MDMA Reconsidered

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On May 17 and 18, 1986, the Haight Ashbury Free Medical Clinic sponsored a national conference on the drug MDMA. One population that was very much in attendance, the *informed lay user*, seemed to have been intentionally excluded from presenting papers and thus an important point of view was absent from the conference. The aim of this article is to present material from the point of view of this population, which in the 1960's was dubbed the *recreational user*. Despite efforts by health professionals and the law to change this use pattern, psychedelic drugs are and have been largely employed in "unsupervised" settings by lay users (Stafford 1985: 220). This article will explore MDMA within the context of psychology, history, politics, sociology and spirituality. This broad context and the implications that arise from such a perspective are usually considered to be unimportant, if not irrelevant, to drug use issues by scientists, doctors, therapists and drug abuse specialists. However, they are of deep and abiding interest to the lay user.

When attending this conference, I had high expectations that both the obvious and the hidden issues surrounding MDMA would be addressed; not only because it was hosted by a prestigious organization and that the presenters were on the leading edge of research, but because this particular psychoactive substance—as described in the literature—invites honesty, unbiased assessment and risk-free dialogue. My hopes for this were notably dampened when I came across this line, written by one of the conference hosts, in a book (Seymour 1986: 77) that was distributed to each participant: "In general terms, LSD represents the drug that got loose and poisoned the minds of a generation of young people."

This statement, distributed under the aegis of an informed agency (The Haight Ashbury Free Medical Clinic) and written by its director of training and education, is as inflammatory and value embedded as the comments of Spanish friars four centuries ago on *Psilocybe* mushroom use among native populations (Ott & Bigwood 1978) and the testimony of Christian missionaries in the 1850's and 1860's against peyote use by members of the Native American Church (Flattery & Pierce 1965).

For the most part, other speakers exhibited this same judgmental attitude toward lay users, but in subtler ways. For instance, the word *anecdotal* was used to describe reports of nonsupervised MDMA use and the connotation and nuance of this terminology discounts and trivializes the validity of such use. This seemingly minor etymological point reveals an attitude by health professionals toward the lay user that is reminiscent of the stance of a priestly class; an attitude that is prevalent in the psychedelic literature (Anderson 1979; Masters & Houston 1966). Thus, at a conference focused on a drug that has been described as inviting gentleness and empathy toward others, there seemed to be little in the way of an I-Thou attitude on the part of the professionals toward the lay user. Rather, the prevailing attitude seemed to be Us-Them. Hopefully, as many of the speakers at the conference expressed, if the mistakes of the 1960's are not to be repeated with this substance, then this stance needs to be changed.

This thrust was particularly evident in the frequently expressed view that when self-administered for self-therapy by lay persons, MDMA use is improper if not

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harmful as compared to its use an an adjunct to therapy with a trained professional. Only one presenter, Joseph Downing, spoke to the contrary (during a panel discussion) and stated that he felt that ". . . with the proper set and setting and some common sense, MDMA can be self-administered. People can do self-healing. That's what's going on now anyway as a result of the DEA's scheduling: under-the-counter use."[1]

The therapist is only the personification of the healing aspect within each person. If an individual can tap this force directly from time to time, why not? If by ingesting MDMA, a person can put on a therapist's thinking cap for a few hours and *see* him/herself with new vision that is presumably empathetic to him/herself, why not? Interestingly, Freud was in favor of lay therapy and wanted to protect analysis from both physicians and from priests (Bettelheim 1983). In fact, he envisioned a profession of secular ministers of the soul, perhaps akin to Ph.D.'s, M.F.C.C.'s and M.S.W.'s. One can only surmise why the founder of psychoanalysis wanted to keep his child out of the hands of physicians and priests. One reason relevant to the drug issue is that Freud often said that all he did was reorganize in a different format the profound insights into the unconscious of artists, such as Goethe, Nietzsche, Dostoevsky, Shakespeare and the Greek tragedians. Artists are part of the class of persons (the lay user) who traditionally have derived much benefit from psychedelics and whose use of these substances has been disparaged by the clergy and medical professionals as *unauthorized* and *illegitimate*.[2]

