TESTIMONY OF THOMAS B. ROBERTS, Ph.D.

My name is Thomas B. Roberts. I am currently a professor on the faculty of Northern Illinois University. A summary of my educational and professional background is attached to and incorporated in this testimony.

Summary

MDMA is a drug of strong potential in psychotherapy when used by professionals, and with low potential for abuse. This psychotherapeutic potential is especially noteworthy in cases of emotional blocking by the patient/client. Administration typically consists of taking a dose in the presence of trained professionals, rather than on the patient's own with a prescription. Additional research is needed to verify current leads.

Background

Most new drugs are discovered or invented by a pharmaceutical company. When a potential candidate for research and development is discovered or invented, the company is likely to spend hundreds of thousands to millions of dollars on its development, on proprietary patents, on necessary research for Federal regulation, and on production and promotion.

But what of a drug in the public domain? Who is going to invest the money and time necessary to bring it to fruition? Such is the problem of MDMA. If it were patented by a large pharmaceutical house with millions to invest, it

would appear in the normal stream of new drugs, but this isn't the case. Instead, research to date on MDMA points to probable psychotherapeutic uses of the drug, but is not complete enough to be conclusive.

Potential for psychotherapy

As one of the pilot subjects in Greer's pilot study of the use of MDMA in clinical use, my experience with the drug is that it is useful in helping clients attend to emotionally charged memories which they may have been blocking. Since these memories are usually the cause of much mental distress, they are the focus of attention during psychotherapy. MDMA offers the possibility of making therapy more efficient, a gain for the client, his family, society, and the professional administering the drug.

MDMA also may have other uses such as immediate intervention during depression. One of the problems with current anti-depression drugs is that they may take days or weeks to become effective. MDMA may be used in the interim, or it may replace some current anti-depressant drugs.

For any drug, there are always some people for whom it doesn't work or who cannot take the drug due to peculiarities in their personal biological make-up. MDMA may be useful to this population which cannot use existing antidepressants. More research is needed to discover which populations are most helped.

It is important to note that the suggested psychotherapeutic protocol for MDMA is strikingly different from the use of most psychotherapeutic drugs. Most such drugs

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are prescribed by the psychotherapist, bought by the patient, and self administered, hopefully according to the doctor's prescription. MDMA, on the other hand, is recommended for administration in the presence of the psychotherapist (and perhaps an assistant) for the purpose of enhancing psychotherapy. Self-administration, "street" or casual use, and use for recreation and/or curiosity are outside the prospective medical protocol and should not be confused with the prospective psychotherapeutic use.

Abuse potential

As someone who has tried MDMA in the past, I find no particular desire to abuse it. It was a pleasant experience as well as being psychotherapeutically valuable, and I can see that others would find it that way too. In my opinion, based on my review of what is known about MDMA and on my own experience, MDMA has a low potential for abuse.

In my opinion, arguments to the contrary are not persuasive. First, instances of supposed abuse which are brought to the attention of the law enforcement and/or mental health communities need to be examined with extreme care to determine their accuracy. Since MDMA is not produced by professional drug companies, it is likely that some batches are below standard and/or contaminated during manufacture.

Second, drug dealers are noted for their eagerness to make a sale without regard for the drug they are selling and its effects on their customers. It is possible, even likely, that supposed purchasers of MDMA are getting any number of other substances sold as MDMA. These could be

MDA, other amphetamines, or many other substances; therefore, great care must be attributed to claims of the alleged effects of MDMA.

Third, among drug abusers, polydrug abuse is the rule rather than the exception. The combined effects of two or more drugs is not the added effects of each drug separately, and so-called MDMA reactions may be the result of two or more drugs in the blood stream simultaneously.

Fourth, among illegal users of drugs who seek care on their own or who come to the attention of medical and law enforcement authorities, it is common practice to admit to taking a legal drug in place of an illegal drug, which was actually taken. This is done to try to deflect the legal complications which may arise if one admits to taking the illegal substance. Since MDMA is not currently a controlled substance, it is a natural "target" for this misinformation, and as MDMA becomes better known, it is likely to appear increasingly often for this reason even if its actual consumption drops.

Fifth, medical and law enforcement authorities see only those cases which cause physical or legal problems. A person who took MDMA, or any other drug, with a positive result, would hardly be likely to call his doctor or law enforcement office to report that he is well.

Consequently, current legal and medical opinions are to an unknown extent based on unsubstantiated claims. Those who present evidence that MDMA contributes to illegal activity or to impaired mental or physical health need to

substantiate their claims by giving laboratory evidence that the drug in question was in fact MDMA, that the person abusing it was free from other drugs and was not already affected by other drugs in a manner that contributed to the problem, and that apparent citations of MDMA by abusers are accurate. I do not mean to imply that MDMA cannot be abused by the abuse-prone. It, like any other substance, has that potential, but the potential is, in my opinion, low.

Since MDMA's abuse potential is low and since it is safe to use under medical supervision, MDMA should not be classified in Schedule 1.

The act of scheduling implies that knowledge is sufficient to render a secure judgment; however, sufficient knowledge is not available in the matter of MDMA, and placement on any schedule would be likely to misrepresent the drug either in its abuse potential or in its potential for medical use. If MDMA is scheduled in an abusive category, it is unlikely that the money, time, and effort necessary for further research will be forthcoming, and a potentially valuable psychotherapeutic drug may never be made available, causing needless suffering and the expense of protracted psychotherapy. Likewise, from a law enforcement concern and considering public mental health, the degree of potential abuse is clearly not known. Any scheduling of MDMA implies that enough is known to render a decision, but such is not the case.

Summary: In the matter of MDMA, what policy should be pursued? To date the evidence for its use as an

adjunct to psychotherapy is clearly positive, but the evidence is of an early pilot-study nature. The evidence for its possible abuse is questionable and probably invalid in some instances, but not all. When competent authorities disagree, the proper course is to obtain more information so that firmer conclusions and recommendations can be made.

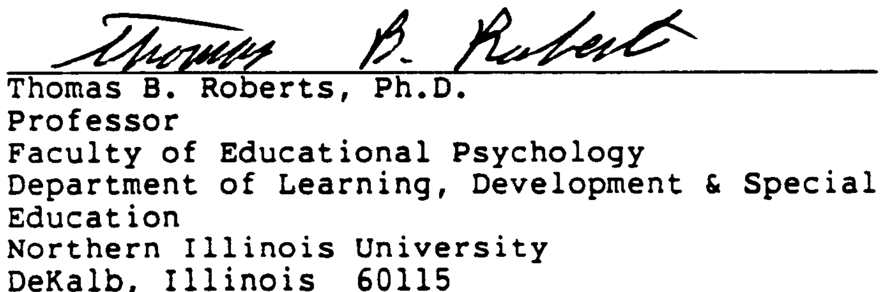
In an effort to gain the necessary knowledge to make an informed decision, I recommend that the DEA

1) not schedule MDMA at this time in any category

2) recommend that additional studies be done

3) request NIMH to fund such studies and report back to the DEA.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct. Executed on April 23, 1985.



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