HIGH TIMES

NOVEMBER 1986

$3.95 (CAN.)

THE DROUGHT IS OVER!

SMUGGLER'S JOURNAL

CHOCOLATE WATCH BAND

WHY IS ECSTASY ILLEGAL?

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 briskly. "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, Ecstasy 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 changing. 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 jaw kept clenching throughout 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?"

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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 follo 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 MDA in which we discussed the 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 a new drug in Rio de Janeiro and other urban centers in Brazil. The users were calling it "Ecstasy." 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 Ecstasy 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 Ecstasy 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 MDMA, MDM, Ecstasy, 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?

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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 (or 3,4-methylenedioxyamphetamine), and the aromatic substitution pattern of the essential oil safrole, MDMA is synthesized from molecular components of methamphetamine and safrole from sassafrass, nutmeg, or piperonylacetone.

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 psychedelic 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 all fall within three primary categories. There are "downers," which include pain killers or analgesics and sedative-hypnotics; uppers or stimulants; and psychedelics. There are other drugs which effect the central nervous system, including antipsychotic drugs.

The efects of MDMA are similar to those found in both the stimulant and psychedelic 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 psychedelics would be very 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 even all that similar to those of its closest chemical neighbors, MDA and the other methoxylated amphetamines.

SHOULD MDMA BE BANNE

When a drug comes along that the mass-media scriveners like, that drug is always doomed. Last year, a couple of *Newsweek* magazine scribes and a handful of miscellaneous network-telly news producers abruptly became infatuated with MDMA, a pleasantly-intoxicating euphoriant compound known as "Ecstasy," or "XTC," among recreational drugniks 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 disorienting, and would assuredly be of some use in the practice of psychiatry. So for a few months, all the magazines and the telly were full of rave reviews of this new perfectly-legal "hug 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, perceiving that these harebrained media twits 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-*verboten* 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 idle, viciously-inclined, thrill-seeking drugniks 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 briskly enough. "There is no denying that such a situation would greatly simplify the scheduling task of the DEA staff," he wrote. "It pro

? NO, SAYS A DEA JUDGE.

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 their own lurid interpretation of a basic rat experiment which had been carried out years previously at the University of Chicago by researchers Louis Seiden and Charles Schuster. Basically, Seiden and Schuster had shot up their rats with gigantic doses of MDMA, to see if it might cause the same sort 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-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 unlicensed 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.

—Dean Latimer

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

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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 anesthetics 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 out the blocks these clients have created between 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 the appropriate and sensitive use of MDMA with patients in the course of psychotherapy seems to have led to 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, loss of coordination, and intoxication, 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 medical 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.

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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.

Treatment 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 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 methoxylated 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 dose related symptoms usually dissipate as the drug wears off, and the patient can be discharged within a few hours.

In treatment data, MDMA is lumped in with the methoxylated 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 delusion—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-effective drug, these psychotic breaks can happen, especially if the user has underlying psychopathology.

MDMA is a relatively recent addition to the national pharmacopia. There is not enough hard use data to firmly establish just where it is on the abuse spectrum. Certain intrinsic 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 intrinsic quality control in a clinical setting could be provided by physicians synthesizing their own under competent supervision, no such assurance exists for MDMA manufactured underground for non-medical consumption.

On the illicit drug market, the byword is *caveat emptor*, let 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 the contents of their products. Under current conditions, there is no way at all, short of arresting all the currently illicit manufacturers, of controlling the stree preparations that are sold as MDMA, a

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URINE TEST

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cases, and urinalysis challenges have come to predominate his caseload over the last few years.

"Once you've determined in court that the drug testing was inadequate," counsels attorney Bishop, "you'd obviously be better off demanding money damages instead of reinstatement and back pay. If your employers have already fired you because of some drug test, then what's to keep them from doing something like that again? And anyway, you're going to have to pay your attorney, and if he expects he'll get part of a good fat settlement, he'll really go after the other charges: infliction of emotional distress and slander. And the judge ought to be ready to award something pretty substantial, too.

"Here's where there could be trouble for you," Bishop warns. "To try to cut down the size of the damage award, your employers are liable to try to blacken you as some sort of drug addict before the judge. If they've got lots of money, they can hire private investigators to root into your personal history; and so if you ever so much as smoked pot with your pals in college, years ago, that's likely to be brought up in court, as luridly as possible, by your boss' lawyers. The judge might react by paring the damage award down to a token settlement; or he might *enhance* it, disgusted with your boss' smear tactics. These are all things you ought to think about beforehand."

A person might also think about simply insisting that all these piss profiteers, with their billion-dollar defamation racket, be subject to appropriate prosecution, fines, and imprisonment. Last May, in fact, several celebrated Congressional "antidrug hardliners"—led by Reps. Charles Rangel and Benjamin Gilman—emphatically called for new legislation to police and regulate the notoriously crooked urinalysis industry. Congresspersons currently drafting such legislation include Sen. Pat Schroeder (Colo.), Reps. Gary Ackerman and George Crockett (Mich.). If you were to just write your personal congressperson right now, expressing your opinions and questions about drug-urinalysis in the American workplace, you could actually make a significant difference.

Appropriate legislation to regulate the chemistry industry would take the bread right out of the mouths of all these piss profiteers, who have been working so hard, for so many years, to break into and plunder our bladders, but that's democracy for you. If Syva and Roche can't make any more piss-money here, they could surely peddle *millions* of their obnoxious surveillance gimmicks to the Kremlin right now, with absolutely no legal trouble at all, ever. *Pravda* lately has been chock-full of horrific kids-and-drugs propaganda behind the Iron Curtain, but that's another dope story, of which more in the next issue. ●

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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 crystalline 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. There are no reports of insufflation or snorting. Street forms of the drug are reportedly sold in low dosages, ranging in price from $10.00 to $30.00 for approximately 50 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 coital sensitivity enhancer. 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 state 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 young urban folks who would probably 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 many of these have stopped using the drug, not because it's less available since scheduling but because of increased tolerance losing the desirable effects. Several have cited fuzzy-headedness and difficulty in concentrating during chronic use as reasons for quitting.

The street supplies of MDMA probably come from underground laboratories. Street doses of the drug are often distributed by pre-existing marijuana and cocaine dealers. They have added it to their line, as it were.

By and large, these dealers see MDMA as strictly a temporary sideline. They shrug off its current notoriety.

"It's a fad," they say. "Next year it'll be something else again."

They cite the lack of a real psychedelic or euphoric "punch" and point out that MDMA doesn't produce a rush like marijuana, or speed, or cocaine, and it doesn't enhance sexual performance.

"The name Ecstasy makes it sound like it's a very sexy drug, but it doesn't really do anything for sex at all. If anything, it may retard both male erection and climaxing. The name was made up by a dealer on the East Coast who thought it would sell more pills."

Whatever its physical effects, Ecstasy has certainly caught the imagination of the American public, or at least the American media.

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My own greatest concerns 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 hyperbole by well-meaning supporters 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, sociopathic and just plain ignorant manufacturers and dealers can sell just about anything they want to a gullible market and call it MDMA. Although the current one-year ban on MDMA may be an over-reaction, and it certainly casts a pall on research and experimental treatment, it enables the Drug Enforcement Administration to go after underground manufacturers and dealers of whatever passes for MDMA. Hopefully, this will allow enforcement, research, and treatment to work together in placing MDMA where it may do good instead of harm. ●