CHAPTER III

MMDA AND THE ETERNAL NOW

MMDA IS AN ABBREVIATION for 3-methoxy-4,5-methylene dioxyphenyl isopropylamine. Like MDA, from which it differs only in the presence of a methoxyl group in the molecule, it is a synthetic compound derived from one of the essential oils in nutmeg. The chemical similarity between these two compounds finds an echo in their psychological effects on man—in each case predominantly one of feeling enhancement. Their chemical difference is reflected in some qualitative differences in effect, however: MMDA frequently elicits eidetic displays, and not the past but the present becomes the object of attention for the person under its effect.

MMDA stands with MDA in a category distinct from that of LSD-25 and mescaline as well as from that of harmaline and ibogaine. In contrast with the transpersonal and unfamiliar domain of experience characterizing the action of these two groups of drugs, these feeling-enhancing isopropylamines lead into a domain that is both personal and familiar, differing only in its intensity from that of every day.

MMDA SYNDROMES

One possible reaction to MMDA, as to other psychoactive drugs, is a peak experience. How this experience differs from that brought about by other compounds will become apparent in the following pages. An alternative to the artificial paradise of MMDA is its hell. This is a reaction characterized by the intensification of unpleasant feelings-anxiety, guilt, depression—which may be regarded as a mirror image of the first, and constitutes, too, a clear syndrome. Yet these two types of reactions may be classed together in that they are essentially feeling-enhancement states, and contrasted to other states where the feelings are unaffected, and there may be passivity, withdrawal, and/or sleep rather than excitation. I find that both imagery and psychosomatic symptoms are more prominent in the absence of vivid emotions, so that I would tentatively regard this syndrome as one of feeling substitution. Lastly, there are occasions when a person reacts to MMDA with little or no productivity, both feelings and their equivalents being absent, a state that could well be regarded as the limbo of MMDA. In these cases, the effect of MMDA is one of even greater apathy or deeper sleep, so that I would suggest understanding them as instances where the repression of feelings does not even allow their symbolic expression, a state that can be maintained only at the expense of consciousness.

Broadly speaking, then, and for the purpose of deciding how to proceed in the therapeutic situation, I will consider the effects of MMDA as belonging to five possible states or syndromes: one which is subjectively very gratifying and may be regarded as a particular kind of peak experience; another where habitual feelings and conflicts are magnified; a third and fourth in which feelings are not enhanced but physical symptoms or visual imagery are prominent; and, lastly, one of lethargy or sleep. Psychosomatic symptoms or eidetic imagery may be present in

any of these states, but are most prominent in the third and fourth (as feeling substitutes), while feelings are the most prominent part of the experience in the first two, and a state of indifference (possibly defensive in nature) sets in in the third and fourth and culminates in the fifth. In the latter, as in normal dreaming, there may be much mental activity, but this becomes difficult to grasp, remember, or express. These states may follow one another in a given experience, so that the reaction to MMDA may be initially one of anxiety and conflict until better balance is achieved or somnolence supervenes; or a session may begin with the pleasurable balanced state and then lead into one of emotional or physical discomfort, and so on.

ON THE ASSIMILATION OF PEAK EXPERIENCES

We have elsewhere remarked how the peak experience that may be possible under the effect of MDA is one affirmation of the individual aspect of the self, in contrast to that of LSD, where the typical experience is one of dissolution of individuality and the experience of self as oneness with all being. In the peak experience that MMDA may elicit, it is possible to speak of both individuality and dissolution, but these are blended into a quite characteristic new totality. Dissolution is here expressed in an openness to experience, a willingness to hold no preference; individuality, on the other hand, is implied in the absence of depersonalization phenomena, and in the fact that the subject is concerned with the everyday world of persons, objects, and relationships.

The MMDA peak experience is typically one in which the moment that is being lived becomes intensely gratifying in all its circumstantial reality, yet the dominant feeling is not one of euphoria but of calm and serenity. It could be described as a joyful indifference, or, as one subject has put it, "an impersonal sort of compassion"; for love is embedded, as it were, in calm.

Infrequent as this state may be for most persons, it is definitely within the range of normal human experience. The perception of things and people is not altered or even enhanced, usually, but negative reactions that permeate our everyday lives beyond our conscious knowledge arc held in abeyance and replaced by unconditional acceptance. This is much like Nietzsche's *amor fati*, love of fate, love of one's particular circumstances. The immediate reality seems to be welcomed in such MMDA-induced states without pain or attachment; joy does not seem to depend on the given situation, hut on existence itself, and in such a state of mind everything is equally lovable.

In spite of MMDA being a synthetic compound, it reminds us of Homer's nepenthe ("no suffering"), which Helen gives to Telemachus and his companions so that they may forget their suffering:

> But the adimirable Hclcn had a happy thought. She lost no time, but put something into the wine they were drinking, a drug potent against pain and quarrels and charged with forgetfulness of all trouble, whoever drank this mingled in the bowl, not one tear would he let fall the whole day long, not if mother and father should die, not if they should slay a brother or a dear son before his face and he should see it with his own eyes. That was one of the wonderful drugs which the noble Queen possessed, which was given her by Polydamna the daughter of Thon, an Egyptian. For in that land the fruitful earth bears drugs in plenty, some good and some dangerous: and there every man is a physician and acquainted with such lore beyond all mankind, for they come of the stock of Paieon the Healer.'

What the therapeutic implications of such an episode of transient serenity may be can be seen in the following case of a twenty-eight-year-old patient who was sent to me

[1] Homer, The Odyssey, trans. W. H. D. Rouse (New York: New American Library, Mentor Books, 1971), 49.

by another psychiatrist after six years of only moderately successful treatment.

The patient's reason for consulting, now as in the past, was chronic anxiety, insecurity in his relationships with people, and women in particular, and frequent bouts of depression. After an initial interview, I asked the patient to write an account of his life, as I frequently do, in view of both the value of such psychological exercise and the interviewing time that may thus be saved. As he was leaving, I said, "If nothing new comes up, come back when you have finished with the writing. But if you really put yourself into it, you may possibly not need me any more by then." The man came back after four months with a lengthy autobiography and reminded me of what I had said, for the writing had indeed been one of the major experiences in his life and felt to him like a new beginning. Reading it, I could understand that, for seldom have I seen anyone so explicitly burdened by his past, nor such a heroic act of confession, in which the author struggled page after page to overcome his sense of shame.

Much of this autobiography, from childhood onward, spoke of his sexual life, and it ended with a description of aspects of it in his present life which were related to his generalized insecurity. On the one hand, he was disturbed by the appeal which anal sexual intercourse held for him and concerned with the thought that women would regard this as a homosexual trait. On the other hand, he liked to stimulate his own anus while masturbating and felt ashamed for this aberration. When questioned about his own judgment as to how homosexual he might be, he said that he did not know of any homosexual inclination in himself, but that he could not dismiss an "irrational" fear that others would not see him as a truly masculine person. Whether his anal eroticism betrayed a latent homosexual trend he did not know, and he was frightened by the thought of it.

While awaiting the first effects of MMDA, the patient felt uneasy and somewhat afraid of looking ridiculous, but

to his own surprise, he gradually entered into the state of calm enjoyment which is typical of the more pleasant experiences with the drug: "Like not needing anything, like not wanting to move, even; like being tranquil in the deepest and most absolute sense, like being near the ocean, but even beyond; as if life and death did not matter, and everything had meaning; everything had an explanation, and nobody had given it or asked for it—like being simply a dot, a drop of honey-pleasure radiating in a pleasurable space."

After some time, the patient exclaimed, "But this is heaven, and I expected hell! Can this be true? Or am I deceiving myself? Right now, all my problems seem to be imaginary ones. Can this be so?" I answered that this was possible and that if his problems were really the fruit of imagination it would be good to understand this very clearly, so that he could remember it later. So I suggested that he might compare his present state of mind with his habitual state and try to grasp the difference.

The difference was obvious to him. What the drug had done was to turn off the judgmental side of him that we had exposed in the previous appointments, the inner critic that would not let him live.

I said that now he knew what life was like when his "judge" was artificially put to sleep, but that he would wake up again—and then it would be the patient's choice whether to put up with him or not. He agreed, and I proceeded to confront him with his problems and photographs of persons in his family, in order to fix in his mind the views of his postponed, non-judgmental self. In doing this, he realized even more clearly the reality of his tendency to self-torture in his ordinary life. As he later said, "I had an intuition of it long ago in self-analysis. But now I see it more clearly than ever, and it is not just a cause any more, but a character with all its attributes. And its importance in my life and problems—I feel it now—has been enormous."

