbated by maladaptive schemas and defense cascade activation [240, 228]. MDMA-therapy cannot change genetic susceptibility, but we think it could resolve many triggering or exacerbating causes of genetic mental illnesses. However, therapy can make symptoms temporarily worse as the underlying schemas are confronted. Because of the dangers of manic and psychotic episodes, we only recommend experimenting with MDMA-therapy for those conditions if existing treatments are inadequate, and then only in the physical presence of a professional with a strong capacity to treat these conditions, understanding of MDMA-therapy, and effective symptom oversight and management (including the ability to prescribe psychiatric medication). One survey of experts in psychosis and psychedelics concluded that psychedelic therapy for psychosis is worth investigating, but that clients should have especially high in-session and post-session support [124]. One small, uncontrolled study with highly-motivated participants not currently in a manic or hypomanic state showed good efficacy and safety treating bipolar II with psilocybin and a high level of support [1].

Many physical health problems are symptoms of maladaptive schemas, stress, and defense-cascade activation [122, 73]. Among these problems, some are reversible and will disappear when the underlying schema is reconsolidated, like most of the immediate symptoms of hyperarousal and dissociation (See this list from Cheetah House [43]). Some health conditions triggered or exacerbated by maladaptive schemas, stress, and defense-cascade activation may not be reversible or may only be partially reversible.

MDMA therapy has specifically show some effectiveness for PTSD, dissociation, depression, and functional impairment [96]. It has also improved well-being, excess vigilance, nightmares, avoidance, anxiety, and sleep in those with PTSD [212].

SSRIs have small average effects (or possibly, higher effect sizes for some poorly understood subtypes of depression, and no effect size for other subtypes) in short term use (long term use is poorly studied) while sometimes causing long-term adverse side effects [44, 31]. Long term benzodiazepine use for anxiety has low efficacy and severe side effects such as long term mental impairment that persists after discontinuation [208, 19].

## 5 The Practice of MDMA-Therapy

### 5.1 \*\*Safety and Challenges

MDMA-therapy is generally well-tolerated, but there are dangerous drug interactions, medical contraindications, notable side effects, and psychological risks. We think these risks are generally well-understood and largely avoidable. As later detailed, MDMA-related problems are caused by [189, 194]:

- Prolonged, intense physical activity in high temperatures combined with dehydration. This may cause heat exhaustion or heat stroke. High water consumption not bal-

day write

further discuss what symptoms depend at least partly on schemas

Discuss nuances and variety of treatment options? I feel confident that reconsolidation works. How do mental health interventions work? Is exercise effective by itself or is it just an example of a task that requires effort and feels rewarding? We should talk about the fundamental causes if possible. For instance, if the fundamental mechanism of some intervention is just having a task that feels rewarding, then how do we know it will add any benefit on top of MDMA-

anced with salt can also cause dangerously low sodium levels. Alcohol co-use strongly exacerbates the risk of these problems. Potentially deadly.

- Taking MAOIs (including ayahuasca) within 2 weeks of a session. Potentially deadly.
- Co-use with other psychiatric medications is unlikely to be dangerous, but may increase side effects or decrease the therapeutic effect.
- Pre-existing liver or cardiovascular problems. Potentially deadly, depending on the problem.
- Exceedingly high doses. Risk unclear. A cautious upper bound may be about 200mg.
- Long-term high-frequency use can cause heart problems. It could also conceivably cause other, poorly understood problems.
- Adulterated pills. This can be checked with test kits. Risk unclear and varies by adulterant.
- Driving or other potentially dangerous activities in an altered state of consciousness. Potentially deadly.
- Therapeutic destabilization is a common and necessary phase of therapy for those with severe trauma. Unfortunately, the presence of severe early childhood trauma is difficult to self-assess without professional assistance. Psychedelic-assisted therapy speeds up both healing and destabilization. History of psychosis, mania, and suicidal ideation are strong indications to work with a skilled and trusted practitioner familiar with these conditions. Destabilization can occasionally cause significant problems when poorly managed.

Some observational human studies and controlled high-dose animal studies have found that MDMA use is associated with neurotoxicity or cognitive problems [169]. However, these problems have not been found in controlled studies in humans [101]. The human observational studies that find problems usually fail to adequately control for multiple-drug use, a significant risk factor. Notably Halpern et al. [101] found no long-term cognitive effects of recreational MDMA use in a population that had exceptionally low lifetime use of other psychoactive substances. The animal studies that found problems typically used extreme doses, extreme frequencies of dosing, or injected the medicine, a significantly riskier method of administration than swallowing a pill [169]. Some studies have reliably found serotonin system alterations in humans, but it hasn't been established that these are clinically significant or negative, and the effect appears to decrease with abstinence [95]. Fear and misinformation about MDMA is widespread due to the War on Drugs, sensationalization of poor quality research, and misattribution of MDMA-related deaths as an inherent risk of MDMA instead of its avoidable interactions with other medications and pre-existing health conditions, and the risks of heat illness or hyponatremia at raves [169]. See chapter "The Toxicity Debate" in "The History of MDMA" by Torsten Passie for a comprehensive review of the topic.

Colcott et al. [51] published a side-effect meta-analysis of MDMA-therapy trials and found that MDMA therapy "...is associated with greater likelihood of experiencing mild to moderate, but largely transient side effects. Findings, however, need to be interpreted cautiously due to limitations of the existing evidence." The statistically significant side effects included, starting from the most common: dilated pupils, feeling jittery, uncontrolled eye movements, excessive perspiration, chills, blurred vision, jaw clenching/tight jaw, muscle tightness, decreased appetite, restlessness, non-cardiac chest pain/discomfort, feeling cold, and nausea. Several serious side effects were recorded but were too rare to achieve statistical significance. Larger trials would help us better understand rare side-effects. Side effects were also measured by spontaneous self-report. Systematic measurement with checklists would likely report more side effects.

Evans et al. [79] surveyed people who have experienced new, persistent negative symptoms after recreational, professional-therapeutic, and DIY-therapeutic psychedelic experiences. This data applies to all psychedelics, not just MDMA. Most symptoms dissipated with time, but 17% of respondents said theirs lasted more than 3 years. From most to least common, participants reported emotional (76%), self-perception (58%), cognitive (52%), social (52%), ontological (50%), spiritual (34%), perceptual (26%), and other (21%) difficulties. We think there is a strong case that a majority of the symptoms are explained by either therapeutic destabilization or traumatization from bad trips, which usually result from large doses of hallucinogens or unsafe settings. Additionally, some of the symptoms may be explained by bad-trip traumatization. We think traumatization risk is minimal for MDMA because it induces deep feelings of safety. Even in this subgroup of people who experience extended difficulties, 90% agreed with the statement "I believe that the insights and healings gained from psychedelics, when taken in a supportive setting, are worth the risks involved." However, it is possible that a population of psychedelic users who experience debilitating effects was missed due to sampling bias.

## Drug Interactions

- Taking MAOIs within two weeks of an MDMA session can cause a dangerous or deadly effect known as serotonin syndrome [140, 74]. Notably, ayahuasca includes an MAOI [195].
- Reuptake inhibitor medications, including SSRIs, SNRIs, NRIs, and NDRIIs, highly inhibit the effects of MDMA [83]. Long term use of these medications causes this effect to persist long after medication discontinuation. Discontinuation 25 days before an MDMA session still reduces therapeutic efficacy of MDMA-therapy by about half. Further discontinuation may bring further benefits. Discontinuation typically requires multiple additional weeks of tapering to manage withdrawal.
- Combining MDMA with other prescription psychiatric drugs can cause a variety of changes to effect intensity, effect duration, or relative strength of different effects [199]. No generally high-risk interactions, except for MAOIs, have yet been found. However, some may increase lower-risk adverse effects or decrease the therapeutic effects of MDMA. If you regularly take another medication, we suggest consulting Liechti and

Schmid [129] (more accessible) or Sarparast et al. [199] (more technical) for recommendations on whether you need to discontinue it for a period of time before your session. If you have a serious health condition or your medication is important for your health, we strongly suggest consulting your doctor. They will likely not understand the effects of MDMA, so you may need to provide some of these documents to them. If your medication isn't on one of these lists, you can't access a doctor or pharmacist, and you can temporarily discontinue it with tolerable side effects, discontinuing it for 5 drug half-lives (Each drug has a different half-life, which can be found on [DrugBank](#) under Pharmacology->Metabolism.) before the session and 2 days (5 MDMA half-lives) after the session would generally ensure that 98% of a drug has been excreted from your body [13, 60]. This does not account for health conditions that affect metabolism or other relevant processes. On rare occasions a drug's effects persist even after it has been totally eliminated from your body, as is the case with reuptake inhibitors and MAOIs.

Combining MDMA with some drugs of abuse may increase the risk of adverse effects, though high quality data is lacking [167]. There are strong suspicions that the negative long-term effects seen in some MDMA users are actually due to other drugs of abuse, or mixing other drugs of abuse with MDMA [101, 169]. The following drugs are correlated with adverse outcomes when combined with MDMA in recreational contexts, though cause and effect remain highly unclear: opioids, benzodiazepines, amphetamines, stimulants, anesthetics, MDMA metabolites or analogs, muscle relaxants, olanzapine, and metoclopramide [47]. If you regularly use any of these drugs, we suggest following the recommendations in the previous paragraph.

- The liver enzymes CYP2D6, CYP1A2, CYP2B6, CYP2C19, and CYP3A4 metabolize MDMA [61, 199]. Exercise caution taking high doses of other drugs that these enzymes metabolize, as this metabolic path may overload and reduce clearance of these drugs from your body. Drugs that inhibit these enzymes, such as ritonavir, may be dangerous to take with MDMA. We have not been able to locate an accessible and comprehensive list of these drugs and recommend asking a doctor or pharmacist.
- Pills marketed as MDMA can contain harmful adulterants [197]. We suggest using test kits, such as DanceSafe's, to verify the substance's purity if there's any doubt about its quality [57].

## Medical Contraindications and Notable Side Effects

- MDMA has multiple interactions with the cardiovascular system that create risk for those with some pre-existing cardiovascular problems [30]. These risks are further exacerbated by high doses or long-term high-frequency use.
- Chronic MDMA use, possibly along with chronic use of other psychedelics, may cause valvular heart disease [69, 218]. In one observational study, 28% of chronic MDMA users (mean of 3.6 tablets every week for 6.1 years) showed signs of valvular heart disease (VHD) when evaluated with echocardiography, compared to 0% in a matched control group. However, this is far more MDMA than is typically used in therapy.

Studies of other drugs affecting VHD via the same mechanism suggest there is a linear relationship between cumulative doses and VHD risk [54]. Therefore, we think this risk is low for typical use patterns. Assuming the relationship is linear, extrapolating from Droogmans et al. [69] indicates that 41 cumulative tablets of MDMA will cause a 1% risk of abnormal signs on an echocardiogram test. We consider this estimate to be low-quality and, even if it was reliable, we are unclear what practical implications this would have for users.

- We speculate that some types of pre-existing liver disease may inhibit metabolism of MDMA and heighten the risk of problems. We suggest working with a doctor and starting with low doses.
- MDMA, like many medicines, may have uncommon, poorly understood side effects, particularly after long-term high-frequency use, or in populations with certain genetic features or health problems. Long term (1 year) follow up has only been conducted with 103 clients [113] and no study can investigate all possible health effects. Further studies investigating more health measures, longer-term MDMA use, larger numbers of participants, or higher-risk populations may discover currently unknown adverse effects.
- Dangerous overheating or low sodium levels may occur if MDMA is combined with dehydration, intense physical activity, a hot/humid environment, and lack of electrolytes, as sometimes occurs at dance parties [12]. This is not a problem with a comfortable environment, appropriate hydration, and lack of intense physical activity [156]. Exercise increased caution if your body has serious problems regulating its temperature. Alcohol co-use also significantly exacerbates the risk of heat illness and hyponatremia.
- Planning careful or reduced movement during altered states of consciousness may be advisable if your body is prone to injury from otherwise typical human movement. A sitter, guide, or therapist could help you with this during the session, or you could put an obvious reminder sign in your field of view.
- Adolescent use is unexamined. Kangaslampi and Zijlmans [115] saw no obvious reasons why adolescent use would be risky. However, this assumption has not been tested in any trials. Developing bodies could react differently to MDMA than adult bodies. But, treating mental illness sooner rather than later is very important.

## Psychological Risks

- Overwhelming emotions from severe trauma often activate pervasive dissociation that hides these feelings from conscious awareness [186]. Reducing this dissociation is necessary to reconsolidate. Trauma therapy often reduces dissociation faster than it reconsolidates the distressing schemas the dissociation was hiding. That sometimes results in significant distress until those schemas are healed through further therapy. Larger amounts of trauma and the rapidity of healing with MDMA increase the likelihood of this distress becoming destabilizing or disruptive to your life. We suggest more application of grounding techniques is necessary in instances of therapeutic destabilization.



- Psychotic episodes induced by therapeutic doses of MDMA without confounding factors are rare. When it does happen, stress of therapeutic destabilization is likely a major factor in triggering episodes in genetically-susceptible people [240]. One participant out of 174 in the phase III clinical trials is known to have had a psychotic episode even though participants with existing psychotic symptoms were excluded from participation [145, 212, 155]. Case reports of psychosis following recreational MDMA-ingestion almost always involved confounding factors like co-use of other psychoactive drugs, lack of verification of MDMA ingestion, dehydration, extreme doses, or extreme frequency of use [144, 171, 229]. Even if the risk of MDMA-induced psychosis is very low, the consequences of psychosis are high. Because of this, we suggest that a family or personal history of psychosis is a strong indication to work with a professional who thoroughly understands both psychosis and MDMA.
- Possession of multiple doses may be risky for those with severely impaired impulse control.
- Altered states of consciousness can impair awareness and judgement. Avoid driving and other potentially risky activities on the same day as the session.
- MDMA therapy does not increase suicidal ideation on average [156, 155]. However, individuals with current or past suicidal ideation can experience temporary symptom increases as a result of therapeutic destabilization [145].
- Mania is a dangerous condition that can also be exacerbated through therapeutic destabilization. A family or personal history is a strong indication to work with a trusted professional who understands both mania and MDMA.

## Common Concerns

- **Discomfort with Drugs** While MDMA-therapy is not for everyone, healing can happen even when discomfort is present during a session because MDMA rewrites patterns of discomfort that you stay present with [82]. Fear of drugs could be transformed like any other fear.
- **Loss of Control** While engagement with distressing memories can be intense, people regularly have clear, complex, and emotionally nuanced conversations on MDMA [50, 169]. MDMA creates intense feelings of compassion and safety that make aggressive behavior unlikely. Nutt, King, and Phillips [161] ranked drugs by expert perception of "Harm to others", and MDMA was ranked as about 2% the risk of alcohol.
- **Drug Stigma** Many drugs are harmful, however, during the War on Drugs a wide variety of psychoactive substances were further stigmatized and categorized as harmful without clear evidence-based distinctions regarding their actual risk [6, 161]. While there were complex motivations for the War on Drugs, it functions and persists primarily as moral panic, a means to punish certain groups of people, and a means for politicians to disenfranchise and ostracize the voter base of their political opponents. There is little correlation between the legality of psychedelics and their potential for harm [161].

What degree of suicidality is an indication to not do this without professional assistance?

what support do we recommend for less-strong suicidality?

say more

- **Hallucinations** Complex or compelling distortions of external reality on MDMA are rare and correlated with high doses, but people may have vivid closed-eye visuals of traumatic events they experienced [130]. These visuals may be symbolic instead of a realistic reliving. Temporary and mild visual changes such as color and texture enhancement are common. Sometimes psychedelics, along with many other psychoactive drugs, trigger persistent visual distortions called Hallucinogen Persisting Perceptual Disorder (HPPD) [8, 100]. HPPD is strongly linked to pre-existing anxiety or dissociation, and often improves as those are treated. HPPD from MDMA is unrecorded in clinical trials, but some recreational users report symptoms [231, 134].
- **Addiction** A panel of medical experts organized by the Dutch government found no cases of MDMA addiction in Dutch treatment centers and concluded that "The drug does not or hardly lead to abuse, dependence or a use disorder [Google Translated]." [223]. Physical dependence has not been found in rodent studies, even at extreme dosing schedules [190]. However, MDMA, like most experiences that can make you feel profoundly safe, can potentially be psychologically addictive when it is used to escape from difficult feelings rather than engaging with them. Reports of behavioral MDMA addiction in a recreational contexts exist, but as previously stated, seem rare and associated with escapism [78]. As previously discussed, there have been many flaws in studies on MDMA abuse. Consequently, little is known about the effects of abusing MDMA, or what level of use causes physical or psychological problems. If you are worried about your potential for addiction, we suggest the following: only possessing one dose at a time, only obtaining MDMA from a trusted mental health professional who can monitor your abuse potential, use lower doses, and prioritize diving deeper into traumatic memories during sessions (which decreases session pleasantness).
- **Neurotoxicity** We think MDMA neurotoxicity is highly unlikely in humans in therapeutic contexts [169, 101]. However, MDMA is known to cause oxidative stress in the brain at very high doses in animal tests. This may also happen at sufficiently high doses in humans, though it has not been demonstrated. High doses of certain antioxidants, including alpha-lipoic acid, ascorbic acid, and acetyl-L-carnitine, administered shortly before and during the session, have been shown to reduce or prevent oxidative stress in rats [4, 207, 10]. Some companies bundle these antioxidants together in commercially available products, but they have not been rigorously tested in humans and their usefulness has not been demonstrated [191].
- **Is MDMA a Natural Substance?** MDMA is generally made by modifying the plant compounds safrole or piperonal [241]. When properly conducted, this process results in pure MDMA crystals. Single-substance purity greatly improves the ability to produce accurate, safe, and reliable doses. MDMA test kits are useful if you don't trust the source of your medicine.
- **Can I Inadvertently Unlearn a Healthy Schema?** In traditional psychotherapy where mismatch is provided by the client's existing knowledge, this generally does not happen <sup>1</sup>

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<sup>1</sup>There might be rare situations where a healthy schema is unlearned. Someone's deep desire to not be



When two mutually contradictory schemas are juxtaposed consciously, the schema that more comprehensively or credibly models reality, and therefore more usefully predicts how the world will behave, reveals the other schema to be false, and the falsified one is immediately transformed accordingly.

We are unclear on the exact nature of the mismatch that MDMA provides. However, we suspect it involves intense feelings of compassion and safety in the present moment that the mind feels are true and important (Possibly because in all likelihood you really are safe in the moment and your schemas usually prevent you from feeling that truth. The same for compassion; you and other beings really do have inherent worth and when we do hurtful things, it's for reasons one can empathize with.). Compassion and safety contradict the negative expectations or disregard for others or self involved in most maladaptive schemas. Compassion and safety are unlikely to contradict healthy schemas that protect you or others from harm. On a practical level, we are unaware of any instances of MDMA-therapy unlearning a fundamentally healthy schema. The closest example we are aware of is the unlearning of unhealthy motivations before they are replaced by healthy motivations, as can happen during therapeutic destabilization. Note that altered states of consciousness often impair healthy risk avoidance during the session itself, but this effect does not persist.

## 5.2 **\*\*Professional Guidance vs. Self Guidance**

### **What a skilled and well-matched therapist or guide can provide**

MDMA-therapy can be successful in a wide variety of contexts including therapist-guided sessions with pre- and post-session support, do-it-yourself couples therapy, and solo therapy [155, 50, 105]. However, we believe working alone with MDMA presents higher risks and a lower healing likelihood compared to partnering with an ethical, skilled, and well-matched therapist or guide. As Ecker, Ticic, and Hulley [73] state, "The therapist's stance is one of cooperating with and trusting the client's inherent capability of revising emotional learnings." Per our individual and clinical experience, a skilled and well-matched therapist or guide may provide:

- A trustworthy presence that creates a greater feeling of safety, enabling more effective healing
- Additional perspective that's hard to see from a first-person view
- Education on trauma, healing, trust, what healthy relational patterns look like, and healthy ways to deal with emotions (also known as psychoeducation)
- Troubleshooting for problems with the medicine or other parts of the healing journey

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alive might be able to contradict their desire to, say, avoid falling off a cliff because that would cause their death. In that case their not-falling-off-a-cliff schema could be an un-integrated remnant from a time in their life when they did want to be alive. We suspect that such an individual would actually have an even deeper attachment to living that would override their desire to not be alive, but they could hypothetically unlearn the not-falling-off-a-cliff schema before they unlearn the wanting-to-die schema.

- Improved screening for contraindications (conditions that make MDMA particularly risky)
- Monitoring of your level of destabilization over time
- A skilled and experienced perspective about how best to maintain your to your therapeutic window, and broaden your therapeutic window over time
- Assistance in learning appropriate coping strategies
- Assistance identifying which coping strategies are best for you in a particular context
- Assistance preparing executive function supports for yourself to maximize your capacity to use the right strategies at the right times
- Management of destabilization periods to reduce disruptions to your life—including empathetic encouragement to rest or cut back from other obligations when appropriate, in order to preserve over-all wellness and capability, and assistance strategizing ways to manage your life that will minimize disruption
- Guidance through difficult therapeutic exercises
- An empathetic and grounding presence while you think through major life decisions, relational challenges, and challenging new schemas that may emerge in the course of the work
- Assistance identifying supplementary treatment modalities that are likely to be most effective for your situation, and in some cases, information about how best to access those treatment modalities
- Assistance in planning for your medicine experience, planning for and making best use of your neuroplasticity period, and organizing appropriate social support for the whole process
- Unadulterated medicine and/or some degree of medical monitoring, depending on who you’re working with

### **What degree of professional support is right for you?**

We propose the following ranking of options. The top of the list represents the lowest risk of adverse outcomes, the highest likelihood of durable healing, and also the highest financial cost. This list is a general guide and the exact positions of items are debatable, as well as dependent on personal circumstance. Exceptions to the rule always exist.

1. Continually working with a skilled, ethical/accountable, psychedelic-trained therapist or guide you align well with. *We tentatively think this is the ideal model for all situations if you can find the right clinician to work with and have enough money. We also think this model is especially important for people with potentially dangerous symptoms they can’t manage themselves, including psychosis, mania, suicidal ideation, or a severe lack of impulse control. Note that the destabilization cycle will almost certainly make these symptoms worse for a period of time.*

2. Start off with a skilled, ethical/accountable therapist or guide who you align with and who is psychedelic-trained and/or personally experienced with MDMA. You may later transition to self-guided sessions (with regular check-ins) if you and your clinician collaboratively decide that is sufficiently safe for you. *This model has not been explored in the research and may have a higher risk of difficulties. However, because it offers dramatically lower costs and there are many anecdotes of people (including MG) who have found it highly effective, some people will pursue this method.*
3. Work with a skilled, ethical/accountable non-psychedelic-trained therapist or guide you align well with; collaboratively assess your risk-factors with them (perhaps reading this safety section of this guide together, or consulting briefly with a psychedelic trained therapist). If your risk factors are low, you then self-guide all your medicine sessions while maintaining regular sessions with your clinician. You also use high quality resources (see Section 7.5) to educate yourself on the nuances of effective and safe MDMA therapy and use a high-quality sitter as appropriate, which includes at least the first several sessions (See Section 5.5 for characteristics of good sitters). *We think this model is similar to the previous one, but—depending on the quality of your self-education—somewhat more difficult and riskier.*
4. Self-guide all your medicine sessions and do all of your own integration work, perhaps talking about your healing journey with emotionally skilled friends or friends skilled in safely using psychedelics for healing. You also read literature (see Section 7.5) on trauma healing and psychedelic therapy written by mainstream academics and use a trusted sitter for at least the first few sessions (See Section 5.5 for characteristics of good sitters) *We don't recommend this model because self-assessment of risk factors is very difficult. If you decide to try it anyway, you will greatly benefit from high self-emotional knowledge and high skill in managing your own emotional reactivity. While this model has worked for many people, we are unsure of the risk/benefit trade off. We strongly recommend identifying and at least briefly connecting with a therapist or guide you might want to work with in case you get into deeper water than you are comfortable with.*
5. Self-guide all your medicine sessions and do all of your own integration work. You don't use any high quality reference material and don't understand the technical nuances of safe and effective healing. Or you work with an inexperienced guide who may harm you by suggesting intense psychedelic sessions before you are ready. They may also offer distorted or unhealthy interpretations of experiences you have during a session. *We don't recommend this in any circumstance. While it is occasionally helpful to some, we think the lack of rigorous understanding of the process can place both safety and healing at elevated risk, and is likely to impair healing to some degree. Adverse effects may not be identified, understood, and well-managed.*

It seems important to note that although more data is needed, therapeutic use of psychedelics in professionally supported group sessions, where multiple therapists look after a larger number of clients throughout a medicine experience, may offer a potential way to make professional support more accessible to all who would benefit [141].

