ECSTASY ON TRIAL

When the federal government's Drug Enforcement Administration invoked its emergency powers and placed MDMA on Schedule I of the Controlled Substances Act, a number of people thought that the last had been heard on the subject. They were wrong. Rarely in our history has a conscious effective substance so excited both mass media and the public imagination as has MDMA. In the months prior to its scheduling, virtually every major newspaper and television network did a feature on MDMA. Such diverse magazines as Life, Cosmopolitan, New York, and HIGH TIMES (Nov. '85) each did their own version of “in depth” studies on the drug. Some of the reports have been from the viewpoint of researchers and clinicians who have worked with MDMA as an adjunct to psychotherapy. Others are from the Drug Enforcement Administration (DEA). Often, they sound as though they are talking about two totally different substances.

A corporate lawyer who, fifteen years ago, attended rock concerts on a regular basis, can barely contain his enthusiasm when he talks about MDMA.

"I've been taking it for a long time," he says. "It's just great...I don't take it very often, but I take it regularly. And it's the only drug aside from an occasional beer or glass of wine that I do use. I don't mess with cocaine like a lot of guys in my profession do. Who needs it? Let me tell you, it's a real revolutionary drug. It's totally different from LSD. If nothing else brings about world peace, Ectasy will."

The lawyer felt that all his experience with MDMA had been positive. The reaction of a San Francisco-based drug abuse counselor who tried it once was less than enthusiastic:

MDMA has stirred up more controversy than any mind-altering drug since LSD.

RICK SEYMOUR of the Haight-Ashbury Free Medical Clinic tells why.

"I got three tablets from a friend who I considered reliable in terms of contents, but I didn't know what dosage each tab contained and neither did he. I was going to save them and trip with my roommate in the country over the weekend, but in that I had three tabs, I decided to try one on Friday night. I had eaten dinner about an hour earlier and had a couple of beers after.

"I swallowed one tablet and waited, and waited. Nothing happened. About an hour later, I took another half tab. Nothing was happening. It occurred to me that the dosage per tab might be very low so, what the hell, I swallowed the last tablet.

"Within a few minutes it all hit me at once and I was on the phone to Suicide Prevention. I knew that I was about to lose control, not pass out but black out. I had had enough experience with PCP victims and clients on high doses of amphetamines to know that out of control, blacked out but still able to function at a physical level, I could be a danger to myself and to others. My pulse was going a mile a minute. I was slipping into a wide awake unconsciousness and I was scared. Fortunately, I was also experienced in dealing with bad trips and other drug reactions from work. Also, thankfully, there was no real ego disruption. The counselor at Suicide Prevention stayed on the phone and talked me through the crises, which lasted about half an hour. My life kept going the rest of that night and most of the next day."

A graduate student from Texas referred to his experience on MDMA as "...getting to Stage Two."

"Most of my friends use it recreationally, you know, on the weekends to relax and feel good about themselves. I started out doing that too, but what happened was like I learned something. It was like getting beyond myself and making contact with a higher reality. What I want to know now is, is it really real?"

David E. Smith, M.D. looks like he could play sixty minutes of rough and tumble professional football with the San Francisco 49ers on a Saturday afternoon, then go home, change into a tuxedo and conduct the San Francisco symphony at Davies Hall that evening. Instead, in 1967, he founded the Haight Ashbury Free Medical Clinic.

Although the Haight Ashbury Free Medical Clinic provides a wide range of medical services, its national reputation is based on drug abuse research and treatment. Working in a national epicenter of street drug experimentation, the Clinic's physicians, counselors, pharmacists, researchers, and epidemiologists have often been the first to point out new trends in substance use and abuse that have later been reflected nationwide.

Clients treated in the Clinic's drug treatment facilities usually come in voluntarily. The Clinic has a basic philosophy that health care is a right, not a privilege, and that it should be humane, demystified, nonjudgmental and free at the point of delivery. That philosophy, plus a street reputation for humane treatment, confidentiality, knowledge, and expertise in the field of substance abuse treatment attracts a wide range of highly diversified patients.