This insight did bring about a difference during the days following the session, for the patient no longer identified as much with his self-punishing criticism, but looked at it with some detachment, as if he had a life (his own judgment) independent of both the accuser and the victim.

Looking at a diary from which the patient has kindly permitted me to quote, it is possible to see that up to four days after the intake of MMDA there is an almost undisturbed carry-over of that state of mind first made known to him with the help of the chemical. On the fifth day, he felt depressed for a few hours, but recovered after writing in his diary. This writing dealt first with his depression and then with what he had felt when "I was at that center, the center of myself, and I knew that I would never lose this, for I needed only to breathe deeply, smile at the universe, and remember the bookshelves that I looked at that day." He continues: "I understood that a few seconds and an empty room are enough to justify a whole life. It does not matter any longer, then, to die or to lose an arm. It is not a matter of quantity. In zero minutes and with no things, life is as good as possible. In a minimal space and with no money, even without health, with no social success and all that shit." And he adds: "Rut I feel this even today. I am at some distance from the central point of the Aleph, but I continue to be at the center, my center that is still chaotic, but yet everywhere, and pure."

I think that the patient is being very accurate when he perceives that in spite of his being "centered" in the newly discovered domain of intimate joy, self-sufficiency, and indifference to frustration, he is nevertheless in a state of disorder. In other words, he does not confuse (as patients and even therapists sometimes do) the experience of transcendence with that of psychological balance and sanity. He is aware of negative emotions that he recognizes as part of his neurosis and he continues to react in ways that he knows are not the most desirable; but in the same way

that "losing an arm" would not matter, he no longer tortures himself for such shortcomings. Instead, he experiences a less compulsive but perhaps more effective wish to "construct" and "make order" in his life, "like a duty of love, or holy labor."

As different as spiritual detachment and healthy psychological functioning may be, I believe that the latter may gradually develop in the presence of the former, making the therapeutic implication of such a peak experience an indirect one.

One of the ways in which a mood of serenity may result in further change is that it increases the possibility of insight, much as an analgesic can permit surgical exploration of a wound. Such insight cannot be possible insofar as the patient's sense of identity depends entirely on the integrity of an arbitrary idealized image of himself. But when our subject now says that "death would not matter," even though he is most probably exaggerating, he may be unknowingly stating a metaphysical truth; for "at the center" death of the self-concept does not matter.

How a "not caring" mood and attitude can lead to greater awareness may be illustrated by other passages of the same diary. The following was written three days after the session:

> Something could not come out of my throat. Anal masturbation: the great guilt, the supreme offense, that the Great Puritan does not forgive. The utmost degeneration, the worst garbage.
>
> It was necessary to discuss it with Dr. N., but it did not come out . . . the fact of having caressed my anus, having introduced objects into it while I masturbated with the other hand, having daydreamed of being penetrated . . . the great hole, the ass, the center of my hell . . . remained hidden, not deeming itself forgivable or understandable, seeing itself as something at which even a person like Dr. N. would feel disgust.
>
> I can shove that Great Inquisitor into my ass, shit or

piss on him—but all this is already giving it too much importance, the solution lies in understanding clearly and feeling that it does not matter too much, that it is, like the rest of the problems, a surmountable thing. And not something evil or horrible, or a sign of inferiority, but a transitory way out for a torrent that is transitorily stopped.

And he adds, three days later:

I have understood that the great guilt does not lie in anal niasturbation but in being homosexual; and I feel dizzy at the thought of it, because it seems to me that this is the worst that could possibly happen to me.

The sequence of psychological events described above portrays a familiar process in psychotherapy, where by an object or concern (i.e., ways of masturbating) loses importance, while increased importance is attached to a more substantial issue (e.g., being homosexual). A detached, serenely accepting attitude is truly the power that makes the change possible, and petty conflicts may eventually lead to greater conflicts that enrich life rather than detract from it.

Here are further illustrations of the patient's increased ability to see himself:

I felt that nothing mattered. I thought about many things in the following days. I understood that my preoccupation about wearing comfortable clothes, clothes to my taste (I felt some shame when I retorted with this as the first answer to Dr. N.'s question as to what I wanted to do) stems from my mother's *imposition* on me to wear clothes which I found humiliating. I understood why I don't do things that I like or that I find convenient: because I consider them an obligation, and my mother has been telling me of my obligations for twenty-eight years. And I suspect that not wanting to phone my girlfriends when she or my father are around indicates guilt feelings about sex—and I also feel guilty about giving other women the love that I don't give her.

I do not believe it is just a coincidence that the passage telling of his insight into three different situations begins with a statement of the feeling that "nothing matters." For insight, we well know, does not depend on thought processes alone, but is one of the facets of change. Only when "nothing matters" could he accept being the "bad boy" that he never was and conceive thoughts in which he opposes his mother, for such thoughts are inseparable from his own self-assertion and rebellion.

The behavioral equivalent to the openness to insight described above is an openness to feelings and impulses which would be incompatible with the acceptable self-image. These become bearable now because there is something other than an image to rest upon—a "center," which gives the patient confidence to let go of his habitual patterns. If death does not matter, why would getting angry matter, or not doing the "right" thing according to previous conditioning?

The following passage is a good illustration of such increased spontaneity in behavior and constitutes a very exact parallel to the understanding expressed in the previous quotation:

> Once more I have felt rotten for living in this house where life is impossible, with such heat, with the old quack and his clients who keep ringing the doorbell, and the old woman nagging, nagging, nagging. Why don't I go with my car and get those chairs, and why don't I go and get the other crazy woman at the clinic on Saturday, and what would Uncle John say if he knew that I am not going to do this or that errand'for her. (And how full of ants the house is, millions of them, and they fly! And they don't let me write.) But I told them: Fuck Uncle John and all the relatives and what they say! I shouted at her and pounded on the table once, twice, three, four times. And I told her not to expect me to go on listening to her just because this was what I had done for twenty-eight years, and so on. And she left with a bag. I thought that she was

going to her sister's house, but she has come back, so that it seems that she just went over to the laundry with some clothes. And I felt rotten—guilty at hating a shitty woman who has screwed me up and wants to go on screwing me up.

But enough! They will have to learn not to plague me in these last days that I'll spend with them.

The episode described above might be compared to the period of "worsening" that often supervenes at some point in the course of deep psychotherapy without drugs. In truth, the patient's hostility has only been laid open, and this may be the unavoidable price for him to pay for the possibility of experiencing it fully and understanding it, before he can leave it behind. The utter rejection of his environment portrayed in the patient's account may seem the very opposite of the unconditional acceptance of reality that is characteristic of "the MMDA state of mind" at its best. How can ants matter so much to one who has felt that not even death does? Nevertheless, the patient is accepting his own anger to a much greater extent than before, rather than repressing it and having it emerge in the form of symptoms. Such anger probably constitutes a defense against other feelings which he is still not readv to experience (the loneliness of not feeling himself loved or respected by his parents, for instance) and which are triggered by certain stimuli in the house, so we may expect that further progress *in the same direction* should bring such feelings into focus and make him less vulnerable to the heat in his room, the ants, his father's clients or his mother's demands. We might picture the psychological state presently described as one in which the "amount" of serenity remaining for the maximum of five days before is just enough to dissolve, as it were, one layer of the mental onionskin. But if this change remains, the same power will be henceforth going to uork on the next layer.

A parallel may be seen between the unveiling of the patient's anger and that of his fear of homosexuality. Nei-

ther his irritability nor his sexual doubt is a manifestation of health and psychological balance, but now he can at least face them — and facing them he faces *himself* to a greater extent than when he was concerned about the clothes that he wore or what a woman would say of his love-making. An indication that this is so is his evolution, for even at a later hour the same day he was feeling as well as he ever had, and for the following week had no more downfalls than recoveries of a level of well-being that had been unknown to him before. In these moments, he would write passages like this one:

> I have understood that there is very little that matters. It doesn't matter that the car doesn't work, that a girl won't love us, that they won't give us the best appointments at the university, that they say that I am a homosexual, that I don't have a lot of money or a kingdom, that my parents will die. that Aunt Rose is as crazy as ever. It only, matters. perhaps, to be able to breathe deeply and feel here, now, enjoying the air, and that fly. It doesn't matter not to be able to go to England, not to be a writer or a playboy.