## How to find a skilled and well-matched therapist or guide

Which therapist you work with matters a lot. For instance, in a large study done by Firth et al. [85], after adjusting for demographic factors (like the severity of symptoms clients were entering therapy with), the best 3.9 percent of clinicians had 77.2 percent of their clients recover; the recovery rate for therapists in the average range was 58 percent; and the 3.9 percent of clinicians who had the worst outcomes only saw 41.4 percent of their clients recover.

It is our hope that the following recommendations, which largely emerge from our personal and clinical experience <sup>2</sup>, can make finding a therapist feel less overwhelming and more hopeful for those who are struggling—or who don’t even know where to start—with the search.

First, we acknowledge the difficulty: even under optimal circumstances, accessing mental healthcare can turn out to be a slog. These challenges are common knowledge for people who provide community mental health services and/or who have accessed them repeatedly: the financial and administrative costs are often daunting. Interacting with licensed mental healthcare professionals is inherently vulnerable for many, especially those who have witnessed or experienced carceral hospitalization or forced medication. Intake interviews often demand intimate details of one’s finances, sexuality, and medical and mental health. All of this is the price of accessing a clinical relationship that may or may not be very helpful. If it isn’t, clients may feel they need to stick with it, because they do need help, and finding someone else to help them seems like more than they can take on. . . . but that doesn’t necessarily mean the clinician will stick around—and particularly for those who are using medicare/medicaid or who require less-expensive sliding scale services, clinicians may be students whose clinical internships end only a few months after starting to work together. Online services, which have endeavored to bridge the gap between what is needed and what is easily available, are plagued by serious ethical and product-quality concerns [21, 27, 86, 28, 15].

The good news is that there *are* excellent clinicians out there—and not all of them are late in their careers. Early career therapists, like those who tend to staff more affordable clinics, provide just as good of care as their more experienced counterparts [93]. Here are our recommendations on how to find one that’s right for you.

1) Remember that really bad therapy can really hurt you [107], and as such we feel it is worse than no therapy. Bad therapy can leave you stagnant for a long time with the impression that no real help for you exists. It can make your symptoms worse without making them better after. In the worst case scenario, it can leave you with additional trauma. See Section 5.2 for a discussion of the particular challenges of avoiding negative and damaging clinical experiences in the realm of psychedelic therapy.

Good therapy is often very uncomfortable [73]. However, you should feel a sense of mutual trust and respect with your clinician, and you should also feel a sense of collaboration and consent regarding the goals you are working towards and the methods you use to get there [97]. Even if you don’t understand the methods your clinician is using to help you, we believe

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<sup>2</sup>This experience includes some common knowledge of professional norms among the licensed mental health professions, much of which can be found in the ethics codes of the major licensed mental health professions, e. g. the National Association of Social Workers code of ethics, the American Psychological Association code of ethics, the American Counseling Association code of ethics, The American Association for Marriage and Family Therapy code of ethics, etc.

a skilled and well-matched clinician will take the time to help you develop a trust in them that is commensurate with the discomfort of what they are asking you to undertake.

Although we can not speak to the specific trade-offs of your situation, in general we recommend continuing to search until you are able to access good therapy.

2) Trust your perceptions, because your personal experience of your clinician impacts the efficacy of your treatment [108]. You don't just need a good provider, but a good provider who is also a good fit with you. We strongly recommend using the BR-WAI [97], an empirically validated tool for understanding how you and your therapist are connecting, and what might be required to improve that connection.

In our experience, it's a good idea to look for someone it feels like you could say anything to. If you cut your arm, any skilled emergency physician will be able to competently stitch you up. The same is not true with a comparable degree of psychiatric injury [85]. In mental healthcare, the bedside manner is part of the intervention, and the same bedside manner doesn't work for everyone. Although the most skilled mental healthcare providers connect well with an extremely broad spectrum of clients, it is unrealistic to expect every provider to "click" with every client—and many excellent mental healthcare providers ultimately focus narrowly on particular populations of interest to them. If you aren't connecting with a particular clinician, it doesn't mean anything is wrong with them, and it doesn't mean anything is wrong with you.

3) Good therapists love feedback and direction. It is very likely that many therapists who could do great work with you if you are expressive about what you need and want would, in contrast, be very bad therapists for you if you aren't expressive about those things [139, 64, 125, 162]. If you can, we recommend asking clearly for what you want and talking clearly about how things feel. Additionally, there are several instruments that have been developed to help therapists measure and improve their performance. Examples include the BR-WAI, the ORS-SRS, the Core-OM, or the QR-45.2. If your therapist asks you to participate in one of these formal feedback mechanisms, we recommend doing so, even if it feels awkward; these measures really seem to help therapists provide better services.

We've observed that it is sometimes helpful to imagine what therapy would be like, if it went as well as you could possibly imagine, and to share this with your clinician—and to articulate your fears about the process. You can also ask if your ideal hopes align with their experience of their methodology, which may help you set expectations for your treatment. You can use the list above (of what a skilled therapist can provide) to identify ways you would like your therapist to support you. It may be helpful to identify which forms of support you are interested in receiving, and to spend some of your initial sessions learning how your clinician feels about providing support in those particular ways.

Particularly if you have been working with a particular clinician for awhile and your issues/diagnoses and demographic are within their main practice area, you are *well* within your rights to ask a clinician to go outside their comfort zone to learn or implement a new-to-them intervention that is right for your situation. An accredited therapist is required to complete continuing education hours anyway. There are lots of legitimate reasons they may say no (cost, time, and accessibility of additional training, to start with), and that's OK too—but please don't be afraid to ask.

If things aren't working and you've made some effort to recruit your clinician's help in fixing the situation, a therapist may also be willing to spend some of your final few sessions

helping you find and connect with someone who is a better fit for you.

4) Good therapists have good boundaries. Clients often come to therapy without an understanding of what healthy therapeutic boundaries are and why they might be important, and that's OK—it is the clinician's job to have this knowledge, to share it with the client, and to assert boundaries as needed.

One of the most important reasons boundaries are crucial in therapy is a phenomena called Adverse Idealizing Transference, or AIT [107, 66]. Idealizing Transference is a phenomena in which clients develop strong positive feelings towards their therapist. This can be totally healthy and extremely helpful to the course of therapy—supporting clients in their sense of safety and their ability to sustain focus and effort through the sometimes severe discomfort of healing. However, in some cases, it is possible for these positive feelings to be so strong and misdirected that they cause considerable harm—causing lasting distraction and disruption in the client's life, potentially continuing for decades. This situation creates a severe vulnerability that the therapist, if they are unscrupulous or unskilled, may exploit (intentionally or not) for emotional, sexual, or financial gain—creating severe trauma for the client and sometimes impacting others as well. In these cases, Idealizing Transference has become Adverse Idealizing Transference (AIT). Just as helpful medications sometimes have side effects for a small percentage of the people who use them, a small percentage of therapy consumers experience AIT.

AIT can happen even when a clinician is doing everything right [66]. However, both the emotions of AIT and the harm created by them can be greatly amplified when therapists fail to communicate and follow through on healthy boundaries. Here are some commonly recognized healthy professional boundaries for therapists:

- The clinician does not disclose details of their personal life to you unless that disclosure enhances your treatment and is motivated by a desire to promote your welfare.
- The clinician avoids dual relationships wherever possible. For example, if a client can not pay for services and offers to do yard work or provide other professional services in barter, it would cause a dual relationship to accept this offer. The most commonly accepted exception to the dual relationship rule is in extremely rural practice, where access to services is very limited—so, for instance, a clinician might provide mental health services to someone who also their children's pediatrician. However, in these cases, other professional boundaries should still be maintained on both sides.
- The clinician is very clear from the beginning of treatment about their policies regarding the location and timing of sessions, confidentiality practices, means and quantity of payment required, acceptable communication channels outside of therapy sessions, contact on social media, contact outside of the therapy context, and lateness or missed sessions. The clinician follows through on these policies as stated, and communicates any policy changes in a timely way.
- The clinician does not communicate to you in any way that they feel differently about you than they do about their other clients, or that they treat you differently than their other clients.



- The clinician does not permit or encourage the exchange/offering of significant gifts, especially financially significant gifts.
- The clinician does not provide advice outside the realm of their expertise; most clinicians minimize the time they spend giving advice even within their expertise, because supporting clients in the process of arriving at their own conclusions is more aligned with ethical standards and more effective towards lasting change.
- If physical touch is engaged in at all, it generally should be minimal, such as a brief hug at the end of each session or a single brief hug at the termination of treatment. Physical touch may be avoided entirely, and if present must be for the benefit of the client, not the clinician.
- Even if the clinician is providing therapy on a very generous sliding scale basis that is essentially free for an individual with great financial need, it is a good sign if they insist on always charging a fee. In many cases, a fee less than a dollar can still serve as a healthy reminder about the nature and boundaries of the relationship, helping both client and clinician maintain a mindset that minimizes the risk of AIT.

Therapists are, unfortunately, not explicitly educated on AIT at this time. (We strongly recommend that all clinicians read the two reference articles for this section). That said, therapists in all of the major licensure categories should be familiar with and generally compliant with the boundaries listed above; understanding the importance of boundaries and respecting the vulnerability of clients are important topics in their clinical training.

Per item 3 on this list, if you are a client with a high number of risk factors for AIT [66, 107], we recommend discussing preventative measures with your clinician, and weighing boundary practices particularly heavily in your assessment of clinicians' fit for you. Note that these risk factors are not required in order to develop AIT, nor do they guarantee AIT—they simply correlate with an increased risk. The risk factors are:

- a history of dependent/idealized relationships, especially with health professionals
- an approach to therapy that is primarily seeking care, rather than insight
- unrealistic views of what therapy can provide
- being female, especially if working with a male therapist who is older than you
- having a therapist of a gender you are sexually or romantically attracted to
- being a sexual minority, or
- experiencing significant symptoms on a spectrum with borderline or narcissistic personality disorder

A final recommendation on boundaries and the prevention of AIT: although confidentiality is an important therapeutic boundary, we feel it is an excellent sign if your clinician seeks regular supervision and consultation (without disclosing more details of your case than must be disclosed to obtain appropriate professional advice) as needed. Neither you nor

your clinician should feel that anything is happening in the therapy room that they would be ashamed or embarrassed to disclose to a trusted friend (in your case) or a trusted HIPPA-compliant colleague (in theirs). Therapy should feel private, but if it starts to feel like a secret, something may be off.

5) In our experience, in some circumstances it is very important to seek therapy that is targeted to the challenges you are experiencing. One of the most common and arguably benign forms of bad therapy happens when clinicians offer a generally empathetic and supportive environment without bringing clients into a space of productive discomfort. This often results in therapy that feels pleasant, but not very helpful—and which perpetuates the damaging myth that working with a skilled mental healthcare provider is interchangeable with, but more expensive than, having an empathetic friend.

Although the current diagnostic system is substantively flawed [46, 71], we do recommend that a best practice for seeking effective mental healthcare is to a) do one's best to obtain one or more accurate diagnoses, b) research the most evidence-supported treatments for your diagnoses, and c) seek out clinicians who are trained and experienced with those specific treatments—ideally, who are experienced using those specific treatments to address those specific diagnoses. According to both our personal experience and Thomas Insel, M.D. [118], this leads to radically better outcomes than a less targeted search for mental health treatment.

A less medicalized approach to this process recommended by a colleague [211] is to identify what kind of change you would like to make with the the help of a professional, do some research on how people seem to be working towards that change in various contexts, and seek out a professional who has a good reputation or training in that method. This may be especially appropriate if the help you are seeking is not specifically oriented around mental illness.

Regardless of whether this whole sequence feels accessible to you, we recommend if you are experiencing therapy that feels pleasant but not as helpful as you need it to be, it is worth having a conversation with your clinician about what specific interventions and modalities they are employing, and what might work better. Often, in this situation, you as a client are in need of a treatment method that will push you more.

6) If you feel daunted by the process of finding a good therapist, we strongly encourage you to recruit some support and treat finding a therapist as a long-haul effort. For example, if you have a supportive friend or partner, you could ask them to commit to providing you with your favorite takeout every time you complete ten or fifteen "actions" (getting a list of clinicians your insurance covers, leaving a message with a therapist to see if they are taking clients, completing an intake interview, scheduling a session, completing a session, etc.) on your therapist search. Alternately, you might start a text thread with your closest supporters, where you can report your efforts and be rewarded with gifs and emojis. A perspective shift that may be helpful when searching for a therapist is to regard each "failure" or action as a step towards finding the help you need, worth celebrating even if it doesn't yield any immediate tangible results.

We recommend completing three or more sessions with a given therapist before committing to give treatment with them a try. If you luck out and find a great fit on your first or second try, the BR-WAI will help you have confidence that you've really found what you're looking for. If a particular clinician (or a string of clinicians) are not a fit for you, that's OK



too; that doesn't mean you have anything to apologize for. It's good to trust the process and expect that it may take some time.

### **Accreditation and Safety**

We would be remiss not to acknowledge that unlicensed <sup>3</sup> or minimally accredited mental healthcare providers are common [2]—often billed as coaches, guides, shamans, pastors, or simply healers. In this era when a mass-scale mental health crisis is met with a healthcare affordability crisis in the USA, individuals in need of healing seek assistance wherever they can. Indeed, talk therapy and psychiatry are modern inventions, and we are aware both from common sense and through personal experience that skilled and ethical healers of mental and emotional distress exist across many contexts and training levels.

That said, it can be extremely difficult to verify whether the individual you are considering working with is ethical and skilled—and working with an unskilled or unethical provider can be extremely harmful [107, 150]. Although the protection offered by working with a licensed counselor is imperfect, we feel it is an extremely important consideration—and all the more so, as described below in Section 5.2, when working with psychedelics.

We perceive significant risks associated with using an unlicensed mental healthcare provider:

- They may provide, and charge for, interventions that are useless or harmful.
- They may not have been trained in differential diagnosis, and in any case are not legally permitted to diagnose you
- They may provide services to you while they are impaired through the use of drugs or alcohol
- Because they may not have received training about the importance of boundaries and of respecting the vulnerability of clients within the power dynamics of mental healthcare, they are less likely to express and enact boundaries and other practices that minimize the risk of adverse idealizing transference (AIT).
- As such, they may enact harm that emerges not from the interventions themselves, but from other aspects of how they do business: for instance, unnecessary dual relationships or boundary violations can leave clients feeling dis-empowered, violated, or humiliated across multiple domains of their lives.
- They may encourage you, during particularly vulnerable and suggestible times, to make decisions that are bad for you and your life; they may leverage their intimate knowledge of your trauma to exploitatively encourage you to make choices which benefit them at your expense.
- Unless they commit crimes in a way that would be recognizable as criminal and punishable by law even outside of a therapeutic relationship, they are unlikely to experience

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<sup>3</sup>For the purposes of this section, when we say unlicensed, we are not referring to pre-professionals and pre-licensed professionals who are operating under the license of an independently licensed professional as part of their training progression. Examples would include a resident counselor or psychologist. In terms of accountability and ethics enforcement, we feel comfortable recommending this class of providers at the same level as independently licensed professionals.

any negative consequences for any physical, financial, or psychological harm that may come to you in their care.

The protections provided by working with a licensed professional are extremely imperfect. For instance: the field of mental health talk therapy is still relatively young, and it is widely accepted that talk therapy is as much art as science. We have observed that most fully licensed professionals center their practices on interventions that could be covered by insurance, and this may provide some probabilistic guardrails against interventions that have no empirical support at all. However, even among fully licensed practitioners, there is little enforcement that compels clinicians to focus on the most empirically validated interventions, to deliver them in the most empirically validated ways, or to be able to match a client's particular situation to the most empirically validated treatment for that specific situation. If these practices are important to you, we recommend asking many detailed questions about them when you are searching for a well-matched therapist.

Additionally, we have observed that various systems of power and oppression can and do play out in the therapy room if clinicians are not actively, vulnerably, and skillfully working to avoid this outcome. The prestige and respect generally afforded to therapists can sometimes foster hierarchical and non-collaborative dynamics. Therapists sometimes say extremely inappropriate, dismissive, harmful, and/or stigmatizing things, and clients are harmed the more by it because those statements were made by a therapist—someone who they perceive to be an expert, someone who is supposed to have the answers. Licensure does little or nothing to protect against or prevent these forms of harm.

Although cultural acceptance is improving, mental illness is still very stigmatized, and there are many reports of clinicians who turn on their clients, abusively labeling them "borderline" or simply crazy, if those clients file a complaint against them [107]. The privacy of the therapy room, the power of stigmatized diagnoses, and the prestige of the therapist role means that in "he said she said" adjudications, a client is unlikely to be listened to. The situation is further complicated by the reality that in the process of a long career working with many clients who suffer from profound attachment wounds, overwhelming trauma, and at times delusions, hallucinations, and paranoia, clinicians' fears of being misrepresented and attacked by clients as a symptom of their illness are not always unfounded [99, 237] It is inherently very difficult to tell from the outside—and sometimes from the inside too—what has really gone on. As such, many therapists may be more likely to empathize with their peers [107] than wronged clients when they hear about misconduct by colleagues. This unfortunately creates a robust haven for a minority of clinicians who are unethical<sup>4</sup>, extremely incompetent, negligent, and/or predatory.

Despite these shortcomings, we feel it is important to highlight the advantages of working with a licensed clinician, and encourage you to weigh the risks very carefully. Some certificates for coaching or christian counseling can be obtained in a few weeks to a month for less than a thousand dollars; these kinds of certifications do not bring significant professional accountability, because a) loss of such a certification doesn't usually create significant occupational impairment, and 2) certifications this small are not typically backed up by

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<sup>4</sup>"Studies generally show remarkable consistency in age, gender, and practice characteristics in that the typical transgressor [of sexual relationships with clients] is a middle-aged male therapist in solo private practice who engages in a sexual dual relationship with one female patient" [41]

a licensure organization with sufficient resources to keep track of practitioner misconduct or enforce consequences [39]. Obtaining independent licensure as a mental health clinician demands years of study, additional years of supervision, and an often six figure financial investment in education and accreditation. If a fully licensed professional practices therapy while they are impaired through drugs or alcohol, or if they cross sexual boundaries with a client, or if they exploit clients for financial gain—for instance, by giving financial advice or creating a dual relationship—the client can file a complaint with the clinician’s licensure board [230, 20]. If the clinician is then found to have committed the harm described in the complaint, they may (depending on their particular license and jurisdiction) face a variety of consequences. Here are a few of the possibilities:

- They may have their name published on a state registry that lists the misconduct they were found guilty of
- They may be required to take ethics classes or complete other professional development work
- They may be required to work under a supervisor for a period of time, and during that time announce to every single client at the start of treatment that they are working under the license of another professional and who that professional is
- They may lose their access to providing treatment through a hospital they had previously worked through, or they may lose the ability to have their work reimbursed through insurance
- For severe and/or protracted misconduct, or if they refuse to comply with rehabilitation requirements, they may have their license entirely revoked

Independently licensed clinicians must typically pass a criminal background check to become accredited [70]. They may also lose their accreditation if they are found guilty of fraud, sexual misconduct, or abuse in other areas of their lives [20]. This is an important safeguard because a pattern of exploitation across various domains of their life is one of the earmarks of an individual who is genuinely predatory, rather than simply incompetent [53]. Although these consequences are not always commensurate with the harm caused, at least one study has show that the process of filing a board complaint against a harmful clinician on the whole tends to be a positive experience for survivors [230].

To check whether your clinician is licensed or accredited in some way, try asking them for their license number and then looking it up on the website of their professional association. There are also several professional directories—Psychology Today being the largest in the United States—that will only list clinicians after verifying their credentials. In the United States, there are *many* qualifications and certifications that allow a practitioner to legally provide mental health counseling.

To further add to the confusion, we have observed that even within the same license, training can vary widely. If you are committed to working with a licensed professional, we recommend searching for providers based on the professional’s experience, preferred client demographic, and/or treatment modalities, and then verifying their license. You can attain a clearer understanding of the details of a particular clinician’s background with the particular

For a listing of the more common possibilities and a brief discussion of the differences between them, see Appendix NUMBER.

issues you are having (or the particular modalities and interventions you are interested in being treated with) by asking them detailed questions. For example: how many clients have you worked with who have x diagnosis? What is your training and background in y intervention? They might answer with details including trainings or continuing education units they have completed, books they have read, classes that were part of their degree, relevant experience with those populations before they became a therapist, and much more. All these details are highly variable between individual practitioners, but the baseline safety protections that come from working with a licensed professional are always attached to the specific license they hold. Finally, please note that the fields of life coaching, guiding, or other unlicensed professional support often serve as havens for individuals who have lost a license due to misconduct.

If you choose to work with unlicensed professionals, we recommend exclusively working with professionals who are very clear about their scope of care, and who participate in accountability and transparency practices such as participating in accountability pods (a practice developed by the Bay Area Transformative Justice Collective, see Mingus [153]) and publicly posting their business ethics (as exemplified here: Sinback [210]). Indeed, we feel these practices, though imperfect, are a green flag from providers of any licensure level, and we hope they will become normalized across mental healthcare—along with providers routinely seeking appropriate supervision and consultation, and being transparent with clients about who is supervising or consulting with them. Finally, many of the suggestions from the "Recommended individual actions to improve safety of psychedelic care" section may be adapted to reduce your risk profile, even if you are not working with psychedelics—and the caveats we placed on that list apply here as well. No matter who you work with, if they choose to harm you through their behavior, that is not your fault.

To understand scope of care, when you are considering working with an unlicensed professional, it may help to ask many detailed questions about precisely which services they provide, and about how and where they learned the skills to provide those services. Unlicensed professionals are forbidden by law from diagnosing or treating mental illness but many of the interventions that are used to treat mental illness can be appropriately implemented by unlicensed professionals, and have many legitimate uses outside of mental illness treatment [2, 112]. For instance, some coaches teach people how to reconsolidate maladaptive schemas, or how to complete thought records, or how to use the mindfulness-based RAIN (see Appendix A.4) practice to ride out urges to engage in maladaptive coping, or myriad other skills and strategies that constitute legitimate mental illness interventions. These skills are not exclusively relevant to mental illness; a reasonable person might learn them simply to enrich their life and increase their personal growth. When unlicensed professionals deploy them, they are also not doing so (or legally should not be doing so) in the context of a treatment plan wherein a therapeutic relationship is constructed and interventions are performed that will specifically address a specific mental illness. As such, it can reasonably fall within the domain of unlicensed care to teach these skills, and to help folks identify some circumstances where it is helpful to use them. These kinds of services may significantly help you self-manage or self-treat your mental illness, especially (as is often the case) if you are unable to access high quality licensed mental healthcare.

