The Great Entactogen - Empathogen Debate

David Nichols, Richard Yensen, Ralph Metzner, William Shakespeare

Dear Rick,

I write to respond to the letter from Ralph Metzner regarding the name empathogen versus entactogen [for drugs such as MDMA]. I did tell Ralph that I believed that the pronunciation em-PATH'-o-gen would create a negative impression in the mind of a psychiatric patient, because of the distinct embodiment of the word 'pathogen' within the name. Indeed, this was not even my own observation. I was discussing possible names for a new drug class several years ago with individuals who were not familiar with the MDMA literature. It was they who pointed out this parallelism between empathogen and pathogen. This was thus not my speculation, but an actual observation.

However, there were two other important reasons to coin the term entactogen. First of all, within the medical profession, it seemed much more likely that some term other than empathogen would gain acceptance, since the later might be viewed by hard-line clinicians as being rather trite. Second, MDMA and related substances do more than simply increase empathy. In addition to their ability to produce, as Ralph states, "a feeling of connectedness... with others...," in the context of therapy they also produce a powerful anxiolytic state which is accompanied by what could be described as a sort of chemically-induced hypnosis. This latter, as in hypnosis itself, manifests as a state of increased suggestibility, with heightened powers of concentration and mental focus. As is also true with hypnosis, this state facilitates the recovery of repressed memories and allows age regression techniques to be used. Thus, empathogen is also a restrictive term because it fails to take into account these important properties of the drug class.

I would also argue that it was not the drug-evoked "empathic resonance" that made MDMA such as "outstandingly valuable therapeutic tool," but rather the actions I describe above. The "empathogenic" effects, if you will, were what made MDMA such an outstandingly popular drug. Perhaps a need may exist to draw a distinction between the properties of the drug that make it pleasurable and those that make it valuable for medical/therapeutic uses.

On a philosophical level, I object to the use of the term empathogen in a medical context, since the therapist should be able to develop feelings of empathy for the patient in the absence of taking the drug him/herself. To talk about MDMA in the context of helping the therapist develop "conscious attunement with another's emotional state, together with understanding," is to state, actually rather explicitly, that the therapist will self-medicate with the drug. To underscore this point, consider whether a patient generally has the need to "tune in" to the therapist's emotional state. I am well aware that a good deal of MDMA use has occurred when "therapist" and client both take the drug. I am sure that there are many who would even advocate this as the best paradigm. However, the main thrust of my efforts has been to make these drugs acceptable to the medical community at large, following generally-accepted standards of practice. In that context, MDMA would not be administered to the therapist, and any discussion of drug-induced enhancement of empathy in the therapist is completely irrelevant.

We spent a long time trying to develop a term that would be descriptive of what these drugs do; one is faced with the problem of a treatment in search of a disease. If MDMA were useful for treating a specific pathological condition, a name would have been easy to find; consider names such as antidepressant, antianxiety, or anti-psychotic. Based largely on a belief that the ability to access repressed or unconscious material would ultimately prove to be the effect of these drugs most widely exploited in medical practice, we tried to develop a term that would reflect the drug's ability to facilitate the retrieval of "inner" material and enhance introspective states. Hence, the term entactogen, meaning essentially "to produce a touching within." While this term may be no more precise than many others, I still feel that it is to be preferred over empathogen, at least when discussing it in a legitimate scientific or medical context.

Sincerely,

David E. Nichols,
Professor, Medicinal Chemistry
and Pharmacology,
Purdue University

Dear Rick,

Congratulations on the 50th Anniversary of LSD issue of the MAPS newsletter, I think it is the best ever! I would like to comment on Ralph Metzner's letter concerning entactogen & empathogen as possible names for a novel drug class to describe MDMA and related compounds.

My Ph.D. dissertation examined the use of another amphetamine/mescaline-like phenethylamine, MDA, in the treatment of neurosis. I believe that characterizing a psychedelic as having a specific emotional property as though it were a chemotherapeutic effect is a misunderstanding. For example, when MDA hit the streets it was immediately called a "love drug." MDMA seems to have replaced MDA to become the love drug of the 90's. These are lay descriptions and confusions, researchers need to be more precise.

