

Why MDMA Should Not Have Been Made Illegal

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The most recent "recreational" drug to be made illegal is MDMA, or "ecstasy."^[1] Its criminalization never should have happened. MDMA had a beneficial therapeutic use prior to scheduling. Hundreds of therapists and psychiatrists used MDMA-assisted psychotherapy with thousands of patients suffering from terminal illness, trauma, marital difficulties, drug addiction, phobias, and other disorders. MDMA was also used outside of therapeutic circles. With many anecdotal claims of benefits, users showed little evidence of problematic physiological or psychological reactions or addiction.

Scheduling and the attendant media attention on the controversial public hearings *created* an expanded market. But the scheduling process was fraught with problems, with the Drug Enforcement Administration's emergency scheduling itself declared illegal by the courts and its scheduling criteria overturned. Ultimately, criminalization had little deterrent effect on the recreational user population while substantially reducing its therapeutic use. Perhaps the most profound effect of MDMA's illegality has been the curtailment of scientific research and experimentation with a drug that held therapeutic potential.

The information to be presented here is taken from a recently completed NIDA-funded study of MDMA conducted by the lead author.^[2] Using a qualitative methodology, this was an exploratory study in which 100 MDMA users were interviewed in depth between 1987 and 1989.^[3] The second author was involved in the scheduling process and had done physiological research on MDMA.

This chapter begins with a short history of MDMA's use and the scheduling process. Ultimately, it presents an argument critical of criminalization.

A SHORT HISTORY OF MDMA USE

Early Therapeutic Use

Although first synthesized by Merck Pharmaceuticals in Germany in 1912, MDMA was almost completely unknown until the mid-1970s. In 1973, the first study in the literature mentioning MDMA was published, based upon toxicological research conducted in the early 1950s by the Army's Chemical Center (Hardman et al., 1973). Around this time, MDMA began to be explored by a small group of therapists and researchers who were part of the human potential movement. MDMA was typically called "Adam," and its use, by individuals interested in self-actualization, was therapeutic. MDMA encouraged the experience of emotions by reducing the fear response to perceived emotional threats. There were no direct observable harmful physical effects. For example, couples who were having marital problems were treated with MDMA-assisted psychotherapy by psychiatrists and psychotherapists who believed that MDMA could facilitate communication. Trauma victims were treated with MDMA-assisted psychotherapy to help them delve into the source of their problems, experience a healing catharsis, and subsequently function more effectively.

In sum, prior to 1982-1983, the major distribution networks had a "mindful" attitude. The handful of chemists who produced MDMA were more concerned with making a meaningful contribution to psychological health than with making money. Roughly 500,000 doses had been consumed between the early 1970s and the early 1980s, with no publicity and little notice taken by drug abuse officials or police. Use grew by word of mouth, with occasional periods of greater supply than demand.

Distribution Changes and Recreational Use

By 1983, with an eye toward enlarging the market, a member of a Los Angeles distribution network coined the term "ecstasy" because, "it would sell better than calling it 'empathy'." "Empathy," he said, "would be more appropriate, but how many people know what it means?" (Eisner, 1989). Simultaneously, a more aggressive marketing campaign took place in Texas. "Ecstasy" was distributed openly in bars and nightclubs in Dallas. There were pyramid sales structures, 800-numbers and credit card purchase options. It became a "phenomenon" among Dallas yuppies, college students, and gays, who would go out "X-ing" on Friday and Saturday nights. Distribution grew and recreational, as opposed to the more therapeutically oriented, use increased dramatically. [4]

Enter the DEA

But there was a war going on—the War on Drugs. In 1982, the DEA's Drug Control Section began collecting information on MDMA. Although there was not much data, as one DEA spokesman said, "If we can get enough evidence to be sure there's potential for abuse, we'll ban it" (Dye, 1982). By 1984, the open sales in Texas resulted in a request from Senator Lloyd Bentsen to the DEA for scheduling, and in July 1984 the DEA filed a formal notice in the Federal Register, announcing its intention to place MDMA in Schedule I.