One of our public information activities is a monthly drug abuse folio column that is published in HIGH TIMES. The column provides current information, history, effects, myths, and dangers of individual psychoactive drugs. It was as a result of our HIGH TIMES column that Dr. Smith and I first became aware that the street use of MDMA was becoming an issue. We had published a column in March of 1983 on MDMA in which we discussed its nature, use, hazards, and liabilities of all the
methoxylated amphetamines. MDMA was not specifically mentioned.

A year later, in March of 1984, I got a phone call from Helio Costa, the bureau chief of the Brazilian national television network, Globo TV. The network was concerned, he explained, over the proliferation of the drug in Rio de Janeiro and other urban centers in Brazil. The users were calling it “Ectasy.” One of Helio’s colleagues had read our MDA column and thought it sounded like a similar drug.

Following up on that interview, we investigated the nature of Ectasy through our national network. Dr. John Morgan, a colleague at the Sophie Davis School of Medicine in New York, reported to us that samples of material sold there as Ectasy and Adam had proved on testing to be “either MDA, MMDA, or a new drug called MDMA.” We later got similar reports from PharmChem Laboratories in Palo Alto, California.

PharmChem reported a 50% validity rate for alleged MDMA samples submitted to their Analysis Anonymous service for qualitative analysis between 1978 and 1983. During the five year period, they compiled data on sixty samples that were submitted as MDA, MDMA, Ectasy, XTC, or Adam. They say there is no way of knowing if clients submitting samples under street names actually understood what they were supposed to be. These street names have only become popular synonyms for MDMA since the recent widespread publicity about the drug.

We began asking the questions, just what is MDMA? And who is using it?

A paradoxical chemical in many ways, MDMA is often thought of as a “new” drug, even though it was first synthesized in 1914. MDMA is a synthetic drug. In synthesis, one or more substances are molecularly changed and may be combined to form a new substance. This process distinguishes synthetics from chemicals that are direct extracts or purifications of an existing substance. Similar in structure to both MDA (3,4-methylenedioxymethamphetamine) and the aromatic substitution pattern of the essential oil safrole, MDMA is synthesized from molecular components of methamphetamine and safrole from sesamgrass, nutmeg, or piperonyllactone.

It belongs to a large group of synthetic drugs called the phenethylamines. These differ in their effects, depending on their molecular structure. Some of these drugs are relatively inactive. Others, including the drugs that we usually think of as amphetamines, produce a stimulant effect coupled with feelings of euphoria. Still others are consciousness effective and produce both psychodile and stimulant effects. MDMA belongs to this latter group.

MDMA is most similar to a sub-group of amphetamines that are called “methoxylated amphetamines.” These drugs are similar to mescaline, the active ingredient in the psychedelic buttons of the peyote plant found in the southwestern United States and Mexico.

MDMA is a psychoactive drug. This means that its primary effects are on the psyche. It can also be called a central nervous system, or CNS, effective drug in that it interacts directly with the brain and spinal column, the central nervous system, to produce its effects.

Although there are many psychoactive, CNS effective drugs, they fall within three primary categories. There are “downers,” which include pain killers or analgesics and sedative-hypnotics; upper or stimulants; and psychedelics. There are other drugs which affect the central nervous system, including antipsychotic drugs.

The effects of MDMA are similar to those found in both the stimulant and psychodelic categories and also has some unique effects that are not common to any of the three psychoactive drugs. In the opinion of some researchers who have worked with the drug, any direct comparison to either stimulants or psychedelic would be misleading. Their conclusion is that MDMA has a unique pharmacology that cannot be properly described within the existing categories. Further, they note that its actions are not only similar to those of its closest chemical neighbors, MDA and the methoxylated amphetamines.

SHOULD MDMA BE BANED

When a drug comes along that the mass-media scriveners like, that drug is always doomed. Last year, a couple of Newsweek magazine writers and a handful of miscellaneous network-televy news producers abruptly became enamored with MDMA, a pleasantly-intoxicating euphoriant compound known as "Ectasy," or "XTC," among recreational drug users since the 1970's. Not only was this drug legal, they reported in amazement, but there was no lack of perfectly respectable physicians with legitimate M.D.'s who were ready to say that it wasn't terribly harmful or even disenchanting, and would assuredly be of some use in the practice of psychiatry. So for a few months, all the magazines and the talkies were full of rave reviews of this new perfectly-legal "drug" which was reportedly saving troubled marriages, enhancing sex, and providing illuminating poetic and philosophical insights to its users.

