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Stronger than heroin, more addictive than cocaine, synthetic opiates—many of them legal—are hooking doctors and

SPECIAL REPORT

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AN ETHICAL QUANDARY: WHO SHOULD GET THE EXPERIMENTAL AIDS DRUG?

MDMA: IS THERE EVER A JUSTIFIABLE REASON FOR GETTING HIGH?

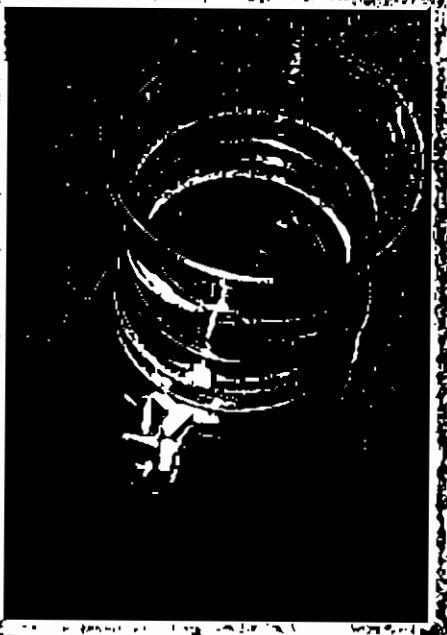
MDMA—known to its users as ecstasy—is a designer drug of a different stripe. Structurally, it's related to stimulants and hallucinogenic amphetamines, but its effects are different from either. In addition to evoking the bonhomie that makes it a popular "hug drug" among hundreds of thousands, possibly millions, of young professionals, gays, and college students, MDMA appears to grease the emotional and cognitive gears that produce insight. Some psychiatrists who gave the drug to patients when it was legal say they can accomplish in one MDMA therapy session the equivalent of a half a year of traditional treatment.

While these doctors think MDMA can be useful in clinical situations, its potential neurotoxicity and abuse as a party drug led the Drug Enforcement Agency (DEA) to outlaw the substance in July 1985, until it could be evaluated further. The agency's final decision on the classification of MDMA, which is expected this summer, is of particular interest because it concerns an issue larger than the fate of a single drug. If chemists can engineer benign or even useful psychoactive drugs, how can these drugs be regulated in a way that curbs abuse but permits legitimate use? Further, does legitimate use mean that a person can only ethically take a drug when he's sick?

David Nichols, a professor of medicinal chemistry at Purdue, points to the plight of the chronically infirm, who are often pacified with culturally acceptable sedatives that make them tractable but cut them off even further from their families and their own thoughts and feelings. They aren't permitted to use a drug like MDMA that might provide them with a little clear-headed pleasure, augment their ability to reflect and remember, re-establish their rapport with others, and reduce pain. "We have for some reason adopted the notion that chemically induced pleasure is an absolute evil to be avoided at any cost," says Nichols, "but what sort of evil is it to provide some comfort or delight to the dying patient? We have no right to insist that some alleged 'inner strength' must sustain them, and that they can only be helped with drugs that cloud the mind."

Although his is a controversial opinion, Lester Grinspoon, a professor of psychiatry at Harvard, thinks MDMA might improve the efficacy of psychotherapy, which is increasingly being criticized for its uncertain results. "Is there a chemical way to facilitate insight?" he asks. "I don't think it's an outrageous question, and I believe the answer is yes."

Doctors impressed by the drug stress that MDMA isn't a cure for mental illness, but rather a catalyst for psychotherapy. "You've been seeing this patient for six months, and you think you know him pretty well," says Richard Ingrasci, a Boston psychiatrist who treats many critically ill and dying people. "Then you give him some MDMA, and suddenly you're hearing all kinds of stuff you haven't heard before. That's when the therapy really takes off." Ingrasci finds the drug's propensity to stimulate trust and empathy helpful in marriage counseling, and in increasing the bond with the therapist; he notes that six of his patients were able to recall or to discuss being sexually molested in childhood only after taking MDMA.



Ecstasy capsules—insight facilitators?

No expert thinks the drug is abuse-proof, or that it should be made broadly available. "When psychiatrists say a drug like MDMA is benign, they mean it's benign in a benign, supervised setting, like psychotherapy," says David Smith, the director of the Haight-Ashbury Free Medical Clinic in San Francisco. "They have an entirely different perspective from that of enforcement agencies, or from that of the compulsive drug abuser who lives life in the fast lane and takes MDMA frequently to participate in sexual marathons."

No psychoactive drug is without risks, but most of those concerned with drug regulation in the U.S. concede that the present system is inconsistent in the way it evaluates those risks. For example, according to the Controlled Substances Act, alcohol should be at the top of the DEA's Schedule 1, which is reserved for drugs whose dangers far outweigh whatever medical utility they may have: it's addictive, destroys brain cells, and causes social destruction, disease, and accidents. According to Smith and others, the ravages of all other drugs combined pale before those of alcohol. Yet alcohol is legal. MDMA and marijuana, on the other hand, are Schedule I drugs, controlled as strictly as heroin and more strictly than cocaine, although they don't begin to compare with them in terms of destructiveness.

The main difficulty in determining the fate of MDMA is that there's very little scientific information on which to base a decision. Other than the fact that it has caused few emergency room visits, almost nothing is known about its short- or long-term physiological and long-term psychological effects. The answer would seem to be to do tests, but some scientists claim that getting approval to do them with a Schedule 1 drug is a bureaucratic Catch-22 that effectively prohibits research by anyone except pharmaceutical companies with great financial resources. Federal drug officials disagree about the difficulty of doing such studies, but at present no MDMA research on human subjects has been licensed. Grinspoon and Ingrasci hope that MDMA will be moved from Schedule 1 to Schedule 3, which would more readily allow human studies. "The DEA and I want the same thing—to prevent the trivial use of an uncertain substance," says Grinspoon. "I think MDMA should be controlled too, but not in a way that absolutely frustrates attempts to research it." —*M.C.*

ALEXANDER THARAS