I believe that clues to the unique properties of the phenethylamine family can be garnered from the structural

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CORRESPONDENCE

similarity between MDA/MDMA and amphetamine/methamphetamine as well as their similarity to mescaline in another aspect of their molecular structure. I see both drugs has having varying amounts of classical psychedelic, i.e. mescaline-like, activity. What is unique about this family is that unlike classical major psychedelics the mind-manifesting properties of these two compounds are colored by the euphoric properties of the stimulant/euphoriant side of their molecules. MDA seems to have a stronger classically psychedelic property which is modified by the moderate euphoria induced by the amphetamine-like side of its molecule. MDMA appears to have a quite modest psychedelic property and a very pronounced euphoric property due to the methamphetamine-like side of its molecular structure.

Many observers and commentators on MDMA appear to confuse its propensity to induce a profound sense of well-being with the complex experiences of love and empathy. What is most amazing is that even an experienced psychedelic raconteur like Ralph Metzner, who helped pioneer the set and setting hypothesis, is quite willing to discard his hard won insights about the pivotal role of set and setting by characterizing MDMA as an empathogen.

The research on MDA done at the Maryland Psychiatric Research Center in the early '70's characterized its effects in a preliminary way:

Dynamically, the drug seems to reduce the need to defend or aggrandize the ego. In this state of enhanced well-being, the subject seems more able to accept and integrate concepts emanating either from the unconscious or provided by the guide or therapist., In substance, many of the subjects indicated that MDA seemed to "invite" inner exploration in contrast to LSD which demands it.

The state of consciousness which MDA facilitates would seem to make the acquisition of new insights an easier process. This type of experience may be especially helpful in breaking through obsessive, anxious and depressive patterns of thought and feeling. Another possibility is its application in group therapy settings to facilitate interpersonal interaction, enhance sensitivity to feelings and promote emotional expression. (Turek et al. 1974)

A reduced need to aggrandize or defend the ego is another way of describing the amphetamine-like euphoric effect on the subject's self-esteem. I find that MDMA has at once a stronger euphoric and a milder psychedelic action than MDA. The feeling of well being becomes more pronounced and the preoccupation with emergent inner material is less absolutely compelling than either MDA or a classical psychedelic such as LSD. Thus the pharmacological properties of MDMA can lead to greater openness in the interpersonal sphere. Empathy and experiences of deep love and transcendence are possible with MDMA as with all psychedelics, but a specific drug action, i.e. that of methamphetamine, is a part of its pharmacology that is often confused with these deep experiences. A reduced need to defend or aggrandize one's self can lead to empathy and greater contact, but this depends on non-drug factors (set & setting) and is not a pharmacological property.

For these reasons David Nichols' term entactogen seems a more correctly conceptualized word. I wish I liked the way it sounds, I don't. It's too staccato for my tastes. Ahh, the joys of splitting hairs amongst friends!

Sincerely,
Richard Yensen

Dear Rick,

I don't know whether the debate over "empathogen" or "entactogen" has much significance in the larger scheme of things, or even for the future potentials of drugs such as MDMA. Was it the Mad Hatter or the Queen of Hearts who said to Alice: "When I use a word I use it to mean whatever I mean it to mean"? Nevertheless, since my remarks in your MAPS newsletter elicited comments from my esteemed friends and colleagues Richard Yensen and David Nichols, perhaps I can be permitted a brief response.

Richard Yensen refers to me as a "psychedelic raconteur", perhaps to contrast my opinions with his, presumably more scientific, based on his Ph.D. dissertation on MDA therapy. While I am happy to take on the role of a "storyteller" when requested, I would like to point out that my remarks about drug terminology are actually based on my more or less direct participation-and-observation of several thousand sessions, group and individual, with psychoactive and psychedelic drugs and plants, over the last thirty years. More specifically, my suggestions about MDMA resulted from my work on the book *Through the Gateway of the Heart*, for which I pored over several hundred detailed first-person accounts of MDMA, from the files of a dozen or more therapists.

Nor does calling MDMA an "empathogenic" means that I "discard... the role of set and setting." Quite the contrary: the role of set and setting is quite obvious to anyone who has worked with psychedelics or similar compounds. Who can doubt that the experience of the thousands who consume "XTC" at a "rave" are having a different kind of experience from those who take it in a therapeutic or meditative context? At the same time, even the ravers report feelings of emotional oneness and connectedness. Researchers and experiencers consistently report consistent differences between the MDMA-type drugs and the LSD-type drugs. The terminological problem is: how best to describe this difference?