MDMA was accordingly made totally illegal before another couple of changes of the moon, on July 1, 1985. The Drug Enforcement Administration in Washington, perturbing that these hardned media crits were prattling the exact same nonsense about MDMA as they'd been prattling about LSD-25 two decades previously, put a stop to it tout de suite. They put MDMA on the same "emergency legislation" list with the hideous new Parkinson's-Disease "designer" opiate, MPTP, and railroaded them straight onto Schedule One along with LSD, heroin, marijuana, and all the DEA's other eternally-verbatim killer drugs.

Unlike the hideous MPTP, however, MDMA had some fairly important people ready to go to bat for it: numerous eminent Ivy League psychiatrists who would testify in its favor, and some extremely influential Washington and New York law firms working in the interest of a certain multi-national drug company with a budget the size of Fort Knox. So the DEA's designation of MDMA for Schedule One went under a formal challenge in its very own administrative law courts in Washington last winter: ultimately the DEA's very own in-house judge ruled that MDMA rightfully ought to be placed on Schedule Three, where it would be available to doctors for prescription to their patients, though its sale to the public remained, viciously-reined, thrill-seeking druggists would still merit truly ferocious penalties.

The written decision of the DEA's in-house legal overseer, Judge Francis Young, makes for a lovely read. In arguing for its Schedule One designation for MDMA, the DEA's lawyers had essentially told the judge that they believe they're entitled to eternally banish any drug which has not already been accorded a specific "accepted medical use" by the FDA; which would necessarily eliminate any possibility that the FDA physically could in a million years, ever define an "accepted medical use" for any drug the DEA has scheduled beforehand, such as MDMA.

Judge Young unlatched this Catch-22 brusquely enough. "There is no denying that such a situation would greatly simplify the scheduling task of the DEA staff," he wrote. "It pro
vides a quick solution to the problem for the DEA. It provides a certain answer. But it is wrong. The policeman’s job is only that easy, the judge reminded the DEA, in a police state.

After that, all the DEA’s other arguments were extraneous, but the judge diligently took notice of them anyhow. The liveliest of them was the brain-damage rumor, which the DEA had cooked up to justify banning MDMA on the same “emergency” list as their hideously potent neurotoxin, MPTP.

When they undertook to lodge MDMA forever in Schedule One last year, the DEA regaled all its pet mass-media mouthpieces with the own lurid interpretation of a basic rat experiment which had been carried out years previously at the University of Chicago by researchers Louis Sieden and Charles Schuster. Basically, Sieden and Schuster had shot up rats with gigantic doses of MDMA, to see if it might cause the same sorts of brain damage as methamphetamine does when it’s shot into rats in gigantic doses. As expected, they found that the brain cell damage was considerably less extensive with MDMA, and responsibly reported that. And they never once reported that any human being would ever, even accidentally, shoot up an even remotely gigantic dose of MDMA, or necessarily sustain any least bit of MDMA-induced brain damage. But of course that’s precisely what all the DEA’s pet media mouthpieces reported to the public, after they’d been fed the DEA’s misrepresentations of this U. of Chicago rat study.

This was not the first time judge Young had seen the DEA trying to turn responsible scientific drug research into witchcraft. "The MDMA was injected into rats," he blandly noted. "The route of injection, which will make a vast difference in the meaning of the results noted, is not given in the DEA’s report. Humans are known to take MDMA orally, not by injection. This difference is of great importance, and renders the test results meaningless for our purpose."

And anyhow, this was no decent argument for putting MDMA on Schedule One. The appetite-killing drug fenfluramine, marketed for years now as “Pondimin” by the Robens drug company, causes exactly the sort of pinpoint nerve- and terminal damage as MDMA might cause, and does the damage at much lower doses, Young noted; and Pondimin’s only a Schedule Four drug! At least the shrinks and lawyers trying to pry MDMA off Schedule One only want it to be redesignated to Schedule Three, where its licenced sale will still pull dire 20-year prison penalties.