And fifteen days after the session:

> And goodbye to the vicious circle, to the "ontological" boredom about everything, to problems, and psychotherapy. The Sargasso Sea is over, and the dark night and the storm; it is the end of anxiety up to the neck, depression, and shit in little spoonfuls. The sun is out, the sea is out, the world, and the fly.

The reader may have noticed how several quotations in which the patient expresses his new understanding are written in the past tense: "I understood"; "I felt." That they are conveying the patient's state at the moment, which he confirms personally, and the fact that they were not written before (even though he produced a detailed description of the MMDA session, which is not included here) probably indicates that the understanding belongs

only to this moment, even though it was potentially present during the height of the effect of the drug. In other words, the state of feeling at the time of the session was one in which such viewpoints were implied, but which did not depend upon such views. The return process can be understood as one in which the remembered feeling is translated into explicit attitudes about specific issues. Or, using another image, the peak experience might be likened to a spot on a mountain top from which the surrounding panorama may be viewed; yet being on the top of the mountain does not supply more than the possibility of seeing, whereas this process of observation is different from that of mountain climbing. The particular view that can be seen from a given spot implies the viewpoint and makes it explicit, and in a similar fashion the particular insights that may be obtained from a given state of consciousness imply and express that level of awareness. Yet insight is distinct from the mental state from which it originates and constitutes the result of a creative act in which consciousness at a certain height is directed toward what lies below.

In other words, that "center" which can "justify life in an empty room" has to be brought into contact with the periphery of everyday life; the "heaven" of spiritual experience must be brought to bear on the "earth" of particular circumstances before real understanding can develop. And only then can life be created (i.e., behavior chosen) according to the point of view implied in the transient flash of understanding.

The reason it is difficult for the above synthesis to occur is that from the mountain top the valley may be invisible for a dizzy person who may feel inclined to look at the stones, or even to fall. And the atmospheric conditions are such that the mountain top can hardly be seen from the valley. Or, translating this into empirical terms, a person's present difficulties may be hard to bring to mind during the peak experience, when such reflection would be so desirable; or their unpleasantness may lead the person

to avoid remembering them; or the particular state of mind that constitutes the peak experience may be disrupted by such thoughts.

On the other hand, when the person is closer to the issues of his daily life, to which he is most vulnerable, he may not be able to reflect on them at all, for he himself will be lost in them—like our patient with the bell ringing and the mother asking him to do things for her.

Since neither one of the alternatives is a complete impossibility, though, I believe that much value should be attached to the attempts at directing the mind, at the time of the "good" MMDA experience, to the conflicting situations in a patient's life, as well as to the patient's remembering his peak experience at the time of contact with his difficulties.

It is the latter that naturally occurred during the days following the session under discussion, and this explains the patient's use of the past tense, even when he was not only recalling, but re-experiencing, the taste of "centeredness" in face of given circumstances that he had potentially contemplated during the course of the drug's effect.

The way in which the patient alternates between "remembering" his experience of calm satisfaction and moments of despair (when he thinks that the treatment has been worthless) indicates that the state of mind reached under the facilitation of MMDA is not something that simply lasts for a given time and then is lost, but one that may be *learned.* Once a person has used his mind in that way, he has easier access to the same way of functioning. And in this learning, whereby a desirable attitude can be "remembered" not only intellectually but functionally (as the movements of writing and walking are remembered when we do them) after it has been adopted once, lies, I believe, one of the major justifications for the elicitation of an artificial peak experience. This could be likened to the guiding hand which holds that of a child to show him how to draw a letter, or those of the practitioner in M. Alexan-

der's system, showing a person how to stand or sit so that he can feel the "taste" of rightness, or, in the conception of Mexican shamans using peyote, the guiding hand of God. Once in possession of such discrimination or knowledge, it is up to the individual to remember it and put it into practice. An expressive passage on the role of learning when applied to a state of mind is the following recollection of Jean-Pierre Camus (quoted by Huxley in his Perennial Philosophy):

> I once asked the Bishop of Geneva what one must do to attain perfection. "You must love God with all your heart," he answered, "and your neighbour as yourself."
>
> I did not ask wherein perfection lies, I rejoined, but how to attain it. "Charity," he said again, "that is both the means and the end, the only way by which we can reach that perfection which is, after all, but Charity itself. Just as the soul is the life of the body, so charity is the life of the soul."
>
> "I know all that, I said. But I want to know ***how*** one is to love God with all one's heart and one's neighbour as oneself.
>
> But again he answered, "We must love God with all our hearts, and our neighbour as ourselves."
>
> I am no further than I was, I replied. Tell me how to acquire such love.
>
> "The best way, the shortest and easiest way of loving God with all one's heart is to love Him wholly and heartily!"
>
> He would give no other answer. At last, however, the Bishop said, "There are many besides you who want me to tell them of methods and systems and secret ways of becoming perfect, and I can only tell them that the whole secret is a hearty love of God, and the only way of attaining that love is by loving. You learn to speak by speaking, to study by studying, to run by running, to work by working; and just so you learn to love God and man by loving. All those who think to learn in any other way deceive themselves. If you want to love God, go on loving Him more and more. Begin as a mere apprentice, and the

very power of love will lead you on to become a master in the art. Those who have made most progress will continually press on, never believing themselves to have reached their end; for charity should go on increasing until we draw our last breath.'"[2]

What complicates this picture is that in the case of higher (non-instrumental) attitudes and ways of mental functioning, as in that of motor skills, the learning process is interfered with by the arousal of habitual patterns of response that are incompatible with the new. In other words, *remembering* the sane state" becomes possible only when specific stimuli are not eliciting the conditioned responses which the individual wants precisely to get rid of. Consider, for instance, one more quotation from our patient's diary:

It is now one week since the session with MMDA, and today I felt alone again, in my bed, in my dark, hot room, in this sinister house, and I feel like escaping, like going someplace, to a movie perhaps, or to visit Alberto, or anybodv, and I know that I will feel bad anyhow, for I won't be able to get out of myself, and I will be with them like a zombie, like a little boy crying inside, licking his wounds or masturbating, and introducing his fingers into his anus, hating his parents and dreaming that he is a king.

And I feel all this today, only a week after having seen something of a definitive cure. And why? Because I didn't sleep well last night (after a quarrel with Alice), because garbage is accumulating in my soul again, because I came to wait for Ana's phone call. (Damn her! She slipped away

[2] Aldous Huxley, *The Perennial Philosophy* (New York and London: Harper & Brothers, 1945), pp. 89–90.

[3] In calling it "sane," I am assuming that this is the natural state and that only because there is such a thing as a natural state can it be manifested spontaneously and without learning. Learning becomes necessary only for its "realization," i.e., its translation into practical reality.

from me) That is it!! She screwed me up by not calling me. My security is down to zero again, and I continue to be one hundred per cent dependent on others.

The fact that the patient was temporarily precipitated into his neurotic pattern when the girl rejected him shows that such rejection had not really been taken into account when he felt himself so invulnerable. Only after being confronted with it and recovering from his fall, could he really say, as he actually did, "It doesn't matter if a girl doesn't love us."

I believe that in such confrontation with experience (or its possibility) lies the healing property, as well as the insight that gives permanence to the new condition. Such confrontation may take place during the session with MMDA, if the patient is led to consider the conflictive circumstances of his life, or later, when living is unavoidable. In the present case, I did lead the patient to a contemplation of his difficulties when he seemed ready to look at them with pleasurable calm, but I did not realize how he was dissimulating his avoidance of certain issues. This was his first concern afterward ("things that did not come out"), and he aptly describes the effect of the session, later, as "an antiseptic that eliminated the infection for two or three days, so I felt completely rid of my neurosis."

It is to be expected that the more the issues have to be avoided in order not to disrupt a "peak experience," the more unstable and short-lived such experience will be in the midst ,of ordinary living conditions. But I use quotes here for "peak experience" to imply that such an experience has an element of self-deception in it, in that it is possible only at the expense of repressing, or not looking at, what is incompatible with it. What can the validity be of feeling that we can accept death if we are unable to imagine it? Yet I believe that in most pharmacologically induced peak experiences there is a substratum full of issues that cannot be confronted.