But just as the DEA had been slowly gathering its forces, so had the MDMA-using therapeutic community. Psychiatrists and therapists from around the country formally requested that the DEA hold a hearing on MDMA's scheduling. This request surprised the DEA, which had no idea that MDMA had any use other than "recreational." The press was immediately interested in this group of respectable professionals, who had emerged from a decade of secret work into the courtrooms of the Drug Enforcement Administration and were ready to engage in the legal defense of the medical use of MDMA. As a publicity avalanche started rolling, several monks and rabbis testified about their beneficial use of MDMA, complicating the DEA's efforts to portray MDMA as a wholly dangerous drug.

While a guest on a *Phil Donahue Show* devoted to the MDMA controversy, a DEA official heard physiological brain researcher Dr. Charles Schuster (now head of the National Institute on Drug Abuse) discussing a study by one of his students, which showed changes in the brains of rats as a result of the injection of large, frequently repeated doses of MDA, a chemical "cousin" of MDMA. The fate of MDMA was sealed with this piece of information. Within a few weeks, the DEA called a press conference to announce that it was placing MDMA in Schedule I on an emergency basis. This action was justified by reference to MDMA's potential brain-damaging effect and its widespread use (that was partially the result of publicity about the original hearing).

THE SCHEDULING PROCESS

In order for a drug to be placed in Schedule I, the Controlled Substances Act of 1970 stated that it must have a high potential for abuse *and* have no accepted medical use *and* no accepted safety for use under medical supervision.^[5] The only legal uses of a Schedule I drug are those that are specifically authorized by the federal authorities for limited medical or scientific purposes.^[6] Schedules II-V are used for drugs that have some accepted medical uses and accepted safety and have potential for abuse ranging from high to medium or low. The appropriate schedule for drugs that have no accepted medical use but only medium or low potential for abuse is extremely unclear.

The DEA Administrative hearing process began in the fall of 1984. DEA Administrative Judge Young planned to hold hearings in three separate cities, with lawyers arguing over scientific data, governmental statistics, and expert witnesses. At issue was whether or not MDMA had: (a) a high potential for abuse, (b) no accepted medical use, and (c) no accepted safety for use under medical supervision.^[7]

Defenders of MDMA's medical use argued that MDMA should be placed into Schedule III, whereby physicians could legally prescribe MDMA. All recreational use would be criminalized, but medical treatment and scientific research could still be conducted. The arguments were based on the rejection of each of the three basic criteria for Schedule I placement. The attorney argued that MDMA did not have a *high* potential for abuse, but rather a medium or low potential. This argument was based on the minimal number of mentions (8) for MDMA in the National Institute on Drug Abuse's Drug Abuse Warning Network (DAWN), particularly in view of the roughly 3,000,000 doses that had been consumed both therapeutically and recreationally by the time of the hearings. Numerous psychiatrists asserted that MDMA did have an acceptable medical use.^[8] The claim that MDMA had accepted safety for use under medical supervision was supported by three studies.^[9] The MDMA attorney also cited the lack of alleged harm to any patient as evidence of the safety of MDMA under medical supervision.

The DEA chief attorney made three basic allegations. He claimed that a drug need not have caused any actual harm before being placed into Schedule I, merely that the drug had to have a high *potential* for abuse. He further argued that only the FDA could accept a drug for medical use, and without FDA approval, no drug could have accepted safety under medical supervision.

In May 1986, after almost two years of hearings, Judge Young issued his final ruling, recommending that MDMA be placed in Schedule III.

He made three basic findings: that MDMA had a low potential for abuse; that it had an accepted medical use; and that there was accepted safety for use under medical supervision. Furthermore, Judge Young ruled that the Controlled Substances Act contained a logical inconsistency and was written in such a way as to preclude drugs, which had no accepted medical use but only medium or low potential for abuse, from being scheduled at all. Despite Judge Young's ruling, the DEA administrator placed MDMA into Schedule I.

