Conscious Life presents

MDMA and the Future of Mental Health Treatment

Guest: Dr Rick Doblin

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[00:00:05] Alexander Beiner

Our next guest is Rick Doblin. Rick is the founder of the Multidisciplinary Association for Psychedelic Studies, or MAPS, which is one of the foremost psychedelic research organizations.

He's the preeminent researcher on MDMA assisted psychotherapy for PTSD and addiction patients. And he's an activist who spent the last 40 years campaigning for MDMA to become a legal medicine, a mission he is very close to achieving. So Rick, welcome.

Dr Rick Doblin

I'm very delighted to be here with you today.

Alexander Beiner

So, Rick, the first thing I wanted to ask you about is, and I know this is quite a big question, but you started MAPS in 1986. In fact, the year before I was born. For my entire lifetime, you've been on this incredible quest to get MDMA legalized as a medicine.

What are some of the differences? What are the key differences culturally when you look out the window at culture right now between how people perceived medicines like MDMA or other psychedelics in 1986 and today in 2024?

Dr Rick Doblin

Well, the biggest difference that we have right now is that we're in the midst of an incredible renaissance in psychedelic research. There's four or five times as many studies now as there were in the '60s. There's billions of dollars that have been sent to for-profit psychedelic companies and

several hundred million, low hundreds of millions to non-profits. We're in the midst of this enormous explosion of research, and we're also in the midst of a mental health crisis that is widely acknowledged.

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Back in '86, we were in the midst of this suppression of psychedelic research research, not just in the United States, but all over the world. That began starting near the end of the '60s, The Controlled Substances Act of 1970, and then the US government was near its height of its power at that point. We're sending somebody to the moon. We were very successful in exporting the drug war all over the world.

In a counterreaction to people using psychedelics, in quote, the 'counterculture' to protest the Vietnam War and other things, not only was the nonmedical use criminalized, but the medical research was shut down, too. In '86, we were at this point where research had not happened for almost several decades, that there was this rise of Nancy Reagan and Ronald Reagan and the whole 'Just Say No', re-escalation of the drug war.

For example, in the '60s, there was... Psychedelics brought things to the surface. The confrontation with death, confrontation with birth, meditation, spirituality, mystical experiences, buried traumas, things like that. The culture in the '60s was such that you didn't talk about it.

People had cancer and didn't talk about it. Women were tranquilized in the delivery room. Men were not allowed in the delivery room. The Beatles brought Maharishi Mahesh Yogi to America, and these weird people wearing these white robes talking about meditation. That was strange. Mindfulness hadn't been accepted or even started to be developed much. People were worried that if you did yoga, that you'd be turning into a different religion. There were all these suspicions.

Over the last 60 years, and I would say at the time in '86, this was in early stages, was the mainstreaming of mindfulness. I think we've gotten there, the mainstreaming of meditation. The first hospice center in the United States was 1974. We've changed our approach to death. You don't have to be tranquilized, medicalized, and everything done to save your life. At some point, you say it's time, and you can do that in a more compassionate context. Within the hospice centers, there started to be birthing centers. Now, there are all different ways of natural childbirth, or men are in the delivery room and meditation is everywhere. You go to the YMCA and you learn yoga.

If you look at art and media, there's all sorts of psychedelic imagery used in movies and TVs and commercials and things like that. I'd say in '86, we were at this second wave of the massive drug war, and everything was suppressed. People were saying... The reason that DEA tried to criminalize or did criminalize MDMA in '85 was they said, "Oh, MDMA is a terrible, brain-damaging drug".

I met my wife in 1989, and at the Kennedy School of Government. We were both in a master's program. Our first, I call it a date, she said it wasn't even a date. We went out to lunch for her to talk to me about her mushroom experience in college. But then she said to me, "I want you to know I'd never want to have a real relationship with anybody like you". And I'm like, "Why? Why would you say that?" She said, "Well, you've probably done so much LSD. Your chromosomes are all

screwed up". And I'm like, "Wait a second. You're a smart woman. You're here at Harvard, and you're telling me my chromosomes are screwed up. You believe that?"