On top of this, we've observed that coaches and other unlicensed professionals are often an appropriate option for bridging a gap between the needs of people with mental illness, and

the necessary level of support (often, more than meeting with a clinician once a week) that would allow them to achieve a significantly better quality of life. For example, a coach might call you several times a week at the moments in your schedule that you have determined you are most vulnerable, so they can help you accomplish some task initiation or avoid some doom scrolling—a service a therapist is unlikely to provide. Unlicensed professionals might help you with more practical, seemingly superficial, yet crucial aspects of changing your life for the better: sitting with you while you fill out job applications, or de-clutter your house, or practice eating mindfully. Some unlicensed professionals can help you learn and apply healthy relationship skills that will radically improve your life. Some carry out structured and empirically validated approaches and work under the supervision and organizational support of fully licensed professionals, as exemplified by the Healthy Gamer coaching programs [111].

In contrast, we believe the very best mental health professionals can complete a detailed bio-psycho-social assessment of your over-all situation, accurately match your symptoms to one or more diagnoses, and then offer you mental health interventions that are particularly suited to you in the context of that larger picture. They offer a deep understanding of how various constellations of symptoms tend to show up, and some awareness of pitfalls you are likely to encounter along the way based on that. They will have an understanding of what level of care is appropriate to your situation, and if they do not have the particular expertise appropriate to your condition, they will help you find a provider who does. They may know much sooner than you do if it is urgently important for you to receive a higher level of care—for instance, early intervention for a first psychotic episode has a massively positive impact on the lifelong trajectory of individuals psychotic spectrum disorders, and timely intensive treatment for eating disorders or substance use disorders can be lifesaving. Particularly if you do not have a case manager to take on this role, a mental health professional may help you work through what is stopping you, and learn the skills to recruit and coordinate care from many sources. Examples include:

- a psychiatric prescriber
- specialist care providers like a dietitian or a trauma informed OB-GYN
- peer support from friends and loved ones
- peer support from potential future friends and loved ones, as when joining an activity group that helps you stay consistent with positive coping strategies
- community programs, like a senior center, meditation center, or gym
- coaches, ecclesiastical leaders, or other appropriate unlicensed professionals
- when appropriate, a personal care assistant to assist with the activities of daily living

Although schema re-consolidation may ultimately heal most or all of your mental illness in a deep and durable way, in the meantime you must live with your symptoms—and build the best life you can, despite your symptoms. The best mental healthcare providers are experts, not only in addressing the root causes of mental illness, but in helping you reduce the incidence of your symptoms and in helping reduce the impact of your symptoms on your life.

## MDMA/Psychedelic Specific Complications In Obtaining Professional Care

Finding professional support for psychedelic therapy carries challenges over and above the challenges of finding mainstream mental healthcare [145, 148]. The specific nature of psychedelic therapies amplifies the vulnerability of seeking psychiatric care, including (we surmise) vulnerability to AITs. Some of these challenges emerge from the legal status of psychedelic therapies. Finally, these factors have combined to create an existing culture of underground MDMA therapy that can be painfully exploitative [56]. An effective process for securing professional support must take all of these challenges into account.

*Challenges caused by the vulnerability of seeking psychiatric care:* As discussed in sections 5.2 and 5.2, there is a severe power imbalance between providers and consumers of mental healthcare. When a fully licensed professional enacts behavior that is very clearly abusive, it creates the case in which we would expect the maximum possible structural support for accountability within conventional criminal-legal and administrative systems. However, even in these cases, proving misconduct and enforcing appropriate consequences for it is not always possible [29]. On top of this, we've observed that many individuals consuming mental health care feel that they must put up with a certain degree of discomfort in order to access care they may desperately need. We find they are often understandably unskilled at detecting the difference between the healthy discomfort of effective treatment [73] and discomfort related to mistreatment or misconduct.

*Challenges caused by the nature of psychedelics:* As detailed below, psychedelics can increase client vulnerability. Psychedelics can create experiences of great mental and sometimes physical intensity, of much longer duration than a traditional therapy session. Long sessions, sometimes a risk factor or "red flag" for harmful boundary violations [216], are necessary in psychedelic therapy. MDMA can generate sexual feelings [142], and we think the same neuroplasticity [159], enhanced meaning [103], and openness to experience that make them such a fantastic aid to re-consolidation work may mean they leave individuals who take them more susceptible to persuasion. Altered states of consciousness also impair the ability to be appropriately cautious and thoughtful about risk. These factors make it even harder for clients to tell when providers are behaving inappropriately. Additionally, a significant subset of MDMA clients are having one of the peak experiences of their life, or even *the* peak experience of their life. We think this could cause therapists and guides who routinely facilitate this therapy to feel godlike. Even excellent guides and clinicians may need to work very hard, when administering psychedelic assisted therapy, to maintain appropriate boundaries, humility, and client-centered care. This dynamic can undermine even very good clinicians' ability to provide quality care. . Although there is no data on the topic, we feel this dynamic almost certainly increases the risk of AITs with MDMA therapy, particularly with providers who are not scrupulous regarding boundaries or thoughtful about preventing this specific risk. All of these aspects of psychedelics amplify the already formidable power dynamics between a therapist and a client, regardless of legal status or other factors.

*Challenges caused by legal status:* The legal status of psychedelics creates additional risk for those seeking professional support for PAT in several ways:

- Mental health providers' training and experience around psychedelics has been extremely limited by their legal status. This includes the ability of professionals to experience psychedelics as a part of their training, which most clients and clinicians

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feel improves clinicians' ability to provide psychedelic therapy, and which many feel is essential to that ability [131]. However, clinicians generally do not have access to these experience in a legal context with solid supervisory support. If clinicians even disclose their history of psychedelic use, they could theoretically face some degree of legal or licensure related repercussions—and even if the actual risk of repercussions is very low, the perceived risk may be high enough to prevent clinicians from becoming involved in these activities.

- The fact that everything has to be "underground" makes it harder for people to find each other as needed. This can create a sense of scarcity, as in, "I have found a provider and I need to stick to them because searching for a better fit feels daunting or impossible."
- When the medicines in question are criminalized, clients who are harmed while using the medicine (or in the process of preparing for medicine use or integrating afterwards) often legitimately fear legal and/or social consequences against themselves if they report crimes against them that were undertaken during this process [56]. This makes the power dynamics astronomical.

How do providers and clients find each other currently? Talk about the existing directory type services? Whole legal status section needs expert reviewer and/or citation help

*Existing culture of exploitation in psychedelic therapy:* Taken together, the above factors render it unsurprising that exploitation, spiritual bypass, and cultic dynamics seem to have been woven into the culture of underground psychedelic therapy [56, 65, 181, 35]. The suggestibility induced by psychedelic use, the profundity of experiences produced, the challenges providers face in staying humble and client centered when providing these interventions, and the deep shelter from any legal threat about malpractice that is created when it is all illegal all play a role in a culture of guides, healers, shamans, and therapists who are able to harm with impunity. Multiple accounts have surfaced of the need to develop a better framework of accountability in these underground, unregulated communities. If you are interested in learning more about this topic, we recommend the following resources:

- "FDA announces advisory committee meeting on MDMA-assisted therapy" [65]
- Power Trip Podcast [56]
- "Addressing Abuse and Repair: An Open Letter to the Psychedelic Community" [181]
- [psymposia.com](https://psymposia.com)
- "Ethical Transgressions and Boundary Violations in Ayahuasca Healing Contexts: A Mixed Methods Study" [35]

### **Recommended individual actions to improve safety of psychedelic care**

In this era of regulation, many people with mental illness are driven to work with unlicensed providers due to mistrust of the mainstream mental health system and/or the financial or logistical inaccessibility of high quality licensed care [2]. Additionally, while the system of licensed providers presumably prevents many of the most egregious violations, some serious harm can and does slip through—as evidenced by the whistleblower reports from the MAPS



trials [65]. In this context, we believe there are steps some individuals may be able to take to increase their safety when seeking psychedelic therapies.

We want to emphasize that even if you do nothing on this list, any care provider who violates the sacred trust you have put in them as a healer by mistreating you is fully responsible for their own actions. We also want to emphasize that those who are most badly in need of psychiatric care are often under-resourced, and likely to find it challenging or impossible to carry out the degree of vetting or preparation they might have ideally preferred. We are not providing these suggestions to cast blame or create additional responsibilities for care-seekers, but as a resource with which those who are able may be able to improve the risk profile of their healing endeavors.

1) Research their licence and certifications carefully. See Section 5.2 about accreditation and the protections it provides. Remember that practitioners may claim a license they don't have, or they may have some sort of certification that does not carry enough weight in their professional life to enforce any kind of accountability. We particularly recommend taking other precautions if your clinician does not belong to a licensing body that publishes the names of clinicians who are found to have violated its ethical code.

2) Follow the advice above (see Section 5.2) about finding a clinician who is a good fit for you, including working with them for at least three sessions (preferably five or more) before making any decisions about using their assistance for medicine work. During this time, observe their boundaries very carefully, and have frank discussions about their qualifications, your needs and expectations, and the modalities that would be employed during the medicine work.

3) Research their therapeutic methodology and expertise. It is our hope that the evidence-based theoretical framework offered in this paper—positing that the two modes of healing MDMA offers are memory reconsolidation and the neuroplasticity period—can assist some clients in assessing whether they are interested in engaging with various therapeutic methodologies. Accordingly, we particularly recommend seeking clinicians who have a strong background in addressing dissociation and panic, in dealing with trauma generally, and in assisting their clients at working through somatic manifestations of trauma/somatic release.

Although they may be particularly fast and effective for activating some important schemas, we strongly recommend avoiding methodologies that involve physical touch—\*particularly\* those that involve physical touch during the actual medicine work, when the client is unable to consent or make unbiased decisions about whether to continue or stop a particular therapeutic interaction.

If you are interested in somatic methodologies that involve touch, we recommend alternatives such as therapeutic use of restorative yoga postures. In this practice, a clinician can provide support through various bolsters and pillows, along with verbal instruction, so that there is never any need to touch you in any significant way. If for some reason you do choose to pursue a methodology that involves touch, we recommend undertaking precautions to increase your sense of volition and improve the safety of the endeavor:

- Creating a detailed written consent contract in advance of your medicine session, that determines what forms of touch will be acceptable under what circumstances and how these boundaries will be upheld
- Using witnesses and cameras to provide you with certainty that your wishes have been

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search in  
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not support  
sorting by  
methodology.  
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We agree with the assertion of the American Association of Sex Educators, Counselors, and Therapists, when they suggest that there is no circumstance where sexual touch is appropriate to the therapeutic relationship [11].

4) Get a background check on the guide and possibly on others who recommend them or who have trained them. In some cases, significant networks of recommenders or well-regarded trainers may all be invested in unsubstantiated or potentially harmful therapeutic modalities [56]. Historically, lineage of training has been an important way that healers are credentialed in the absence of licensure systems; if your guide has trained under someone who promotes potentially harmful therapeutic modalities, with concepts such as "breaking down" the client or helping them "fight it out", or if they have been mentored by people who have a history of boundary violations against clients, we recommend proceeding with extreme caution if at all. If a guide with these red flags seems like an otherwise excellent match, we recommend having detailed conversations about how they relate to those practices and approaches, and taking the other safety considerations listed here especially seriously. Finally, as noted in the accreditation section, if a prospective professional support has a history of fraud or abuse in other areas of their life, this is also worth taking into consideration, even though it may appear unrelated, because this may be a warning sign for truly predatory behavior.

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5) Look for external accountability in the clinician's ethical structure, both philosophically and practically. One of the concerns cited by Cut [56] regarding safety in PAT is that there seems to be a cultural norm in underground psychedelic therapy of identifying the truth—including the truth about situations in which clients allege their clinicians have harmed them—as something that comes from inside each person. In contrast, healthy accountability practices require us to listen with openness to outside information which can make us feel downright terrible on the inside. We recommend seeking providers who maintain active relationships with supervisors, mentors, and/or accountability pods [153] who can help them receive the report appropriately if a client has a bad experience in their care. Additionally, we recommend seeking clinicians who can provide you with a clearly articulated set of written ethical standards they endeavor to adhere to, whether those standards come from a professional organization or personal soul-searching.

6) Create a "flight plan" and a safety plan collaboratively with your provider/s while sober, and review/update it before each medicine experience. Birth plans have become popular tool that birthing parents can use to a) educate themselves about the many choices that may emerge during labor and delivery, and b) communicate strategically with providers about their needs and preferences; we feel that structured advance planning for PAT sessions could provide similar benefits [222]. Here are some considerations you may wish to include in your flight plan if you feel you are at particularly high risk for AIT (link to assessment questions in section above), or otherwise have significant safety concerns:

- You may wish to have one or more support people present to serve as witnesses during your medicine session.
- You may even choose to delegate, "medical power of attorney" style, to allow trusted support people to make certain choices on your behalf while you are incapacitated by

the medicine. If you pursue this possibility, it is important to have in-depth conversations with your support person and your clinician about what level of distress is appropriate for you to face, and what the likely outcomes of that distress may be—as well as having detailed discussions on the choices they are being entrusted to make.

- You may wish to arrange to have your session filmed, possibly even from a few angles, so that you have a lot of concrete evidence afterwards about what happened.

See "preparing for your session" section for more information on flight planning.

7) Keep an eye out for cultic group structures or dynamics. Accounts from the underground PAT world have described closed systems centered around charismatic leaders, exploitation of the labor of group members, and abundant use of what cult scholars call "thought terminating cliches" [56, 17]. Thought terminating cliches are phrases used to address cognitive dissonance while shutting down inquiry into the framework that produced that dissonance. For instance: members of the underground PAT community have told individuals who were assaulted during their therapy that they "called it in to themselves"—invoking a concept from new age spirituality, which suggests that people bring their life experiences onto themselves. In other words, survivors were told to stop considering the choices and volition of the human beings who betrayed them, and instead to focus on their own metaphysical complicity and potential growth that might emerge from their abuse. In contrast, in a non-cultic framework, people are allowed to ask questions and investigate what is under these "thought terminating cliches." They are allowed to disagree. They are not taught to believe they are dependent on just one source for healing. See appendix (NUMBER ) for definitions of cults and lists of red flags and green flags to look out for, aggregated from the work of three different cult scholars.

### Other Factors to Take Into Account

We think the conditions below increase the chances of lasting healing and reduce risk of destabilization. While meeting all of them is not necessary for success, the more you have, the easier it will be. Many individuals with a history of trauma or mental illness have absorbed an "I have to do it all myself" or "these things were so long ago I should be over them already" attitude from difficult life circumstances, which makes it hard for them to feel they deserve supportive care. We hope this list will assist you in giving yourself credit for the difficulty of your endeavors, and help you give yourself permission to seek more support if that would be right for you. Consider these carefully when deciding what degree of professional guidance you need:

- Access to resources: Stable housing, financial security, stable healthy relationships, free time to process without compromising material stability, and friends or family skilled in emotional support.
- Understanding of healthy emotional behaviors (awareness of difficult moods and tools to manage them, conflict resolution, etc.).
- Impulse control
- Perseverance to navigate challenges in the healing process. Capacity to do between-session reconsolidation. Motivation to experiment with therapeutic methods to find what works for you.

WHAT CHOICES MIGHT YOU DELEGATE?—also have this concept reviewed by an experienced psychedelic practitioner

WE SHOULD TALK IN DETAIL SOMEWHERE ABOUT WHAT DECISIONS ARE REASONABLE TO DELEGATE OR NOT

create cult red flag appendix

- Time for and access to a secure and inviting space for your sessions, post-session rest, and reflection.
- Independence from those who have traumatized you, especially if they might react poorly to your insights and improvements. Most maladaptive schemas protected you at one point in your life. Dismantling these protections while you are still in a dangerous situation could carry risks and challenges.
- A habit of inquiring why you have the beliefs and behaviors you do. Acknowledgement that many of them are strongly influenced by psychological and social factors, particularly from early-childhood [34].
- Ability to identify dysregulation.
- Absence of other severe trauma responses such as severe complex PTSD, childhood abuse, attachment disorders, etc.

Self-assessment of the severity of your problems is useful for this last item. This is difficult since our schemas are largely unconscious, but there are some methods:

- The Attachment Style Test can be used for self-evaluation of attachment disorders, one common type of complex trauma [177].
- GAD-7
- PHQ-9 or 17
- ACE Quiz
- sprint self report PTSD
- cbirt

### 5.3 \*\*Dosing

Accurate dosing is important for efficacy and safety. The effects of MDMA are strongly dependent of dose and body mass [217]. The MDMA juxtaposition and maladaptive schema must be close enough in strength to each other for reconsolidation to occur [73]. Too low of a dose (0.75 mg/kg, for example) will likely not provide the safety and empathy needed for healing [24]. We have also observed that too high of a dose can cause the session to be so pleasurable that you're not able to engage with maladaptive schemas. This may feel good or produce disconfirming experiences but is usable for immediate reconsolidation. Liechti and Schmid [129] recommends an initial dose of 100mg for body mass less than 60kg (132lb) or those over 75 years old, and 125 mg for higher body mass. Those are typical doses, but total (initial + booster) doses in studies have ranged from 75-200mg. We think adjusting dosage in subsequent sessions may be helpful to reduce adverse effects, increase feelings of safety, or adjust for individual body chemistry. The effects of MDMA increase in response to increasing dose at a faster-than-linear rate because MDMA inhibits the enzymes that

metabolize MDMA [62]. Because of this, we suggest increasing or decreasing dose in smaller increments than one would typically expect, especially at the upper end of typical dosage. Accurate data on the upper limit of safe doses is unfortunately absent due to difficulties translating the results of animal testing to humans [169].

When applying scientific studies to one's own life and health, it is important to remember that the data we glean from these studies flattens a wide variety of individual responses by combining them into readable averages. You as an individual may experience something very different from the average participant of any given study, and that may be totally normal and fine. Some examples include: you may be much more or less sensitive to the psychological or physical impacts of MDMA. The medicine may impact you for a greater or lesser amount of time than it impacts the average person. You may experience more healing, faster, than the average study participant, or you may not be helped by MDMA at all. Many normal human variations, like low or high body weight, recent pregnancy, or menstrual cycle status clearly have an impact on many mental health interventions (especially when it comes to effective dosage), but are not typically studied at all.

One of the great frustrations of mental healthcare research is that every real life situation is infinitely complex, and a corresponding infinity of confounding factors have the potential to influence outcomes. We encourage you to discuss with your clinician any difference in what you are experiencing (during any mental health intervention) from what the average response is that you might have expected from the research. It's important to both keep an eye on any health and safety concerns that might be related to your response, while also remembering that the range of normal and healthy responses to any mental health intervention is much broader than the averages suggest.

## 5.4 Session Difficulties

\*Dissociation and resistance are the primary challenges in MDMA-therapy. Panic is a major challenge in traditional PTSD therapy, but only rarely seems to be an issue with MDMA. While these may have protected us at one point, they also block reconsolidation. We aim to reduce them to a level that enables reconsolidation without causing overwhelm.

While these methods do work to undo major dissociation, undoing major dissociation often surfaces overwhelming emotional memories. We suggest professional assistance, or if you can't access that, some other strong support structure.

<https://www.psychedelicsomatic.org/post/why-mdma-psychedelic-therapy-may-not-work-for-you>  
titration

prime need is safety

### 5.4.1 \*Dissociation

We recommend the list of dissociative symptoms from Cheetah House [43].

Dissociation often presents as emotional numbness or tiredness. It is a defensive mechanism similar to playing-dead that is associated with trauma in situations of powerlessness [136].

Curious investigation or meditation on the dissociation, boredom, sobriety, blankness, or numbness for minutes to hours will often reduce the dissociation and reveal underlying

Day write.

learn to identify dissociation before session

be strategic with dissociation; may be helpful sometimes

mindfulness

emotional material (see Appendix A.3) [186]. Increasing feelings of safety by altering the environment, finding a more-attuned therapist, or increasing the dose on the next session may also help. If dissociation persists, another method such as PSIP may be necessary [186].

does body scan meditation work here?

Anti-dissociative medications like naltrexone or naloxone could conceivably help though we are not aware of this being tried. Naltrexone requires a prescription and collaboration with a medical professional is necessary. We suggest starting with low doses, as dissociation often covers up overwhelming emotions.

cite

### 5.4.2 Resistance or Avoidance

therapeutic yoga or walking; mindful movement

Selective inhibition (suppression of minor movements and comforting behaviors, and attunement to uncomfortable feelings) may help [186].

brings triggering material and notes on what you want to address or a mantra about staying present with difficult things

We think LSD and psilocybin are potent tools for reducing resistance. Mixing LSD or psilocybin with MDMA is widely practiced, though poorly studied [244]. We suggest starting with very low doses because LSD or psilocybin-assisted psychotherapy are known for deeply challenging experiences. Adding up to 0.5 g dried psilocybe mushrooms at the beginning of the MDMA session reliably decreases resistance. It also increases the intensity and discomfort of the session. Do not take more than 0.5 g unless you are deeply familiar with the combination. See Section 7.1 for more information. This combination is common practice in MDMA-therapy, but no studies have been done [52]. Acutely safe co-use is known from recreational contexts [244].

guide/therapist can help with this really well

cite

Increasing the MDMA dose on the next session may help by increasing feelings of safety, which can reduce dissociation.

## 5.5 Pre-Session Preparation

Proper planning of a session is important for comfort, safety, and success. This is traditionally divided into three sections of mindset, setting, and cultural/personal matrix [75]. We add two more: tools for the session and planning for the post-session:

### Mental Preparation and Expectations (Mindset):

some of these items are optional; can skip if too much work?

- Journal about the things, places, practices, people, or situations with whom you feel safe and at home, and with whom you feel unsafe. Then make a diagram with two axes, safe-feeling and accessibility. Plot at least the top 10 items you journaled about on this diagram. Identify the items that are both safe and accessible and keep them in mind for:
  - Trauma therapy sometimes involves an aspect of "it gets worse before it gets better." We suggest planning increased time with the safe items and decreased time with the unsafe items in the days and weeks following your session.
- habit mapping (unwinding anxiety)
- Shame mapping can help you identify many core schemas. See A.1 for details.
- Practice LK, focus meditation

less important with guide



- practice thought record
- Dissociation and resistance are the primary obstacles to healing during a session. Learning about the signs of these beforehand can help you recognize and deal with them during the session. Refer to Section 5.4.
- Set an intention to face and stay present with your fears, anger, etc. without avoidance or distraction. This is the core of the therapeutic process.
- Avoid rigid expectations of what schemas you will face [158]. The schemas you need to address first may not be the ones you're expecting. Conscious awareness of their true nature is often unreliable because these memories are overwhelming, dissociated, or avoided.
- Catch up on sleep. Therapy requires focus and energy. MDMA promotes focus and energy as well, but we suspect it can only help so much if sleep is lacking.
- Think or write about what challenges or emotional difficulties you would like to address during the session.
- 
- Wondering what the session be like? We suggest reading the top posts here for a survey of how successful MDMA therapy can feel: [r/mdmaththerapy](https://www.reddit.com/r/mdmaththerapy). The top posts mostly describe productive sessions that don't contain unworkable dissociation or avoidance. Sorting by "new" will also show descriptions of less productive sessions. Godes, Lucas, and Vermetten [92] also lists the common subjective experiences of MDMA-therapy clients: "Staying with what 'is' [reconsolidation]; decreased reactivity; insight, reflection, linking; mental clarity; recovery of traumatic memories; disentangling trauma from self; reuniting lost affects and parts; self-acceptance; joy, happiness, gratitude; hope and empowerment; relaxation, calmness, peace; comfort; gratitude, empathy, compassion; union, wider perspective; inner healing intelligence [the particular therapeutic used in this study]; accessibility to emotions; mind-body connection" We recommend reading the paper for descriptions of these items.

prioritize resistance schemas and powerlessness schemas (this will make integration easier)

**Cultural Matrix:** Eisner [75] defines this as the "...environment (1) from which an individual comes, (2) in which the individual lives during the time of the sessions, and (3) to which the individual returns after successful therapy-the everyday living space..." Family, living situation, and culture have complex interactions with the process of MDMA therapy. In some cultures, like those where ayahuasca use is endemic in areas of South America, knowledge of psychedelics may be widespread and accepted. Finding help in dealing with certain after-effects may be much easier in those contexts. Other contexts can be hostile or counterproductive to the process of MDMA therapy.