We can ask ourselves, therefore, which may be the

more desirable: to take a directive attitude during the MMDA session and attempt to confront the patient with what he is avoiding, at the risk of disrupting a state of partial integration, or to let the patient experience as much as he can of his newly discovered centeredness, so that the taste of it remains while he later meets life as it comes.

In truth, there is not so much room for choice as it might seem. In my experience, only about 25 per cent of the persons react to MMDA with a spontaneous peak experience, while an additional 30 per cent arrive at it after working on their problems. In the latter instance, there can be little doubt that the experience has occurred *in spite of,* and as the result of, the resolution of at least some of the person's conflicts, which has generally been the object of most of the session. As to the former 25 per cent, it is generally my practice to allow the experience to proceed undisturbed for about two hours and then devote the remaining three to the examination of the patient's life and problems. In doing this, I am assuming that I can help the patient more by being present at this confrontation than by leaving it to him to experience in the following days, and that remembering life at the time of a peak experience may be easier than remembering it at the time of living. In actual practice, this does not violate the patient's inclinations, for he is either feeling open to whatever is proposed, in his accepting mood, or else feeling naturally drawn to such self-examination. This was true in the case (among others) of the man in our illustration who, after about two hours of enjoying his heavenly state, wanted to know where his hell was and to ascertain whether his present state was really valid or justified.

Sometimes, the crucial confrontation occurs spontaneously in vivid imagery, as was the case of a patient who had always felt insecure in his work as a manager, and would compensate by adopting a bossy attitude. Toward the end of his MMDA session, he imagined himself at

work in the present state of relaxed warmth and really learned from such creative fantasy how this was truly possible, how his defensiveness was unnecessary and his undistorted expression of himself more satisfying and not inconvenient. There was very little talking with this patient, but his mood and behavior at work changed.

That there are limits to how much a person wants to confront at a given time is also true, and I think that the therapist's possibilities are more limited here than it would seem. The patient will not hear, or he will just pretend to hear, or his feelings will not parallel his thinking, his mind will go blank or be filled with distracting thoughts, and so on, and this will have to be accepted. Moreover, there may be a natural wisdom in the unconscious regulating process that controls the length of his steps toward integration. All the therapist can do in these instances is be available to offer what he can.

Another instance of such spontaneous confrontation in imagery is described by a patient in the following words:

> Then something significant happened. First I just felt something had happened, something was different. As if I had forgiven myself for something. Then I became convinced that the forgiveness was associated with the throwing-up some time earlier. Then I found myself in fantasy moving about within my office at the college. I discovered that I no longer was caught up in the self-flagellating depression that I had been in during the last week. I was free and at ease.
>
> Then I had moments of realization of a quality of peace of mind that I almost never have (in my anxiety, computing, rehearsing, manipulating, worrying, and other habitual states), and the quality was—and still is today, after fifteen days—a state of being able to let time pass with graceful ease, even to luxuriate and enjoy friends in the moment.

What is it, then, in practical terms, that the patient may be offered in such moments, when his state of mind

could not be better? In general, I would regard the following immediate aims as conducive to the stabilization of a peak experience:

1. Explicitation or Expression of the Present State and Point of View

It may be assumed that the change that has taken place in the subject's feelings is not just a matter of metabolic processes in his nervous system, but that it entails an implicit change in the perception of people or relationships, or in his values. Since it is such changes that may support the new feeling state if they endure, it is desirable to make them as conscious as possible, and thus help him consciously discard the implicit distorted views that were supporting the symptoms. Thus somebody may no longer be seen as a persecutor, or the individual may discover his own worth in an area where he had been rejecting himself. The whole approach amounts to asking the patient *why* everything seems all right to him now (or why it is unnecessary to worry so that he may translate into concepts his implicit understanding).

In the case of the patient in our first illustration, this led him to a greater awareness of his self-punitiveness, as was mentioned earlier. Another realization that helped him in the expression of his new state of mind was the one he described in terms of "nothing matters," meaning really something like "nothing can take away from the joy of existing, which is an end in itself." The value of expression is that its products are like reservoirs of the experience that gave them birth and are to some extent the means of re-creating the experience. The fruits of expression are, like art, a means of making the invisible visible and fixing in a given shape a fleeting instant in the mind.

2. Contemplation of Everyday Reality

Most important here is the confrontation of stimuli (circumstances, persons) which are normally painful or elicit neurotic reactions. This is the opportunity for the discovery of a new pattern of reaction stemming from the integrated state, which would be less likely to occur after the peak of serenity is over, and where proximity to the given circumstance is too great. Confrontation in the mind before confrontation in reality takes place in a strategy which might be compared to that used by Perseus in his approach to the Medusa: he does not look at her directly, but at her reflection in Minerva's shield.[4]

Photographs are useful to this end, since the cues offered by them are valuable starting points for association with life experiences, in contrast with the stereotyped views that are often elicited by verbal questions.

Whenever a new approach or feeling is expressed which breaks the vicious circle of neurotic attitudes, the expression of it may be encouraged in order to *fix* it in the mind as part of the enlarged repertoire of responses. An imaginary encounter with a given person, in which a dialogue is produced, may be a useful resource, and also writing, which is perfectly compatible with the effect of MMDA.

The following illustration is from the report by a young man who had been in therapy for five years and was at the time of the session living through a chaotic and painful period in his marriage:

> . . . I remember lying on the carpet in the room, fully enjoying a warm, glowing, soft sense of well-being. Dr. N. came to me and suggested that we talk together. I told him

[4] Minerva is the goddess of wisdom, suggesting that the mirror-shield represents the mind.

about my love for Jeanne and the hurt I felt. He suggested I write down my feelings on paper. I wrote as though writing a letter to Jeanne. I told her how much I loved her. And that I was waiting for her. During this time, I experienced the most acute sexual response, especially in the pelvic area. I was thoroughly immersed in the joyful fantasy of loving Jeanne. Loving her in a quiet, tender way, caressing her ever so gently. I felt, perhaps for the first time, that my desire to be tender and loving toward her was the power that would break through her sexual anesthesia.

Their relationship improved after the session, since the attitude expressed in this letter persisted to some extent and replaced previous feelings of rejection and resentment. The act of expression (by committing these feelings to paper) can be conceived of here as a commitment, as well as a realization, in the sense of "making real" what was merely a feeling, living out what was only a possibility.

3. Exercising of Decision in Face of Present Conflicts

I usually ask the patient to make a list of the conflicts that he is aware of, or I make it with him before a session with MMDA, and this provides many questions to consider at the time of an eventual state of psychological harmony.

Conflict is perhaps the most central single manifestation of a neurotic disturbance, since it is the expression of a disunity or split in personality. In the exceptional moment of integration, when the usually incompatible fragments of the person's psyche are united, many of his conflicts will disappear. If the integrated attitude of the person is not rendered explicit at the moment, it will be lost more easily once the exceptional state is over; yet this is the occasion on which the person may know the attitude

of his integrated self and learn what it feels like. When his self is not there any more, the memory of such an attitude will be one more thread in his fabric of experiential remembering—and perhaps the best possible advice as well.

HANDLING THE STATES OF FEELING ENHANCEMENT

Everything that I have elaborated upon up to this point applies to the kind of experience that ensues spontaneously in about 20 per cent of all instances after the intake of MMDA. It may apply in part to the similar experience which supervenes in an additional 30 percent of cases after therapeutic intervention, as conflict resolution and personality integration are achieved. But in about 50 percent of all instances, such feelings of "all-rightness," calm, and loving acceptance are not experienced at all, and in 80 per cent they are not present at the beginning of the session.

In such instances, the reaction to the drug may be predominantly that of an enhancement of certain emotions and/or psychosomatic symptoms, or one where imagery becomes the main object of attention. Each one of the possibilities constitutes a type of effect that calls for a distinct approach, and I shall presently deal with the predominantly feeling reactions. These feeling-enhancement reactions might well be grouped together with the "peak-experience" reactions, for the emotions are the focal point in both kinds of experience, yet both are in contrast in terms of the kind of feelings involved. As the peak experience constitutes MMDA's "heaven," the feeling-enhancement state constitutes its "hell." Instead of calm and loving acceptance of experience, the emotions of the second state are typically those of anxiety and discomfort, which render immediate experience unsatisfactory.