So the DEA’s own in-house judge formally decreed that MDMA ought to be shifted from Schedule One down to Schedule Three, where M.D.s and drug companies can exploit its demonstrated therapeutic properties. At this writing, though, DEA administrator John Lawn can still overrule his own judge, and decree that MDMA is going to stay on Schedule One forever. Lawn is entirely likely to do this. 

If it is not a psychedelic, if it is not a stimulant—and it is certainly not an anesthetic or a sedative,hypnotic—then what is MDMA?

It may be the prototype of an entirely new drug category, David E. Nichols, Ph.D., who is currently studying a series of chemicals that he has called “entactogens,” stated in testimony to the federal MDMA hearings that the effects of MDMA are unique in their own right. He compared its potential importance to that of diethyl ether and nitrous oxide in the development of general anaesthetics that led to modern surgery. Other researchers maintain, further, that the effects of MDMA are not psychedelic, but represent a revolutionary means of furthering mental health treatment and exploration that has not been available through any previous source.

Those who have worked with MDMA state that although it can be looked on as consciousness-altering, and therefore called “psychedelic” for want of a better term, it is not hallucinogenic. The drug does not appear to cause visual hallucinations or distortions nor is it reported to lead to a delusional state. Subjects involved in medical research have not reported any of the ego loss, dissociation or mental confusion that can occur with psychedelic drugs.

According to therapists who have administered the drug to clients, MDMA is characterized as bringing about conditions of peacefulness, an ability to feel trust, a lowering of psychological barriers and reported increases in insight. It provides these clients an opportunity to see clearly and dispassionately within themselves by opening up the blocks that are creating or sustaining their own consciousness and suppressed painful experience. These effects, occurring at therapeutic dosages, are cited as what makes MDMA potentially valuable when used within a course of psychotherapy.

A number of anecdotal cases have been cited wherein patients suffering from severe depression seem to have had major treatment breakthroughs. Patients with problems that include long-term communication blockages and psychic traumas such as rape, the onset of terminal illness, and delayed stress, have been reported as benefiting from MDMA therapy.

Although MDMA is said to be free of the clinically less desirable effects associated with many other psychoactive drugs, such as visual distortions, mood swings, and indecision, there are exceptions and reactions vary with the individual. The drug is, after all, still in an experimental state.

Researchers and health professionals unanimously agree that MDMA should never be used for recreational purposes or without adequate supervision. It is not a drug for recreation, intoxication, performance enhancement, or self-medication. The proper use, as they see it, is for specific and carefully planned and supervised sessions within a course of psychotherapy or other mental health treatment, or for directed research on human consciousness. MDMA is not a toy.

But the Haight Ashbury Free Medical Clinic drug treatment staff reported that MDMA was being used recreationally. At least what was called MDMA, or MDM, or Adam, or Ecstasy, was being used.

In the twilight world of illicit or street drugs, things are rarely what they seem. Often easily obtainable substances are disguised to resemble others that are in demand but harder to get. The notion that habitual users can tell the difference between their drug of choice and a counterfeit is often a myth.

The current centers will not always know what specific drug a client may have used. It takes sophisticated drug testing equipment to tell the difference between two drugs such as similar in structure as MDA and MDMA. The process is also comparatively expensive and unnecessary for symptomatic treatment of sympathomimetic reactions. In such cases, the Clinic’s staff usually takes the word of the client for what they have taken. The client, for that matter, has usually taken the word of the

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person who sold the drug as to what is in it. With MDMA and the methylated amphetamines, as is the case with most stimulants and psychedelics, the acute toxicity symptoms that are usually seen in treatment are similar and result from taking too much of the drug. These acute toxicity symptoms usually dissipate as the drug wears off, and the patient can be discharged within a few hours.

In treatment, MDMA is handled with the methylated amphetamines. The acute toxicity symptoms for all of these involve anxiety, fear reactions usually accompanied by a racing pulse and rapid heartbeat, paranoia—sometimes with delusions—and a sufficient sense of unease to prompt their seeking treatment. Treatment usually begins with reassuring the patient that these feelings are a result of taking too much of the drug, are not dangerous, and will wear off as the drug wears off. There is some variation depending on the individual. In some cases, these patients come back for a series of counseling sessions. In most cases, a talkdown similar to that used for psychedelic bad trips is sufficient.

