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The Role of MDMA (Ecstasy) in Coping with Negative Life Situations Among Urban Young Adults

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Abstract

This article examines the role of Ecstasy (MDMA or 3, 4-methylenedioxymethamphetamine) as a drug used for self-medication and coping with both short- and long-term negative life situations. We show that urban youth who do not have a specific diagnosed mental illness are more likely than those who have been diagnosed and have received treatment to use Ecstasy to cope with both situational stress and lifetime trauma. Diagnosed and treated youth sometimes self-medicate with other drugs, but do not choose Ecstasy for mediation of their psychological stress. We discuss the implications of self-medication with Ecstasy for mental health services to urban youth experiencing mental health disparities, and for the continued testing and prescription of MDMA for therapeutic use in controlled clinical settings.

Keywords

coping; Ecstasy; MDMA; mental health; self medication

Many young urban adults in neighborhoods characterized by cumulative disadvantage and structural violence are exposed to at least one major form of trauma during their lives and research shows that exposure to trauma is associated with persistent psychological disorders (Mazza & Reynolds 1998; Berman et al. 1996). Social stigma, institutional racism and other forms of systemic and individual discrimination continue to affect urban youth, particularly males (Pascoe & Richman 2009; Aten, Siegel & Roghamnn 1996) and further fuel patterns of violence, imprisonment, and exploitation (Fazel, Xenitidis & Powell 2008). Exposure to stress and trauma in low-income urban communities is exacerbated by limited availability of mental healthcare services to address the specific needs of impoverished communities (Brown et al. 2000). Even with better access to mental health services, the existing delivery system is not organized to address the broader structural factors that cause stress, depression, anxiety and trauma in the lives of these young people. Thus, many urban youth are left to address the consequences of trauma on their own.

In communities where alcohol and illegal or illegally diverted prescription drugs are readily available, young people coping with trauma and other forms of hardship may find substance use to be an effective temporary or more permanent solution to mediate or dull

psychological pain and unresolved emotions and conflict resulting from past or persistent experiences. An extensive literature review suggests that individuals with both diagnosed and undiagnosed mental health problems may use alcohol and other drugs as a means of dulling or numbing psycho-emotional pain (Bizzarri et al. 2009; Bolton, Robinson & Sareen 2009; Robinson et al. 2009; Suh et al. 2008; Tomlinson et al. 2006; Carrigan & Randall 2003), particularly where other treatments are perceived to be ineffective or inaccessible (Khantzian 2003, 1985).

In this article, we use data from a larger study of MDMA and sexual risk taking to explore the use of MDMA (3, 4-methylenedioxymethamphetamine or Ecstasy) for self-medication of stressful life situations, including family and partner conflicts and/or histories of violence or abuse in an ethnically diverse group of Ecstasy-using urban young adults. We compare the influence of past and current treatment histories on the use of Ecstasy for self-medication in both diagnosed and treated and undiagnosed individuals in our analysis. The implications for improving access and quality of mental health services for urban youth experiencing mental health disparities and the potential of MDMA for use in controlled therapeutic settings to address emotional traumas, relational problems and enduring intrapsychic conflict among young adults are discussed.

HISTORY OF TREATMENT USING MDMA (ECSTASY)