What the second type of experience has in common with the first is the relevance of the feelings experienced in

relation to the present situation and to the immediate environmental and social context. I find such a "here and now" quality of the MMDA experience particularly suited to the non-interpretive existential approach of Gestalt therapy, which I have used—as will be seen from the forthcoming illustrations—almost free from admixtures in the handling of most sessions.

Experiences of discomfort are usually the outward expression of self-rejection or the fear of imminent self-rejection. Once this becomes explicit, the top-dog–underdog impasse can be re-examined to see whether the person can discover some value in his rejected side, whether his judgmental standards fit his true judgment or are in the nature of an automatic reaction, which can be dispensed with. Some examples may make this more clear:

A female patient has been encouraged to do or express whatever she wants during the session. When the drug begins to take effect she withdraws to her bedroom, where she lies down and listens to some music. After five minutes or so, she returns to the therapist in the living room and explains that she has not been able to enjoy these minutes since she has felt distressed at what she calls her "voraciousness"—she could not really listen to the music since she wanted a number of things at once, such as a drink, the therapist's presence, and, most of all, to be special.

Since her discomfort seemed to be associated more with her self-accusation of greed and voraciousness than with the unavailability of means to satisfy her needs, I inquired, "What is wrong with wanting more and more?" This comment proved to be more than superficially supportive, since it led her to an open-minded consideration of the question. When I later insisted that she state her wants and be increasingly direct, she found that in giving way to the expression of such wants she became more herself. What she initially labeled "voraciousness" soon came to be seen as wanting to be specially loved by a man. As I emphasized the humanness of this want, she saw the accept-

ability and even essentiality of fulfilling it in her life, in one way or another. "I've been going after my wants indirectly all my life, and the indirectness and lack of consciousness are what have fouled me up."

The process of increasing self-acceptance depicted in this illustration came about by the therapist's repeated invitation that she take sides with her rejected urges and acknowledge them as her own, rather than as something happening to her.

The following fragment of a retrospective account by another patient illustrates in greater detail the process of gradual unfolding of rejected urges in an atmosphere of support:

> . . . As I felt the first effects I lay down on my bed. Dr. N. sat next to me and suggested that I relax and let myself be carried by whatever I might feel. I began to feel much anxiety and a great desire to cry. Dr. N. told me to do so if I wanted, but I was resisting. I told him that I would not permit myself to do that, for it seemed ugly to me; that I disliked persons who indulged in self-pity and that I, who had chosen my way with so much struggle, felt that I had no right to feel unhappy.
>
> Dr. N. said that perhaps I had good grounds to feel pity for myself, so to go ahead and not mind crying. He said: Take a holiday for an afternoon and do whatever you feel like. I asked whether he would approve, and as he said yes, I wept bitterly. Dr. N. then asked me how would my tears explain their flowing if they could speak. I said they were flowing for the world's sorrow. He asked what that was. I said I imagined a great lake formed by the pain of every human being since the world exists, from the smallest, such as that of a child that falls down and cries, to the greatest. A ground of collective sorrow, in the fashion of Jung's collective unconscious. Dr. N. said he believed that I might be weeping for my own experiences, for concrete and definite things. That perhaps I had lacked something as a child, for instance, and this fact was still affecting my life.

> I continued to weep and suffer, but with freedom and a feeling of relief. I had put a Vivaldi concerto on the record player. I felt the music very deeply and felt that through the music I could reach into the being who had produced it. I think Dr. N. asked me what the music was expressing, and I replied that this was Vivaldi's being, turned into a voice; a voice that expressed him totally. I marveled that he could have turned his inside out so completely.

As is usually the case, once the patient contacts her own urges before they could be supported and could conshe is turned inside out, she can read the expression of another being.

Such "turning inside out" in the last illustrations can be understood as an achievement of greater directness in the expression of wants. In both instances, it was important to point out to the patients how they were opposing their own urge before they could be supported and could consider the possibility of letting go of their opposition. Only when self-criticism is voiced can it be looked at in the face and reconsidered. So, questions such as "What's wrong with wanting more and more?" or "What's wrong with crying?" had to uncover the self-accusations of greed or self-pity before the patient's mature judgment could evaluate such automatic condemnation in a new light and make a decision. The end result is that unconscious desires become conscious and therefore a matter of intelligent problem solving.

Whereas the unconscious want is expressed in devious and symbolic ways, the satisfaction of which never quenches the underlying thirst, a conscious want can be fulfilled. Furthermore, the more conscious a wish is, the more it is accepted and becomes in itself a satisfaction. Thus, unconscious sexuality is experienced as isolation, loneliness, frustration, whereas conscious and accepted sexuality is a pleasurable experience of enhanced vitality. Unconscious rage may be experienced as unpleasant irrita-

tion or guilt, whereas accepted rage may be welcomed as a powerful striving for an end.

The following serves as one more instance of the bringing out of an unconscious desire and will show a way of dealing with visual distortions:[5]

> Dr. N. now looked to me like a hidden wolf, an animal that is used to hunt for its prey in caves. He invited me to address the monster (that I saw him as), to relate directly to it, forgetting it was he, that I knew him, that he wouldn't harm me, and so on. I spoke with all the courage I had: "Why are you so ugly?" "What do you care about my being ugly?" he answered. "That is my problem, not yours." "But I wonder how you get along with that face. Who can love you like that?" And then I began to laugh as I thought that perhaps in his country everyone had a sinister face and maybe he was regarded as handsome. I told him of this thought, and his face began to clear up until Dr. N.'s face emerged with no distortion. He said that in his experience such distortions indicated repressed anger, and even though he did not see this in me it would be profitable to explore the question of possible resentment. I said that I could not imagine any resentment toward him since I had such good feeling toward him; he had helped me so much and been so kind to me. As I finished saying this, I went on almost unconsciously, as if somebody were using my voice to say, "Why should I resent you except for not having loved me." I was surprised. Dr. N. commented that this was an excellent reason for resentment. The experience ceased to be so burning and became more sweet, with that sad sweet sadness that remains after a good weep.

The importance of this session lay in the fact that not only could the patient's wish to be loved by the therapist be expressed, but even this appeared to be a substitute for the expression of her own loving. Some days later, she was able to accept her feeling as a richness rather than as a

[5] Exceptional with MMDA (5 per cent of subjects).

shortcoming, as she wrote a poem that was the first after ten years of interruption in her creative production.

In the examples cited above, the patients were in a conflict where a given urge (to love, to cry) was opposed by a resistance, and the outcome was the expression of the urge. This need not always be the case, and one of the foremost contributions of Gestalt therapy has been that of showing how the defense, too, is an urge that can be redirected to more satisfactory expressions than self-controlling and self-squeezing. To this end, the patient is encouraged to take sides with the voice of the super-ego ("top dog"), and to experience this as his own judgment rather than an external command by voluntarily "becoming" it.

WORKING THROUGH A PSYCHOSOMATIC SYMPTOM

The following excerpt from a tape recording deals with the conflict between the need to rest and self-squeezing in the most literal sense, relaxation and dysfunctional contracture. In fact, this is an example of working through a psychosomatic manifestation, since for the patient in it, the "squeezing of the soul" by her defensive system was embodied in a parallel physical symptom which caused her abdominal pain, and for which she had sought medical advice.

So, in dealing with this idea, we are also turning to the question of how to deal with MMDA syndromes of type 3 in our proposed classification: those in which the positive or negative feelings of the foregoing types are replaced by physical symptoms.[6] Naturally, an enhancement of physical sensations may be part of type 1 experiences, but the

[6] The aim will here be one of decoding the individual's attitudes toward self and others which lie encoded and expressed in body language.

substitution of bodily symptoms for feelings understandably occurs in the measure that the subject will not give in to experiencing the emotional discomfort of the type 2 state. This may reflect the chronic tendency of the individual, as in the case of this patient, who at the time of the session may have been described as a hypomanic hypochondriac — happy with herself and unhappy about pains that she tended to regard as the consequence of physical illness.

This time I am quoting only my side of the dialogue for a period that may have extended over twenty or thirty minutes and eventually led to a figure-ground reversal in the patient's experience. More than a dialogue, in fact, this session might be regarded as comparable to that between a movement therapist or a chiropractor and his patient, the verbal part of it consisting mostly in therapeutic manipulations and the patient's reactions to them, often in the form of postural changes, moans, yells, and sobs.