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So in '86, there was just this... I'd say most people were very scared of psychedelics at that time, and there was a massive amount of misinformation, and there was way more fear than hope. I would say the main thing that's happened now over these last... It has been 38 years since I started MAPS in '86, as of April 8th, four days from now, was our anniversary.

Well, a bunch of us will be, by the way, in Texas for the Eclipse. The Eclipse is on the same day as the MAPS anniversary. But now there's more hope than fear. I'd say that's the main difference between the '80s was when MDMA is criminalized, more fear than hope, and now more hope than fear.

Alexander Beiner

Great. I love that. That's a really nice, concise history of a lot of stuff happening.

What I'm really curious about is, as someone looking at that situation, 1986, what was it about MDMA in particular that really drew you? Because every psychedelic acts differently. Everything gives us a different experience, it's used for different things. Why MDMA? You could have started campaigning for LSD to be legalized. You could have... Or psilocybin.

Dr Rick Doblin

Well, and the point is that really I am interested in psychedelic medicine. So the goal is to bring forth all these different tools LSD, MDMA, psilocybin, Ibogaine, ayahuasca, 5-MeO-DMT, and to have therapists cross-trained in all of them so then they can customize treatments for each individual patient. So that's the goal.

Why did I choose MDMA? Well, first off, MDMA is similar, somewhat, to a drug called MDA. MDA is Methylenedioxyamphetamine, MDMA is Methylenedioxymethamphetamine. Very similar. But MDMA was invented or rediscovered after MDA was criminalized. MDA was like a MDMA-LSD combination. It's a little bit more psychedelic than MDMA. It was used quite a bit in the '60s and even in the '70s.

But then in the middle '70s, MDMA came to the attention of Leo Zeff, who he called The Secret Chief, the leader of the underground psychedelic therapy movement. It became the drug of choice for therapists, underground therapists, and around half a million doses were used between then and around '85 when MDMA was criminalized in these therapeutic settings. I learned about MDMA in 1982.

I learned about LSD and the value of LSD in 1972. I woke up to LSD after the backlash, and I thought this is a good thing for me to work on. It's being shut down. There's got to be a reason for that. Let me try to bring it back because I think the spiritual connections, the sense of now we're all unified that you can have under the classic psychedelics would be really important.

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When I learned about MDMA, it doesn't have the ego-dissolving aspects of LSD or psilocybin. It doesn't drive towards this beyond a sense of ego, mystical, unitive experience. But like the classic psychedelics, MDMA brings things to the surface. But it does it in a reassuring way. It releases oxytocin, which is the hormone of love, connection, and nursing mothers. MDMA quickly became relatively widespread, both in therapeutic circles, but then also now as ecstasy.

But the reason that I chose MDMA was that it's the most gentle of all the psychedelics. It's the most reassuring, it's incredibly profound. I originally misunderstood what it was, and when I heard about it, I was not that interested. I thought, "Oh, I feel love already. It makes you feel love. I'm in love. I'm a good listener", I had all these thoughts.

I like to say that I was stupid enough to underestimate it, but smart enough to buy some. When I took it home and did it with my girlfriend in 1982, I was utterly amazed by how similar it was to normal processing, but how subtly different it was that made an enormous difference in how we could communicate to each other, less defensive, more open, more loving.

I think in many ways, it's easier to integrate the experiences of MDMA than it is psilocybin or LSD or the classic psychedelics because you're in these states that you're not so connected to your ego sense. You hear stories about bad trips that people have with LSD or psilocybin. It's possible for people to have bad trips, meaning they're overwhelmed with their feelings, they're scared with MDMA, but it happens way less.

It has the fear reduction part of it, the self-love, self-acceptance, easier to integrate. I saw MDMA revitalize the psychedelic therapy community because it is now available, more people would come to it, and also it's very profound. But then the other part of this is that in the training of therapists, we believe, all the therapists believe, that they'll be more effective if they've done the drug themselves and know what it does.

Now, you don't expect a psychiatrist to give themselves electroconvulsive therapy before they give it to their patients, or you don't expect them to take antipsychotics or necessarily even antidepressants, because the treatments are the drugs or the ECT. But with MDMA, the treatment is really the therapy and the therapeutic alliance.