Richard first castigates me for the "misunderstanding" of "characterizing a psychedelic as having a specific emotional property as though it were a chemotherapeutic effect". He then proceeds to write about the "euphoric properties of the amphetamine/euphoriant side of their molecules", and the "euphoric properties induced by the amphetamine-like side of its molecule". Molecules with euphoriant sides? Talk about confusing levels of reality. What happened to set and setting here? Amphetamines as "euphoriants"? — most people regard them as stimulants (not quite the same). I don't know who is confusing MDMA's propensity to induce a "profound sense of well-being with the complex experience of love and empathy." I do know that the most frequently reported characteristic that distinguishes MDMA from LSD-type experiences is the emotional communion, the oneness, relatedness, emotional openness — in short empathy or sympathy, or something to do with affect. LSD can produce it too, but it does a lot of other things as well, and MDMA does it consistently.

It seems to me that if you are trying to describe an experience most effectively, you should use the language that most people use when describing the experience; not draw on pharmacological theories about euphoriant molecules, or transitory psychological theories of "reduced need to defend the ego" etc. Of course, as David Nichols observes, the medical profession (like other academics) likes to have its own terminology for objects and processes known to the lay public as well, so it can discuss them in a "legitimate scientific or medical context" — and I certainly have no objections to doctors or anyone else using words in any way they want. But my question would be — what does this term really communicate and to whom? Is empathy really such a "trite" experience, that you have to disguise it as something else?

Like Richard, David too has a theory about MDMA, that the empathy is really some kind of secondary or derivative effect. His is that MDMA produces an "anxiolytic state... accompanied by chemically-induced hypnosis". As if we knew what hypnosis did or how it worked. And just because hypnosis, and MDMA, can be used to facilitate age-regression, this does not make age-regression a property of the drug, or of hypnosis. And anyway, why do all the

Photo: Psychedelic Illuminations/Vic Cook

possibilities of the drug experience have to be included in the descriptive label? And does "entactogenic" include references to age-regression, empathy, euphoria, "reduced ego defense" and all the other suggested "properties" of MDMA?

Of course not: and the reason is that it is a newly-coined technical term, which doesn't communicate anything to anyone unless you explain in detail what you mean. At least, "empathogenic" (or "sympathogenic" , which German therapist Constance Weigle uses in her recent book on MDMA therapy) has the virtue of using commonly understood terms. And how does "entactogenic" — "reflecting the drug's ability to facilitate the retrieval of inner material and enhance introspective states" in David Nichol's terms — distinguish this class of drugs from the LSD-type psychedelics? It doesn't — in fact "touching within" or accessing inner states is pretty much what "psychedelic" means; and LSD and the tryptamines could be considered highly effective entactogens, in that sense.

One last point: David's insertion of a diatribe about self-medicating therapists into this discussion is both irrelevant and unfair. I never suggested, nor do I support, the practice of therapists taking MDMA with their clients. I said that the kind of empathic response characteristic of MDMA experiences is the same as psychotherapy training institutes spend years trying to inculcate in their trainees. Empathy, conscious emotional attunement with another's feeling-state, is a complex response that can be learned; and of course it can practiced, and learned, without drugs of any kind. What I was (admittedly) implicitly suggesting in my comments was the often-discussed potential value of MDMA and similar drugs in the training of therapists. In my opinion, the three potentially most valuable applications of MDMA in psychotherapy are: one, for working with traumatic memories; two, for interpersonal communication and openness; and three, for the empathy training of the therapists.

In the end, perhaps it all comes back to the Mad Hatter; — or is it the Queen of Hearts? We can use words to mean what we want them to mean. My esteemed friends Richard and David will use "entactogenic" as they wish; I now have a better idea what they mean by that term. For my part, I shall continue to use "empathogenic" — it doesn't take as long to explain for one thing. On the other hand, I really like "Adam", the term coined by our revered master Leo Zeff. This means something like "primordial being", "original nature", "primal parent", "great ancestor"...

Thanks for allowing me to comment.

Ralph Metzner

"... a rose by any other name..."

– William Shakespeare
Romeo and Juliet

CORRESPONDENCE

To Whom it May Concern:

I'm writing this in hopes that my experiences may be significant in the lives of others who also suffer from fibromyalgia; or other CFIDS type disorders.

I am twenty-two years old, thin, white, female, the typical scenario for most of us with fibromyalgia. I have been sick for about seven years now. Each day is a test of mind over matter,. I've got to forget the pain, the fatigue, and work beyond my limitations. In short, life is an ordeal.