MDMA was first patented in Germany by the Merck Company in 1914 as an experimental compound (Shulgin 1990). It was later rediscovered by the psychedelic therapy community in the 1970s when psychiatrists and therapists began utilizing it as an adjunct to psychotherapy (Cohen 1998; Saunders 1995). During the 1980s, MDMA was widely used to facilitate the therapeutic process in individual, group and couples settings (Greer & Tolbert 1986). Both therapists and clients noted that experiences of the drug were characterized by physiological effects such as heightened arousal and psychological effects including increased introspection and openness to new ideas, enhanced capacity for communication and intimacy with others, and inhibition of negative emotions including fear, anxiety and depression (Sessa 2007; Bayen & Rosenberg 2006; Winstock, Wolff & Ramsey 2001; Davison & Parrott 1997; Cohen 1995). Patients receiving treatments with MDMA also reported an increased ability to negotiate certain thoughts and emotions, moving toward or away from thoughts and memories ordinarily experienced as disturbing or unpleasant (Doblin 2002). An overwhelming majority of subjects reported an overall positive effect from the drug, as well as problem resolution in many cases (Sessa 2007). It is estimated that between 1977 and 1985, half a million doses were distributed to patients suffering from trauma, depression and other psychological conditions (Sindicich, Degenhardt & Hall 2010; Climko et al. 1986).

As the therapeutic use of MDMA spread, the drug began to be produced under the trade name "Ecstasy." Ecstasy had high currency in the electronic dance scene, and was marketed and sold to ravers for recreational use in bars, clubs and raves in Europe and later in the U.S. throughout the 1980s (McDowell & Kleber 1994). By 1985 it had been classified by the Drug Enforcement Agency (DEA) as a Schedule 1 drug. Scheduling prohibited the manufacture and distribution of Ecstasy and severely limited its use in research and medicine (Peroutka 1990). However, supporters of the drug claimed that the healing potential of Ecstasy should not be lost to the therapeutic community (Cohen 1998).

Despite scheduling, Ecstasy use among young users increased substantially over the period of 1999–2002 (Olsen 2009; Boyd, McCabe & d'Arcy 2003; Morgan 2000) as the rave scene spread globally and within the U.S. (Boys, Lenton & Norcross 1997; Franck & Bertrand 1997; Kua 1997; Lenton, Boys & Norcross 1997). Furthermore, Ecstasy use began to spread

to settings and demographics outside of the club/rave scene (DEA 2010), including its reach to college students and urban youth living in low-income neighborhoods (Olsen 2009; Gfroerer, Larson & Colliver 2007; Schensul et al. 2005; Diamond, Bermudez & Schensul 2006; Eiserman, Diamond & Schensul 2005; Boeri, Sterk & Elifson 2004; Hansen, Maycock & Lower 2001). From 2002 to 2004 recorded use of Ecstasy among high school students slowed precipitously in response to national campaigns designed to increase perceptions of the dangers associated with use. After 2005, however, perceptions of harm associated with Ecstasy use began to decline, and evidence suggests that street availability and the appeal of Ecstasy persisted (Wu, Liu & Fan 2010; Degenhardt & Hall 2010). Recent reports suggest that Ecstasy use is once again rising (Johnston 2010). A report issued in 2011 from the Center for Substance Abuse Research (CESAR 2011) estimated an 83% increase in users from 2004. The same report shows that the number of Ecstasy-related emergency room visits since 2007 nearly doubled (CESAR 2011).

While some researchers suggest that Ecstasy is most often used for pleasure-seeking, intoxication and to increase sociability (Hunt, Moloney & Evans 2009; Wish et al. 2006; Levy et al. 2005; Liechti Gamma & Vollenweider 2001; Davison & Parrott 1997), others suggest that for a subset of users, Ecstasy is taken for the purpose of coping and self-medication (Klee & Reid 1998). Singer and colleagues (2004) found that urban young adults who used MDMA reported experiencing more psychological distress in conjunction with social, familial, and childhood trauma as well as more peer-related problems than a similar group of nonusers. Further, individuals with a history of childhood and adolescent mental health disorders show an increased tendency to use Ecstasy (Huizink et al. 2006; King et al. 2004; Lieb et al. 2002). Jansen (1999) found dependency to be linked with self-medication for post-traumatic stress disorder (PTSD) in a sample of Ecstasy users. Data derived from our study of Ecstasy use and sexual risk provide the basis for improving the understanding of the circumstances under which Ecstasy is used as a means of self-medication to cope with trauma and life stresses and the implications for expanding the therapeutic use of Ecstasy to facilitate counseling therapy in clinical settings.