Doctor. I can help you then, but I think there is only one way in which you can stop squeezing, and that is to learn ***how*** you are squeezing, become aware how you do the squeezing, and you can only really become aware by becoming that part of you that is really squeezing. . . .

Did you become the squeezer or just the victim of it? . . .

Yes . . . Is that something you can decide to do again? . . .

I would like you to tell me what you are feeling. Just be aware how it is squeezing. . . .

Preventing what? . . . Don't interpret, don't make theories, just go with your feelings. Do you feel squeezed? . . .

Only there? . . .

Does your voice sound squeezed? . . .

Now do you hear it? . . .

Are you aware how you are squeezing your own voice, *how* you squeeze your throat? . . .

You are aware of the squeeze in your chest? . . .

OK, there is a squeeze in the chest and down in the belly, both places.

You feel squeezed in your movements, your arms, your neck, your fingers? . . .

What about your hands now, and your arms now? You are squeezed now? . . .

Can vou squeeze now, deliberately? . . .

No, I don't expect it to be the same thing. Just experience it. . . .

What does it want from you? . . .

What does it respond? . . .

Can you be it squeezing you so that you know what it wants, what you want when you are squeezing yourself? What is it you are wanting when you squeeze vourself like now? What do you want to do to you? And what is the satisfaction you are getting from this squeeze? . . .

Yes, the squeezer is getting a satisfaction. It wants to squeeze; it gets pleasure from squeezing. . . .

Don't struggle. Let it happen, let yourself be squeezed. Don't try to back out, be the victim now-, let the torture end. . . .

You don't have to have the strength to suffer. To resist, you must, but if you . . .

Try not resisting now. . . .

Let go. Don't stop it. . . .

Let go, let go. Don't resist it. Let everything be. . . .

Don't resist it, you are resisting it, experience it. Be as open as you can and experience it. . . .

What are you experiencing? . . .

I saw a lot of activity coming through you for the first time. Can you feel . . . ? . . .

Can't you feel any desire for that activity, as if you wanted to go back to it? Any enjoyment of that movement? . . .

Just despair? .

This being tired is like a deadness, a grey deadness, lack of energy, and all this energy is contained behind it. . . .

And I feel that in the squeeze you have this energy, this force. . . .

So you have to become that other side, if you want to have strength. . . .

Maybe, while the squeezing is taking place, while you are being open to the squeezer, maybe you can experience yourself as wanting to squeeze. . . .

I want you to talk about it, the squeeze wanting sex. Can you elaborate on this, say more how it feels? But try to be the squeezer while you are talking about it. Say what you want as squeezer. . . .

Can you experience the squeeze as your urge, your satisfaction? . . . Your sex urge, your anger, your desperation? . . . Your longing? . . .

You still haven't been able to identify with the squeezer. . . .

Well, do it without taking pleasure, just let it come as it comes. "I am the one squeezing you," you can begin, even if you don't feel it. Just play the game.

Speak of what you want, you the squeezer, how you are, what kind of a person you are. . . .

At this point the patient had the insight that turned the session into a success. Being able now to switch from the position of victim to that of "squeezer," she could see that the force causing her pains was none other than greed for all and everything, a rapacious, clutching infant that could never be satisfied. Immediately after this, she spontaneously understood and was exhilarated at the discovery of the perversion involved in the turning back of desire upon herself in a relentless squeeze. Meister Eckhardt says that all our desires are ultimately the desire for God. Many woud perhaps choose another word and speak of a life urge, the absolute, Good, a longing for the ideal state, Eros; yet all these conceptions imply the recognition of a unity beyond the apparent multiplicity of human wants. A given desire can be understood as the expression of an implicit belief that the attainment of such specific goals will bring about happiness. Of course, this is not the way it works, but implicit or unconscious beliefs cannot be altered by reasoning (or even experience). Thus most thieves get little satisfaction from their stealing, moneymakers from their riches, or compulsive scholars from their learning. Whenever the therapeutic process leads to an understanding of the urge, the subject attains some freedom from that particular need, since it is now understood as merely a means to an end—and often a roundabout or inadequate one. So when the thief understands, not with the mind but with his feelings, his need to have something from others, he may begin to ask for love, and when the neurotic intellectual acknowledges his need for recognition, he may become less attached to the prestige game, since its value now does not appear to him as something intrinsic to the accumulation of knowledge.

I believe that an experience such as the one quoted above, leading to the realization of a "life force," is one step beyond all this, in that it leads to a realization of unity beyond rather limited needs, such as sex, ambition, greed, and protection. This is the domain of experience

which interests the mystic, even though in the present quotation there is no usage of religious or mystical terms. And it is the domain that Jung regards as archetypal, beyond personal differentiation, even though its presentation in the case report is not essentially mediated by images.

ACTIVE PARTICIPATION AT NEUTRAL POINTS

One might understand the different types of reaction to MMDA as different points on a gradient of awareness and openness. An increase in awareness may transform the psychosomatic type of experience into one of the feeling type; and the latter, through understanding of resistances, may give way to the integrative peak experience. If we go to the other extreme, we find reactions in which the patient has less and less to report. Even physical sensations seem to be blurred in a state of restricted awareness, most probably of a defensive nature, which may culminate in drowsiness or sleep. It would seem that this state of calm constitutes a manifestation at another level of that calm or serenity which is characteristic of the peak experience with MMDA. One is a calm in richness, a stillness in the midst of inner movement, the other, a state of calm where little happens, a placid bluntness.

As we approach the unconscious end of the scale, where passivity takes the form of somnolence, the subject even becomes unaware of his dreamlike imagery. When questioned, he may be able to report an isolated scene that he is visualizing at the moment, but he is unable to remember the previous one. Or possibly he knows that his mind is active but cannot grasp the content of his thought or imagination. Fortunately, this is the case in only about 25 per cent of all instances.

Whenever the effect of MMDA is not remarkably productive in terms of either positive or negative feelings, a

very active participation by the therapist may be required in order to deal with the patient's somatic sensations, imagery, or actual behavior.

Feelings may thus be brought into conscious focus by attending to the outer symbolic or physical expressions and the unfolding of experience or behavior, as is the practice in Gestalt therapy.

Take, for instance, the following illustration:

Doctor. Are you aware of your tight jaw?

(Patient nods affirmatively and intensifies the contraction of her chewing muscles.)

Doctor. Intensify that.

(Patient begins to grind her teeth.)

Doctor. *(after a few minutes)* Intensify that.

(The grinding of teeth now gradually becomes a locked jaw once more while the patient, who is sitting, raises her head, opens her eyes in a fierce stare, and breathes deeply.)

Patient. I feel strong. Not tense anymore, but severe, masterful.

Doctor. "Stay with it."

Patient. *(She gradually relaxes and begins to swallow saliva.)* My chewing has become swallowing. Now that I have found my strength, I don't have to knock angrily at the door to get satisfaction, but I can simply give it to myself.

Another patient felt very sleepy and relaxed, but tended to stretch his toes. He was encouraged to attempt to give in alternately to his desire to rest and his desire to stretch, and soon he realized the bearing of these! opposed tendencies on his whole present life. He perceived the tension in his toes as an urge for excitement, an expression of boredom and dissatisfaction with his passivity, whereas the latter he understood as a resigned withdrawal from conflict. With this awareness, his need for excitement became stronger than his need for withdrawal, and this is

what led him to engage in additional psychotherapy after his MMDA treatment.

Whenever not only feeling but physical sensations or the desire to communicate is slight, this may be an appropriate occasion to deal with a dream. As mentioned earlier, because of the increased faculty for creating imagery under MMDA, it may be easy to re-experience dreams, whereas an increased insight into symbolic or metaphoric forms is favorable to the unfolding of their meanings.

IMAGERY AND DREAMS

When imagery, rather than psychosomatic manifestations, dominates in the picture of symptoms elicited by MMDA, it is the content of such images which may be regarded as "the royal road to the unconscious." Indeed, such cues, like fertile seeds, may develop from within and reveal some of their meaning, if only attention is given to them. The first task of the therapist will usually be that of helping the patient to direct his attention to the unfolding sequence of scenes, so he can become aware of and remember their detail. The following example is from the session of a forty-seven-year-old man who lay most of the time with his eyes closed, feeling pleasantly relaxed, and who probably retained very little of what he saw. When questioned at one point, he described a scene that is one of three that he could remember after the session was over. This is how he described the image on the following day:

> One picture that came to me was about a camel being led by a lean, angular, Sherlock Holmes type of Englishman. They were on a tour. I don't know why the Englishman was leading the camel. It had no pack on its back. Possibly the Englishman was too impatient and felt he had to drag the camel in order to get there at all. My body goes slowly, has to, and much of the work I do seems to

have to be done in spells, with much resting in between times.