More severe reactions to what users believed to be MDMA have been reported, including prolonged psychotic reactions, but we haven’t seen them. As with any consciousness-expanding drug, these psychotic breaks can happen, especially if the user has underlying psychopathology.

MDMA is a relatively recent addition to the national pharmacopeia. There is not enough hard data to firmly establish just where it is on the abuse spectrum. Certain inherent qualities indicate that MDMA is probably a psychoactive substance with a generally low abuse potential. These qualities include a short period of effect, two to six hours, and a reported lack of incentive to immediately readminister the drug. This may be partially due to a rapid onset of short-term tolerance, or a diminishing of desired effects. Subjects report that at dosages only a little above those used in treatment, MDMA ceases to have any further desirable effect and only increases the undesirable “wired” feelings.

A major area of concern is the quality control of MDMA manufacture. While some interest in quality control in a clinical setting could be provided by physicians synthesizing the drug under competent supervision, no such assurance exists for MDMA manufactured underground for non-medical consumption.

On the illicit drug market, the bywords are safety, efficacy, and the buyer beware. Manufacturers of street drugs are not answerable to the Food and Drug Administration or any other agency for the quality, or even safety, of the contents of their products. Under current conditions, there is no way at all, short of arresting all the currently illicit MDMA manufacturers, of controlling the street preparations that are sold as MDMA, a

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ECSTASY ON TRIAL

Is MDMA the recreational drug of choice of the future, a trendy fad, or a potentially abusive substance?

Matter what they may actually contain.

MDMA usually appears as a cream-colored or very light tan crystal-like powder, but color can be affected by anything from the binding agent to the manufacturer's fancy. Some MDMA tablets reported to be from Texas are bright lemon yellow.

While some long-term intravenous amphetamine users have reported injecting large dosages of MDMA for the stimulant effects, it is usually swallowed in pill, capsule, or powder form. There are no reports of this occurring. Street forms of the drug are reportedly more expensive, ranging in price from $10.00 to $30.00 for approximately 30 mg. Unit measurements can vary greatly, however, with little correlation between price and dosage.

Most first, second, third, and multi-hand sources, including the media, identify several population groups wherein non-medical MDMA use appears. In the San Francisco Bay Area, at least, one of these is the gay community where the drug is called Adam. As Ecstasy, it is used by young, well-educated, professional men and women. Individuals in both these populations appear to limit their use to occasional recreational trips, often to enhance either self-realization or interpersonal communication. In spite of its exotic street names, MDMA doesn't appear to be a sexual performance or cortical enhancement. It's not an aphrodisiac.

Most of these users are young adults. There are reports from other parts of the country, however, that many college and high school students are using MDMA non-medically as well. Shortly before the emergency scheduling, both the DEA and sources within the drug were reporting massive use on Texas university campuses.

Dr. David Smith identified another population of MDMA users through his communication with past clients of the Clinic's drug treatment facilities. These were mostly urban folks who probably would be blue collar workers if they worked. Instead, they deal marijuana, cocaine and other substances, and added MDMA to their inventory and experimented with it themselves. Through these, we came in contact with a small population of chronic drug users who took MDMA on a regular and frequent basis. It's my understanding that the use of these has decreased using this drug, not because it's less available since scheduling, but because of increased tolerance.

My own greatest concern about the non-medical use of MDMA are twofold. For one, many people who should not be using this or any psychoactive drug may get lured into its non-medical use through positive hypnosis by well-meaning posters and out-and-out proselytizers. These potential victims include the young, the drug naive, and those who are susceptible to compulsive abuse and addiction.

The second concern is one that MDMA shares with all other popular underground drugs. With no quality control, it can be a dangerous and risky drug to use. If you're not sure about anything they want to do, I'm going to call MDMA. Although it's currently under ban on MDMA may have an over-reaction, and it certainly cast a pall on research and experimental treatment, it enables the Drug Enforcement Administration to go after underground manufacturers and dealers of what is now classified as MDMA. Hopefully, this will allow enforcement, research, and treatment to work together in placing MDMA in the same category as other drugs that may do good instead of harm.