I felt that as we try to bring forward a tool where it really does make sense for the therapists to try it themselves. There's a lot more resistance to LSD and psilocybin or classic psychedelics that dissolve your sense of self. Often people confuse this... I like to call it ego dissolution, some people have used the word ego death. But people confuse this letting go of your normal frame of reference with physical death sometimes, we're so identified with our ego.

To reach out to psychiatrists and therapists who are going to be the core of this community that's going to to move this forward, I felt that MDMA would be easier for them to be willing to try. Also, I thought that the kind of thing that we needed to do to bring these forward is we needed sympathetic patients. These are highly stigmatized drugs.

By the time I heard about MDMA in 1982, it had already been used with Vietnam vets with PTSD. In 1984, I was learning to be a therapist and had an opportunity to work with a woman who had been

deeply traumatized and was suicidal. I talked about it in my TED Talk. I knew in '84 that MDMA was great for PTSD.

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I also knew that even at that early stage we needed bipartisan support. We're way more polarized now than we were in '86. The work with veterans, in particular, was something that was politically advantageous. All of it is the gentleness, the profound nature of it, the reassuring, the fear reduction parts of it, the appeal to therapists, and the stories that I heard were so profound and so many different people of all different kinds of how MDMA helped them to go through all sorts of different problems.

All of that made me think, yeah, MDMA is the most likely substance, and then paired with either people scared of dying, cancer patients or PTSD. And so that was the impetus for me choosing MDMA.

Alexander Beiner

So that's fascinating. Thank you for that.

There's a few practical questions that start to come up for me because I know from the literature that obviously MDMA therapy, like you said, is very dependent on the therapist and the therapeutic relationship. And in some other psychedelic therapy models, it's more about eliciting that mystical experience. And the therapists are really taking a step back in some models, perhaps in a psilocybin model. It's like, okay, well, they're there and they're supporting, but it's really about helping someone go on their own journey.

Those are very different models for what's happening now, which thanks in large part to your work, we are seeing psychedelics being integrated into the medical establishment. So MDMA in particular requires an awful lot of trained therapists. What's that process like? What's happening to make that a reality?

Dr Rick Doblin

Before I get into that, first off, I'll say that I do think that for LSD, psilocybin, that we still really will get better results with trained therapists. This idea of all you need is psychological support from somebody that doesn't even have a license, these are business decisions based on how do we reduce the cost of the therapy? How do we get more insurance coverage? How do we sell more of the drug for the companies to make more of the drug? They don't make money on the therapy. I don't believe...

Well, when I've had difficult LSD trips in the therapeutic setting, it was very important for me that the therapist had this sense like, "Yeah, you can dissolve. You can go into these spaces and you will come back and I will support you". There wasn't nearly as much dialog with the large doses of LSD or psilocybin or mescaline or anything like that, or ayahuasca. Much, much more dialog with MDMA. But I do think that the results will be better with the classic psychedelics if those therapists are very well trained.

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The spaces you can get into are much more frightening often than with MDMA. In a way, you could say you need more skilled therapists. I'll be speaking about the training and educational programs that MAPS is offering. The format that our trainers really prefer is a six-day program in person, residential with about 50 people or so, where people are at a resort or some place where it's overnight stays as well.

People have lots of time to talk during the meals in addition to the session time. That's going over the treatment manual, our method, how we have adherence criteria, meaning core competencies, what are those? We show videotapes of therapy sessions. There's role play.

A lot of what we teach therapists to do is to unlearn what they've learned before, so that when you don't have a catalyst like the psychedelic, like MDMA or something, the therapists say, "Oh, tell me about your trauma" or, "Let's get into it" because there's hour-long therapy sessions often. There's guided imagery, There's cognitive behavioral therapy, there's prolonged exposure. There's all these therapies that are relatively directive to try to get the patient to overcome their resistance to these terribly difficult emotions.

In traditional therapy, a lot of them drop out because it's retraumatizing. We actually help people to unlearn a lot of things, and then to learn that they're not the healer, that the person is healing themselves. We try to create a context where the person has to do their own work. The MDMA helps, the therapists help, but it is an interesting shift of the power dynamics. It's not like the psychiatrist of all, or the Freudian psychoanalysis that tells you the interpretations that you can't see yourself.