PSYCHOTHERAPY AND THE BEHAVIORAL SCIENCES

One of the presenters, James Bakalar, proposed that before MDMA and similar drugs are classified as legal for psychotherapeutic use, psychotherapy needs to be more scientific in its methodology, more empirical by having internal consistency with regard to statistical results and verifiable according to the double-blind experiment. This seems to be two steps backward and none forward on several counts:

1. The issue at hand is not psychotherapy but MDMA. The studies that need to be carried out ought to compare the results of psychotherapy with and without the use of MDMA along certain norms, such as enhanced ego strength, capacity to love, spontaneity, ability to forgive, willingness to feel and express emotions, ability to listen to others, isolation, nearness to self and nearness to the meaning of life.
2. The client-therapist alliance, irrespective of particular therapeutic stance, mitigates against psychotherapy being conducted as a double-blind experiment. This would be a gross instance of Heisenberg's principle wherein the observer's presence influences, if not changes, the outcome of the experiment. Furthermore, there are few psychological insights that can be statistically proven in the empirical sense. At best there is only corroborative evidence of each person's unique subjective experience. As a result, the scientific approach is not able to describe the uniqueness of a particular individual, and can only do so inasmuch as a given person resembles other people; hence the drive to make individuals resemble scientific models of people.
3. Psychotherapy is idiographic and deals with events that never recur in the same form (if they have ever occurred at all, except in the mind) and thus can neither be replicated nor predicted, while the sciences are nomothetic and require verification as well as mathematical and statistical analysis for the prediction of future events. The apparent purpose of the sciences is the control of nature; hence the attempt to understand and control human nature through the medical model of behaviorist psychology and controlling mechanisms, such as psychiatric drugs.
4. Most probably, if a statistical survey was undertaken of the overall results of allopathic medicine—the model that Bakalar used—there would be similar statistical results as the current surveys of psychotherapy, which purportedly show its failure as a healing modality. Most physicians admit, if they are candid, that neither they nor their medicines do the healing, and that healing depends on the patient's attitude and the patient's faith in the healer in conjunction with the healing force of the patient (Becker & Selden 1985). In medicine, as in psychotherapy, the therapeutic alliance is the basis of cure (Frank 1973).
5. The methods of the experimental sciences, while useful tools, are inappropriate for the study of human consciousness, including therapy. This is because the controlled experiment in human psychology, unlike animal psychology for creatures who "do as they are told," negates the uniqueness of the human species. It is scientifically correct, yet humanly wrong. The qualities of being human include unpredictability, variability, creativity, complexity, autonomy and multidimensionality as well as the freedom to think, to be and to choose.[3] To deny these in order to conform to a fabricated norm is to offer up the essence of being

human on the sacrificial alter of science; a sacrifice that is no different than that of ritual sacrifice, anywhere at anytime.

A correlate of this is that as long as psychotherapy is talk, it is subject to personal choice, variety, complexity, spontaneity and the unfolding of the unknown within each person's heart. When psychiatry becomes drug specific, it tolerates no argument or variety, and it mirrors (if not enjoins) the *theology* of the dominant Western culture, the ideology of mental health as being adjustment to the norms of society (Schrag 1979).

At the conference, reductionism in human psychology was taken to its logical extreme by Enoch Callaway who suggested that for psychology to be a "real science," all psychological behavior needs to be reduced to biological and neural responses to pharmaceuticals in particular loci in the brain. Furthermore, he indicated that the day may not be far off when psychoactive drugs could be designed to modify behavior in any direction for any length of time. As a lay person who is already concerned about social control, I thought, "God help us. This new science, when coupled with genetic engineering, will surely make the fascists, behaviorists and puritans happy, if no one else."