WHY MDMA SHOULD NOT HAVE BEEN CRIMINALIZED

There are a number of reasons why MDMA should not have been made illegal. In the following paragraphs we discuss problems with the

scheduling process; the media and its role in the spread of MDMA; the lack of a deterrent effect on users; the loss of research that may have illuminated MDMA's therapeutic benefits; and the continuing lack of evidence that MDMA use is socially and personally problematic.

Problems with the Scheduling Process

The decision to place MDMA in Schedule I was immediately appealed to the U.S. Court of Appeals, First Circuit. In September 1987, after appellate review, the decision of the DEA to place MDMA into Schedule I was found to be flawed. The court sidestepped the logical inconsistency in the Controlled Substances Act, finding that MDMA did have a high potential for abuse. It agreed with the DEA's decision to focus on the word *potential* rather than on the word *high*. However, the court disagreed with the DEA's assumption that Congress intended that FDA approval determine accepted medical use. As a result, the court voided the DEA's placement of MDMA into Schedule I and remanded the decision back to the DEA for reconsideration.

The DEA, after several months of reflection, had placed MDMA into Schedule I once again. Rather than a rationale requiring FDA approval (that had been overturned by a court order), the DEA devised a new rationale. But it was Catch 22. A series of criteria were used that were virtually identical to current FDA approval.^[10] Since only a pharmaceutical company could afford the required studies, for which FDA permission would be impossible to secure, the DEA's new criteria was of dubious legality. Rather than simply requiring FDA approval, the DEA broke down FDA approval into a series of criteria that looked identical to FDA approval, and then required virtually all the criteria.

DEA arguments that "currently accepted medical use" implies FDA approval have been clearly and repeatedly repudiated by the courts. Since essentially the same issues were at stake in the current legal debate over the medical use of marijuana, the defenders of MDMA's medical use, who were drained of both patience and money, decided to lodge no further appeal. They accepted the fact that MDMA would remain in Schedule I until the legal definition of "currently accepted medical use" was resolved in the context of the medical marijuana lawsuit, or until research had satisfied the FDA that MDMA was both safe and efficacious for human use.

The stonewalling of the rescheduling process was an attempt by the DEA to continue to promote the message that all illegal drugs are inherently "bad." Scheduling has effectively eliminated all approved medical uses of Schedule I drugs. The costs of this loss of medical access^[11] may vastly exceed the benefits in reduced drug abuse, if any, that result from the government's continued decision to propagandize the

American people about the unqualified harmfulness of these drugs.^[12] Judge Young himself calls the DEA refusal to accept the medical use of Schedule I drugs disingenuous, arbitrary, and capricious.

MDMA's emergency scheduling itself was found to be illegal in the courts. Congress gave the attorney general the power to criminalize certain drugs through the use of an emergency scheduling process. Yet the attorney general never formally subdelegated those powers to the DEA. Therefore, the DEA had no legal authority to declare the emergency scheduling of any drug. Thus, MDMA was actually legal until the Designer Drug Law of 1986 went into effect.^[13]

In sum, the scheduling process itself was flawed, marred by illegal and inappropriate government actions.

The Media's Role in the Spread of MDMA

The popular media loved MDMA. They loved the name "ecstasy"; they loved its users—a white, affluent contrast to the popular stereotype; they loved the bar scene in which it was distributed in Texas. And they wrote glowing reports about it in nearly every popular publication, including *Newsweek*, *Time*, and the *Washington Post*. This was not the first time the media helped to advertise a "new" drug. In 1972, Edward Brecher detailed the media's role in publicizing glue sniffing in his "How to Launch a Nationwide Drug Menace." (Brecher, 1972). More recently, Reinerman and Levine exposed the media's contribution to spreading the crack epidemic (Reinerman and Levine, 1989).