What the patient said nine days later, writing about the session, shows how the number and significance of associations between the symbol and his personality were increased after a period of spontaneous elaboration:

> What I originally mentioned hardly expresses what I have later come to feel about this picture. The Englishman who is taking a world tour is not riding; he is so foolish as to pull the camel along because he is impatient. The Englishman is me. He is very "hawk-nosed," and this is much emphasized. Actually I think of Englishmen as being fools who would go on playing cricket while their world falls apart and who play games with no one but themselves. The camel is the part of me that can carry me there. It represents all the wisdom of the East. The idea of the self, the kingdom of God within, is familiar to me. In my daily life, I do not seem to believe this; I do not feel it within or project it without . . . As for my thoughts about the camel, I feel that in this lifetime I am not going to allow myself to ride him and take me on the journev. I do not act as though there were a self to carry; evidence of inner spontaneity is very faint. Depending on others to run things, however, is becoming more intolerable to me.

The therapeutic implication of such readiness to read into the symbolism of the reverie is obvious. And since this is frequently of spontaneous occurrence, it may be mentioned as a cognitive aspect in the description of the MMDA experience. It might be suspected that it is precisely this proximity between visual and conceptual understanding that accounts for the tendency of some individuals to prevent aspects of their inner life from becoming expressed in conscious images.

In dealing with imagery at the time of the session proper, the aim should be, as with psychosomatic symptoms, that of contacting the experience which is dormant in the visual symbols. Mere contemplation of the latter

may not be sufficient to this end; on the other hand, identification with the characters or objects in the fantasy may lead the patient to undo a projection and recognize a hitherto unacknowledged part of himself. This was the case of a woman, for instance, who felt disgust at the sight of a ridiculous clown, but who, when attempting to identify with such a character, suddenly yelled in panic, for she felt like a little baby tossed in the air. Then she realized that she had been played with like a doll; she had actually adopted this role and played the clown all her life to please others. Yet all along, in the process of this "show," she was suffering from postponement of her real urges and feeling the loneliness implied in the assumption that nobody would want her except as an object of amusement.

This sequence of events shows that the facilitating effect of MMDA on the therapeutic procedure lies not only in the presentation of a significant clue (image of the clown) to the patient's conflict ("playing" the clown vs. wanting to be loved as she is). Once the button of the significant symbol uas pressed, her experience changed in quality: The patient's emotion was released, and she switched from a visual type of reaction to one of the feeling-enhancement type (being tossed in the air, treated as an object). As a consequence of attending to the unpleasant feeling of being treated as an object, insight ensued: She was treating *herself* as an object, in presenting herself to others as such. Lastlv, a new feeling came to the fore: She did not *want* to treat herself like this; what she wanted was love. It is significant that, for several days after the session, she felt an intense desire for food, which ended abruptlv at a later appointment, during which she came to accept her desire for love more fully. The entire process may be seen like a rising from the feelingless type 3 MMDA reaction, though the latter was achieved after the end of the session.

The condensed illustration above mav give an oversimplified view of what form the therapist's intervention

can take in the process of leading the patient to the desymbolization of the experience embodied in visual terms. An image may have to be brought to mind again and again, its transformations followed, and attention directed to the patient's feelings, while watching or identifying with objects or persons in the scene, interpretations given at this or that point, and so on. The following passage, from the transcript of a tape recording, never led to the expected explosion of feelings, but illustrates in detail the exploration of an image and shows how much interpretation can be achieved by means of a non-interpretive approach:

Doctor. Let us work on this image. Could you be this place into which you enter?

Patient. Be that place?

Doctor. Yes, speak out of the experience of being that place.

Patient. I have a problem here, because I don't know what is in the center of it until I open it, so to find this place I have to be aware of what is inside of babies. Is that all right? Which one shall I do?

Doctor. Either.

Patient. OK. I'm this place, and there is this baby inside, and I'm waiting for someone to come and open the door and take it out. And somehow I'm trying to watch. I want to know what is inside, somehow. I'm being curious about it.

Doctor. Can you say how you are? Could you describe yourself?

Patient. I can't do it too well, but there is a part of me that is looking outside. Outside of me there is light, a bright light, a beautiful outside world, and I am kind of a shield that doesn't let this outside penetrate to the inside. The inside is amorphous, black, neuter, nothing about sense, but the sense of being shut off, kind of stopped, waiting for someone to pick up this baby and bring it out, and in a way my task seems to be to shield the baby from the outside, keep it in cold storage, almost.

Doctor. Keep it in cold storage. Can you sense this part of yourself, this protective function?

Patient. You mean in my normal self, or right now?

Doctor. No, in your life, in your everyday self. Do you see yourself as shielding a very precious part?

Patient. That's very interesting, My tendency—oh, I'm getting quite a bit, I think-—my conscious tendency as soon as I realize how to get it will be to go in and pick it up and get it out real fast, probably faster than I should.

Doctor. The same thing! "Probably faster than I should" . . . the fear of. . .

Patient. I want it to be that I get it out right away. I force it.

Doctor. So there seems to be a conflict here for you between the tendency to overshield and really remove this core of life from life, keep it in storage, and the opposite tendency and over-tendency to take it out fast into life.

Patient. Now I think what's happening is that, consciously, I'm doing it much too fast, so it's blocked to my conscious mind so I can't get to it any faster than I'm supposed to. So, unconsciously, I have to go to the other extreme, to keep it shut. There is one interesting thing which may help. In meditation and other experiences, whenever anything interesting starts happening, I have to grab it spontaneously and put it down. So I don't let myself. I pull myself out of it, as soon as an image . . . I had this experience before, so this may just indicate that.

Doctor. M7hich is, in a way, shielding the experience, and in another way it is taking it out.

Patient. I try to take it out, so I lose it. Yes, mow!

Wife. *(As* spectator): I don't know if it's the MMDA or Dr. N.

Doctor. It's the dream; all it takes is to start with a good seed. So I think you can get more out of this, if you go on being this room. Say all you can about yourself, as a room, not disregarding the obvious—anything about color, temperature, the dimensions, whatever.

Patient. I get the impression it was painted white, almost like an apparatus you'd see, like a machine in a hospital. It was obviously man-made.

Doctor. But say it in the first person.

Patient. I am painted white-yellow, kind of a warm white, and I'm obviously man-made, with handles and knobs and things, and the significance I get is that I am the part of intellect, not of emotion. That's very much like my conscious mind really is. Consciously, I'm usually very intellectual; the emotions are inside.

Doctor. So you are an artificial room, designed to protect this baby.

Patient. It's interesting that I wouldn't call it artificial at all. In a way, "artificial" is true, but to me it has a connotation of not being real. To me a machine is just as real as a human being. It's just created in a different way, so it kind of bothered me to use that connotation "artificial." It's here, but it's something else. It's just as real, though.

Doctor. Yes. You are controls, man-made . . .

Patient. . . . More a matter of well-defined, with boundaries and laws, that are clear-cut, that aren't fringes. Either it's here or it isn't here, like I can have it exactly, and that's what it is.

Doctor. What else can you see as a room in you? Could you give a description of your feelings regarding yourself as a room?

Patient. My main purpose, that I can see, is to take care of what's inside, which is this baby, and I can't get to it, for I feel that I have all around these devices and apparatuses, to maintain the right environment for the inside, like temperature, atmosphere, etcetera. So my main function, as I see it now, is to just keep the optimum environment for the baby.

Doctor. You said something about being sanitized?

Patient. Yes, the way it was in the dream . . . Now I am almost an incubator.

Doctor. Would you concentrate a bit more on that—how it feels to be an incubator.

Patient. How it feels to be an incubator? Somehow it

doesn't seem to be enough. I'm having trouble identifying with it, because what I was doing before was half looking at it. Now I'm trying to be it completely, and the action of being this incubator just isn't enough. I'd like to do other things, somehow, but I can't, because I'm an incubator, and an incubator isn't supposed to, and this baby is the most important thing, so I can't really be concerned with anything else.