It is unfounded to claim that this apotheosis of the behaviorist approach will be *objective*. Certainly a machine will record the data (e.g., that serotonin has just been released in such and such a quantity at such and such a locus in the brain), but someone is going to have to interpret what this response means from the inside. Someone is going to have to make a value judgment and be subjective, at least the first few times, before the textbooks and licensing tests are written. (After that everyone will be able to close their eyes, stop thinking, utter the party line and conform to how its *supposed* to be.) Who is going to be this judge? Who is going to appoint this arbiter? On what basis will these so-called objective observations be made? And who will *it* be *good* for this to happen to?

THE CONTROLLED SUBSTANCES ACT

History reveals that to be *objective* in science and medicine is relative and often means whatever the dominant culture dictates. This becomes problematic when one considers the supposed safeguard value of the various stipulations in the Controlled Substances Act. For instance, one condition of the Act states that for a drug to be legally prescribed by physicians, it must be within the framework of "approved medical practice." However, at one time approved medical practice utilized heroin, cocaine, marijuana and opium, but now due to political pressure and not to medicinal or pharmacological properties, these medicaments have been cast out of the pharmacopeia—much to the chagrin of some practitioners (Trebach 1982). As for peer review, in a climate of fear this safeguard is not effective. Fearing loss of license, opprobrium from colleagues and the effects on their families and lifestyles, few professionals are willing to publicly state what they really think about the utilization of psychedelic drugs (Grinspoon & Bakalar 1983). Thus the view presented by the drug control apparatus is lopsided, and psychedelics remain classified as dangerous narcotics with no known medical value. This is despite the fact that they are not addictive (McGlothlin & Arnold 1971), despite millennia of use in native cultures to the contrary (Emboden 1979; Schultes & Hofmann 1979), and despite the findings of Western researchers about their healing value for alcoholics (Osmond 1969), severe neurotics and traumatized individuals (Bastiaans 1983), convicts (Leary 1969; Leary & Metzner 1967-68), preterminal cancer patients (Kurland 1985; Grof & Halifax 1977) and autistic children (Mogar & Aldrich 1969; Bender, Cobrink & Siva Sankar 1966).

Another supposed safeguard is *informed consent*. When it comes to public mental health in the United States, there is little, if any, informed consent. Electroshock, chemical and physical lobotomies are routinely carried out without the informed consent of most patients (Breggin 1983; Frank 1978). Who is to safeguard that psychedelic drugs, which have great potential for mind control, would not be similarly used by zealous mental health workers perhaps in conjunction with electroshock? Contrary to their Hippocratic oath, allopathic physicians are first and foremost servants and guardians of the dominant culture, and not the patient. This has been highlighted recently in the advice of the attorney of the American Medical Association (AMA) counseling physicians that in certain cases of drug use the obligation of the physician to safeguard patient confidentiality should be overridden: They should set aside doctor-patient confidentiality and tell police and other authorities about patients who "threaten public safety" because of drug abuse (Unsigned 1986).[4]

The substance testing safeguard of the Controlled Substances Act also appears specious to the lay user. Standard practices for testing psychoactive drugs produce skewed results in favor of who is underwriting the test (usually the Establishment) or if the test results are politically unfavorable they may be downplayed. In addition, the effects of potent drug extracts (e.g., THC from marijuana) that are often used in these tests to prove its risk and

danger are interpreted as the normal range of effects that occur when the substance is prudently used in its unmodified state. Moreover, the effects of one compound, such as MDA, are used to ban a related but different compound, MDMA (Ricaurte et al. 1985). Lethal doses of a drug, such as MDMA, are frequently used as the determinant of its safety. These deadly doses are administered to rats, for example, at 150 times the accepted therapeutic level (Goad 1985) and the results are taken to predict the effects on humans. The test results on rats—acknowledged by testing researchers, such as Lewis Seiden (of the University of Chicago), to be of dubious value in predicting the effects on humans—are used in the scheduling of drugs as if they were equivalent to the effects in humans.