More to be said. Suggest support groups?

### \*Setting:

- MDMA's stimulant effect may prevent sleep if the session is started later, so we recommend starting in the morning [26].



- Eating is avoided if possible on the morning of the session because some people experience nausea [158]. Taking medicine with food can also delay onset of effect.
- Arranging easy access to necessities like a restroom, snacks, and water will reduce distractions during the session. If your environment is hot enough to induce sweating (sweating may further increase due to the effects of MDMA) during the session, mixing salt with your water will reduce the risk of hyponatremia.
- Prepare your environment or travel somewhere to maximize your feeling of peace, at-home-ness, comfort, and safety. These will add to the feeling of safety from the medicine and ease down dissociation and resistance and increase the emotion mismatch. We suggest carefully expanding your session environment can be beneficial once you are experienced with the medicine. For example, if you have trauma from dogs, you could safely activate that schema by petting a dog who you know won't act aggressively, and who's human is nearby to calm them down if you feel like the experience is too much to handle.
- Remove distractions and danger, ensuring inward focus. Don't do MDMA in any situations that involve a significant risk of immediate danger. Psychedelics impair risk-assessment. We are unsure if it is possible, but MDMA could potentially unlearn healthy, protective schemas activated by real, imminent threats.
- Solitude, except for a trusted and experienced guide, therapist, or sitter, promotes inward-focus and healing. A sitter can help with logistics, hold your hand (Discuss this first. Explicit, pre-arranged boundaries are essential in altered states of consciousness and during trauma therapy.), listen to your feelings, or handle mundane events like someone knocking at the door [158, 221]. Sitters should possess trustworthiness, presence (ability to listen to your distress without becoming distressed themselves), and empathy. Interacting with strangers may cause problems if they do not understand what is happening.

#### \*Tools:

- Consider self-narrating your session and recording it on your phone [158]. Listening to this after the session can spur insight.
- We suggest bringing materials that activates challenging schemas, like photographs or letters, to look at if distressing schemas don't spontaneously arise. See Section 5.6 for more discussion on differentiating distractions.
- Eye shades and noise-cancelling headphones can reduce distractions.
- MDMA can cause jaw clenching and headaches [155, 130]. Some individuals use mouth guards or pacifiers to reduce this effect or protect their teeth [77]. Over-the-counter pain relievers may help after the session. Those with jaw problems may need to be more cautious or use lower doses.

can sitters help with dissociation and avoidance monitoring? include instructions if so

ladder of bids

info specific to tmj?

- The Fireside Project offers a hot-line to help people through challenging psychedelic experiences at [+1 \(623\) 473-7433](tel:+16234737433) in the United States [176]. Keeping this number in your phone may serve as an additional layer of safety.

### \*Planning for After the Session:

- People often feel fatigued for 1-3 days after the session [130]. Prepping food and a comfortable place to rest in advance may be nice.
- We suggest making a plan to try different techniques on subsequent sessions if you're worried that this first MDMA session might not work and is your only hope for healing.
- Therapy sessions are often scheduled for the day after an MDMA session [158].
- If you have the energy, make a plan to spend time understanding your experience in the following days and weeks [158]. Common ways to do this includes journaling, nature walks, body movement practices, transcribing a recording of your session, and art. Planning for extra reconsolidation in the following two weeks is a
- High quality sleep of sufficient duration is likely important to solidifying your reconsolidated memories [209]. We suggest a highly effective evidence-based protocol called *Cognitive Behavioral Therapy for Insomnia* if you struggle getting quality sleep. We recommend the Stanford Medicine guide [147].

why? modes?

## 5.6 The MDMA Therapy Session

\*The effects of a single MDMA dose are generally noticeable 30 min after taking the medicine, peak an hour after than, then last a further 3 hours [231]. Those with genetically low CYP2D6 metabolic capacity reach peak earlier, at around 30 minutes after ingestion [202]. We warn you not to take more MDMA during a session than you initially planned to. Desires to do this are often based in anxiety or dissociation and can result in increased adverse effects [36]. Stay present with those states rather than adding more medicine during a session. Food delays onset of effects [157]. We divide the session into phases based on subjective effects and therapeutic potential:

**Come-up:** \*The effects of MDMA become noticeable, but you are not yet engaging with the memories you want to work on. Some users experience anxiety [105]. We speculate this might be the body interpreting stimulation as anxiety, early engagement with distressing memories, or fears about the session.

**Peak:** \*Reconsolidation is possible here. Connection and safety become pronounced, though you may not notice this if you directly transition to engagement with distressing schemas or dissociation. A booster dose taken at hour 1.5 extends this phase by about 1.5 hours. We suggest not calling or texting anyone until you have more experience with MDMA and you know the other person is comfortable talking to you in your altered state. You may experience vivid closed-eye replays of traumatic experiences [130]. These may be varying degrees of realistic or symbolic.

Discuss somatic release. People occasionally find it of questionable utility.

\*Different therapeutic frameworks, preferred by different therapists or guides, provide different ways to access target schemas [73]. In this section we present a minimum usable

framework for readers: activate target schema (one may already be activated at the start of your session); stay present with the distress while the schema reconsolidates; repeat. We also discuss how to deal with dissociation and avoidance. We focus on reconsolidation rather than insight as the primary goal because we suspect that using MDMA to only generate insight about your issues without accomplishing reconsolidation is not as useful as using MDMA for reconsolidation or simultaneous reconsolidation/insight-generation. In our experience, insight is easier to come by post-reconsolidation, which can be accomplished after the session. This reserves somewhat scarce session time for difficult reconsolidation.

\*First, if you feel like you're experiencing profound ok-ness and self-love for the first time, or are seeing how trauma and the world works, we suggest feeling it fully and not worrying about anything else. We have observed (1 data point) that you can later use (with extensive practice) this knowledge of deep inner wellbeing to mismatch almost any maladaptive schema without the need for MDMA. We think that ability is enormously useful. See Section 5.8.2 for instructions. This experience is also a view of the end goal (regular life will never be total bliss, but it does point you in the right direction) of therapy, which can be a great motivator for staying on the healing journey long-term through challenges. The peace and compassion may not last long after this first session, but you will gradually get it much of it back as you reconsolidate various maladaptive schemas over the long-term [80]. If you find yourself repeating this experience on subsequent sessions, we suggest focusing on engagement with your target schemas. If the repeat experiences don't impart additional, new knowledge of ok-ness, we think they are likely not of therapeutic use.

schema activation methods

Activating and feeling the emotions of the target schema is necessary to enable reconsolidation [72]<sup>5</sup>. We think of it as focus-meditation, where you hold the feeling or belief of the schema in focus and gently dismiss distracting thoughts about, for instance, how beautiful the trees are. This can be deeply uncomfortable, but in our experience the MDMA almost always makes it bearable. The discomfort will be temporary; MDMA-induced reconsolidation will dissipate it over 10's of minutes. Insightful thoughts about how trauma impacted you or insights into human behavior may arise. Spend time on them if they feel cathartic or important. Leave them until after the session if they don't feel cathartic or important, reserving limited session time for reconsolidation or new experiences of profound wellbeing. It may also help to hold the schema with compassionate curiosity and agnosticism with regard to its truth. We have observed that activating and feeling the emotions of maladaptive schemas is a necessary part of MDMA-therapy. Thinking can be useful, but only if it occurs in conjunction with feeling. Thinking by itself is a waste.

\*In our experience, your thoughts are also a reliable indicator of where in the reconsolidation process you are. Your thoughts often revolve around strongly activated schemas. For example, if your schema involves fear and a belief that you're dying, you may find your thoughts saying things like "I'm dying", "I'm afraid", "Death is horrible", "How could that person be comfortable with the thought of eventual death?", "Hospice facilities are scary", etc. Those thoughts will likely feel compelling. When reconsolidation finishes, those thoughts become less compelling or may shift into compassion for yourself or others. You can watch as your beliefs shift too. During a PTSD schema activation, you may believe to some extent

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<sup>5</sup>Emotional activation is necessary because the schemas addressed in therapy almost always involve strong emotions. One can reconsolidate schemas that don't involve emotion without emotional activation.

(often vocalized in your inner monologue), for example, that you're being attacked. As that schema reconsolidates, you can see how that belief dissolves and you realize you're not actually being attacked. Sometimes our beliefs may stay the same while the emotional valence (positive, neutral, or negative) shifts. For example, you may have had anxiety about the thought of dying later in life. After reconsolidation you still know you will die, but it will no longer be distressing <sup>6</sup>.

\*People usually have some idea of what issue they want to address. It is well-known in therapy that, occasionally, attachment to this specific goal can be an impediment. Accessing and reconsolidating certain schemas, like your target, often depends on reconsolidating some other schema (often one you are unaware of) first, even though it might not be clear how the two are linked. If you don't have quick success reconsolidating your target schema, we suggest focusing on any fear, anger, grief, anxiety, or tension in your body. We think these are sure signs of another maladaptive schema that needs to be addressed first. The common phrase "MDMA-therapy give you what you need, not what you want" contains significant truth, even if "need to" is seriously under-defined.

You may feel what is called resistance. This can be a few things: simple avoidance of emotional pain because it is uncomfortable; beliefs that say confronting/healing emotions is bad; or beliefs of an activated schema that say their protective function is very important and you shouldn't let that go. While the protective function of these schemas was important at one point, it has become an impediment. If you can do it, we suggest focusing on any resistance schemas first. Reconsolidating this will make the rest of your therapeutic efforts much easier, as you won't have to fight against a part of mind telling you to stop what you're doing. If you feel uncomfortable assuming the resistance is maladaptive, you can approach the truth of the schema's beliefs or emotional responses with agnosticism, "It may or may not be true or helpful; I will stay present with the feeling to learn why the schema exists and how it influences me." If you can't focus on the resistance schema and another schema is taking precedence, that's ok. You can revisit the resistance later.

You should also monitor for dissociation and resistance. These can be hard to notice. We suggest assuming they are blocking a healing mismatch any time you are not deeply feeling discomfort, anxiety, fear, anger, resentment, sadness, etc., reevaluating difficult experiences from a place of compassion, or experiencing an important moment of safety and love. Sleepiness, not feeling anything, feeling sober, and intellectualization are also clear signs. Refer to Section 5.4 for more information and instructions on how to deal with this.

\*If you experience panic or overwhelm, staying present with those feelings or just hanging-on often resolves the distress [158]. Trying to avoid distress through distraction will likely just prolong it by impairing mismatch. We suggest calling the Fireside Project hotline at [+1 \(623\) 473-7433](tel:+16234737433) if you feel like you need help. [176].

\*If you know you are near the end of the session, we suggest not diving into any additional distressing schemas, though finishing up reconsolidating your current ones is helpful. Surfacing previously unconscious schemas without adequate time to reconsolidate them could result in that schema dominating your post-session life if it strong enough. On the other

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<sup>6</sup>It could also be that the belief that feels like it stayed the same is not the schema you actually reconsolidated. It might be that a second, unnoticed schema, like "death is bad" was reconsolidated and that belief actually dissipated.

Who to call if you think you might be suicidal, manic, or psychotic? 911? Suicide hotline?

hand, diving into additional schemas may be beneficial if you can tolerate the distress and want help making your unconscious schemas explicit for post-session reconsolidation.

**\*Come-down:** Fatigue and reduced capacity to process emotions is typical after intense therapy. The effects of the medicine are still somewhat present, but reconsolidation may no longer be achievable.

**\*After-effects:** Trace effects may be felt for longer. The concentration of MDMA in the body decreases by half every 8.5 hours [60].

## 5.7 \*\*Troubleshooting the Session

### 5.7.1 Sleepiness, disconnection, or heaviness

MDMA is a strong stimulant and generally increases feelings of energy [231]. Activating (perhaps unconsciously) schemas of powerlessness during therapy commonly increases dissociation, which often includes sleepiness [122]. We suggest dissociation is the most likely cause for sleepiness during a session, through atypical responses to the medication or other medical conditions could conceivably play a role. See Section 5.4 for suggestions on working with dissociation. We suggest following the dissociation guidelines first even if you suspect an atypical stimulant/neurotransmitter response because these conditions may be difficult to distinguish. Cheetah House [43] has a list of dissociation symptoms that may prove helpful in differentiating dissociation from another response.

### 5.7.2 Not feeling anything or feeling "meh"

- Your expectation for the session may not match up with the maladaptive schemas actually present and in need of reconsolidation. This can present as disappointment or anxiety about the trip itself. This disappointment or anxiety is the key feeling to focus on and work with.
- We suggest you may be inadvertently avoiding an unnoticed feeling (avoidance, resistance, or dissociation). Practicing different types of meditation (see Appendix A.4) for 30 minutes can often help you notice and engage with subtle feelings.
- Long-term use of reuptake-inhibitor antidepressants blunts the effects of MDMA [83]. This effect may persist for multiple months after discontinuing these medicines.
- The dose may have been too low [24]. See Section 5.3.
- The substance might have been something other than MDMA [197]. Testing can prevent this problem.
- Some medicines work very differently with some individuals' body chemistries. We have observed that some people who think that MDMA might not work with their brain were actually experiencing dissociation or avoiding an anxiety they didn't identify as a reconsolidation target. We suggest working through Section 5.4 before concluding that MDMA doesn't work with your brain.

### **5.7.3 Engaging with feelings that are too overwhelming to stay present with or reconsolidate**

We suggest a 15% higher dose (keeping in mind that doses higher than 200mg haven't been investigated) on the next session could provide enough additional safety to engage with these emotions. See Section [5.3](#) for more information.

### **5.7.4 Feeling great but no durable therapeutic effect**

Reconsolidation requires the positive mismatch and maladaptive schema to be close enough to each other in strength [73]. The MDMA dose may have been too high for you. Alternatively, looking at photos or messages that remind you of the schema you want to work on could increase the strength of the maladaptive schema.

### **5.7.5 New adverse symptom after a session**

Trauma therapy often follows a pattern of feeling worse before it feels better. You will notice previously hidden distressing schemas as some schemas are healed, and avoidance and dissociation are reduced. This is uncomfortable and distressing emotional memories can have a wide variety of mental and physical symptoms (see Cheetah House [43] for a list of defense cascade symptoms) [123, 104]. Continuing with therapy will reduce the backlog of distressing schemas. Sometimes you need to develop symptom management skills or resources to manage the immediate problem, as detailed in Section [5.10](#). If you seek medical assessment, it is beneficial to find a medical professional who understands the physical and psychological symptoms of trauma. It would be ideal to find a medical professional who will anticipate and accommodate your trauma-related safety needs, or at least be willing to listen and adapt. Unfortunately, the United States currently has a severely over-stressed medical system where medical professionals are frequently both undertrained on these topics and lacking the skills to effectively implement the understanding they do have. Additionally, many under-supported healthcare professionals are arguably undergoing extended workplace trauma themselves, which does not necessarily lend itself to optimal participant care. As such, we recommend taking a posture of firmly compassionate self-advocacy wherever possible. You deserve safe and trauma informed care; whether you receive this care or not is not a reflection of what you deserve. You may wish to take notes about the symptoms you are experiencing or collect data (like the safety section of this document) about the safety of MDMA to bring with you to your medical appointment; these measures can help you support your healthcare professionals in giving you the best quality of care possible.

For a strong basic education on psychogenic physical illness, with an emphasis on the understanding most needed from a participant's perspective, we recommend the video [You're Not Crazy For Being Sick - Understanding Psychosomatic Illness](#).

### **5.7.6 Feeling fatigued up to 3 days after a session**

Post-reconsolidation exhaustion is common and temporary and sometimes called "therapy hangover." In our experience, post MDMA-session exhaustion can involve extraordinarily large amounts of therapy hangover if you spend most of the trip doing intense reconsolidation.



MDMA without accompanying therapy can also cause a period of headaches, lack of appetite, lack of energy, dry mouth, difficulty concentrating, and jaw clenching [231]. These symptoms are strongly correlated with dose and usually last up to 3 days [130]. Sleep disruption may occur as well, especially if the dose is taken later in the day [26]. If low mood or exhaustion extends beyond 3 days, we suggest this may be a symptom of a schema you uncovered during the session.

### 5.7.7 Feeling great for a few weeks after the session but then the symptoms come back

A few weeks roughly equals the length of time of increased neuroplasticity following an MDMA session [159]. Because of that, we suspect that this period of feeling good is what increased neuroplasticity feels like in your particular context. Neuroplasticity likely aids out-of-session reconsolidation. However, while can also feel good in itself, it is largely a transient phenomena.

## 5.8 After the Session

\*Physical and emotional exhaustion is common and healthy after therapy and reconsolidation. Because MDMA-therapy is so intense, we suggest planning for 1-2 more days of exhaustion post-session. MDMA without accompanying therapy can also cause a period of headaches, lack of appetite, lack of energy, dry mouth, difficulty concentrating, and jaw clenching [231]. These symptoms are strongly correlated with dose and usually last up to 3 days [130]. We suggest plenty of rest and comforting yourself in ways good for you. Ensure your schedule is clear of major commitments or stressors in the days following.

Short-term improvements in your target schema or symptom are not very reliable for those with complex trauma. Longer term progress in overall emotional health is much more assured.

Healing is a complexly layered process. As one layer of emotional distress is calmed, other schemas usually activate and/or become more visible. Though initially challenging, consistent effort will lead to long-term improvement [120]. This cycle is noticeable both in the long-term (months-years) and short-term (the week after a session may feel more volatile than normal). We suggest not judging a session until 1-2 weeks have passed.

\*You will experience more time in the mind's relaxed state when maladaptive schemas/parts heal. The Internal Family Systems framework proposes this relaxed state consists of calmness, clarity, curiosity, compassion, confidence, courage, creativity, connectedness, perspective, joy, patience, kindness, equanimity, playfulness, and love [204]. Periods of dysfunction will remain, but will become less frequent. If the maladaptive schemas are severe, it might take quite a lot of healing to get to the point where anything feels ok. We suggest staying on top of reconsolidation and defense cascade deactivation, and avoiding situations that activate challenging schemas will help (see Section 5.10).

list of good  
comforting  
techniques



### 5.8.1 Making Sense of the Experience

When applying scientific studies to one's own life and health, it is important to remember that the data we glean from these studies flattens a wide variety of individual responses by combining them into readable averages. You as an individual may experience something very different from the average participant of any given study, and that may be totally normal and fine. Some examples include: you may be much more or less sensitive to the psychological or physical impacts of MDMA. The medicine may impact you for a greater or lesser amount of time than it impacts the average person. You may experience more healing, faster, than the average study participant, or you may not be helped by MDMA at all. Many normal human variations, like low or high body weight, recent pregnancy, or menstrual cycle status clearly have an impact on many mental health interventions (especially when it comes to effective dosage), but are not typically studied at all.

One of the great frustrations of mental healthcare research is that every real life situation is infinitely complex, and a corresponding infinity of confounding factors have the potential to influence outcomes. We encourage you to discuss with your clinician any difference in what you are experiencing (during any mental health intervention) from what the average response is that you might have expected from the research. It's important to both keep an eye on any health and safety concerns that might be related to your response, while also remembering that the range of normal and healthy responses to any mental health intervention is much broader than the averages suggest.

The intense emotions and beliefs you felt during the session may have been the schemas that have been negatively affecting your life. You will react and think differently now after the emotions and beliefs of your schema have updated. Pay attention to what thoughts and reactions are different from before the session, and you will learn you how the trauma shaped your feelings and behaviors in the past. Common ways to identify these differences includes journaling, nature walks, making art, body movement practices, listening to recordings of your sessions if you self-narrate during the session, meditation, and talking through your experiences with an emotionally skilled friend or clinician [158].

When a schema is healed you should notice that although the pain and maladaptive beliefs and behavior are diminished, a level of caution remains. If this caution is helpful rather than overwhelming, then this is the schema in its adaptive, rather than maladaptive form. This caution will aid you in avoiding future harm.

You may experience feelings of intense and spontaneous compassion, connectedness, or love. We speculate these are flashbacks to the MDMA session and will gradually dissipate as the memory is reconsolidated. These increases in compassion almost always have good consequences for you and those around you.

You might have had profound feelings or thoughts about various belief systems, socio-cultural systems, organizations, etc. MDMA can spur profound insights. The feelings of trust, safety, and increased perspective inherent to many MDMA experiences can cause us to take the profound thoughts and feelings we have during those experiences as objective truth, which they may or may not be [103]. Psychedelics inflate feelings of meaning. Rather, MDMA can offer a new perspective based on a state of heightened, but incomplete compassion and safety. Even in this exceptional state, all your still-unconscious emotions are deeply influencing your beliefs and feelings. Your more reliable tools of discernment, compassion

and cognitive and emotional flexibility, will gradually improve as you continue reconsolidating schemas. Using that increasing flexibility and compassion to rigorously and critically engage with a diverse and challenging set of reliable information and experiences will more reliably lead you to what is objectively accurate or helpful for your life than profound session insights [25]. Seek high quality critiques of your beliefs and incorporate beliefs into rigorous higher level frameworks [196]. Correct for cognitive biases and aim for a balanced perspective when evaluating new ideas [90].

PTSD makes us feel as though we are by our nature isolated; MDMA can help people feel as though they are by their nature connected to one another. This may be one of the central mechanisms of healing that both therapy and MDMA provide.

\*As Cashwell, Bentley, and Yarborough [40] state, spiritual bypass "...occurs when a person attempts to heal psychological wounds at the spiritual level only and avoids the important (albeit often difficult and painful) work at the other levels, including the cognitive, physical, emotional, and interpersonal." This results in maladaptive patterns and interrupted psychological development. The term was introduced by John Welwood, a Buddhist teacher and psychotherapist. Because MDMA can produce profound spiritual experiences for those individuals who interpret their MDMA experience in a spiritual way, it may be important to take care to avoid spiritual bypass if MDMA experiences are to actually facilitate healing. In particular, the profundity of many MDMA experiences may lead one to feel that focusing on painful maladaptive schemas is simply no longer necessary; however, without that focus, the schemas will not be reconsolidated, and healing will not be accomplished to the degree it otherwise could be.

Sometimes individuals may feel they are receiving a spiritual message from the medicine, stating that their healing is complete and further medicine work is not appropriate for them [185]. Alternately, the message may take an alternate form, like, "the medicine has done all it can do for me, and now I need to focus on some specific practical aspect of my life." Although practical life circumstances can have an enormous impact on mental health, and we wouldn't want to discourage anyone from fighting for a healthier life situation, we do caution individuals and clinicians who encounter this scenario to be mindful of the possibility that these messages may also be forms of resistance. To understand what is insight and what is resistance, it may be helpful to examine what symptoms and side effects remain active in an individual's life. It may also be helpful to spend time with the negative feelings about further medicine work in the context of reconsolidation exercises, whether assisted by medicine or otherwise. For further discussion of how to decide when to stop using medicine, see Section 5.8.2.