MDMA received free advertising as a result of media publicity, which was beneficial for those MDMA distributors interested in expanding their markets. News accounts, which were primarily favorable reports (the nickname alone was enough), piqued the interest of casual recreational (as opposed to therapeutic) drug users. Many of these individuals had started using illegal drugs such as marijuana and psychedelics in the 1960s. They had dabbled with cocaine in the late 1970s and early 1980s and continued to use marijuana on occasion. As busy, "conventional," productive individuals, most had long since given up psychedelics as too time-consuming and debilitating. Few were interested in experiencing the lack of control and related difficulties they associated with LSD. But reports of the "ease" and euphoria of "ecstasy" made this drug sound different. And while media reports did not cause this group to rush out and try to find MDMA, if it did appear in their social worlds, they now, because of the publicity, had some familiarity with the drug. As a result of the publicity and the scheduling, recreational interest and use of MDMA among non-therapeutically oriented professionals, students, and yuppies appears to have greatly *increased*. Had it not been for the scheduling controversy that first attracted the media, it is very likely that the use of MDMA would

have followed the earlier diffusion pattern of its first decade (the 1970s), growing slowly by word of mouth.

The Non-Deterrent Effect of Criminalization

Making MDMA illegal did not significantly deter its recreational use. It did increase demand, raise prices, and limit availability. [14] In the study population, most individuals who had started using MDMA after it was scheduled had already had experience with illegal drugs. The younger (under 35) users had discounted government information about drugs as propaganda, not to be taken seriously. The older (over 35) users had been alienated from the conventional view of drugs since the 1960s and saw government decisions about drugs as wholly political. When asked if MDMA's illegality made a difference, one 42-year-old physician said: "That didn't make any difference. My friends were using drugs before—smoking dope certainly. I think that's one way that one selects their friends. You sort of seek out people who, like you, are a little extra-legal."

Most respondents had ceased the use of "heavy" psychedelics such as LSD, but MDMA offered excitement without the "Who am I?" dilemma and other challenges associated with "acid." In general, recreational, post-1985 MDMA users had turned the notion of illegality on its head: "If it's illegal, it's probably good."

End of Research on Therapeutic Benefits

Scheduling did have a deterrent effect on the therapeutic use of MDMA. As a result of its illegality, there have been far fewer "guided" sessions with professional therapists and instrumental use of MDMA. Therapists almost uniformly abandoned their clinical use of MDMA, since their licenses and careers were at stake. These same people were among the most cautious users of MDMA, producing the greatest benefits. Only a few psychiatrists, who reported to us their continued use of MDMA in the psychological treatment of AIDS patients, have chosen to risk their licenses for the benefit of their patients.

Many respondents reported on the therapeutic benefits of MDMA. They had used it to uncover painful childhood memories and experiences that had been repressed; to decrease fear and defensiveness; to increase communication and empathy with one's spouse; to get through traumatic experiences such as rape and incest; to live with the pain of cancer; to resolve oneself to dying.

Formal therapeutic use and human research of MDMA has been deterred by its Schedule I status. This is perhaps the most regrettable

aspect of its illegality, as argued by the therapists during the hearings. Though the FDA claims that its refusal to permit experimentation is based on concern for the health of the volunteers, after more than 11 million doses of MDMA have been taken in the United States, the literature does not contain even one case of an individual suffering neurological symptoms linked to MDMA-related brain damage. In Switzerland, psychiatrists have used MDMA successfully in hundreds of cases. [15] Even the animal data shows that primates receiving doses equivalent to amounts used in psychotherapy show no evidence of any physiological changes. When excessive doses sufficient to cause changes are given to primates or rats, all evidence shows that such changes are temporary and without observable behavioral significance (Battaglia, Yeh, and DeSouza, 1988; Ricaurte, 1988).