Doctor. Does it make sense in your life to say, "I am an incubator for the baby to be born, but this is not enough—to be an incubator"?

Patient. In my life I have never been aware of being this incubator. What I have been trying to do is have the incubator do what the baby is supposed to do, if anything. I'm trying to get the baby out of here. Well, in the dream, the way I do it is to wait until somebody . . . No . . . OK, the way it is in the dream, I go to the incubator and pick up the baby. Now, as the incubator, I'm trying to do what the baby is supposed to do, rather than waiting for someone to come and pick it out, and it's interesting that there is no feeling that at some point the baby is going to wake up and open the door. It has to be an action from the outside.

Doctor. Isn't there anything in being an incubator that suggests an action from the outside?

Patient. I am an action from the outside, you say?

Doctor. The incubator is an action from the outside, a lot of action, a lot of manipulation of machinery, in that room, that sanitized room, which is all action from the outside, which converges on the baby, as if there were not enough faith that the baby will survive without so much incubation.

Patient. Well, it feels like this: I have been set up to do something specific, which is to keep everything normal and constant and all that. I should be doing that, and if I'm not, I'm failing. And I don't have any free will of my own as an incubator, so I have to wait until somebody from outside tries to do something through me, whether it's open the door or change any of the

> constants. Now, whether the baby needs it or not I don't know, because I don't really know anything about the baby.

The tape goes on for a long time and shows an impasse that could not be resolved in the session: The "baby" in the patient wants to get out, to be born, but will not cry for help or *feel* the despair of being locked in. Yet only feeling could free him, for it is the patient's feelings that are being locked in and replaced by thinking and self-manipulation (incubator). After this situation was exposed, the problem was tackled more directly in an encounter between the patient and his wife. The rule was that they could voice nothing but the feelings of the moment (i.e., withholding opinions, judgments, interpretations, thoughts). This was not only useful to the patient, but a rewarding experience in communication for the couple.

Whenever not only feelings and physical symptoms but imagery and the desire to communicate are slight, a previous dream of the patient may be taken as a starting point for therapy. The increased faculty of creating imagery under MMDA makes it easy for the patient to re-create dreams and deal with them as an ongoing process, whereas an enhancement of the ability to read into metaphoric or symbolic forms is favorable to the unfolding of their meaning.

The following instance, from the session of a young scientist, will complement previous examples of the handling of imagery, since it shows the process of "encountering" between the patient's different sub-selves as portrayed in multiple dream elements. This is a common resource of Gestalt therapy, but little has been described of this procedure, and it can be so useful with MMDA (and ibogaine) that it deserves detailed illustration.

The dream that was examined in this session consisted

of a single image, which the patient described before the drug had begun to take effect. In this scene — part of a dream that he could not remember — there was a shrimp stapled to the inside of a plastic bag full of water.

He was first instructed to look at the dream scene as a picture of his existence, regarding himself as the shrimp. He said, "This is my existence. I am a shrimp in a plastic bag. I am stapled. I can't move. And I have no head."

This made sense to him, since there was a sense of being immobilized in his life. At the suggestion that he describe the experience of being a shrimp, he now realizes that not only is he enclosed by the bag but by the shell that covers his body. He reacts to this by wanting to be free and have direct contact with the environment, and realizes that this is a true though unexpressed urge in him.

But then, when asked to enact the shell, he realizes that this is also part of himself, since he wants to protect himself. As he pursues the enactment of the dream elements, it turns out that all these are engaged in mutual antagonism, but after the various "voices" talk with one another, a sense of unity develops.

Thus the subject as shrimp does not feel encased in his shell, but endowed with it for his own purposes; the shell does not insist any more on protecting the shrimp beyond its interest, but wants to serve as his instrument; shrimp and water enjoy each other, and they all feel protected in the bag.

A new element of the dream is now recalled by the patient. It is from his mother's hand that the plastic bag is hanging, with all that there is in it. Shell, bag, and mother appear now as progressively explicit presentations of a function of himself, which both protects him and restrains him. I now ask him to enact the shrimp talking to his mother. At first, he wants to say, "Let me out, let me free," but cannot be heard from inside the bag. He cannot reach her, feels too distant and isolated, in the same manner that he does in real life. He now realizes he cannot communicate intimately with his mother.

I then ask him to take a step out of the dream and imagine his mother sitting in front of him and tell her of his feelings of constraint or imprisonment. The outcome of the encounter is a long episode which he retrospectively summed up as follows:

> I couldn't, I couldn't. I knew I had to really get angry at her, to hit her. I remember now the first time I saw her. I had set her up on the floor. She was just about two feet tall, and I felt like smashing her to pieces with a club. I reallv wanted to so much, hut again I couldn't. Finally, she just sort of fell to pieces. I hoped for a second that this meant that she was gone for good, but I soon found out that she was still with me. I guess she won't ever go away until I knock her away, get really angrv, cry, etcetera. When that day comes, I believe I will be totally free from her.

He was not able to go beyond the impasse, but he could now understand how his unfulfilled feeling was not mere inertia, but a silent struggle between rage and guilt.

We worked on the dream scene for about four more hours, in the course of which he was able to understand the image of the staple. It represented biting, childishly vindictive rage turned against himself. But after a period of contemplating this "Baby-me" attitude, his closed-off, clinging, biting hardness gave way—now he just wanted to be tucked up (folded and put away) and dropped in the corner of the bag. In other words, the hostility of the staple, which was initially directed to a possessive and hardheaded "biting" at the shrimp, came to be felt by the patient as a misdirected desire to hold on, to have contact, to be not alone. And he now saw that the baby in him that wanted to be loved did not need to go about it aggressively, but that, on the contrary, he could achieve much more by just enjoying his surroundings.

As to the bag, it was she "who is in charge," who wanted the status quo. Everyone else has other things he (or she) wants to do. Shrimp wants to go back to the sea

and live free, with his head back on; water wants to evaporate; and staple wants to find his place, too. Only the bag wants to keep things the way they are-"she feels full and warm with water, shrimp and shell and staple all inside her." The end result of the session for this young man was insight into his inner world to an unknown and surprising degree.

He started out his report on the following day with the assertion, "I now really know how I see myself." And now, after eight months, he still explains that he is different from before, "in that now I see myself, understand myself." He values this understanding to such an extent that he has decided to study psychology.

The reading of the case illustrations presented on the foregoing pages may well seem, on the whole, not very different from a collection of accounts taken from ordinary psychotherapeutic sessions not involving the use of a drug. Most of the reactions to MMDA may be understood as an intensification of feelings, symptoms, and visual imagination rather than a qualitative change thereof. The value of such an intensification in the psychotherapeutic process lies mainly, perhaps, in that clues to the significant issues take more frequently the therapist's or patient's attention than they otherwise would, whereas, in the normal situation, much of the time and effort in a therapeutic process may go into cutting through a veil of verbiage and automatisms that form part of the habitual social role. With MMDA, there is a more prompt access to the patient's underlying experience, or symptoms resulting from its denial and distortion.

Another aspect of the effects of MMDA that contributes to the greater density of the therapeutic interaction, if not to its qualitative change, is that, without loss of the reflective disposition, thinking takes on a more experiential quality than it ordinarily would. Instead of being purely conceptual and verbal, the thinking that characterizes the

MMDA-elicited state seems linked to visual images, sensory data, and emotional experience, so that an abstract statement tends to bring about in the person's mind concrete instances of its application, and insight tends to be a complete, feeling-intellectual process rather than conceptual realization.

The value of visual fantasy in psychotherapy is another instance of this experiential thinking, bound to images and not divorced from feelings. Though some persons have a natural facility for summoning up visual images, and others may acquire it through training, the facilitation that MMDA can effect in active imagination must be listed in this final summary of its usefulness as an adjunct to psychotherapy.

Last but not least, the value of MMDA lies in its potential to bring about peak experiences which may occur either spontaneously or as a consequence of therapeutic work, and which may last seconds or hours. In such moments of serenity and love, a person may experience his reality from a different point of view and thus learn to let go of his habitual attitudes. The bearing of such peak experiences on the doctor-patient encounter may be that of a step toward learning to relate in the Now, a present free from transferential bondage to past conditions and stereotyped mechanisms.