We have this six-day program. We did... Well, MAPS before the Lykos was really big was during the pandemic, there was training online for several hundred people, and the trainers did not like that very much. They didn't think it was good enough. Plus, you don't have the sense of building a community.

We have this program like that. We just finished one in Iceland recently, and there's going to be one in Sarajevo coming up. That's the intro. Then the next step, which is the more expensive, more difficult, more regulatory complicated step, which is to provide an opportunity for therapists to volunteer. We will never require it, but to provide therapists with an opportunity to have their own MDMA experience in a therapeutic setting so they can understand from the inside out what their patients are going through.

Even therapists, we all have our own issues to work with, so people often get a great deal out of it. Again, we will not require that, but it is something that we strongly recommend. We're trying to create options like that. We're working with Numinus in British Columbia and Vancouver. They're getting permission for group therapy to give to groups of therapists for them to experience. It's less expensive than one-on-one. It's not as good as having a therapist have an individual session because they'll be treating people individually.

But we're trying to create these contexts for people to have these experiences. We did have a protocol from the FDA that we've trained about 125 people in who worked on phase 3 and phase 2. But then the third part of the training is supervision or consultation when people are working with

their first PTSD patient. We're asking for them to videotape the sessions. The technology has now gotten pretty inexpensive to set up these cameras and upload stuff to the cloud.

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We have, what we call, adherence raters that evaluate how well the therapists are adhering to the core competencies and the principles of our therapeutic method. Then we give feedback, and then a couple of sessions. Once we've got a sense that they understand the method, then they're certified and ready to work. They'll be on a list of the pharma company, of these are the authorized therapists, either ones that we've trained, or eventually, we want the training to be offered by schools of psychiatry and psychotherapy as part of the core curriculum.

But that will only happen after MDMA has been approved by the FDA, after psilocybin gets approved, after it's really happening, then you can expect these academic centers to be followers, not leaders, and to start putting it into the core curriculum.

Then the other thing to say, though, is that once people have learned the methods that we used in phase 3 to get the results that we did that we hope will lead to FDA approval, then what happens is that they're free to practice as they want. There's not going to be continual monitoring, are you sticking to our method? If somebody wants to combine it with prolonged exposure, cognitive processing therapy, EMDR, whatever, they're free to do that. We just want them to understand the method that was used to get the results in phase 3 that will hopefully have led to FDA approval.

That's the training. Now, we're going to start to explore group therapy as well. So once we learn more about group therapy, I think there'll be different training for people that will be working in group contexts.

As MAPS focuses internationally on humanitarian projects, where there's lots of suffering, but not a lot of resources, we're going to be going into places like Rwanda, Somaliland, South Africa, Lebanon, other places where there's not a lot of therapists or psychiatrists. I think the big challenge will be to find culturally relevant local healers that don't necessarily have the same credentials that we do in the West, but that then can help people from their own communities.

Alexander Beiner

That's fantastic. I was going to ask you about group work because there's this whole other world, which I'm part of. I'm trained as a counselor and run legal retreats in the Netherlands with some colleagues. We're obviously partly because it's economically the one of the only viable ways to do it, and also because it's a different format running groups of, say, 10 to 12 people.

My training is as a group work facilitator. It's always what I've been drawn to. And it's fascinating the differences between one to one and a group, because as a group, people learn from each other, they flow together. There's a magic to it where different unconscious material surfaces through the group. So it's really great to hear that that's on the cards.

[00:23:29] Dr Rick Doblin

So let me just say that we have started the first group therapy study at the Portland, Oregon Veterans Administration. Chris Stauffer is the doctor there, and it's an investigator-initiated trial, not sponsored by Lykos. And it's four therapists for six veterans with PTSD. Each of them will get two MDMA experiences, but the first will be in an individual session, and then the second will be in a group session. Then there's preparation and integration.

In Israel, we're raising funds for 400 people to go through group therapy. They will also get two MDMA experiences, but the first one will be in a group, and the second one will be in a group. They won't have an individual session first. They're going to try a different model of two therapists, two helpers, and six people with PTSD. And then if that works, they'll try to increase, as you said, up to 8 or 10 or 12 people, and maybe add one additional therapist or we'll just explore.