I am very persistent and have made it a point to put my intelligence to use in understanding what I am suffering from. My psychological profile is what I would consider a very positive one given my circumstances. I am not a depressive person, but I do get frustrated. I'd consider that normal. I remember what life was like being a normal, healthy young person. Up until this disease surfaced I was healthy, and very athletic. This is primarily the most frustrating part of all this for me.

On top of my severe fibromyalgia I suffer chronic daily headaches and almost daily migraines. I suffer deep pain in my joints and biting pain in all the typical tender points. On top of all this is extreme fatigue. I am barely able to function and when I do I pay the price, and it is dear.

Over the years I have been prescribed many different drugs in varying dosages and combinations. There never has been anything I've taken that works to make life comfortable. As it seems after all is said and done, there still lies the exact same problem and nothing has changed it in any noticeable way. Life is still very painful and exhausting.

In my pursuit of personal enlightenment I have experimented with some psychedelics and used those experiences as spiritual and intellectual aides. I have taken LSD, psilocybin, and smoked marijuana. I know what is meant in terms of sensations and feelings produced; such as " euphoria, tripping, high." These vague terms are often totally ambiguous to those who have never experienced these psychoactive chemicals.

In the spring of 1992, I tried ecstasy (MDMA). There were four other people besides myself on this drug, their experiences were much different than my own. When the drug took effect the others that I was accompanied by were experiencing euphoric feelings and being mentally and physically high. My experience was different, I felt "normal" (normal being as I was before my fibromyalgia surfaced). I could keep up with my healthy active companions, something I could not have done without this chemical effect. I was energetic and could keep up with them on a hike up to the very top of a mountain, something that normally was a monumental struggle with pain and fatigue. I felt like I did when I was active in sports, just a little winded but I could make that ascent like the other people I was with.

The difference between myself and the rest of this group was I was not experiencing the "tripping" type of mind set, I just felt "normal". It was just like being given my body back. I no longer was trapped by fatigue and pain. This effect lasted for about three days. Where the others felt nothing after the first day, I was full of energy.

There was another very interesting effect. I usually need 10 to 12 hours of sleep to function at any level but on this drug I only slept a normal eight hour night and woke up refreshed and renewed and proceeded to have another day of the same caliber.

I have had only five experiences with this drug but they all had an effect on me even after the 12 or so hours that it effected the other takers. I felt energized for about one to three days after taking it.

I don't understand why it worked or how it worked but I know I felt a profound change from the extreme fatigue and inhibiting pain I suffer due to this disease. I said at the time I felt normal, and actually it felt more like a miracle. Each experience did prove the same. It had little effect on me psychologically, but on my physical energy and ability I felt like I'd been freed from a painful suit of armor.

My experiences impressed on me the idea that there can be something for me other than pain, fatigue. I want to find out if this effect can be recaptured and harnessed into working for me and others like me, making life less restricting and exhausting.

I am asking that someone may take an interest in my suffering and at least try to find out whether this may be a new and effective treatment for the fibromyalgia/CFIDS sufferers. I am willing to work with anyone who would like to take me on as a case for experimental testing.

Anyone is welcome to communicate with me further about my experience and my medical history. I hope that I may be considered a good case for further research and offer myself to any interested researcher.

Sincerely yours,
Jill M.G. Chapleau-Canavan
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Editors Note: After receiving Jill's letter, I contacted her physician to see if he was interested in trying to secure FDA permission to conduct research with Jill with MDMA. Fortunately, he was willing to go through the various time-consuming procedures that trying to secure FDA approval involves. I then contacted an official at the FDA to see if he would be willing to review an application to conduct research with Jill under what is called an N=1 methodology. Fortunately, the FDA is willing to entertain such an application.

The N=1 methodology involves a specific sort of research design in which Jill would be the one and only subject in the study. She would be given repeated administrations of MDMA or placebo in a double-blind methodology where neither she nor her physician would know which drug she was receiving at any specific time. After three or four administrations each of MDMA and placebo, her medical records would be reviewed to see when, if ever, she felt relief from her crippling symptoms. If she felt relief with the MDMA and not with the placebo, then further studies would try to explore what the MDMA did that was helpful to her. Depending on the results, a larger study with other similar patients might be undertaken. For now, Jill and her physician are preparing the application to the FDA for the N=1 study. At this time, I am hopeful that the study will be approved. Any progress will be reported in subsequent MAPS newsletters.