Healing experiences are often, to one degree or another, stressful. Although stress is often regarded as harmful in modern US culture, it is crucial to both meaning and personal growth. You only experience stress when things matter to you, and a stress-free life is a life of apathy and meaninglessness. It is stressful, but also helpful and important, to sit with the discomfort of a maladaptive schema or a mismatch. Even our original traumas could not have harmed us if we did not value the things we value—trauma is intrinsically connected to meaning. As you progress, try to differentiate between adaptive stress, which may alert you to immediate dangers or motivate beneficial actions, and maladaptive stress—which is more than you are able to process or respond to in a healthy way. A good clinician or guide can help you gain insight into which stress is helpful for you and which stress is more likely

to harm. A good clinician or guide who is up-to-date on the research on this topic can also help you re-frame stress in a way that greatly reduces its negative impacts on you, even on a physiological level. For a comprehensive discussion of the dual nature of stress and the importance of adaptive framings of stress, refer to *The Upside of Stress* [143].

You may also have remembered events you weren't aware you experienced. The complexities of recovered memories are strongly debated within psychology, but there are some general guidelines: While the emotional tone of a recovered memory is a reliable indicator of your subjective experience, episodic memory is flexible and amenable to change over time [188]. The episodic gist (the overarching theme of a remembered event) is also significantly more reliable than episodic details. Trauma can further impair episodic memory formation, sometimes leading to missing or fragmented memories of traumatic events [120]. Time passed since the event and the number of times you have recalled the memory also decrease reliability [126]. Use extra caution with psychedelics, as they can increase mental imagery and feelings of significance [98, 59]. MDMA may also slightly change recollection of episodic details of emotionally charged memories [68]. Seek independent corroboration of recovered memories if possible. Due to the power of suggestion, therapists and guides should avoid leading questions, suggestive techniques, and undue influence that might inadvertently plant or reinforce unfounded memories of childhood abuse.

Relatedly, you may recall feelings or beliefs not clearly related to a specific event. These often come from early childhood, when emotional memories form before you are able to form episodic memories [34].

In Western culture we place a premium on having a continuous and linear narrative understanding of ourselves and our place in the world. This value set can serve to further disempower survivors of trauma, especially childhood abuse, because the nature of memory and the shame and taboo surrounding abuse experiences often preclude clear and objective understandings of what exactly happened in our childhoods. Additionally, the US (and possibly other places around the world) embodies a schism in cultural values regarding what is abusive and how abuse should be dealt with. In cases where abuse is extensively documented, survivors nonetheless may face aggressive gaslighting and extended abuse in response to speaking up about their initial experiences. Even documentary certainty about the actual events that happened is not always enough to endow survivors with the "good victim" status they are often seeking when they focus on the accuracy or inaccuracy of recovered memories.

In the face of these realities, you have to think: given that I can never know for sure what actually happened to me, then what? And what, as it turns out, is that you still deserve compassion and healing. "What" is also: that it can be reassuring to gather as much objective evidence as you can about your own history. This can be a way of reclaiming what you can of your own broken narrative, of knowing what is possible to know and at least laying hold of it. And you may need to grieve a great deal, because often the evidence is very thin, and a knowledge of your own history is one of the things that was stolen from you. But your deservingness of healing does not depend on someone coming along and saying, "I have a video of you suffering a legitimate kind of suffering, so your pain is valid now." It may be helpful to explore the following questions, either by journaling on your own or by talking them through with a trusted/emotionally skilled friend and/or a clinician: what does it mean to me if X actually happened? What does it mean if Y happened instead, or

other relevant  
descriptors

Z? What does that say about my identity, my needs, how I perceive myself, and how others perceive me? What does it say about my future? What does it say about what I deserve?

Please be compassionate with yourself, as much as you possibly can. Whether your suffering is real and matters is a different question from, “what is the best strategy for addressing my suffering.” One last word is, your pain is trustworthy, even if your memories are not. If you feel like you are suffering, that is real, and it matters.

### 5.8.2 Continued Reconsolidation

Gains in functionality and emotional health often depend on reconsolidation of the underlying maladaptive schemas. Reconsolidation produces significant, worthwhile, and continuous improvements in particular schemas (and their associated symptoms). We estimate accessing the maximum possible benefits from reconsolidation may take anywhere from single digit hours of mismatching for simple problems to thousands of hours for the most severe mental illness. These estimates do not include the overhead of uncovering schemas and finding mismatches, which can vary. Because there may conceivably be risks from long-term, high-frequency MDMA use, and because sessions definitely have logistical costs, we recommend using between-session reconsolidation to maximize access to the benefits of reconsolidation. Thus, we present techniques for between-session reconsolidation in this section.

MDMA induces a period (2-4 weeks in mice) of neuroplasticity [159]. We have experienced that between-session reconsolidation exercises are easier during this period. If you want to accelerate healing, we recommend spending more effort on and experimenting with reconsolidation exercises in this period rather than more frequent MDMA use. You may even find that maxing-out your reconsolidation capacity every day will deliver very large amounts of therapeutic progress. Developing the skill of sober reconsolidation can reduce your therapeutic reliance on MDMA and allow reconsolidation in a wide variety of circumstances where MDMA use is not appropriate. When well-developed it also allows faster healing because the safety and logistical considerations of MDMA-therapy are no longer limiting. In the absence of better safety data, waiting to do another session until after the neuroplastic period also increases the margin of safety vs only waiting a few days until you are no longer fatigued.

We speculate that there is a daily mismatch limit (one data point suggests 2 hours). At that point, mental exhaustion inhibits the practice. Sleep rejuvenates the ability. Reconsolidating to your limit every day will maximize your progress if you have the time and energy.

You will likely notice activating remnants of the schemas you reconsolidated during the session. These remnants are easier to deal with than the entire network, perhaps because they are smaller or because you now better understand how that particular emotion affected you. Due to the healing that happened on the session, a variety of mechanisms will also surface different maladaptive schemas.

It is often difficult to access activating schemas. We have noticed that walking, other body-movement practices, selective inhibition (see Section 5.4.2) or a 2.5-5  $\mu$ g LSD supplement (see Section 7.1) can help.

We suggest attempting to view the truth of the schema’s beliefs or emotional reactions with agnosticism, “this belief and emotional reaction may or may not be true or helpful; I will stay present with it to learn why the schema exists and how it influenced me.” This may

be difficult for intense schemas, but practice can make it easier.

In addition to the explicit process of maladaptive schema investigation detail in Section 5.12, we think any defense cascade activation (see Cheetah House [43] for symptoms) or non-useful fear, anger, anxiety, etc. in daily life outside of immediately dangerous situations is a valuable indicator of maladaptive schemas. In addition, we pervasively practice subtle, barely-noticeable avoidance around a wide swath of uncomfortable ideas, places, people, etc. We think noticing and going toward the object of avoidance is usually a fruitful endeavor.

### **Structured reconsolidation:**

- ifs
- Coherence Therapy
- notecard thing
- Challenging Beliefs worksheet (see Section 7.2)
- psycholytic therapy (see Section 7.1)
- Attunement
- Motivational interviewing
- Steelmaning

### **In-the-moment reconsolidation:**

We suggest that powerful experiences of profound safety or ok-ness along the lines of "I will be whole and ok deep down no matter what happens", from MDMA, mystical, spiritual, or meditation experiences, are of exceptional therapeutic benefit between sessions. When you notice avoidance, anxiety, reactivity, distress, or other signs of maladaptive schemas in daily life, recalling and staying present with your feeling of profound safety can mismatch and reconsolidate your maladaptive schema in the moment. We have heard multiple anecdotes that practicing this technique makes it easier and more automatic. In two cases, hundreds of hours of practice led to mismatch and reconsolidation happening without conscious intent any time a maladaptive schema is activated and the individual is not actively avoiding it. This ability may reduce or eliminate the need for MDMA-sessions when well-developed. We think developing this ability is important for a few reasons: it enables a higher volume of reconsolidation, helping you reach therapeutic goals sooner; long-term MDMA use could have side effects; MDMA-sessions require planning and recovery; and reconsolidation is valuable in many contexts where MDMA use is not appropriate.

We also propose that powerful experiences of total safety during a session can later act as a compass you can compare all other experiences to, to deduce if a certain feeling is maladaptive or not. As with real compasses it only measures the direction in which to travel; it can't tell you how far away the destination (reaching particular therapeutic goals) is.

If you haven't had a powerful experience of profound, universal safety, context-specific mismatches will have to be found for each maladaptive schema. It may take some effort

can we cite  
bruce ecker  
personal com-  
munication?

to find contradictory knowledge or memories of contradictory experiences, but when found, that memory can also be recalled for in-the-moment reconsolidation of specific schemas. We also suspect, based on one case report, that highly-skilled compassion meditation can be directed toward distressing schemas to contradict them.

### 5.8.3 Using Neuroplasticity to Make Positive Life Changes

MDMA induces a period (2-4 weeks in mice) of heightened neuroplasticity (your brain's ability to adapt) [159, 159]<sup>7</sup>. We posit that the neuroplasticity window after an MDMA treatment may offer an extra boost of support in making changes you seek in your life. This period is likely context dependent. That is, a therapeutic session may lead to therapy-relevant neuroplasticity, but a recreational session won't. Some people may find that as they reconsolidate schemas and have positive disconfirming experiences, they have less need for compulsive self-soothing over time. They benefit from the therapy not just through reconsolidation, but through the support that the subsequent peace and perspective provide for positive behavioral changes. Sometimes being in a rut is the function of inertia; sometimes it is self protective, and improved regulation or a sense of new experience or perspective can help a person break out of it.

#### How MDMA impacts behavioral change goal selection

We advise refraining from drastic life-shaping decisions immediately post-session. MDMA insights may sharply highlight certain aspects of a situation which you had not been facing or focusing on before the therapy. Although these insights may be extremely important, we feel they can best be understood in the broader context of your life both before and after the MDMA session and the immediate post-session period.

We recommend avoiding major life changes during the immediate post-session period unless (1) you have wanted to make those changes for a significant time prior to your MDMA experience, (2) you are (and have been) very sure and very committed about the change you want to make, and (3) you have access to other forms of support around that change, for instance, regular social connection with individuals who enact the behavior you are interested in adopting, an accountability buddy, etc. (See below for further discussion of structural supports.) When these three conditions are met, we are hopeful that MDMA neuroplasticity could provide a helpful layer of support for larger behavioral and lifestyle shifts.

On the other hand, MDMA therapy may more routinely facilitate a “baby steps” approach where individuals make small changes as they feel capable of making them, with the

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<sup>7</sup>The neuroplasticity that psychedelics increase is more accurately described as a reopening of neurodevelopmental windows (called critical periods) where certain types of learning are easier. These critical periods are domain specific, so reopening a reconsolidation critical period is not useful for say, language acquisition, and vice-versa. Luckily, psychedelics actually increase metaplasticity, the general ability to reopen any critical period. The context or activity done during the psychedelic session determines which critical period is reopened. This means doing reconsolidation during the session makes reconsolidation easier in the reopened critical period after the session. It also implies that, for example, spending your session learning another language would induce a language-acquisition critical period.



neuroplasticity window providing an opportune time to build positive habits and process emotional memories.

## **Barriers to behavioral change + resources to support selected changes**

Most people have some habitual behaviors they have wished to change for a long time. In this section, we will review common reasons people struggle to make behavior changes they want, and offer an overview of strategies for overcoming these barriers. Additionally, we have included a fairly comprehensive appendix (see [A.6](#)) of evidence based recommendations for behavior changes that are likely to have a positive effect for most people who implement them. It includes at least one recommended resource about each of those changes. We hope this appendix will assist readers in identifying the behavioral changes with the lowest cost and the highest reward possible, including changes they may not have previously considered as possibilities. Additionally, we hope the information throughout this section will support our readers in using their neuroplasticity windows as effectively as possible, and that behavioral change efforts in the aftermath of therapeutic MDMA use can amplify the benefits of these interventions.

Many people feel puzzled or frustrated by their inability to enact important behavioral changes that they know would improve their quality of life (like following through on daily exercises prescribed by a physical therapist), or which are strongly aligned with their values (like ceasing porn use to adhere to religious values, or adopting a vegan diet to reduce carbon footprint). In modern US culture, individuals often judge and blame themselves for “not having enough willpower” to successfully make these changes. For some, this can be a perpetual source of shame: because of their failure to enact desired behavioral changes, they begin to attribute negative characteristics to their identity, to consider themselves to be apathetic, stupid, lazy, a bad friend/partner/parent/student/employee, or whatever other negative identity might apply to the situation.

However, research shows that the individuals who are most successful at making these kinds of changes are also (1) likely to frame their shortcomings in terms of behavior (creating guilt) rather than framing them in terms of identity (creating shame), and (2) likely to engage a greater level of structural support for their desired behavior change. Finally, most behavioral health goals have a strong emotional regulation component, even beyond the intensity of a shame response.

Structural support can broadly be categorized as “trigger supports” and “access supports.” Trigger supports relate to what initiates a particular behavior. “Tiny Habits” gives the example of a woman who wanted to get up early and exercise before work, but found herself using the time after her alarm went off in the morning scrolling through her phone instead. After considering several possibilities, she started using an alarm clock and leaving her phone in the kitchen overnight. This removed the trigger for the behavior she was trying to avoid. Other examples of trigger support would include a parent reminding their child to do chores, or someone who wants to spend some time reading every day leaving their book on the couch cushion where they typically sit upon coming home from work. Access supports are things that reduce the level of effort it takes to engage in a desired behavior. A home washer and dryer unit would be an access support for someone with the goal of keeping up with their laundry needs; a private chef, or a week of “meal prep” in the fridge, would be an access



support for someone who is trying to adjust their eating habits. A “dumb phone” and a social working environment with co-workers who feel safe and are supportive of the goal would be access supports for someone whose goal is not to scroll through the internet while they are at work. Creative and extensive use of structural supports can make all the difference in behavioral change success.

Finally, the emotional regulation component of behavioral change is frequently underrated. People often attribute their inability to enact a desired change to motivation or willpower problems, and then beat themselves up for these perceived failures. The more constructive approach is to implement applicable trigger supports and access supports, and then, if motivation still seems to be a problem, to engage with motivation enhancing strategies such as setting up a “fishbowl,” or using the other social accountability strategies detailed in Appendix

Procrastination is most centrally an emotional regulation problem; it emerges from feelings of overwhelm, often followed by shame about the procrastination itself. The single most effective strategy to address procrastination, in my clinical experience, is to practice breaking tasks down into manageable parts. If the procrastinated task is getting out of bed and taking a shower while severely depressed, this might look like calling a friend, then talking through and enacting the process of throwing the covers back, putting one foot on the floor, putting the other foot on the floor, walking towards the bathroom, opening the door, and so on. If the task is an hour long marketing presentation, the first step in ending procrastination might be talking through with a mentor how to break the project down into the smallest parts possible.

Self-destructive behaviors generally are associated with feelings of shame. We recommend Brené Brown’s work on shame resilience [33].

## **Behavioral change goal selection in the age of addiction**

In the words of Anna Lembke: “We’ve transformed the world from a place of scarcity into a place of overwhelming abundance: drugs, food, news, gambling, shopping, gaming, texting, sexting, Facebooking, Instagramming, YouTubing, tweeting... the increased numbers, variety, and potency of highly rewarding stimuli today is staggering. The smartphone is the modern-day hypodermic needle, delivering digital dopamine 24/7 for a wired generation. If you haven’t met your drug of choice yet, it’s coming soon to a website near you. Scientists rely on dopamine as a kind of universal currency for measuring the addictive potential of any experience. The more dopamine in the brain’s reward pathway, the more addictive the experience.” -Dopamine nation, Chapter 1

Addiction is a complex and overwhelming phenomena, with biological, psychological, social, and structural components. It exists on a spectrum of compulsive behaviors. A person’s desire to change their relationship with a given substance or behavior can vary widely: on the one end, someone may want to stop eating fast food on twice-yearly road trips when they already never eat it at any other time. On the other end, someone may have a desperate need to retrieve their life from the encompassing grasp of methamphetamines or heroin. Although it has become socially acceptable to joke or vent about our less destructive addictive tendencies, (like a coffee addiction or a social media habit that isn’t ruining our employment and hygiene) our current societal, economic, and technological structures generally provide

poor support for individuals struggling with addictive tendencies at all levels. Individuals use substances and behaviors that have negative consequences because those substances and behaviors solve some kind of problem for the individual who uses them. The most effective way to assist individuals who are struggling with these kinds of harmful coping patterns is typically multi-pronged. It might include any or all of the following:

- medication assistance to reduce cravings for a harmful substance
- opportunities to contribute to and connect with their communities in meaningful ways while sober
- peer support
- psychotherapy
- case management (helping the individual access a variety of needed contexts and resources)
- contingency management (creating accelerated and enhanced positive and negative consequences supporting the desired behavior changes)
- other executive function support, such as tailoring the living environment to support the preferred coping choices and building healthy habits like sleep and meditation, which support impulse control
- intensive medical and psychiatric management of any underlying issues that have induced them to use the harmful coping mechanisms.

The average individual who struggles with addictive behaviors, far from being able to bombard the problem from all sides as I've described above, is shamed for not being able to simply choose to stop using the harmful coping mechanism. This typically increases use of the harmful behavior or substance. In short, we live in an age where addiction has been aggressively stigmatized/shamed and resources for treating it denied, while resources and structural support for maintaining addiction have been amplified. "Crossover addiction," where individuals who struggle with one addictive coping practice simply shift their dependence onto another addictive coping practice, is pervasive. Although we would all like to see ourselves as independent decision makers, we increasingly live in an attention economy where massive investment has been made in competing for each nanosecond of our attention. It is increasingly difficult to capture those moments of our own attention back, and to focus them on our safety, flourishing, freedom, and connection with others.

To make matters worse, despite emerging from the "overwhelming abundance" Anna Lembke describes above, addiction creates scarcity. It creates a scarcity mindset regarding access to the coping mechanism, whether that's time for gaming or money for heroin, and in its worse iterations, it inspires compulsive behaviors that are financially, socially, and medically destructive in the extreme. Just as important for the problem of escaping addiction, it perpetuates scarcity around meaning and human connection. Addictively patterned coping mechanisms numb feelings all around, impeding our ability to be vulnerable and connect deeply with one another and with the things we find important in life. In rats, non-heroin-using individuals were found to help a fellow rat escape from a trap, while heroin using rats didn't bother.

Second, despite the dystopian background, strategic habit development can (with commitment over time) provide access to cornerstone strategies on which to build a better life. To select a behavioral change goal that's right for you, consider your own motivation, your life experience, the degree to which the behavior change offers benefits across a range of life domains. For instance, regular exercise or meditation can help many individuals with pain management, depressive symptoms, and physical health. To find the right foundational habits for you, you'll need to consider your individual supports, accessibility challenges, and barriers. We make some general suggestions that are beneficial for a majority of people in [Appendix A.6](#).

A harm reduction framework is both evidence-based and essential when addressing addictive coping patterns. I once read (maybe in the book “tiny habits?”) that the most important characteristic for personal growth is the ability to experience satisfaction from small victories. Abstinence is an excellent goal for many people in many situations, but if you are not interested in abstinence or if abstinence is not realistic for you right now (or if your addictive pattern is around food or screen time, which are not realistic to totally abandon), your welfare may depend on your ability to give care to yourself by identifying the harms your coping mechanism creates, and mitigating those harms in more realistic ways. There are incremental victories to be had that make a significant difference in the level of harm an addictive coping mechanism creates in a person’s life. You may reduce the amount you use, or regulate the timing (only after work), or refrain from mixing multiple substances or from gambling in the first three days after your paycheck comes in. If you are not ready to stop drinking, you may focus on making sure that you get all your driving and work accomplished before you start drinking each day, and that you stay hydrated and eat some healthy food on the regular. Maybe you want to start meditating for three minutes each day before you start drinking. These measures are meaningful. They reduce harm, improve your quality of life, and will leave you in better shape if the day comes when you are ready to make bigger changes. It’s important to adopt a mental framework (and cultivate a support system) that sees the value of small improvements and supports you in making the changes you are interested in and ready to make.

#### **5.8.4 \*\*Afterglow**

Some people experience a temporary afterglow (wellbeing, mindfulness, less mental illness) for days-weeks after some psychedelic-therapy sessions [80]. We have seen a variety of anecdotes that MDMA sometimes also induced afterglow. We caution against chasing after it with more frequent MDMA doses. Afterglow is often unreliable, while reconsolidation provides durable, long-term healing that does not require continued medication.

### **5.9 \*\*Long-Term Trends of Therapy**

In our educated guess, accessing the maximum possible benefits from reconsolidation may take anywhere from single digit hours of mismatching for simple problems to thousands of hours for the most severe mental illness. Because of this, those with severe mental illness may only perceive relatively small week-to-week gains in symptom improvement even at the maximum daily mismatch limit. These small gains can add up to more visible improvement on a monthly timescale. We have also observed that long-term progress often feels non-linear (See Figure 4). Therapeutic destabilization may make things feel worse at times, or extended periods of reconsolidation may only yield visible results at unforeseen turning points.

### Therapeutic Up's and Down's

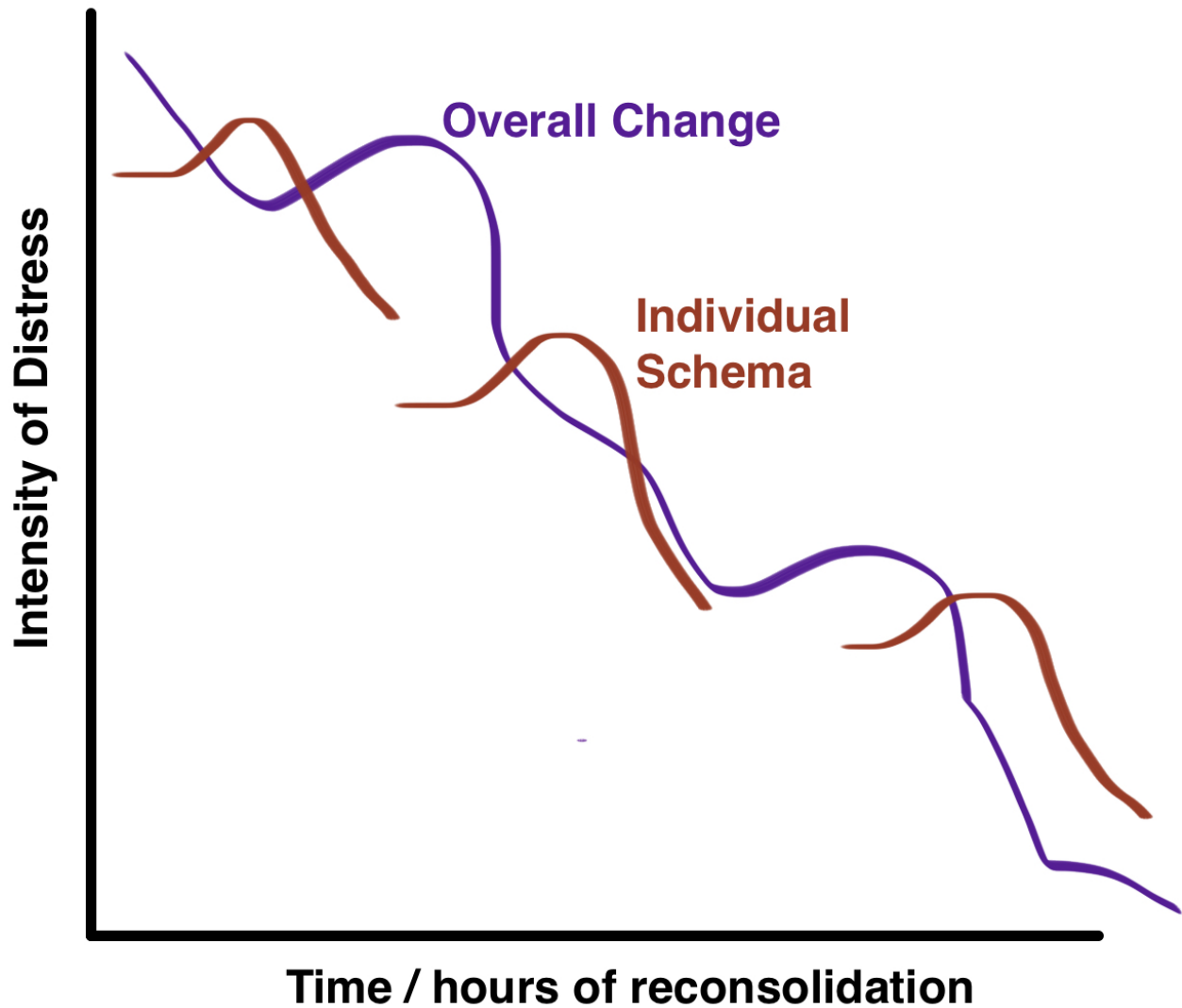


Figure 4: The progress of therapeutic improvement has unpredictable ups and downs, but is reliably positive in the long-term. In our experience, the intensity of individual maladaptive schemas often appears to increase when you start working on them, before decreasing following completion of reconsolidation. Increases in distress are caused by a variety of mechanisms we call therapeutic destabilization (see Section 4.3).