MDMA Use as Non-Problematical

MDMA should not have been made illegal because it never was, and continues not to be, a significant social problem. "Ecstasy" use has not surfaced as a significant problem because there are properties of MDMA itself that contain its use. Respondents reported that frequent use of MDMA almost invariably produces a strong dysphoric reaction that is only exacerbated with continued use. Many respondents described how too frequent use resulted in an increasing number of unpleasant aftereffects (i.e., muscular tension, particularly in the jaw, and anxiety), coupled with an almost total loss of desired effects. These effects occurred with greater rapidity than those experienced with other more commonly abused substances such as cocaine. Unlike classic addictive drugs such as opiates, increasing the dose of MDMA after a tolerance has built up will not result in desired effects. Therefore, although some individuals use MDMA frequently at the beginning, they eventually taper their use in order to derive the maximum benefit (Beck et al., 1989).

MDMA's use primarily by middle-class devotees has also limited potential problems. These individuals contain and control their use of all drugs because they have viable life investments (such as jobs, families, homes) to protect (Rosenbaum, 1989). Secondly, they tend to be well informed about MDMA and recognize that overuse greatly diminishes the drug's positive effects. The majority of individuals in this study population used MDMA infrequently, as "time-out" behavior (Rosenbaum et al., 1989).

Manufacturers and distributors of MDMA tend to be white, middle-class men and women, most of whom have legitimate occupations outside their dealing enterprise. Because they are conventional citizens and wish to remain so, the distribution network is extremely closed. These individuals sell MDMA "on the side" and very rarely sell other drugs.

They do not refer to themselves as dealers and, in fact, look down on those who sell drugs such as cocaine and heroin. Unlike successful crack dealers, they do use their own product and have little problem with abuse. Violent enforcement of debts and murderous competition for markets are unknown. Most lower-level distributors sell MDMA as a service to their friends, making little or no money in the process. There is virtually no interest among these distributors to expand in more "traditional" drug circles to build a business. This helps explain the absence of MDMA in the inner cities.

MDMA's absence in the inner cities may be considered by some to be a sign of the success of the criminalization of MDMA. Pharmacological reasons are more likely to explain this absence, since legal status has nothing to do with a drug's popularity among the "underclass." MDMA is a drug that promotes self-reflection, can only be used enjoyably every few weeks, and is unpleasant to overuse. It is not likely to be attractive to classes of individuals whose life options are so limited that they feel they need to use anesthetizing drugs on a daily basis.

CONCLUSIONS

This chapter has attempted to show that criminalization of MDMA was unjustified. The scheduling process itself had numerous problems and was of dubious legality. We concur with the administrative law judge's concerns about the DEA's and FDA's interpretations of scheduling criteria as applied to MDMA. We also agree with the judge's broader critique of the denial of medical use and research with Schedule I drugs.

These considerations, together with the problems that can result from the criminalization of any drug, lead the writers to conclude that the DEA acted counterproductively in scheduling MDMA. It should have spent more time gathering information before making a reactive, largely blind decision. Given its problematic implications, the scheduling of substances should be viewed as a last resort to be implemented only after determining that, (1) there are real problems associated with a drug, (2) these problems can be remedied by legislation, and (3) legislation will not impede the development of a drug's potential benefits.

NOTES

1. Structurally similar to both mescaline and amphetamine, MDMA produces a mild psychedelic affect and is almost always taken orally, with effects lasting from four to six hours. An average dose (100-

150 mgs.) costs from \$10 to \$25. MDMA typically produces a very euphoric effect, often leading users to feel both optimistic and relaxed. While experiencing the effects of MDMA, communication between individuals can be enhanced, with counterproductive ego defenses lessened. [\(back\)](#)