CORRESPONDENCE

Dear Rick,

My family has a high incidence of cancer. In fact, almost every member that has died, died of cancer. The youngest so far has been my first cousin who died of cancer at about age 50. My father died after 6 months of terrible illness when I was 16; I stayed home from school a half day every day to take care of him and give him his morphine shots. My mother and her family died from various forms of cancer at home. I consider myself an expert on terminally ill cancer patients after holding the hands of many people dying from this painful crippling disease at home for six months at a time.

The medications for pain seem to have remained the same for the past twenty years. Radiation seems to cause as much pain as it does relieve. Codeine, Percocet, and other pain-relieving pills help until the final stages, then morphine shots seem to be the final solace to a dying human.

I had the fortune of knowing and assisting a very close friend dying of cancer who was open to non-traditional approaches. She first tried pot but did not like it because she had never smoked it or anything else before and she was afraid of what other people would think. I had some organic mescaline [from peyote cactus] that a friend had given me and offered it to her. She said she was in terrible pain and the Percocet pills were not helping. So we took some together, a small amount to be careful. The effects were astounding as she relaxed and became a little euphoric and forgot about the pain. This we continued once daily or every few days when she complained of pain. I continued this until she died four months later and everyone around said it was remarkable that this person took so few painkillers. The amount I used was barely 1/10 to 1/4 of what a teenager would take before going to a rock and roll concert. The amount of standard pain pill requests were 1/10 of normal and hardly any morphine was used at the end.

I know this can be blown out of proportion as most drug use is. But the fact is, it was better than any traditional cancer death that I have seen. I have seen several traditional treatments since this person's death, which is why I am writing this letter. To this day, nobody else knows anything other than this person had a very relaxed and peaceful death.

I remember an old leather-bound American home medicine book from 1850 that we had around the house when I was growing up. At least 10 remedies from pain relief to treatments for madness and cancer included marijuana. It is well known that the Incas, Aztecs,and Mayans made extensive use of marijuana, coca leaves, peyote, mushrooms, and countless other naturally occurring drugs. Why are we trying so hard to destroy the knowledge of these drugs that were revered by these ancient civilizations? This can only hurt our society by reducing our data base of information to draw from. Is it possible that the terminally ill patients in these ancient cultures received better treatment and better drugs than we are giving our terminally ill today?

It is nice to have a forum where positive experience with drugs can be recorded. The government is effectively blockading the media. Keep up the good work, MAPS.

Best wishes,

An Interested Party

Dear Mr. Doblin,

May 6 was the 50th anniversary of the genesis of Aldous Huxley's *"The Doors of Perception."* I have naturally been pondering that May morning in Hollywood. Fifty years is a long time in a human lifetime, but in this history of human experience it is quite brief, and in terms of human evolution it is miniscule. It is fortunate that, at least so far, psychedelics have not had much military appeal, in spite of a brief period during which the war men of several nations hoped to misuse them. The automobile, the aeroplane, nuclear energy and much else owe their rapid evolution to their potential for harm, and that evolution was enormously expensive both in lives and treasure. Nearly all the early aviators died in the first few decades of flight. It was World War I that made the rise of the automobile and the plane possible.

I am glad that in spite of the sluggish and often timid way in which the establishment has approached or failed to approach psychedelics that there are still many who believe, as I do, that they have much to contribute to our well being and survival, as they and the experiences associated with them have done in the past. As Aldous Huxley, Albert Hofmann, and many others have stated repeatedly, these are instruments, sharp instruments, which we have to study so that we can use them for the benefit of all of us.

As it is easy to see, all human artifacts are in much the same category. They can help or harm us depending whether we use or misuse them. In earlier human societies hundreds, thousands, tens of thousands of years went by, in the course of which we learnt the social skills necessary to prevent new discoveries from becoming lethal for the discoverers and their descendents. In the last few hundred years, the tempo of discovery has become much quicker and has outstripped our ability to evolve socially and psychologically and especially spiritually to accommodate ourselves to our own inventions. So far our performance looks as if we are bent more on suicide than allowing ourselves to lead a better life and develop what Julian Huxley called "the fulfillment society" and what John Winthrop, possibly prematurely, urged upon his fellow colonists in the Arbella, before they reached Massachusetts Bay, that they would be a "city upon a hill." He told them in his sermon, at sea in 1630, that the "eyes of the world are upon us." Of course they weren't in 1630. The 'world' had no interest in John Winthrop and his little band of Pilgrims.

So all good wishes to you and yours,

Humphrey Osmond
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