METHODS

Data for this article were drawn from a study funded by the National Institute for Drug Abuse (NIDA)¹ examining the contribution of MDMA to unprotected sex and exposure to STIs and HIV/AIDS in a population in which rates of HIV among adults are the highest in the state and rates for STIs (gonorrhea and chlamydia) are highest among youth 15 to 29 (Connecticut Department of Public Health 2011). The study was conducted in Hartford, Connecticut—an impoverished city and the state capital of Connecticut, one of the wealthier states in the U.S. The city has a lively night life with larger clubs concentrated in the downtown area that attract young people from the southern and central parts of the city and many surrounding towns, as well as smaller bars and restaurants throughout the city that tend to serve local youth and families. Though the city is ringed with wealthier communities, Hartford's neighborhoods continue to struggle with many years of economic recession as a result of the disintegration of the agricultural and manufacturing industries and the decline of the insurance and banking sector in the area. Despite various efforts to improve public schools in Hartford, both the quality of primary education and access to higher education remain relatively low, making it difficult for many youth to compete in the primary sources of employment in the city, which are in the finance, business, insurance and health care sectors.

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Opportunities for pursuing positive social and recreational activities are likewise limited by a few public gathering places attractive to youth (e.g. parks, malls, movie theatres, community centers). In addition to these structural constraints, many young people, especially African-American and Latino youth, experience perceived and actual discrimination (especially in downtown clubs) and are exposed to intermittent violence in their neighborhoods. With limited incomes and economic opportunities, many young adults do not have private insurance and thus have difficulty accessing both primary care and behavioral health resources. Youth find it difficult to relieve the stresses associated with urban life either through an active social life or through professional counseling services, both of which are limited in the greater Hartford environment.

Members of the study field team included a diverse group of young researchers with social science or social work backgrounds who had grown up, worked and socialized in Hartford and were very familiar with both the club/bar scene and the neighborhoods. During an 18-month period from June 2008 to December 2009, they recruited the study target of approximately 120 Ecstasy-using sexually active youth who met the eligibility criteria for participation in the study. Participants were eligible for inclusion if they were aged 18 to 35, had used Ecstasy within the last four months and resided in Hartford or the towns immediately surrounding the city. To recruit the study sample, the research team used face-to-face methods including direct street recruitment at bus stops and other locations where youth collected, in addition to focus groups and presentations in colleges and other community settings. They also placed well-designed recruitment fliers in locations that were popular among young people of diverse backgrounds, including clubs, bars, parks, malls, shopping centers and small shops on main streets of the city. Some participants also were recruited through chain referral.

Interested participants called the field team to schedule an appointment and were screened for eligibility on the phone. Participants who met the eligibility criteria were scheduled for an interview and were screened again prior to the interview. If confirmed as eligible, they signed a consent form and participated in a two-part (A and B) interview conducted over the course of one to two weeks. Participants received an incentive of \$30 for their time for each A and B interview, totaling \$60. A semistructured interview schedule was developed for both parts of the interview. One hundred eighteen participants completed the Part A interview including demographic and historical information, gender roles and relationship dynamics, drug use career, history and current use of Ecstasy, beliefs about the effects of use and reasons for use, beliefs about sexuality and condoms, and peer and partner drug use and sex. Interviews were transcribed verbatim by a transcription service and replayed and checked for accuracy. Coding in Atlas ti 5.6, a qualitative data analysis software program, was based on the requirements of specific study topics. The study was approved by the Institutional Review Board of the Institute for Community Research. Part A interviews provided the data for the current article.