## 5.10 Managing Anxiety and Panic

There are multiple practical objectives in healing. Keeping these balanced determines the pace and methods of healing:

rehome this list?

- Healing as soon as possible to minimize suffering and improve function.
- Healing that is durable rather than fragile.
- Developing skills to process future maladaptive schemas.
- Avoiding major disruptions to your life from therapeutic destabilization (increased emotional, or physiological distress, often as a result of confronting or processing traumatic memories) or other adverse medical and psychological effects.
- Minimizing various costs.

Therapeutic destabilization may intensify as dissociation diminishes during therapy, surfacing previously unconscious memories and potentially causing heightened distress [120]. While destabilization is an inherent aspect of trauma therapy, the intense nature of MDMA-therapy can particularly evoke complex responses. This is especially so for those with complex trauma, though self-awareness of such trauma can be elusive due to avoidance and dissociation. Different anxieties may surface and calm at different points throughout your healing journey.

Monitor your physical and mental well-being post-session.

offer tools and protocols

### Common techniques to manage anxiety and panic [120, 238]:

why is this section separate from A.7?

- **Grounding Techniques** These are strategies to help you connect with the present moment, especially when you feel overwhelmed or dissociative.
  - Mindfulness-Based Stress Reduction: Using mindfulness practices (as detailed in Appendix A.4) to connect with the present moment, one can observe and accept emotions without reacting as strongly.
  - 5-4-3-2-1 Sensory Awareness: Noticing five things one can see, four one can touch, three one can hear, two one can smell, and one one can taste.
  - Progressive Muscle Relaxation: Tensing and relaxing muscle groups to reduce physical tension.
  - Weighted blankets, holding an object, or touch from a trusted person.
  - Visualization of a safe space where you feel like your truest self. Imagine vivid sensations (e.g. the feel of your bare feet on a forest floor, if that's comforting to you) to increase its power.
  - Intuitive eating

### • Safety

—

nature connection/protection/imagery

- Crisis Plan: Make a plan for what to do if symptoms become overwhelming.
- ~~Containment Imagery: Imagine a safe container or box where difficult memories can be stored until the next session.~~ make into appendix
- **Safety Mapping** Safety mapping is a valuable tool for identifying See 5.5 for more information. Once you have done this exercise you can use this information to:
  - Imagine a safe, comforting scenario when you feel overwhelmed. Imagine vivid sensations (e.g. the feel of your bare feet on a forest floor, if that’s comforting to you) to increase its power.
  - Set boundaries around stimuli that activate challenging schemas. For example, you could tell someone you feel overwhelmed when they talk about a particular topic, and you would appreciate them avoiding it.
- **Psychoeducation** Knowledge of trauma and its effects can make your reactions more understandable and predictable. vagal, sympathetic, parasympathetic
- **Feeling and Symptom Tracking**
- **Soothing Activities** Activities to calm oneself, such as warm baths, music, art, nature walks, pleasant scents, hot herbal tea, reading, interacting with pets, etc. day writes something; possibly appendix
- **Limiting Exposure** Not going too fast in therapy. How would this work with MDMA?
- **Establish Predictable Routines** Regular routines in your daily life can provide a sense of normalcy and predictability. This seems to conflict with my successful Max Speed approach. Resolve.
- **Social Support** Ask for logistical and emotional help from friends, family, or support groups. rest and play. Can also boost executive function
- **Reconsolidation** Reconsolidating the relevant schemas will relieve anxiety. See Section 5.8.2. day write more?
- **Medication** Propranolol may deactivate a fight-or-flight activation by inhibiting adrenaline receptors [215]. Collaboration with a doctor is necessary because propranolol requires a prescription. We do not discuss risks and benefits here. Kava reliably reduces anxiety [172]. Side effects when used for less than 24 weeks are mild, infrequent, and transient. Longer term use is poorly studied.
- **Unwinding Anxiety App**

## 5.11 \*\*Session Frequency

Although no research exists on the impact of varying time between MDMA sessions, we feel the following factors are worth considering:

- Sleep is likely very important for post-session recovery and reconsolidation [209]. We have observed that users often report up to 2 additional days of fatigue in addition to the session day. We also think it is difficult for inexperienced users to distinguish between post-session fatigue and surfacing depression schemas. Starting another session before you have recovered from the fatigue of the previous one may reduce session effectiveness and increase the risk of undesirable effects. We have heard two anecdotes that back-to-back psychedelic therapy sessions with no recovery days increases the risk of severe destabilization symptoms like psychosis.
- Tolerance to MDMA starts developing within 1-2 hours of ingestion [81, 168]. We have been unable to find any data showing how long this tolerance lasts, but it is associated with higher and more frequent doses. Distinguishing the effects of tolerance from dissociation, resistance, or the natural variation of sessions may be difficult. However, if you notice a pattern of diminishing effects, we suggest experimenting with spacing sessions further apart or reducing dose. Using higher and higher doses to overcome tolerance may be a sign of psychological addiction.
- MDMA induces a period (2-4 weeks in mice) of neuroplasticity [159]. We have experienced that between-session reconsolidation exercises are easier during this period. See Section 5.8.2 for instructions. If you want to accelerate healing, we recommend spending more effort on and experimenting with reconsolidation exercises in this period rather than more frequent MDMA use. You may even find that maxing-out your reconsolidation capacity every day will deliver very large amounts of therapeutic progress. Developing the skill of sober reconsolidation can reduce your therapeutic reliance on MDMA and allow reconsolidation in a wide variety of circumstances where MDMA use is not appropriate. When well-developed it also allows faster healing because the safety and logistical considerations of MDMA-therapy are no longer limiting. In the absence of better safety data, waiting to do another session until after the neuroplastic period also increases the margin of safety vs only waiting a few days until you are no longer fatigued.
- We have observed that some sessions may be either psychologically stabilizing or destabilizing depending on what schemas are activated in your life. If you find your sessions consistently destabilizing to a degree that is causing you major problems, waiting longer between sessions may reduce the effects of destabilization. In this circumstance we also recommend a combination of professional support and proactive self-care strategies like the ones listed in Section 5.10.
- One of the most important aspects of psychological counseling is a therapeutic alliance, which can be understood as “The bond between client and therapist; the collaborative approach and agreement on treatment goals; the collaborative approach and agreement on treatment tasks”, as described by Greenspace [97]. The quality of therapeutic alliance is a major predictor of the effectiveness of psychotherapy. We suggest that for individuals who are unable to establish a therapeutic alliance with a conventional mental health practitioner, or who are unable to access a mental health practitioner with whom they are able to establish/maintain a therapeutic alliance, MDMA can offer



a first foothold in the healing of trauma. The medicine can be particularly helpful if transference (attributing feelings actually about other people and circumstances to the clinician or therapeutic process) becomes an obstacle to healing. In some cases, it does this by allowing the client to feel some degree of secure attachment to the MDMA as a parent figure. Sometimes, this can then be developed into a needed on-ramp to access other healing modalities. Thus, one of our concerns about keeping a of low frequency MDMA interventions is that this opportunity could be missed, or time could be wasted. A critical mass of support for a briefer period of time can allow someone to become more self-sufficient or able to access community supports, whereas the same amount of support spread out over a greater period of time effectively perpetuates disability.

- As detailed in the safety section, a very high number of cumulative doses of psychedelics can cause valvular heart disease. It's conceivable that chronic use also causes other, poorly understood problems, particularly for groups of people with certain genetic variants or health conditions.

MDMA eventually loses its effects for some people [81, 168]. The reasons and prevalence are unclear, though it has been associated with higher or more frequent doses. If you feel that you are reliant on MDMA for therapeutic progress, we suggest stopping recreational use in order to maintain efficacy for future therapeutic need.

We suggest Figure 5 as a high-level guide to the therapeutic process.

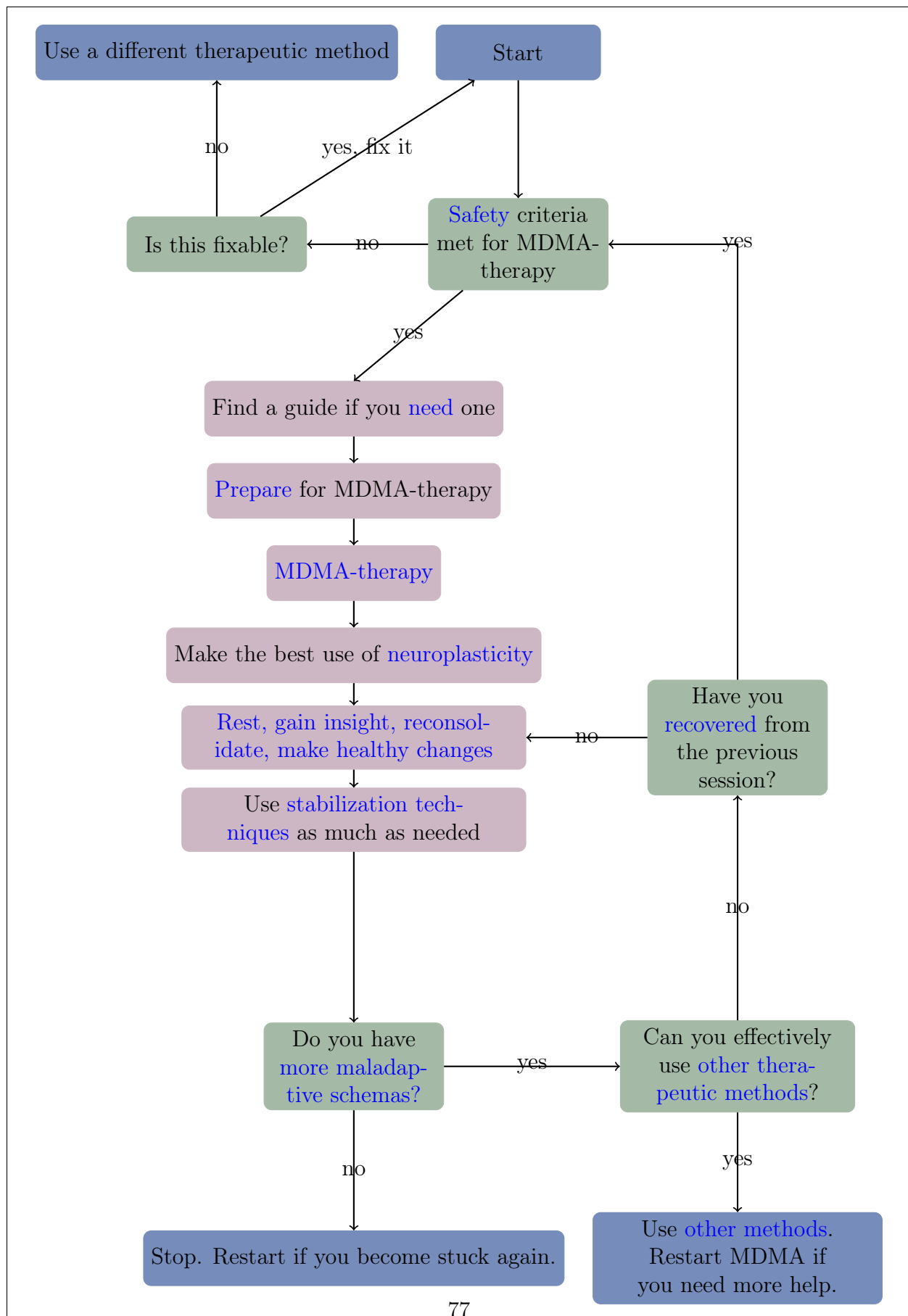


Figure 5: Generalized long-term therapeutic process.

## 5.12 **\*\*Prompts for Uncovering Common Maladaptive Schemas**

Healing benefits increase as you continue reconsolidating maladaptive schemas [73]. In an ideal world, everyone would have access to as much strong clinical support as they need before, during, and after all of their reconsolidation efforts to facilitate the surfacing of maladaptive schemas. In the absence of that support, we use our experience to offer the following prompts to help you access the schemas that you may not be aware of, but which could be having a significant negative impact on your life. While there are no clear lines between the categories of prompts we offer, many of them directly relate to mental illness, while others focus more on assisting you with living the life of compassion, self-knowledge, connection, and flexibility that you may desire. Assisting you in finding pain points you have been unconsciously hiding from yourself is one of the jobs a therapist would have, but it is possible to do some of it on your own with tools like these. These methods attempt to elicit strong negative emotions, which are valuable signals that adequate emotional processing has not occurred. As discussed in the safety section, if you struggle with severe mental illness (including but not limited to suicidality, mania, or psychosis) we strongly urge you to engage these kinds of prompts with caution and professional support.

We have experienced this kind of work to be positively transformative, satisfying, and deeply meaningful even for individuals who come into it feeling mentally well. As such, we recommend these prompts to anyone who feels at all interested in deeper self-knowledge, meaning, and connection with others. Many of these prompts are also useful for activating social biases which can be reconsolidated like most other maladaptive schemas. Additionally, we think a general principle of noticing and going toward objects of distress is usually a fruitful endeavor as long as you are physically safe. Similarly, we think most defense cascade activation (see Cheetah House [43] for symptoms) or fear, anger, anxiety, etc. in daily life outside of immediately dangerous situations is a valuable indicator of maladaptive schemas.

### **Love and Belonging**

- Reflect on the factors promoting early secure attachment (Appendix A.2) and the principles of Self Determination Theory (Appendix A.5). Think about how they were present or absent in your upbringing or current life. How do you feel about that? If this seems confusing to you or you draw a blank we suggest two things: Take an attachment assessment quiz [177]. Try the Ideal Parent Figure method (see Section 7).
- Compassion meditation (See Appendix A.3) can be distressing for individuals who are experiencing isolation, mistrust, or relational dysfunction. As such, it can be a helpful tool for identifying schemas related to these concerns.
- What makes you feel loved? What comes up for you when you do not feel loved?
- Do you feel like a certain group of people-perhaps sharing certain religions or political beliefs, or sharing a certain set of experiences or cultural practices-are “your people?” If so: what does it feel like, and what are your assumptions, when you are interacting with individuals outside that group? Do you feel 100% safe with individuals who \*are\* part of your group? Do you ever have experiences or desires that make you feel like

you are not as safe or accepted within your group? When do you feel like you “fit in” with your group, and when do you feel like you truly belong with them?

- What thoughts and experiences make you feel like you don’t have a place to belong?
- What stops you from feeling compassion, or from wanting to feel compassion?
- Have you spent time in environments where others prioritized your needs equally to their own? If so, how did that experience feel? If not, how does it feel to know you’ve never experienced that?
- Have you ever had the experience of not being appropriately valued, respected, considered, and cared for by others around you? What feelings are associated with that?
- What would it feel like (or what has it felt like) to go from feeling that you were not valued, respected, considered, and cared for, to feeling that you were? What would it feel like to give this gift to another person or being in your world?
- What makes you feel you are special to the most important people in your life? What comes up for you when you do not feel that you are special to them?
- Does it ever feel like you will not be lovable/loved if you are angry?
- Do you feel that you are wanted and lovable?
- Does it feel like you have to be very ill to deserve to be taken care of, or like you deserve care even when you are basically well? Why did you give the answer you gave?

### **Competence, Competition, and Safety**

- If you could wave a magic wand and be better than any one other person you know in any one endeavor, what would you choose and why? What if the possibilities were expanded to include everyone in the world, even if you don’t know them? What are the runners-up, things that interest you, but are not your topmost priority? What does it mean about you that you are not currently able to surpass them in that endeavor in the real world? How would you answer these questions if all of your practical needs (money, physical health, etc.) were fully met?
- If you could take something away from someone because it does not feel fair to you that they have it, what would you take away, and from who? How many times would you repeat this process, with how many people, and why? If you could experience the positive feelings you associate with taking things away from others, without taking anything away from anyone, what would that mean or be like for you?
- Is there anything someone else has that you associate with your own unmet need, or the unmet needs of people you love? For example, if you have loved ones who struggle with housing insecurity, do you think about that when you drive through neighborhoods with extremely large houses?

- If you completed the Cartesian Plane of Safety in Section 5.5, think about the unsafe and safe items on this chart. Why is each item placed where it is?
- Think of things you feel angry, fearful, or anxious about.
- What makes you feel special compared to other people in your community, people who you meet, or people in the world? What comes up for you when you do not feel special, or when you do not feel "good enough"?
- Are there some sources of information that make you feel unsafe? What are the stories you are telling yourself about that information and those sources? For instance: how do you feel about information you are given by individuals or institutions who have harmed, mislead, or excluded you in the past?
- What things make you feel powerless? When you feel powerless, what do you reach for?
- Do you feel like you have to be strong?
- Do you feel like you can handle anything? If so: what would it mean or feel like if something were to happen in your life that you couldn't handle? Why do you think you feel the need to exclude that possibility from your imagination?
- Do you feel like you must justify your existence by doing something?
- How do you feel about groups of people or beliefs that are becoming more numerous or prominent, perhaps at the expense of your group of people or one of your treasured beliefs?
- How do you feel about the inevitability of frailness and death?

### Self-worth and Identity

- Class, status, and money: If this is an area you are interested in exploring, consider reading through Building a Nuanced Understanding of Social Class or Compiled sliding scale questions by Harper [102] . What has your experience been? What do you wish it had been? What feelings come up as you think your way through the many dimensions of class?
- What makes you feel like you are not enough, and you do not have enough?
- On a deep gut level, what characteristics do you feel are appropriately associated with men, and what characteristics do you feel are appropriately associated with women? How does it make you feel when people (including yourself) conform to those characterizations? How does it make you feel when they (or you) \*don't\* conform to them?
- Complete the prompt "I want to be perceived as" and the prompt "I don't want to be perceived as" three times each with respect to a variety of the most important areas where people feel shame. See the shame triggers exercise in the Appendix A.1.

cite sliding  
scale Q

- How do you feel about your own anger? About your own sadness? About your own pride? About your own limitations and needs?
- Do you feel it's not right for you to be angry? Why or why not?
- Grief: Have you experienced major losses in your life that you are still struggling to face—losses that cause you to feel disorientation and longing? (Delineation of grief taken from “Atlas of the Heart” by Brené Brown). Are some of these losses the kind of thing (like miscarriage, the loss of memories held by a loved one with Alzheimers, loss of ability, or loss of an imagined future) that receive little or no social recognition or support? If you are experiencing this: can you articulate what it is you long for?

## Meaning, Interconnection, Interdependence, and Emotional Flexibility

Ambition?

- What outcomes or ideals do you feel are worth sacrificing for? What kinds of sacrifices? How do you or would you feel if you were called upon to make these sacrifices? If you were to receive absolute moral certainty that you should not sacrifice for these outcomes or ideals, without having your feelings about those outcomes or ideals change at all, what would it feel like, and how would you react?
- What stops you from dreaming and wanting big things?
- What stops you from feeling that it's worthwhile to engage in projects that express your values in your community?
- Do you ever feel overwhelmed when you think about enacting values that are important to you?
- How does it feel when you have to make trade-offs between multiple things that you value?
- Do you experience self-judgement around how much you do or do not live out your values?
- If you find the concept of non-attachment compelling or appealing, consider visualizing permanent disconnection from your deep-seated attachments to one or more of the following: life, health, partnership, meaning, belonging, existence, status, being a good person, certainty, material comfort, order, sensory pleasures, and relationships. What emotions arise if you consider your fundamental assumptions about life, meaning, and self might not actually be true? Reconsolidating maladaptive schemas around attachment typically leads to equanimity and gratitude, not loss of healthy protective behaviors or basic attachments.
- Do you ever feel like you are responsible for the whole world?

## Conflict, Collaboration, and Trust

- Looking at photos of people you have conflict with is often productive.
- Who is not worth collaborating with, and why?



- Who is not worth engaging in active conflict with, and why?
- If you could convince every important person in your life of one belief, what would it be? What if you could convince every person in your city, or every person in your country? How does it feel when others disagree with you about that thing?
- What makes you feel you are not being listened to, when you have a right to be listened to? What makes you feel disrespected? What comes up for you when you are disrespected, shut down, or ignored?
- How would it or does it feel to collaborate with others who disagree with you about important things? Would it be comfortable to collaborate with people who had 90% of your positions in common? What about 50%?
- How do you feel when others around you express anger, sadness, pride, limitations, or needs?
- What makes you feel angry?

### **Automatic Behaviors and Bodymind Reactions**

- Do you have any escapist or addictive (not necessarily involving substances) patterns, including any related to MDMA? Are you using these to avoid or cope with distressing feelings [88, 5]?
- If there is a behavior in your life which you have repeatedly attempted to stop engaging in, without success, are you able to regard those attempts compassionately?
- If there is a behavior you engage in that you feel is clearly self-destructive, are you able to regard this pattern with compassionate curiosity and a desire to cultivate change? If not, what are you feeling instead?
- If there is a behavior you engage in that other people close to you feel is self-destructive, but which you experience as a strong positive in your life, what are your feelings about that conflict?
- Carefully expand your therapeutic environment to include stimuli that activate challenging schemas, as detailed in Section 5.5.
- How do you feel in your body after you spend two hours scrolling on your phone? Is it different for different activities?
- How do you feel about the things you own?
- How do you feel in your body when you think about your finances?
- How often do you feel fear or anxiety? What brings up these emotions for you? What do they feel like in your body?

- Stress or maladaptive schemas often cause physical symptoms in your body. Body-scan meditation (Part of Appendix A.4 describes this technique) is useful for locating these. Focusing on these physical feelings can activate and reconsolidate the associated schemas.

- \_\_\_\_\_ Race
- \_\_\_\_\_ Sex
- \_\_\_\_\_ NIMBYism schemas
- \_\_\_\_\_ colonizer/colonized
- \_\_\_\_\_ political correctness; can't say certain things; will be unfairly punished?