Alexander Beiner

Yeah, that's great to hear. I'm fascinated to see the learning process out of that. It reminds me of, I don't know if you're familiar with Simon Ruffell, who is a psychiatrist here in the UK, used to work at King's College, and he's running a project in the Amazon working with veterans. They're doing a study on ayahuasca for combat PTSD with veterans. I think there's a lot to it. Also, Leor Rosemand and Sami Awade, who are running the Palestinian Israelis. They're also guests in this summit. There's some really fascinating things happening with groups. I wanted to move...

Dr Rick Doblin

Let me ask you a question.

Alexander Beiner

Yeah, sure.

Dr Rick Doblin

My personal feeling is that individual therapy will work better than the group therapy during the actual administration because you get the more sole focus on your own histories and the layers and layers of trauma, and then more individual attention, and then more support, and then you're telling your story to the therapist of what's going on. That's a way to repattern your own brain and tell yourself the story.

But I think that while the group session, I don't think will be as profound, directly, as the individual session, the group integration process may really reinforce in a way so the outcomes may be very similar at the end through this group support and integration. Does that make sense with your...

Alexander Beiner

Yeah, it does. There's two things that come up for me with that. One is that I've had people in psilocybin groups who had very powerful psilocybin experiences, but at the end, what their reflection was was, "I've never had a group of people really hear me and really see me, and that's

exactly what I needed". It's impossible to disentangle what was the psychedelic experience, what was the group experience, but they are very powerfully together.

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The other thing that comes to mind is my wife, Ashleigh Murphy-Beiner, she's a researcher also at Imperial, and she just did a whole project on, her doctoral thesis was around this topic. But she works also in the NHS, and she was just hours ago telling me about a service that she encountered where they really encourage people, very traumatized people, to go into group work because it gets the numbers going. You can get 10 people into a group, and it takes a lot longer to get 10 people into one-to-one therapy.

The issue with that being, though, that some people are too traumatized to work in a group because that's activating and that's retraumatizing in itself. When we're screening people for legal retreats, partly for legal reasons, also partly for what we're qualified to do, we're screening out people whose trauma history is too severe or who just aren't in a... Might not even be the history, it's where they're at. Are they resourced enough? Do they feel okay enough to be in all the social dynamics of a group where we trigger each other and there might be different things going on?

I think that also is an important factor. I always come back to the fact that there's no one-fits-all with psychedelics. It's a psychedelic answer to a psychedelic problem in a lot of ways. Yeah. So that's my take on it.

Dr Rick Doblin

I'd be interested in looking at your wife's thesis if she's done with it.

Alexander Beiner

Yeah, I'm sure she'd love to send it. I'll let her know and get her to send it over.

Dr Rick Doblin

Because we are starting to design some group contexts and thinking more about it.

Alexander Beiner

Nice. Rick, the last thing I wanted to ask you about is looking to the future. It's a really interesting time to be talking to you because things seem to be moving in a very positive direction for MDMA becoming a medicine pretty soon. How are you feeling about that? I'm sure you have many different plans, but what would you like to see in a year from now? What would be your hope for a year from now if we were having this conversation, where would it be?

Dr Rick Doblin

Well, okay. The FDA must tell us whether they approve, for prescription use, MDMA-assisted therapy for PTSD by August 11th. So that is the date that they must tell us that we've been given, or Lykos has been given a priority review. Then after that, there's 90 days for the DEA to reschedule. And then after that, the states have to reschedule.

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I like to say that there's loads of people willing to go second and not that many people willing to go first. So our phase three studies intentionally were done in an international context. So we had phase three studies sites in Israel, Canada, and the United States. But both Health Canada and also the Ministry of Health in Israel are looking to the FDA to go first.

What I would hope for a year from now is that sometime around January of 2025, we think that there is a good chance that prescriptions will start in the US. Hopefully in August, after FDA says yes, then we hope that Lykos will be negotiating with Health Canada and the Ministry of Health in Israel to spread it there.

The MHRA in England is actually very interesting. David Nutt just sent a message the other day about how now that there is Brexit and England is not part of Europe, in order to show that something was gained from that, the MHRA, the FDA equivalent in England, may be willing to approve MDMA, it looks like, well before the European Medicines Agency does. We hope that it goes FDA, Israel, Canada, England, Brazil, Australia.