During our coding we noted that though all respondents used Ecstasy on one or more occasion to enhance their sexual experience, some described other reasons for using the drug related to psychological stress or emotional pain. This led us to question whether and how Ecstasy might be used to self-medicate. After reviewing all of the 118 interviews, we found that 45 participants had experienced and coped with one or more serious negative life situation in their lifetime. Thirty-six of them had used Ecstasy for coping purposes. Ecstasy-based coping behaviors were identified on the basis of participants' own explicit statements about coping such as "the main reason I use it [Ecstasy] is to deal with the stress ... when I was little I got raped" rather than on researchers' observations or clinical inference. Nine participants used Ecstasy for pleasure but not for coping. The interviews with these 45 participants are the basis for the current analysis. The other 73 participants did not report

experiencing serious trauma, psychological stress or depression (negative life situations) during their lives and were using Ecstasy for noncoping reasons (fun, better sex, relaxing with friends, going to clubs).

Analysis

Using Atlas Ti (Scientific Software, Version 5.0), the 45 interviews were organized into document families or groupings, based on whether or not participants reported a current or previous mental health diagnosis, and their reasons for using Ecstasy. Codes were organized into code families or classes that included four types of negative life situations, including:

- Abuse: reported past or current maltreatment by another individual, including sexual abuse (rape, sexual assault, sexual molestation); physical abuse (injury, physical suffering, bodily harm); and emotional abuse (threats, fear, intimidation).
- Negative Relationship: Conflicts (excluding abuse) in relationships with intimate partners, family members and/or friends.
- One-Time Loss: Loss of a family member, friend or partner due to death or institutional intervention.
- Lifestyle Stressors: Problems related to everyday socioeconomic concerns, including household finances, childcare, family and employment issues.

First we examined all interviews for instances and types of negative life situations and compared them across treated versus untreated participants, and diagnosed versus undiagnosed cases. Then we extracted those cases where respondents specifically reported Ecstasy use as a coping strategy and compared them to cases where respondents reported other coping strategies, including several instances in which they reported using other drugs, but not Ecstasy.

RESULTS

Of the 45 participants who were the focus of this article, 58% were women and 42% were men ranging in age from 18 to 36 with an average age of 24.7 years. Seventeen self-identified as Hispanic or Puerto Rican (37.8%), 14 self-identified as Caucasian (31.1%), ten self-identified as African-American or Black (22.2%), and four as other race (8.9%). The majority of these participants (77.8%) described themselves as heterosexual, nine (20%) identified as bisexual, one identified as gay and one as lesbian. More than half (68.9%) of these participants were in a relationship that had some duration over time. Demographics of this sample were similar to that of the larger study population in terms of age range, though the sample of 45 for this article included a slightly higher percentage of Caucasians (31% vs. 21%), a slightly lower percentage of African Americans (22% vs. 29%), and a slightly higher percentage of individuals who identified as bisexual than did the larger study sample (20% vs. 13%).

Among those who reported experiencing negative life events, we identified two main groups. Group A (N = 36) included those who were never diagnosed with a mental health problem or who had been diagnosed but were dissatisfied with their treatment and did not pursue it, and at the time of the interview were using illicit drug to cope. Of these 36 participants, 29 had never sought or received a specific mental health diagnosis. Seven reported that they had received a mental health diagnosis in the past, for which they had received no treatment or unsatisfactory treatment, and they were not in treatment at the time of the interview. Group B (N = 9) included those who had been diagnosed, treated and improved, or were still in treatment.

All members of Group A used Ecstasy and/or other drugs to cope with a negative life situation. The majority of Group A members (31) were using Ecstasy (rather than other drugs) to cope with their negative life situation; of these, 26 used only Ecstasy and five used Ecstasy plus other drugs to cope. The remaining five participants in Group A reported using marijuana and/or heroin for coping purposes, and Ecstasy only for pleasure. On the other hand, none of the members of Group B were using illicit drugs to cope with their negative life situation although all of them used Ecstasy for pleasure. In terms of amount of use, there was no significant difference between the two primary groups except for a small number of daily users in Group A and none in Group B. Most participants in Group A had negative feelings about their Ecstasy use; in contrast, half had positive or neutral feelings about their use in Group B. Only 25% of Group A members felt that they were in control of their use as compared to 75% of Group B. Only four participants in the entire group of 45—all members of Group A—expressed a desire to quit use of Ecstasy altogether.