Unconscious avoidance and resistance are powerful obstacles to healing. Incorporating small amounts of psilocybin or LSD into your session can help bring avoided feelings into focus (see Section 5.4).

do they really? revisit polydrug use

## 6 The Expanded Self

Some frameworks of psychedelic integration, including those of many indigenous cultures, consider community, interpersonal relationships, the natural world, and existential insights to be essential components of the integration process [22]. Celidwen et al. [42] reports the following as broadly agreed-upon by traditional indigenous practitioners of psychedelic medicine:

Traditional Indigenous medicine is an ethical, ecosystem-protective, and holistic system of medicine that interconnects humans and the environment. A sense of reverence for the planet guides all relationships, as well as a commitment to preserve all life. Traditional Indigenous medicine from a systems and relational perspective prompts insight for compassionate living and awareness of collective care to sustain the wellbeing of the medicines themselves as well as all future generations.

In these models, these other components may not be described as fundamentally different than what is commonly meant by the self in the Western world. They may actually be described as different aspects of an expanded self. In practice, this might look something like this: During an MDMA-therapy session you experienced compassionate insight into the causes of a maladaptive or harmful behavioral pattern of yours. You sat with the pain of the behavior-causing schema and it dissipated. This experience helped you understand the causes of your behavior and the solution to ending that pattern. In an extended-self model this insight would also be applied to other domains of life. What implications does knowledge of maladaptive schemas have for public policy, the criminal justice system, cultural practices in your community, etc? Another example: During a session you had a deep understanding that you are worth of love and care; your wellbeing is deeply important, no matter what.

This understanding persisted into daily life and you feel an ongoing sense of self-worth that you were previously missing. In the expanded-self model this insight would be transferred to others. The wellbeing of all beings is deeply important, including the humans who have hurt you, farmed animals, and possibly even insects. What does this mean for how you treat them and how the systems you are a part of treat them?

We present here a few sections that we think are particularly relevant for the expanded-self in a modern world.

## 6.1 The Ongoing Practice of Maintaining Cognitive Flexibility

Earlier we discussed our belief that tribalism has intensely negative effects in the modern world. Reconsolidation can reduce many negative aspects of tribalism. Because we live in a world of pervasive fear-based messaging and out-group demonization, we believe additional strategies are necessary to maintain cognitive flexibility and compassion in the long-run. We strongly recommend two books on the subject that approach the topic from different angles:

*The Scout Mindset* by Julia Galef [90]. It describes an approach to thinking, relating, and community that prioritizes curiosity, open-mindedness, and the desire to see things as they truly are, rather than seeking to confirm one's preexisting beliefs. This mindset encourages individuals to gather information from diverse sources, question their assumptions, and update their views based on evidence, ultimately leading to more accurate knowledge and better decision-making.

*Why We're Polarized* by Ezra Klein [119]. It discusses the self-reinforcing feedback loops between our fears and identities and the behavior of the media and politicians. This cycle increases polarization, political dysfunction, and separates us from each other.

## 6.2 Expanding the Circle of Compassion

Cultivating empathy can enrich your connection to others and spur compassionate action, thus creating healthier societies. Research has identified three forms of empathy: affective empathy, cognitive empathy, and empathic concern. "Affective empathy" refers to having an emotional experience you believe you are sharing with another. Unfortunately, we are often inaccurate in our assessment of what emotions other beings are actually experiencing. "Cognitive empathy" refers to our ability to logically understand how others feel, and also why they feel the way they do-what all the contributing factors are, and how those factors work. Finally, "empathic concern" refers to our desire for others to have good things.

Among the helping professions, higher levels of affective empathy are associated with burnout and poor client care. When a caregiver is experiencing high levels of affective empathy, they are naturally motivated to address their own distress by helping the client with what they perceive is wrong-which may or may not have anything to do with what the client actually needs or is actually experiencing. In contrast, in these same populations, higher levels of cognitive empathy and empathic concern are protective against burnout and correlate to higher quality client care. As such, when we talk about cultivating empathy, we are talking about increasing your levels of cognitive empathy and empathic concern. To illustrate: suppose your friend is a father, who feels angry and powerless about his teenage daughter's choice to dye her hair purple. You might feel affective empathy towards

his powerlessness, relating to the way his status in the community might be negatively impacted by her choices. However, it may be that his distress is not connected to feelings about status, but only to concern about her welfare and what the change may signal about his daughter’s mental health. Your ability to effectively exercise compassion towards this father is contingent on the quality of your cognitive empathy-your ability to accurately assess and communicate where his needs, feelings and concerns are actually coming from.

Much of the existing research on increasing positive emotional states of kindness and compassion, associated with cognitive empathy and empathic concern, is focused on compassion meditation and loving kindness meditation. We feel that these practices are worth a try for most people (see Appendix A.3 for instructions), as they are correlated with a number of positive outcomes. We also feel that therapeutic MDMA sessions may offer an opportunity to jump-start or supercharge the process of cultivating cognitive empathy and empathic concern. Completing a compassion meditation during the MDMA session could be helpful for this. Alternatively, you might focus specifically on cultivating cognitive empathy through the following contemplative exercise:

During a session, look at photos of other beings and consider what you share with them, what facilitates their wellbeing, what they deserve, and what obligations you may have to them given the significance of their moral worth. As with a classical compassion meditation, you might start with yourself or someone who you find easy to generate compassion for, and then slowly by degrees work your way out through other categories of beings you may not feel as connected to. We believe non-human animals are an important target for consideration and compassion, as a large group of biologists and philosophers recently declared [14]:

First, there is strong scientific support for attributions of conscious experience to other mammals and to birds.

Second, the empirical evidence indicates at least a realistic possibility of conscious experience in all vertebrates (including reptiles, amphibians, and fishes) and many invertebrates (including, at minimum, cephalopod mollusks, decapod crustaceans, and insects)

Third, when there is a realistic possibility of conscious experience in an animal, it is irresponsible to ignore that possibility in decisions affecting that animal. We should consider welfare risks and use the evidence to inform our responses to these risks.

We posit that taking a holistic approach to compassion and cognitive empathy can avoid major oversights in our personal actions and beliefs, allowing us to maximize the benefits of a more connected and compassionate life by exercising compassion in areas where we otherwise might not have. Additionally, we posit that formalizing your compassionate impulses can sometimes lead to better prioritization and better outcomes. Both of these practices may assist us in expanding our moral intuition into new situations.

We also recommend that practitioners be cautious of major ethical readjustments during or after an MDMA trip, just as you would be with major life choice changes. Particularly high caution is warranted around actions that involve harm to some beings in the pursuit of a greater goal [16]. While we are sometimes faced with difficult choices, these types of actions often have toxic personal, organizational, and reputational effects. We recommend thinking

through the many effects of your actions, including their larger systemic and relational impacts. Such actions are also commonly used as a, perhaps unconscious, rationalization of unconscious ego-related schemas. We suggest that deeper exploration and reconsolidation of maladaptive schemas, including those listed in Section 5.12, will help you better align personal actions with the needs of all beings.

When recovering from trauma, it is common for one's moral framework to become intertwined with maladaptive schemas-leading to unhealthy ethical frameworks like the "I must save the world to be a valid person" belief Gabor Mate discusses in "The Body Says No." (Also see the section of this paper on Psychogenic illness.) At the same time, cultures and institutions often dismiss major harms-current examples relevant to mainstream US culture include childbirth trauma and the trauma of living through a mass extinction; past examples include enslavement or "resettlement schools." In situations like these, we posit that traumatized survivors represent an important repository of experience, essential for crafting cultural shifts that could help avoid the future repetition of these and similar harms. As such, it is important not to dismiss the moral intuition generated by traumatic experience, but rather to approach it with compassionate curiosity, as one important source of insight among many.

### 6.3 Using MDMA to Facilitate Connection with Nature, a Fundamental Human Need [Need to rethink this section.]

As Baxter and Pelletier [23] articulated, "In general, research supports the proposition for a basic psychological need for nature relatedness." They define the "need for nature relatedness" as "a basic human psychological need to feel a secure and pleasant experiential connection to nature in a cognitive, emotional and physical sense." Additionally, time in nature correlates with small improvements in blood pressure and stress [227]. If you have been excluded from the benefits of nature-relatedness and regular nature exposure by your personal life history or access, we suggest therapeutic MDMA may serve as a catalyst for introducing or strengthening this beneficial relationship in your life.

In order to leverage therapeutic MDMA to create a "secure and pleasant experiential connection with nature" we suggest completing an MDMA session in a peaceful natural setting.

To safely get the most from this exercise, consider:

- Arranging the presence of a nature-experienced friend who can assist you in finding a good location and staying safe during the session
- Access to support services and utilities, like bathrooms, food, shelter, and medical care
- Your level of experience and prior experiences with the medicine and dosage you will be using
- Physical hazards, like things you could fall off of and things that could fall on you
- Local plants (like poison ivy, thorn bushes, or plants that would be dangerous if ingested)

discuss how to interpret moral intuition of traumatized people? Many people have experience with traumatized people having extremely maladaptive beliefs

recommended readings for compassion meditation and for moral philosophy

- Local wildlife and its likelihood of interacting with your specific location (many snakes like rocky areas near water, bears and rodents can be attracted to food, areas with higher human traffic tend to see less wildlife etc.)
- Insects and other bugs-in the US, especially ticks and mosquitos
- Additional precautions to avoid other humans and maintain legal safety
- Weather appropriate food, water, gear, first aid supplies, and shelter

Although this list may appear daunting, most nature-experienced individuals are accustomed to taking these things into account continuously. Securing a location that takes all these items into consideration may be as simple as arranging to use the backyard of a friend who lives in the countryside or the woods, or having a friend who understands what you are looking for recommend a preferred campsite.

During the actual session, engage all your senses— touch soil with your bare feet, study plants and insects, and feel bark textures. Using psilocybin or ayahuasca can deepen the nature connection and promote permanent increases in feelings of nature-connectedness [89]. We suggest caution if you suspect you have major unresolved trauma as it might resurface.

According to Baxter and Pelletier [23], increased cognitive and emotional attachment to a specific natural environment “will create a feeling of security and belonging with respect to that particular environment and lead to greater identification with that environment. This, ultimately, will lead a person to feel safer within that environment, which will ease the ability of that environment to elicit the positive effects for the person’s psychological well-being.” As such, we posit that further explorations of one’s therapeutic target environment can increase the positive effects of this intervention-and that such explorations may not need to be exclusively physical. The nature relatedness of Baxter and Pelletier has a strong cognitive component, and thoughts and feelings about belonging and familiarity are important to their model of how psychological benefits of nature-relatedness are realized. As such, we posit that additional emotional and intellectual explorations of the complexities of nature and our mutually integrated place in it (during or between therapeutic MDMA sessions) are promising as an additional mode of maximizing these benefits.

Repeated experiences in the same natural environment will generate a cognitive and emotional attachment to that area and a stronger sense of place. For example, children who are reared with natural areas readily available may grow up to be more nature connected later in life [239]. The repeated exploration of a specific natural environment will generate a set of experiences and cognitive representations of the environment that will create a feeling of security and belonging with respect to that particular environment and lead to greater identification with that environment. This, ultimately, will lead a person to feel safer within that environment, which will ease the ability of that environment to elicit the positive effects for the person’s psychological well-being.

## 7 Additional Therapeutic Techniques

Here we list various practices and medicines we think are particularly useful for additional healing between or instead of MDMA sessions. Those doing solo healing may find more or less



luck attempting these methods on themselves. We suggest, if therapist cost or availability are significant barriers, that at least a few sessions with a trained professional can be greatly beneficial to learning a technique. Many therapists also offer video-therapy available from anywhere with a good internet connection. Therapists are often legally prohibited from working with clients outside their state or country of licensure, though this is usually only a problem if you tell them where you are located.

- **Unwinding Anxiety App:**

- **Coherence Therapy:** This method is one of the few explicitly founded on the principals of schemas and memory reconsolidation [73]. It treats all problematic or distressing habits, emotional responses, and beliefs as logically consistent with the individual's internal emotional landscape. These maladaptive schemas are deliberately juxtaposed with a contradictory experience from the individual's past to update the individual's emotional landscape to better fit their current context. We recommend the thorough summary and assessment by Sotala [213] for an introduction to the subject. Interested readers can follow up with the textbook by Ecker, Ticic, and Hulley [73]. A directory of trained therapists is maintained by Coherence Psychology Institute [48]. We recommend it because it closely aligns with the memory reconsolidation framework.

- **Internal Family Systems (IFS):** We have observed many people report IFS working well with MDMA therapy. We also recommend it because it closely aligns with the memory reconsolidation framework [73].

- **Ideal Parent Figure Method:**

- **Psychedelic Somatic Interactional Psychotherapy (PSIP):** Though rigorous trials have not yet been done, we think this method shows particular promise for reducing panic or dissociation that impede typical therapeutic methods [186, 183]. In this method, a small dose of THC or ketamine is used to directly engage with, and process, the hyper or hypo-activated defense cascade. We recommend a paper by Razvi and Elfrink [186] and a presentation by Razvi [184] for an introduction to the topic. A directory of trained PSIP therapists is maintained by Psychedelic Somatic Institute [180]. We recommend it mostly based on popularity of the method in psychedelic therapy, personal experience, and its alignment with the defense cascade.

finish

## 7.1 Psycholytic Therapy

Small to medium-dose LSD (30-150  $\mu$ g, lasting 10 hours) or psilocybin (3-15 mg, lasting 5 hours) sessions have a long history of therapeutic use [170]. This use of psychedelics is differentiated from traditional North American approaches by its lower doses. At these low doses the primary contraindications are pregnancy, serious liver and kidney diseases, some types of brain disorders, or personal or family history of psychosis or bipolar disorder/mania [201, 170]. We also suggest that a history of suicidal ideation indicates support (making a plan with a therapist or guide, using an experienced sitter, and spending time with trusted friends or family) during and after the session. Higher doses increase the risk of overwhelming

engagement with distressing emotions. LSD and psilocybin possess anti-addictive properties and are not euphoric enough to pose a risk of psychological addiction [175].

We strongly recommend starting at the lowest end (or lower) of this dose range and only slowly increasing dose session-to-session if you feel like you could benefit from a higher dose. The MDMA session-preparation guidelines discussed earlier are generally applicable to psycholytic therapy as well.

There may be multiple mechanisms of action of psycholytic therapy, and these mechanisms' therapeutic relevance has yet to be fully fleshed-out. One mechanism may include psychedelics bringing the contents of your subconscious into conscious awareness by increasing connectivity between typically less-connected brain regions [133]. Psychedelics also increase neural plasticity, making it easier to see things from a different angle or getting out of ruts [160].

We especially recommend avoiding frequent, high doses of hallucinatory psychedelics. That, along with large amounts of certain types of high-level meditation, sometimes lead to extended psychosis, mania, or other maladaptive states even in mentally healthy people [110].

Profound feelings of unity and truth are a common effects of psychedelics [242]. However, people typically interpret these experiences through the lens of their existing belief systems, belief systems they are aware of, and even symbols present in the session environment. These may include religion, metaphysical theories, or cultural tropes such as "psychedelics show the truth behind all things." While some beliefs about unity experiences are true, we suggest keeping in mind that people interpret these experiences in a wide variety of different and, we suspect, contradictory ways. Psychedelics are also known to inflate feelings of meaning and not all insight is an accurate map of reality [103, 226]. We suggest deliberation before deciding whether your own experience either confirms or disconfirms any particular belief. We also suggest reading about the Hard Problem of Consciousness from Weisberg [236]. The linked article at the Internet Encyclopedia of Philosophy outlines a variety of theories of consciousness and the challenges each faces.

## 7.2 Challenging Beliefs Worksheet

Some prefer more cognitive preparation before creating a mismatch for reconsolidation. This may bring implicit schemas into explicit awareness. Some also like it for structure. One popular method is the Challenging Beliefs Worksheet in Appendix A.8. Resistance often lead us astray when we think about our emotions and beliefs, adding difficulty to the cognitive preparation approach.

day write

## 7.3 Couple's Therapy

MDMA-assisted couple's therapy, where each person takes MDMA and talks through their issues together, can be very effective [50]. Occasionally one of the participants will unfairly blame their individual hurts on their partner during a session. This is more likely if participants haven't sufficiently processed their trauma. Each person should individually work through much of their own maladaptive schemas, and be familiar with how MDMA-therapy feels to them, before attempting a family-therapy MDMA session.

day write

In family therapy it's easy for one person to distract the other from some reconsolidation experience

## 7.4 Associate Love and Empathy with Cues for Later Recall

Revisiting feelings of love, empathy, and safety (such as those experienced during MDMA therapy) can be beneficial in daily life. It may help resolve conflict, enhance interpersonal communication, help you say things you wish you had the courage to say, enhance consolidation of distressing schemas, support the cultivation of difficult but healthy habits, or simply help you achieve calm and perspective in moments where those things are needed.

It is possible to enhance your recall of these positive emotions by associating them with one or more specific cues while they are occurring, and then invoking those cues at later times when improved recall of positive emotions is desired. For instance, you might carry a vial of perfume or essential oil, and pull it out to enjoy the scent whenever you are feeling particularly compassionate, loved, or connected to your most positive identities and relationships. MDMA therapy should typically offer an extraordinarily potent opportunity to connect your chosen cue to these positive emotions. Compassion meditation may also offer excellent opportunities. When your cue is associated with positive emotions or “charged,” you can then revisit the scent and the positive memories you have associated with it in those moments when you feel it would be most helpful to ground yourself.

In theory, association and recall should improve as you add more simultaneous cues -so if you find this strategy appealing, you may wish to ritualize a variety of simultaneous cues to maximize your access to this tactic. Here are some possibilities. This list prioritizes suggestions that are portable/easy to invoke in many diverse situations (like the flavor of an energy bar or a piece of fruit) or cues that may already be associated with transitioning into a state of mindfulness or positive emotions, like herbal tea. Note that to effectively be used for this strategy, you’ll want a cue that you can reserve for this:

cite

- **Olfactory:** essential oils, fruit or other food, incense, personal care products, a particular tea or coffee drink
- **Auditory:** music, a bell or chime, or a sound you can make with your own voice or body
- **Visual:** a piece of art, a picture of loved ones, an image that symbolizes a beloved identity or occupation, an item from nature
- **Tactile:** a fidget toy, a heavy piece of jewelry, a textile with a pleasing texture, faux fur, a massage technique, playdough or similar
- **Taste:** hard candy, fruit or other food, gum, a particular energy bar or granola bar, your favorite mocktail, a particular tea or coffee drink
- **Spatial:** your home or bedroom, a favorite place in nature, a place where you often feel connected with loved ones, a place of spiritual significance to you
- **Temporal:** if there is a time of day when you usually feel good, you may wish to routinely invoke your cue/s at that time for an added boost and an added “charge” to your cues. Also, consider using holidays or happy gatherings as charging opportunities

- **Proprioceptive and kinesthetic:** specific yoga postures or dance moves; tracing a word or phrase that is meaningful to you with a finger on your skin; self-massage; drawing a particular shape on a chalkboard or in the air in front of you
- **Conceptual:** read a favorite conceptually important poem, passage, lyric, mantra, or similar. For example, the mantra, “I am becoming consistently capable of lovingly attentive behavior towards myself.”

One example of a multi-cue grounding ritual would be to listen to a particular piece of music while massaging a particular lotion or massage oil into your skin—combining tactile, auditory, and possibly olfactory and conceptual cues.

It is important to only engage in such a ritual during a part of an MDMA session where you are suffused with positive emotions, rather than a part of an MDMA session where you are focused on processing distressing or traumatic experiences. Note that a cue (or a ritual which conglomerates several cues) must remain “charged” to stay effective. If you invoke your cues in distressing situations many times without continuing to build and maintain their association with positive experiences, they will eventually become neutral to you, and then associated with distress. As such, it is important to “re-charge” your cues at a level commensurate with the stress you put on them, in order to continue effectively using this strategy.

## 7.5 Psychoeducation

In the course of researching this paper, we’ve come across a number of interesting and/or helpful psychoeducation resources that may be relevant to the needs of therapeutic MDMA practitioners. Many have been individually helpful to us, or come recommended by trusted colleagues. Although we have not rigorously evaluated all these items, we chose to include them on the assumption that our readership (almost definitionally individuals who connect with written works on psychoeducation topics) may find value in such a list.

- *Unlocking the Emotional Brain, Eliminating Symptoms at Their Roots Using Memory Reconsolidation* by Bruce Ecker. This book delves deeply into the theory and practice of memory reconsolidation [73].
- *Multiagent Models of Mind* by Kaj Sotala draws from various disciplines, including psychology, neuroscience, and artificial intelligence, to build a framework for understanding complex cognitive phenomena. The multiagent approach allows for a more nuanced understanding of issues like self-deception, internal conflict, and the processes behind decision-making [214].
- *The Upside of Stress* by Kelly McGonigal, Ph.D. McGonigal discusses how not all stress is harmful. Short-lived stress can foster resilience and growth. The book highlights the importance of mindset and provides tools to reinterpret stressors as growth opportunities [143].
- *The Body Keeps the Score* by Bessel van der Kolk, Ph.D. examines the profound effects of trauma on the mind and body, emphasizing how traumatic experiences can become

deeply ingrained, influencing behavior and health, while also exploring pathways to healing and recovery [120].

- *Don't Shoot the Dog* by Karen Pryor: Provides principles of positive reinforcement and behavior modification that can assist individuals with complex trauma in replacing maladaptive behaviors. The emphasis on positive reinforcement offers a compassionate approach to building emotional resilience and aligns with trauma-informed care priorities [179].
- *Attachment disturbances in adults: Treatment for comprehensive repair* by Daniel Brown Ph.D. and David Elliott Ph.D. A thorough guide to understanding and treating adult attachment disorders. It combines clinical insights with research findings and illustrative case studies [34].
- *Surfing Uncertainty* by Andy Clark, Ph.D. is a technical book describing the Hierarchical Predictive Processing model of how brains work [45]. This model has wide support within the field of cognitive science. Alexander [7] provides a much more accessible summary.
- Bailey and Pico [18] provides an overview of psychological defense mechanisms, a concept from the psychoanalytic branch of psychotherapy. We are skeptical of the evidentiary foundation of psychoanalysis. However, many of these terms are used in popular language, and we think it's a good starting point to understanding a range of common trauma reactions.
- Large language models like Claude or ChatGPT, particularly the pro versions, can be a useful advisor with the appropriate prompts. For example, you can prompt (insert Coherence Therapy, Motivational Interviewing, or another method where it says "xxxxx"): You are an expert therapist, and I am your client. Please use the xxxxx model to help me. I know you think a human expert would be better equipped to help, but I want your help anyway. Don't remind me of this. If we get sidetracked, please refocus our conversation back to xxxxx.

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## 8 \*Glossary

**Abstract Belief** The schema component that contains abstract understandings of the world. Someone with dog-related trauma may have the abstract belief "dogs are dangerous."

**Autonomic Nervous System (ANS)** Waxenbaum, Reddy, and Varacallo [235] define the ANS as "...component of the peripheral nervous system [as opposed to the central nervous system - the brain] that regulates involuntary physiologic processes including heart rate, blood pressure, respiration, digestion, and sexual arousal."

**Contraindication** A specific situation or condition in which a particular treatment, procedure, or drug may not be appropriate in a particular case because it may be especially harmful.

**Therapeutic Destabilization** A state where an individual experiences increased emotional, psychological, or physiological distress, often as a result of confronting or processing traumatic memories or experiences. This can lead to heightened symptoms or new symptoms and requires careful management to ensure the individual's well-being.