The other part is that many, many countries of the world are looking to the FDA. They don't have their own very sophisticated regulatory agencies like that. So for example, we're trying to bring MDMA-assisted therapy to Ukraine and to Armenia. But Ukraine and Armenia have these terrible laws from Russia that you cannot even do research with schedule one drugs until they're approved as a medicine elsewhere.

So a year from now, what we're hoping is that there will be a whole series of countries around the world that have high trauma but low resources that MAPS the non-profit, can use the approval that Lykos obtains, and can start work in humanitarian projects in places all over the world.

Now, the other big part of it, and now is the time to say this, is the bout of insurance coverage. Because how do we make it so that this is both legally available but also financially accessible. We're hoping that the FDA approval and the conversations that Lykos has had with insurance companies look very promising. From a year from now, we hope that there will be not just legal access, but insurance coverage.

Now, we know that in England and other places with national health care outside the US, the price of drugs is around half or so of what it is in the US. Pharma companies make most of their money in the US. What we're hoping a year from now is that we will have started small pilot studies in humanitarian projects all over the world. Lykos will be trying to roll it out in the United States and potentially starting to think about what to do with MHRA and EMA.

But then the other thing that I'm hoping for a year from now would be for us to submit a grant application for roughly $100 million over six or seven years to globalize access in humanitarian contexts. While Lykos will focus on the United States, basically, because we've had to take in investors, I think that we have to balance public benefit with return to shareholders.

Lykos will go where the suffering is, but where they can sell the drug, where there's people who can pay in insurance. So MAPS wants to complement that by going where the suffering is, where

people can't pay. I hope by a year from now, we'll have enough demonstration projects and enough that we will then be able to go for this $100 million grant that'll set us up for the next 6-7 years.

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Then the other thing is drug policy reform. So for example, in November, there's going to be something on the ballot in Massachusetts, the state I live in, to legalize plant medicines. Something similar passed in Colorado, and we have the Oregon Psilocybin Initiative. But people don't think that, logically, they're really romantic. This idea of romantic... What I mean is that people like plants. But these initiatives, when you start saying, "Oh, let's legalize plant medicines" which I think are psychologically more challenging than MDMA, but you add MDMA and they're like, "Oh, we don't like synthetics" and it doesn't pass.

There is going to be an effort in California through the legislature to add MDMA to a plant medicine legalization law. I would also hope by a year from now that there will be more efforts to add MDMA to the state legal context or potentially some little island nation.

There was a talk for a while, St. Vincent's and the Grenadines might actually, for psychedelic tourism, medical tourism, set it up where we could bring therapists there to get an MDMA experience. Maybe Jamaica would go beyond just psilocybin, and legalize MDMA in different ways. Maybe a year from that is too soon.

But I hope that a year from now, we will still be a couple of years ahead of psilocybin being approved as a medicine by regulatory agencies. But there's over 2,000 ketamine clinics in the United States right now. A lot of the people that run the ketamine clinics really want to be, again, cross-trained, as I said before. At least the good ketamine clinics that provide ketamine with therapy, the bad ketamine clinics that provide ketamine without therapy, they don't care. But the good ones that combine with therapy, they want to learn about MDMA. Eventually, they'll want to learn about psilocybin and 5-MeO-DMT.

I hope that we're, a year from now, really starting to begin this process of scaling both in places where people can pay, but also beginning the work where people cannot pay, and that there will be more and more of these stories that people will share about how MDMA helped me or psilocybin helped me or Ibogaine helped me, so that that will start, like medical marijuana, changing people's attitudes towards legalization.

I hope a year from now, there'll be a growing support for drug policy reform as well, because that's the real way to provide access, not just to people that have a diagnosis, but people that want it for personal growth or celebration or creativity or even workplace, get a team of people working together and have them do micro dosing of this, or MDMA. Before you know it, their performance will probably be a lot better.

Alexander Beiner

Absolutely. Well, it's an exciting vision and Godspeed. It's an exciting time to be in the psychedelic field as well. Rick, thank you so much.

[00:36:05] Dr Rick Doblin

Okay, terrific. I'm very happy to talk with you, and I do look forward to checking out your wife's dissertation.

Alexander Beiner

Thank you. Great. Thanks.