All of the 45 participants in our sample reported at least one and many reported two or three negative life situations at the time of the interview. Twenty-five reported coping with only one situation (five with abuse, ten with relationship problems, three with loss and seven with a current lifestyle situation). The remainder of the participants, with one exception², were coping with the intersection of two negative life situations. There was only one significant difference in negative life events between those who had been and those who had never been diagnosed and treated: a much higher percentage of respondents who had experienced early and severe abuse were in the diagnosed and treated group (89% versus 20% respectively). Below, we describe in greater detail the negative life situations experienced by those untreated or ineffectively treated in the past, along with their reasons for using illicit drugs and Ecstasy in particular to cope with those situations³.

An examination of reasons for initiation to Ecstasy use shows that for the most part, youth did not start their use of Ecstasy because of their desire to reduce emotional stresses, or to numb pain. They began to use MDMA because they were with friends or partners who were using it or introduced them to it. However a small number of participants (four) began their use of Ecstasy specifically to cope with depression, sad feelings or stress. One said that she took Ecstasy because she was feeling depressed and a friend told her it would help her feel better; a second took it because she felt stressed; the third took Ecstasy in order to “numb” himself after his mother died; and a fourth first used Ecstasy to deal with negative emotions associated with his ex girlfriend. The remainder, the vast majority of coping users, reported that they themselves discovered the self-medicating effects of Ecstasy over time as they continued to use it for other purposes.

Abuse

A total of seven participants reported coping with either physical, sexual, emotional or a combination of two or three forms of abuse in the past by using illicit drugs including Ecstasy. Abusive situations involved hitting, beating, threatening, false accusations, and forced sex or rape, sometimes continuing over a long period of time. For each, the first instance of abuse happened either during childhood or in the early adolescent years, but two participants reported additional instances of rape that occurred in later adolescence. The quotes below reflect different forms of abuse including sexual abuse.

... I'm 24 right now and I still don't understand. Because I've been molested, I've been raped, I've been ... I had to abort after a rape, I've been touched by ... my

²The exception was a single individual coping with a current and relationship problem, plus a history of abuse.

³In quotes below “E” represents the ethnographer and “P” the participant

own dad. [He] raped me, [his] own child and ... I had to have been 10 years old (InD 070: 24-year-old Puerto Rican female)

E: ... what was the main reason for you using it?

P: Well the stress with my mom and stuff and when I was little, I got raped so, like, like when I took the pills, I would forget about the rape or, I mean, I get a lot of, like, night terrors, so if I took a pill like before bed or something or if I was rolling that day, I wouldn't, I will sleep blank, like, I wouldn't get any [night terrors] ... (InD 102: 21-year-old Hispanic male)

The following quote illustrates examples of physical and psychological abuse:

P: It's like, maybe that's why I do drugs to forget about it.

E: Was it just physical, was it physical violence? Were there other forms of violence?

P: No just physical, kind of mental, names and saying you ain't shit and shit like that but that's about it.

E: So when you take an E [Ecstasy], does that take away ...

P: Yeah I don't remember about nothing. (InD 008: 24-year-old Hispanic male)

Another respondent said:

P: No, there were a lot of things. Lot of family issues. Just like emotional abuse like. But I'm out here now so it doesn't make a difference.

E: Do you think drugs helped you deal with that?