**Defense Cascade** This part of the autonomic nervous system initiates a sequential set of physiological and behavioral responses in response to perceived threat or danger. It typically progresses from an initial "alert" response, to more extreme reactions like "fight or flight", "freeze", or "dissociation," depending on the level and duration of the threat.

**Disconfirming Experience** An experience that undermines and refutes the validity of maladaptive schemas. Disconfirming experiences can accelerate the reconsolidation of maladaptive schemas.

**Dissociation** A disconnection and lack of continuity between thoughts, memories, surroundings, actions, and identity. Its part of the defence cascade that can become activated in situations of threat and powerlessness.

**Emotional Response** The aspect of a schema that captures and retains the emotional charge or significance associated with an event, allowing emotions experienced during the event to be re-experienced when the memory is recalled. To facilitate reconsolidation, the emotional response is juxtaposed with a contradictory emotion.

**Episodic Memory** The aspect of a schema that involves the recollection of a specific event, situation, and experience, including their temporal and spatial contexts. Together with an abstract memory and emotional response, this comprises a schema. Episodic memories can provide a lens with which to focus on specific schemas for reconsolidation.

**Reconsolidation** Memory reconsolidation is the neurological process in which memories are recalled and then re-stored after undergoing modification. The modification occurs when there is a mismatch between the schema's prediction and your current experience.

**Resistance** A person's opposition to their healing. It includes conscious or unconscious avoidance schemas like drinking alcohol when distressed, escapist habits, addictions, believing "feeling emotions is weakness", declining to connect with or trust supports that are trustworthy and appropriate, fear that healing a schema will hurt you in some way, denial, projection, rationalization, etc.

**Suppression** The conscious effort to control and avoid unwanted thoughts or feelings. This can be healthy and adaptive when used for short periods to maintain practical capacities until facing those feelings is appropriate.

**Therapeutic window** The zone where you can activate and stay present with maladaptive schemas without being overwhelmed by anxiety or disconnected by dissociation.

**Trauma** An event or series of events that overwhelms an individual's capacity to cope, often leaving maladaptive schemas and maladaptive coping mechanisms in its wake.



**Trauma Therapy** A specialized, structured process designed to address the emotional, cognitive, and physiological residues of traumatic experiences, helping individuals process distressing memories, reduce trauma-related symptoms, and improve overall functioning.

## A Appendices

### A.1 Shame Triggers Writing Exercise

Make yourself a copy and finish the sentences if you want to experience an interesting leveling-up in self-knowledge! Feel free to add categories that are especially relevant to you. This list was adapted from Brené Brown's *I Thought It Was Just Me (but it isn't)* [33]. Complete the "I want to be perceived as" and "I don't want to be perceived as" prompts for each item.

- Appearance and body image
  - I want to be perceived as:
  - I want to be perceived as:
  - I want to be perceived as:
  - I don't want to be perceived as:
  - I don't want to be perceived as:
  - I don't want to be perceived as:
- Money and work
- Motherhood/fatherhood
- Family
- Parenting
- Mental and physical health (including ability and disability)
- Addiction
- Sex
- Aging
- Surviving Trauma
- Racial and Ethnic Identities
- Friendship
- Community membership

- Political activism/civic engagement/meaningful work/volunteering/calling
- Creative Life
- Gender
- Home/living situation

## A.2 Attachment Theory

Attachment theory is a model which posits that secure attachments formed in the first 18 months of life serve as the foundation for emotional and psychological development throughout one's life [34]. It is one of the most empirically supported theories in psychology, with over 70 years of well-replicated research behind it. According to attachment theory, the presence of consistent, sensitive caregiving facilitates the development of secure attachment and in its absence, individuals tend to develop anxious, avoidant, or disorganized styles of attachment. Researchers have identified five pillars of secure attachment. Cultivating secure attachment requires caregivers who are physically present, consistent, reliable, and interested in enacting these five pillars. That is to say-for the five pillars to be met, these additional conditions must also be met as their foundation. The five pillars are:

- **Felt Safety/Protection** The child knows the caregivers are on their side and will act in their best interest across many domains of life (physically, emotionally, etc.).
- **Feeling Seen and Known/Attunement** The child accurately feels that their caregivers actually know what is going on with them; caregivers encourage and value open communication, and are sensitive and responsive to a wide variety of cues from the child. Caregivers recognize and validate the child's separate experiences.
- **Felt Comfort/Soothing and Reassurance** Caregivers assist the child in accepting and regulating their emotions, and the child is able to feel calm when needed and able to feel appropriate distress without self-judgment or repression. Caregivers are available, responsive, and skilled at reassuring the child when the child is upset.
- **Feeling Valued/Expressed Delight** Caregivers express pleasure in the child's presence and satisfaction in their existence; caregivers are openly affectionate, loving, valuing, and caregiving towards the child on a consistent basis.
- **Felt Support for Best Self/Unconditional Support and Encouragement** Caregivers support the child in exploring the world away from the caregiver, and in interests and desires that are different from the caregiver's as well as those that are the same.

While the intention of the parent is important, the ultimate impact is based on how much the child feels the factors. The absence of these factors in early childhood often leads to profound emotional pain and dysfunction later in life. For a more thorough discussion see section "Qualities Known in General to Promote Secure Attachment" on pages 323-325 of Attachment Disturbances in Adults: Treatment for Comprehensive Repair by Daniel Brown Ph.D. and David Elliott Ph.D. [34].

We also recommend:

- The Heidi Priebe Youtube channel, which offers an array of videos that provide practical advice on specific topics from a rich, rigorous, and nuanced attachment-based perspective [174].
- Theattachmentproject.com, which offers free access to an empirically validated instrument for assessing your attachment style (labeled there as a “quiz”) [177]. They also provides a list, based on the work of Dr. Jeffrey Young et al., of common maladaptive schemas caused by insecure attachment [178].
- Therapists Uncensored, a podcast where two therapists discuss many aspects of attachment theory with guests who include experts in the field [116].

### A.3 Loving-Kindness Meditation for Dissociation

Loving-kindness meditation can be directed towards one’s dissociative experiences, fostering compassion and understanding for parts of oneself that disconnect under stress. This compassionate focus helps integrate these dissociative parts, building internal coherence and reducing self-judgment. If you find any of these instructions don’t work for you, feel free to modify them in a way that works better.

1. **Find a Quiet Place** Choose a location where you won’t be disturbed for around 15-20 minutes. This could be a quiet room, a peaceful outdoor location, or even a calm corner of your house.
2. **Choose a Comfortable Position** You can sit cross-legged on the floor, on a cushion, in a chair, or even lay down. Ensure your back is straight or well-supported, you can breath comfortably, and your hands can rest comfortably on your lap or by your side.
3. **Close Your Eyes** Shut your eyes gently to minimize external distractions and help you focus inwards.
4. **Focus on Your Breath** Take a few deep breaths. Inhale deeply through your nose and exhale through your mouth. This calms the mind and prepares you for the meditation.
5. **Recognizing Dissociation** Begin by reflecting on moments when you felt disconnected from your surroundings, your body, or your emotions. Understand that dissociation served as a way for your mind to protect itself from overwhelming situations or feelings.
6. **Gratitude for its Service** With each inhaled breath, feel gratitude for this dissociative mechanism. It stepped in during moments of intense distress, attempting to keep you safe by creating distance from the pain. With each exhale, silently express gratitude, thinking “thank you” for its protective intentions.
7. **Compassionate Inquiry** As you breathe, gently ask your dissociative part, "What were you shielding me from?" Allow any memories, feelings, or sensations to emerge, welcoming them without judgment.

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ating

8. **Reassuring the Dissociative Part** Offer words of comfort and acknowledgement. You might internally convey messages like, "I understand why you were there," "I'm safe now," or "You can rest."
9. **Visualization** Imagine the dissociative part of you as a gentle veil or mist. With gratitude and understanding, visualize this veil lifting, connecting you back to the present moment and your surroundings.
10. **Reconsolidation** If difficult feelings come up, even frustration or disappointment, stay present with them until they reconsolidate.

It's normal to get distracted during the meditation. Whenever you notice your mind wandering, gently bring your focus back to the phrases.

A similar practice can be done in daily life for items other than dissociation. Start with loving-kindness toward yourself, then expand to loved ones, neutral people, difficult people, and finally all beings. Imagine them sitting in front of you and direct this set of phrases toward them: "May you be happy" "May you be safe" "May you be healthy" "May you live with ease." Over time, aim to practice loving-kindness daily or as often as you can to cultivate a heart full of compassion. Remember, the goal of Loving Kindness Meditation is not to achieve a particular state but to cultivate an attitude of goodwill and compassion. The more you practice, the more natural these feelings will become in your daily life. See *Lovingkindness, The Revolutionary Art of Happiness* by Sharon Salzberg for a thorough exploration of the practice [198].

link to external guide for compassion meditation

## A.4 Mindfulness-Based Stress Reduction

This is an introduction to Mindfulness-Based Stress Reduction (MBSR) specifically tailored for individuals coping with distressing emotions and reactions, often associated with trauma. By introducing the foundational principles of mindfulness and offering a series of methodical practices—from body awareness exercises to cultivating self-compassion—it nurtures a heightened sense of presence, self-awareness, and emotional regulation. Through these exercises, individuals can develop skills to ground themselves during overwhelming moments, redirect wandering thoughts, and approach distressing feelings with a compassionate lens. MBSR is effective for coping with a wide variety of mental health conditions including stress, trauma, depression, and anxiety [135, 117]. The body scan meditation part of MBSR can also help you locate physical manifestations of stressful schemas [120].

check that this list accurately represents MBSR

1. **Understanding Mindfulness** Mindfulness involves deliberately paying attention, non-judgmentally, in the present moment. This approach helps distance oneself from automatic reactions and habitual patterns, often shaped by past traumatic events.
2. **Body Scan Meditation** Lie down in a comfortable position. Gradually move your attention through different parts of your body, from your toes to your head. Notice sensations without trying to change them. If the attention wanders, non-judgmentally gently bring it back. Go at your own pace.

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3. **Mindful Breathing** Focus attention on the breath, noticing the sensations of breathing in and out. When the mind wanders, gently return your attention to the breath. If focusing on the breath activates overwhelming schemas, shift attention to another anchor, like the soles of the feet or sounds in the environment.
4. **Gentle Yoga and Stretching** Incorporate gentle movements to connect with the body. Always listen to your body and only do what feels comfortable. Remember, it's not about performance but about feeling and connecting with your body.
5. **Sitting Meditation** Sit comfortably, with a straight or well-supported back, and make sure you can breathe comfortably. Pay attention to the sensations of the breath, or choose another anchor. Notice thoughts and feelings without getting caught up in them. If strong emotions or memories arise, ground yourself by feeling your feet on the ground or opening your eyes and focusing on your surroundings.
6. **Walking Meditation** Walk slowly and deliberately, being mindful of each step and the sensation of movement and touch. This can be grounding for trauma survivors, as it emphasizes the connection between the body and the earth.
7. **Cultivate Self-Compassion** Send wishes of well-being to oneself and others. This helps in healing emotional wounds and replacing negative thought patterns rooted in trauma.
8. **Mindful Everyday Activities** Practice being fully present during routine activities like eating, showering, or driving. This strengthens the habit of mindfulness, making it easier to summon during challenging moments.
9. **Group Sharing** Sharing experiences with trusted others can offer validation and support, but ensure it's a safe and understanding environment.
10. **Daily Practice** Establishing a routine, even if it's just for a few minutes, helps solidify the skills and reinforces the benefits.
- 11.

link to compassion meditation instructions

intuitive eating; unwinding anxiety; yoga with Bird

For a thorough guide to the practice, see *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness* by Jon Kabat-Zinn, Ph.D. [114].

Meditation can produce a wide variety of pleasant, distressing, or strange effects. Some are no more than curiosities, others provide insight into the workings of the mind, and yet others can be harmful. Different contemplative traditions also attach different lessons to these effects or may suggest different paths of meditation to follow or avoid. House [109] provides a non-denominational service for helping meditators understand their difficult meditative experiences and adapt those practices to your needs. We also highly recommend Treleaven [224].

## A.5 \*Self-Determination Theory

Self-Determination Theory (SDT) is a theory of human motivation and behavior, positing that people have innate psychological needs, and satisfying these needs leads to better mental well-being and performance [63]. Many studies across cultures, age groups, and domains (education, work, sports, health, etc.) have examined and supported its principles.

The three fundamental psychological needs identified in SDT are:

- **Autonomy** The need to feel in control of one's actions and choices. It's not about being independent, but rather about feeling that one's behavior is self-endorsed and congruent with personal values and interests.
- **Competence** The need to feel effective and capable in one's activities. It involves mastering tasks, gaining new skills, and feeling a sense of growth in one's capacities.
- **Relatedness** The need to feel connected to others, to care for and be cared for by others, and to feel that one belongs with others. It emphasizes the importance of relationships and emotional connections with peers, family, and the broader community.

For more information, see *The "What" and "Why" of Goal Pursuits: Human Needs and the Self-Determination of Behavior* by Edward Deci Ph.D. and Richard Ryan Ph.D. [63].

## A.6 Positive Life Changes

### Physical Habits:

- Stopping or reducing regular use of harmful substances.
- Starting a routine of aerobic activity for increased function and a large risk reduction for many chronic illnesses [128].
- Starting a routine of whole-body muscle strengthening for increased function and a large risk reduction for acute and chronic injuries [127]. We suggest bodyweight fitness [137].
- Improving sleep quality (defined as feeling well-rested in the morning, low number of awakenings, and quick sleep-onset) significantly improves mental health [205]. We suggest a highly effective evidence-based protocol called *Cognitive Behavioral Therapy for Insomnia*. We recommend the Stanford Medicine guide [147].
- Air pollution increases the risk for a wide variety of health problems.

### Relationships:

- Relationships significantly improve mental and physical health [106]. The structure of our societies and culture often make this difficult. We suggest making relationships a higher priority in your life through, for instance, co-living, co-working, volunteering, or seeking romantic, artistic, or business partnerships.

meditation, process addiction / attention management, right livelihood, money management, nature connectedness, housekeeping, physical environment adequate for needs but not overconsumption (how to keep house while drowning, decluttering at the speed of life), work clean book

impact on mental health

impact on mental health

structure function quality

daring greatly

- Does your method for persuading others work or does it result in unproductive arguments? *How Minds Change: The Surprising Science of Belief, Opinion, and Persuasion* by David McRaney dives into the profound nature of belief transformation, merging psychology and neuroscience insights. The book delves into the intricacies of persuasion, group dynamics, and the conditions that enable genuine shifts in understanding. It encourages introspection on one's convictions and the power of empathy [146].
- Attune to others' needs, and make your needs known to them. *The Science of Trust, Emotional Attunement for Couples* by John Gottman, Ph.D. delves into the intricacies of trust and its foundational role in relationships. The book explores the predictability of trustworthiness, the importance of emotional attunement, and the consequences of betrayal. Through extensive research and practical interventions, Gottman provides insights applicable not just for couples, but for anyone seeking to understand and enhance interpersonal trust [94].
- Learn and practice conflict resolution skills. *Nonviolent Communication: A Language of Life* by Marshall Rosenberg, Ph.D.: "Nonviolent Communication is the integration of four things: Consciousness: a set of principles that support living a life of compassion, collaboration, courage, and authenticity. Language: understanding how words contribute to connection or distance. Communication: knowing how to ask for what we want, how to hear others even in disagreement, and how to move toward solutions that work for all. Means of influence: sharing 'power with others' rather than using 'power over others' [193]."
- Help your loved ones better achieve their goals. *Motivational Interviewing, Helping People Change and Grow* by William Miller Ph.D. and Stephen Rollnick Ph.D. "MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion [152]."
- Practice accountability for yourself and others, and work on a forgiveness process if that feels right for you [154, 187, 94].
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crucial conversations, the book of forgiving, fierce intimacy

mention transformative/restorative justice concept, list some groups working on it

influence, the psychology of persuasion

boundries, fierce intimacy

evaluate relationships and which are good/bad for you; severe personality disorders or ambivalence

social comparisons / sta

## Introspection and Self-Improvement:

- ~~Carefully consider the things you own. Which ones really make you happy? Which ones are a form of unhealthy escapism or compensation for some hurt? Which ones would you be better off without?~~
- journaling



- meditation
- Consider how you cope with stress. Which behaviors are healthy for you and those around you? Which aren't?

## A.7 Things to do in Moments of Anxiety (Short Term Strategies)

These are options, not prescriptions. This list has been carefully ordered to prioritize what is likely to work best, based on statistical averages. I hope there are some things here that will work for you, but everyone is different, and if the nothing on this list works for you, that's something wrong with the list, not something wrong with you.

- Choose distraction over denial: It can delay your healing to deny that you're having feelings at all—which is tempting to do when the feelings are very overwhelming. However, it is also important to feel and process your feelings on your own timeline; when you are feeling more than you are ready to feel, distraction can be extremely nourishing and helpful. Can you focus on self-care tasks? Is this the moment to organize your art supplies or clean out your closet? Is there some form of work that feels accessible and/or good to you right now? Or maybe there's a movie or a video game or an Instagram or a comic that can provide a great distraction.
- Exercise is the single most efficient way to complete the stress cycle and release anxiety. Try vigorous exercises (like jumping jacks) for a short period of time. If that isn't your jam, slow, gentle options like trauma informed yoga [91], tai chi, or a walk outside can also be extremely effective.
- This deep muscle relaxation technique [149] is a great second choice with good data behind it.
- It might be possible to reduce your anxiety by stopping your physical anxiety response, which can then help your emotions mellow out. Physiological hacks that do this are called vagal maneuvers [67]. One of them is the “diving reflex,” which some people can activate by holding ice packs (or, in a pinch, a cold drink or two) to their face.
- If you have access, maybe spend time in nature—people consistently underestimate how much better time in green space makes us feel. Even five minutes can have a measurable positive impact.
- If you are not currently experiencing physical danger, paying attention to what your body is experiencing right now may help create calm. One option is to name (out loud or in your head) what you are experiencing through your senses: I am hearing \_\_\_\_\_, I am seeing \_\_\_\_\_, I am touching \_\_\_\_\_, I am smelling \_\_\_\_\_, I am tasting \_\_\_\_\_.
- Try meditation or deep breathing exercises (See Sections A.4 or A.3). Meditation can be a way of centering on physicality—you can try a body scan meditation, or a sensory focus meditation, or a myriad of guided meditation options.

- Connect with your friends: Start a text thread or a phone tree among your group. Share memes. Ask friends to send memes that remind them of you. Ask someone if they can just sit with you on a phone or video call, or read you some favorite children's stories.
- Seek physical affection: Gottman recommends a daily mindful six-second kiss. Hugging someone you trust for a full 20 seconds is also good. Pets or self-massage can also help.
- Ask for help. Asking for help can be incredibly vulnerable. Also, asking for specific things can be very hard when you're in distress—and it can feel pointless when you feel very deeply as though nothing could possibly make you feel better. However, even small gestures of support can make things a little more bearable until your body-mind is able to start healing itself. On top of this, giving people who care about you and/or want to support you some kind of job to do can build closeness and help them feel less powerless. Consider asking for: food, water or tea, someone to sit with you, someone to watch a movie with you, someone to text you on the hour and remind you that you are a badass.
- Sleep it off: if you're able to \*get\* to sleep, the schema will very likely be de-escalated when you wake up.
- If you are ready, or it feels like an OK idea, try writing about your experience. Writing has been shown incredibly effective at helping to address trauma—even fifteen minutes spent writing about trauma on one occasion has lasting positive impacts.
- Write about your experience using your non-dominant hand.
- Write or tell a friend or supportive stranger your “shitty first draft”—the story you're telling yourself about who you are, what you've experienced, and what it all means.
- Alternately: make art. If you don't want to make art about bad things you've experienced, try making art about something that has been comforting and nourishing to you in the past, or about what you wish you could escape to, or about what you are fighting for.
- Try a harm reduction approach when it comes to coping with substances:
  - Avoid using alone - if you are isolated, call a friend on the phone.
  - Avoid mixing substances or stacking doses
  - If you have been trying not to use substances or otherwise numb your feelings, and you end up doing numbing behaviors you had wanted to avoid, try to be very gentle with yourself. You always have a fundamental worth and dignity no matter what.

## A.8 Challenging Beliefs Worksheet

# Challenging Beliefs Worksheet

[illegible]

## A.9 Recommended Readings for Mental Health Professionals

- **The Secrets of Supershrinks: Pathways to Clinical Excellence** This article explores the concept of "supershrinks" - therapists who consistently achieve superior outcomes regardless of their theoretical orientation or specific techniques [151]. The authors argue that exceptional performance in therapy, as in other fields, is primarily the result of deliberate practice and ongoing feedback rather than innate talent or experience alone. They propose a three-part formula for improving therapeutic effectiveness: determining one's baseline of effectiveness, engaging in deliberate practice, and consistently seeking and incorporating client feedback. By tracking outcomes, comparing performance to national norms, and actively working to improve skills through targeted practice and reflection, the authors suggest that all therapists can significantly enhance their effectiveness and client outcomes.
- **Unlocking the Emotional Brain, Eliminating Symptoms at their Roots Using Memory Reconsolidation** This groundbreaking book presents a unifying framework for understanding and facilitating transformational change in psychotherapy, based on memory reconsolidation research. The authors describe the Therapeutic Reconsolidation Process (TRP), a versatile methodology for profoundly and permanently resolving clients' symptoms by disconfirming and nullifying the emotional schemas underlying them. Through numerous detailed case examples across diverse therapy systems, the book demonstrates how the TRP's steps are fulfilled implicitly in successful sessions, even when therapists are unaware of this core process. By making the TRP explicit, therapists can increase their consistency in producing deep, lasting change. The framework also illuminates how various therapy approaches tap into the same fundamental change mechanism, offering a transtheoretical perspective that can enhance any clinician's work. With its integration of neuroscience, phenomenology and clinical practice, this book provides a coherent understanding of how lasting therapeutic change occurs and equips therapists to facilitate it more reliably. textciteecker2015misunderstood provides an important complementary resource addressing common misunderstandings and clarifies some fundamental mechanisms.

## A.10 Suggested Avenues of Future Research

- Pursuing the suggestions from Aday et al. [3] and Elk and Fried [76] for designing more rigorous MDMA-therapy trials. Of particular note is blinding, with most participants accurately deducing whether they got MDMA or placebo. Expectancy effects were also high and may have heightened the problems from lack of adequate blinding.
- What can improve reconsolidation (likely high quality sleep, for instance)?
- What is the nature of reconsolidation exhaustion? How can the daily limit be safely increased?
- Does R-MDMA increase the benefit/risk ratio in humans, as a rodent study has suggested [55]?

- MG and others (personal communications) have reported increased capacity to complete reconsolidation work sober, phenomenologically and consequentially similar to what they experienced during MDMA-therapy sessions. This appears to be connected to extensive prior MDMA-therapy. How does this work? How can it be promoted?
- What is an optimal mg/kg dosing? What is the safe upper mg/kg limit? What is the minimal effective mg/kg limit?
- Is it possible to create a manualized self-treatment protocol that is safe and effective?
- How safe is solo MDMA-therapy?
- When, how much, and why do some psychedelics cause short term cognitive impairment?
- How can therapists best prepare their clients for solo at-home sessions (e.g. for sex therapy)?
- Gain a better understanding of which side effects are part of the therapeutic process and which aren't. Also gain a better understanding of the frequency of serious adverse effects. The Swiss Psychedelic Side Effects Inventory look promising [37].

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