ENTACTOGENS AND PSYCHEDELICS

The word *entactogen* was used at the conference to describe an entirely new drug class. This term was coined by David Nichols to describe a substance that produces empathy and sympathy, which allows the user to "touch gently within." MDMA is an entactogen, and because empathy and sympathy are benign qualities that are presumably desirable to everyone, work is being done to make MDMA legal. Behind this move is the clear desire to separate MDMA from the older psychedelics, although some of them—depending on set, setting and dosage—also afford the user empathy, sympathy and to touch gently within.

Why then search for a new drug class? The first reason, which has political implications, is to prevent MDMA from suffering the same type of undeserved bad press from the scientific and medical communities as well as the general public that psychedelics (the drug group in which MDMA is now classified) have received. The message has been that psychedelics are extremely dangerous because they drive people insane, and all the talk about their potential for creativity, personal growth and religious experience is just a lot of hocus-pocus. In the 1960's and 1970's, the medical establishment and the media unknowingly promulgated as fact the disinformation promoted by the CIA and the military about LSD (Lee & Shlain 1985), and this distorted perception governed the major policy decisions enacted by the drug control apparatus, including the curtailment of legitimate research. It is worthwhile to note that since the late 1970's there have been efforts to call some of the psychedelics *entheogens*, which means "becoming God within" (Ruck et al. 1979).

A second reason for a new name is to address the issue of hallucinations. Psychedelics (which are also called hallucinogens) may produce hallucinations, but MDMA does not. Hallucinations are taboo in Western technological society. Thus many scientists and health professionals who attempt to diminish the high of LSD as being false because it is drug induced and temporary, do not do so with the high produced by MDMA, which is also drug induced and temporary. The reason for this is the nonhallucinogenic quality of the MDMA experience: One never leaves *normalcy* and thus there is no question of what is *real*.

But what are hallucinations? The answer to this question is relative and depends on one's criteria (Siegel 1986; Van Dusen 1981; Ruck et al. 1979). Visions of death and rebirth, hells and heavens, strange people and worlds that are common to some First and Second Wave psychedelics are dubbed hallucinations by mental health professionals. Normalcy, that which is perceived by the senses and intelligible to the rational mind, is called real. The question being raised by the "sledgehammer LSD"[5] (as Rick Ingrasci labeled it) is, What is real and what is a hallucination?[6] When one gets to the very bottom, peels the last layer of the onion and glimpses the liberated state of mind of the mystics, as Sandoz LSD allowed some to do, the notion of being born (i.e., being a separate person doomed to die) is perceived as the ultimate hallucination, the ultimate cookie. So there is a paradox. From the so-called normal state of mind, the liberated state that has been achieved by some mystics is a hallucination; and from the so-called liberated state of mind, the ego is a hallucination—a fictional identity that is held together by concepts such as "I," "me" and "mine" (Nisargadatta 1973).

In this sense MDMA is a *repressive* substance in that it reinforces Western technological society's belief systems. Through its limited spectrum of response it inhibits what Western society wants kept out of view, namely the fiction of the ego that gives rise to the fiction of the world (Lodzer 1971). It is not desirable for this fiction to be seen as such because it is the foundation on which all of Western civilization is built. If a user glimpses that s/he is the Supreme, an insight that given the proper set and setting has a 90 percent probability with the stronger psychedelics (H. Smith 1968), then the question arises as to what has all the striving, killing, judging, profiting, starving and scapegoating been for?