P: Yeah, yeah. (InD 002: 19-year-old Caucasian female)

These and other accounts of abuse remain vivid in the memories of participants. Even when they occurred in the past, many experiences of abuse were described as if they were ongoing, suggesting that they produced enduring trauma. Most respondents report being abused by family members or family friends, and thus found it difficult not only to escape from abusive environments but also to report or to talk about their experiences with other family members, like parents or siblings. Many respondents recounted living in constant fear of abuse because of their inability to avoid continuing interaction with the abusive household member, and the inability of others in the household to protect them from it. Participants reported that Ecstasy was effective in alleviating fear and anxiety, as well as helping them to temporarily forget instances of abuse.

Negative Relationships

Eighteen participants reported using drugs to cope with negative relationships with their primary romantic partners or their family members. Of these, 16 used Ecstasy for this purpose; the other two used marijuana. Here we focus on the 16 participants who were using Ecstasy to cope with serious relational problems with partners, former partners, parents of their young children, or parents or other family members. Problems involved recent arguments and conflicts with partners, separations due to infidelity, conflicts over parenting responsibilities and disagreements with parents. More than half of this group reported coping with another current problem related to loss or lifestyle. Seven participants reported using Ecstasy to deal with the continuing pain and distress associated with past relationships. Others mentioned that ongoing relationship problems resulted in day-to-day stresses that Ecstasy helped to alleviate. For example, one participant described how she felt when her much older husband refused to allow her to leave the house. She described how this caused her to feel depressed and to turn to Ecstasy to relieve her depression.

P: Everything is so and so with relationship because the problem is that he is 20 years older than me and I am stuck in the house, he don't let me go out of the house. That's why I just sit in the house and smoke because I don't get to out of the house; I don't do anything. But we get along good, we don't be fighting he don't be hitting me.

E: How do feel about not being able to leave the house?

P: It gets me stressed and depressed.

E: What are some of the things that happen when you get like that?

P: I take an e-pill [Ecstasy].

E: Why do you take the e-pill [Ecstasy]

P: I am a depression person and I have anxiety and I just can't take my medication because it won't help, I have to smoke and take Ecstasy to take the depression away; if I don't I could kill myself or kill somebody else. (InD 003: 27-year-old Puerto Rican female)

Her feelings of stress and/or depression acted as triggers of Ecstasy use as a means to find temporary relief for depression, hopelessness and potential suicidality.

Fights with partners or family members were also described as events that triggered use. One respondent reported that:

Stuff with my boyfriend's been kind of wacky so every time I get depressed or my mom and I fight or my family and I fight, it triggers me to go out and get Ecstasy and use. (InD 044: 34-year-old other race/ethnicity female)

Emotional pain, anger and feelings of betrayal associated with a former partner's cheating behavior were a further reason for Ecstasy use. The following describes how one woman made the decision to use Ecstasy to numb the pain of her boyfriend's infidelity and to forget difficulties in her life, including disagreements with her mother:

But when I'm on the E, I could care less what happens around me. You can hurt yourself, and I'd be like that's your problem. Or, um, let's see, let's pick one good. Okay. My ex. I caught him cheating on me. It didn't hurt. I was on E. I couldn't feel nothing. I was numb. Everything was gone ... Once I popped the E, it's like, it doesn't even bother no more. It shuts that part of my brain where I'm like okay. What did just happen? Well, that's happened. Oh, yeah, this happened. Okay ... Once I'm off of it, I'll get into it. I'll fall emotional. I'll fall ... I just find E as a solution of not feeling my pain no more. I feel like nothing ever happened, like me and my mom could be just finished arguing, I'll go home, take one, sit down. I'll forget even that I argued with her. (InD 24-year-old Hispanic female)

Two participants mentioned using Ecstasy as a way to improve their negative partner relationships. One mentioned, for example, that it helped her to communicate better with her partner:

We can sit there and we can have a talk and it's like we don't get mad. We can say how we actually feel because normally I'll be like I don't like that you do this. And he'll be like well, deal with it. That time I'll be like yeah, I understand. And like a couple of times, we worked out our problems. We were having big problems, and we worked it out on it [Ecstasy]. It was kind of weird. I don't know but, um, it definitely helped communicate (InD 036: 18-year-old Caucasian female)