2. NIDA Grant No. R01 DA 04408, "Exploring Ecstasy: A Descriptive Study of MDMA Users," Marsha Rosenbaum, Principal Investigator; Patricia Morgan, Co-Principal Investigator; Jerome Beck, Project Director; Beatrice Rouse, NIDA Project Officer. [\(back\)](#)
3. Project staff also did ethnographic fieldwork, traveling to Dallas, Bali, Grateful Dead concerts, and accompanying users during their MDMA experiences. Members of MDMA distribution networks were also interviewed in an effort to trace trends in production and sales of the drug. [\(back\)](#)
4. MDMA's recreational use further increased after several cocaine dealers had MDMA experiences, which convinced them to abandon cocaine and its attendant harms and turn their attentions instead toward distributing MDMA. [\(back\)](#)
5. For a detailed discussion of the scheduling process, see Beck and Rosenbaum, 1990. [\(back\)](#)
6. In the United States, both the DEA and the FDA regulate all scientific and medical use involving human subjects. The DEA regulates the researchers and the FDA regulates research protocols. No federal scientific review is required for nonhuman studies, although researchers must have DEA approval before it is legal to be in possession of a Schedule I drug. [\(back\)](#)
7. Judge Young's ruling would not be final, however, but would be merely a recommendation to John Lawn, the Administrator of the DEA. The actual scheduling recommendation of John Lawn would not necessarily be final either, but could be appealed in the Federal Court of Appeals. Nor was United States scheduling completely an independent decision. The United States was a signatory to the International Convention on Psychotropic and Narcotic Drugs, administered by the World Health Organization, and was bound to place internationally scheduled drugs into domestic schedules at least as restrictive as the Convention's. In May,

1985, an Expert Committee on Drug Dependence for the International Convention was scheduled to issue a ruling on MDMA and a large number of other similar substances for possible inclusion in the treaty. [\(back\)](#)

8. Among those testifying were Dr. Morris Lipton, a psychiatrist and associate editor of the *American Journal of Psychiatry*; Dr. Robert Lynch, the chief statewide psychiatric consultant for two cabinet departments in California; Dr. Lester Grinspoon of Harvard Medical School. [\(back\)](#)
9. Dr. George Greer cited a study he conducted with 29 of these patients; Dr. Jack Downing cited a study in which 21 healthy volunteers were extensively monitored before, during and one day after an MDMA experience. Also cited were animal toxicity studies conducted by Dr. Charles Frith of Toxicology Pathology Associates. [\(back\)](#)
10. This includes multiyear double-blind placebo studies and multimillions of dollars of animal toxicity studies. [\(back\)](#)
11. Legal, medical research in Switzerland suggests that MDMA has a beneficial role in the treatment of reactive depression, addictive disorders, phobias, obsessive-compulsion, and anorexia. U.S. patients with these disorders number in the millions. As for marijuana, almost 100,000 U.S. citizens were treated with THC for nausea associated with cancer chemotherapy last year, even though all studies comparing THC and marijuana find marijuana more effective while producing fewer side effects. [\(back\)](#)
12. Dr. David Blum, brain specialist at the UCLA Neurophysiology Clinic, as well as other physicians, criticized the television ad of the Partnership for a Drug-Free America, which purported to contrast the EEG of a person on marijuana with that of a "normal" person. Blum pointed out that the 1982 National Academy of Sciences report found that marijuana had no marked effects on EEG and that the EEG in the ad was from a person either asleep or in a coma. [\(back\)](#)
13. At that time, several people who had been arrested for MDMA as a result of the 1985 emergency scheduling had their cases dropped. [\(back\)](#)

14. While the scheduling frightened some of the original distributors, who then curtailed business, other producers increased their output. They hoped to take advantage of the expanded profit potential caused by (1) the increased demand caused by the media blitz, and (2) the increased price caused by scheduling. Average price per dose went from about \$10 to about \$15, while consumption rose from about 200,000 to about 400,000 doses per month. [\(back\)](#)
15. Personal communication, Dr. Jorg Roth, Research Director, Swiss Association of Physicians for Psycholytic Therapy. [\(back\)](#)

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