The stronger psychedelics shatter a dualistic world of separation between humanity and God, and replace it with one in which humanness is divine and one with God and all life. This secret of secrets can drive the unprepared to madness. The mystics guarded it for centuries by explaining it through abstruse symbols and sharing it only with those who are prepared through long trials to receive it and use it for the uplift of suffering humanity. Substances that

within a matter of minutes invite glimpsing this truth *do need* to be controlled. There is a need for and wisdom in having drug control laws, but the critical question is who should formulate and administer these regulations: the guardians of the soul whose charge it is to preserve the unknown and unfolding truth within each heart, or guardians of the dominant culture whose task it is to preserve the known and established. The lamentable irony of the present drug laws is that they keep these substances in the hands of the unprepared who, by dint of immaturity and unbalanced mental condition, would benefit least from their use and keep them out of the hands of those who would benefit, including researchers and those who wish to use them in a safe or professionally supervised setting for personal growth and healing. This development is precisely the opposite of what the drug laws are designed to do, and lay users often question why these laws remain in force. Who *do* they benefit?

While MDMA needs to be considered a companion to stronger psychedelics in issues of drug control, it also needs to be seen as different and separate because unlike the stronger psychedelics it lacks the power to annihilate the ego. Under its influence users are able to maintain control and to steer. They do not experience the benefits of surrendering the ego (Blofeld 1968; Havens 1968). Thus in life, as when under the influence of the drug, users continue to gain freedom *of* the ego, rather than gain freedom *from* the ego. The value of MDMA for therapy is in this direction: developing a *coping* strategy that is called *adjustment*. Adjustment, or getting one's life in order, is only a threshold for liberation, not liberation itself (Kornfeld et al. 1979). Freud described the end point of therapy as transforming "hysterical misery into ordinary unhappiness" (Brown 1959) and this is the first step toward basic sanity, a very needful one in today's climate of violence to self, others and all life (as Rick Ingrasci sketched out at the conference).

However, while extremely useful, if not phenomenal, for psychotherapy,[7] MDMA is deceptive for the spiritual therapy whose ends are complete freedom and autonomy as delineated by Buddhism, Hinduism and other mystic traditions. This necessitates the death of mind. Unlike a lobotomy, which moves a person backward on the evolutionary scale by physically destroying part of the brain, the spiritual death of the mind moves one forward and achieves the end goal of the human form (Krishna 1970). One becomes the living embodiment of *Satchitananda* (consciousness, energy and bliss) as attested to by the lives of saints the world over throughout time. Unlike the stronger psychedelics, MDMA does not encourage glimpsing this last development of Love's unfolding. An interesting comparative sign of this is the difference between the topics covered at the MDMA Conference and a conference that was hosted by David Smith in 1967 titled "The Religious Significance of Psychedelic Drugs" (D.E. Smith 1968).

In light of this, one must conclude that XTC (MDMA) is not ecstasy. It is euphoria. Euphoria is to adjustment what ecstasy is to liberation. The *It* of MDMA is the *It* of est, not the mystics. Thus its by-product is empathy and not compassion. This is why MDMA has been dubbed the Yuppie drug. No one is going to contract amotivational syndrome on this substance and there is just enough of a stimulant effect so that the user will not waste any valuable time contemplating the Great Mysteries in one's hand, nature or an unknown neighbor's heart. Use of this substance will not engender any radical change in one's dress, eating patterns or lifestyle. There will not be a new aesthetic in art, literature, dance or music. There will not be a coming together of Whites, Blacks, Reds, minorities, poor, rich, Hell's Angels and preppies. This is a drug of the status quo: It does not foster social change.

MDMA is just another way to say that the world is not psychedelic when it is. By psychedelic I do not mean the bizarre phenomena seized on and celebrated by the media, the AMA and other guardians of the dominant culture to scare the public. Rather, it is an awareness that nothing is real and that Nothing is the Real. On the stronger psychedelics the celebrant is taken beyond the narcissistic love of MDMA to the primordial and unconditioned love arising from the nameless state, the Void out of which love, emotions, thoughts, drives, fears, instincts and desires arise and fall like waves in the ocean of consciousness, the true Self. When the celebrant glimpses this place within him/herself that can be accessed by the stronger psychedelics, s/he asks the big questions of liberation: Who am I? Where did I come from? and Where am I going? These questions, central to solving the mystery and meaning of life, are not catalyzed by nor are their answers glimpsed on MDMA.

CONCLUSION

MDMA and most Western therapies tell us that we are asleep to our egos, whereas the stronger psychedelics and Eastern psychologies tell us that we are asleep to our true nature. We need awareness of both levels of the self, a grounding in the world and in the transcendental realms, a mature ego and freedom from the ego if we are to be whole, free and loving, rather than to be controlled by our shadow side that now threatens to destroy us all.

As a lay person, my fear is that many professionals are prepared to trade the beneficent healing promise of the stronger psychedelics in order to get MDMA reclassified. I would encourage them to use MDMA as the first step in

reclaiming the ground abdicated to the forces of unreason in the drug arena. Lay users applaud those professionals at the conference and elsewhere who have had the courage to stand up, challenge the Drug Enforcement Administration's (DEA) classification and work within the legal structure to say, "No! Not this time. We need this healing substance in our pharmacopeia."

FOOTNOTES

1. The one diagnosed case of an MDMA toxicity that was presented at the conference (see Hayner & McKinney 1986) could easily have occurred in a therapist's office and with the same response on the part of a therapist-observer as this unfortunate woman's friend. No doubt, therapists in the audience must have said to themselves, as I did, "Thank goodness it didn't happen to me. What a malpractice suit this would have been." This was probably the only time when professionals at the conference, if polled, would have expressed appreciation for a specific lay therapy use. In addition, after hearing the details of this case, the person beside me mused, "If they are going to present this case in all its gory details, reminiscent of official LSD scare stories in the 1960's, why not present an example of a person's ecstatic release on MDMA in all its sublime details."

2. This is the downside of rescheduling MDMA: Those who might wish to use MDMA need to view themselves as sick. Allopathic medicine and psychiatry are based on pathology, not health or well being or Maslow's norms (Maslow 1971).

3. For this reason I appreciated Joseph Downing's procedures that gave subjects some opportunity to interact with his experiment.

4. The AMA counsel, of course, was not referring to legal drugs (such as alcohol), but illicit substances. The case prompting his statement concerned an airplane pilot who jeopardized his own life from a cocaine overdose as well as the lives of 23 passengers. The issue of alcohol abuse, which is historically pervasive if not of epidemic proportions among pilots, was not even mentioned.

This oversight has a parallel. In drug legislation recently proposed by Congress, those found guilty of a drug-related murder will be subject to the death penalty. Drunk drivers, who kill with their cars and are by far in greater number than those who kill while under the influence of illicit drugs, were omitted from the provisions of this legislation. These omissions are due to the fact that the medical model is used for the alcohol addict (a good citizen gone astray and redeemable) and the legal-punitive model is used for the illicit drug addict (a latent criminal whose moral character is weak and thus irredeemable). This is part of the mutual accommodation that began in the 1920's (King 1972) between organized medicine, the pharmaceutical companies, researchers, government, organized crime and law enforcement (Grinspoon & Bakalar 1976). I suggest that if a reclassification of MDMA is to proceed favorably, some positive words need to be spoken to the DEA by the AMA.

5. Whereas childhood traumas may need a lighter-weight psychological hammer such as MDMA, strong repressions (such as the denial of death) may require a sledgehammer.

6. Strictly speaking, all the objects hanging in museums, words in books, images on TV and the cinema, drama on stage, and much of what goes on in churches are hallucinations—albeit societally approved ones that carry positive labels, such as art, fiction, nonfiction, the Book of Revelations, transubstantiation and history.

7. It was lamentable that there were no somatic therapists who were invited to present at the conference. Perhaps MDMA's greatest potential in therapy is nonverbal and through the body utilizing the attention, the breath, sound, and hand pressure to open up and remove the blocks that prevent contact with the life force within and hinder the *élan vital* from flowing.

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