The second described why he gives his girlfriend Ecstasy:

My girl has a lot of issues, like depression issues, just the way her life ... I wish I could snap my fingers and change things for her because she wants to be so outgoing and so positive, in the situation that we live in she is forced not be. She kind of like the backbone of the family, when you meet her you will be like ... she is tiny and small, but she is like the head of the household, everybody comes to her house with problems, everybody comes to her to ask for things; so many people depend on her without us having anything. And its like draining her completely, she doesn't eat, she doesn't get out of bed for days or weeks sometimes, she doesn't shower, I have to literally get her up and put her in the shower. But she will pop a pill and she will be like this total bright side to it; like she is happy. So sometimes I see her all pissed and I will give her a pill. (InD 005: 29-year-old Hispanic male)

This participant gauged the mood of his partner as a way to know when it is appropriate to give her a pill. He stated that Ecstasy brought out a positive dimension to his partner that was often hidden because of the past and present difficulties she faced in her life.

Loss

In our sample, loss of a loved family member or friend was not uncommon. Eight participants used illicit drugs, one used heroin, two mentioned "drugs" in general (inclusive of Ecstasy) and five explicitly mentioned the use of Ecstasy to help them cope with the loss of a loved one. Three were coping with the loss of a child (two with death and one with lost custody); two with the loss of a parent; one with the loss of a grandparent; one with the loss of a close friend; and one because her mother went to jail. These losses were both long-term and recent, and resulted in both the initiation and increase in the use of Ecstasy. One participant stated:

Yeah that's when I started doing, like, Ecstasy real hard 'cause I still was doing it before, you know, before that but then when I went out of Quirk Middle School, that's when I started doing it real hard 'cause my mother had went to jail and, you know, it was real hard for me. (InD 100: 25-year-old Hispanic female)

Another participant explained:

... been doing Ecstasy for I'd say a year and six months. When my mother died was when I first started using ... She died of breast cancer. That's all I really know about it. My father got married again and she died of leukemia, which is crazy ... Actually it is a year and six months that she passed ... So I numbed myself by taking E. (InD 043: 28-year-old other race/ethnicity male)

Another participant said she started to use Ecstasy more regularly after her father died some years ago:

Well, because after my dad died I used it a lot, you know, pretty much for depression, when I get depressed just to get my ... clear my head and stuff. (InD 044: 34-year-old other race/ethnicity female)

Although the loss may trigger Ecstasy use, individuals often continue to use Ecstasy long after the loss of the loved one and to attribute their use to the pain of their loss. One participant who experienced multiple negative life events, when asked why she used Ecstasy responded by saying:

... Pain. Things you go through. Things that repeat in your head ... Things you went through life. My beatings. My losing kids. My burying six children in Bloomfield Cemetery (InD 009: 24-year-old Hispanic female)

This participant was using Ecstasy to cope with not only past abuse, but also with the death of her children. Participants such as those who used Ecstasy to cope with loss described its effects as “numbing” feelings of pain associated with their loss. Ecstasy reportedly helped these participants to deal with their losses directly after, and/or to alleviate negative feelings associated with past loss or the ongoing absence of loved ones in their lives.

Current Lifestyle Situation

Of the 36 participants using Ecstasy and/or other drugs for coping, half (18) reported using Ecstasy to cope with a current situation stemming from their efforts to manage, define or refine their lifestyle. Their situations were complex and reflect a wide range of stresses and pressures in their lives, including challenges in finding stable housing, problems with child care, difficulties obtaining and maintaining employment, stress associated with a job, and/or generalized dissatisfaction with their current life situation. Participants described using Ecstasy to reduce anxiety and to escape from stress. One participant said:

It's just to feel good. To, uh, have all your worries put aside. When you're on Ecstasy, you really don't think about money, you don't think about, oh how am I, you know, get a job, how am I going to go to work tomorrow. It's, I'm so good for right now and that's how life is going to be, right now. You don't really have any worries, you just, you just get high off of it. (InD 099: 19-year-old Caucasian female)

Another participant described how Ecstasy made her feel differently:

I'm always thinking about something ... my shut off notice, if it ain't my thing, if it ain't my job, if it ain't God where's my like the daycare thing and it comes through like you know I've gotta a lot um like um depression ... And I got a lot of things with my husband too, ... my twins it's hard, ... it's just I've been through too much ... I just feel like I need that to like, I feel good when I'm, when I'm there but I feel like I don't worry. I feel like I can just lay back and say you know this is life, hug my kids, my husband and be happy. It makes me feel good you know what I'm saying. (InD 032: 28-year-old Puerto Rican female)

Other respondents reported using Ecstasy as a “mood enhancer” in order to shift a negative mood into positive or happy mood and to improving their sense of connectedness with others. One participant described it in this way:

P: I wanted to feel happy, like, I wanted to feel love with everybody and happy.

E: Yeah, and did [Ecstasy] do that for you?

P: Yeah. Yeah, it did that. (InD 102: 21-year-old Hispanic male)

Nearly half of these participants said that unresolved past troubles and painful experiences continued to interact with their current situations, making it difficult to focus on effective approaches to dealing with day-to-day struggles of child rearing and household management. These individuals experienced Ecstasy as a helpful release, reducing tension and anxiety, helping them to forget about their problems, enhance relationships and find ways to relax. As everyday pressures mounted, Ecstasy helped to reduce stress, mediate communication and help to cope with the many ongoing challenges of survival in a resource-limited environment. These respondents' experiences are consistent with research on the physiological and psychological effects of MDMA, which include feelings of euphoria, elevated self-confidence, heightened sensory awareness or arousal, feelings of intimacy and closeness to others, openness to new ideas, and increased depth of emotion (Baylen & Rosenberg 2006; Liechti et al. 2000; Vollenweider et al. 1998; Davison & Parrott 1997; Cohen 1995).

Diagnosed and Treated

Nine participants in the sample were diagnosed formally with a mental health problem and had either undergone treatment or were in treatment. At the time of the interview they were not using illicit drugs to cope with a negative life situation. Five of the nine respondents (56%) were Caucasian, two were Hispanic, one identified as “other race” and another was African America. Their diagnoses included: bipolar disease, depression/anxiety severe anger problems, schizophrenia, PTSD, ADHD and various combinations of these diagnoses. Almost all of these respondents (eight) reported that they were dealing with the consequences of past abuse; and four mentioned other problems of which two were relational and the other two had to do with the loss of a loved one. The ninth participant was also facing a relational problem. All three participants who reported relationship problems were dealing with very difficult family situations. One participant recounted his experience of abuse:

I remember one time he beat me ...he beat me till I had welts on, all over me, my butt, my back, it was like little red welts all over me ... Yes, fist, his palm he used and I'm a little kid and he's a strong man and uh especially when he was drunk, it was even worse and if my mother said anything wrong cuz they used to argue a lot but he would beat her in front of me and I, that was probably one of the worst parts of my childhood. (InD 072: 27-year-old White male)

This participant was diagnosed with manic depressive disorder and PTSD. He described seeing a psychiatrist while he was on military base. At the time of his interview for the study, he was trying to identify a psychiatrist and seek treatment.

Another participant described her experience with loss and how she dealt with it through professional help:

P: So he [her father] ended up with lung cancer. So that, he was real sick and I was the one who always took care of him ... That was hard. And then when he died, I was the only one taking care of him ... It affected me a lot. It was hard for me. Very, very hard for me.

E: Have you ever been in any type of counseling

P: Yeah, I've seen counselors ... (InD 052: 34-year-old Hispanic female)

The same participant continued to describe her mental health diagnoses, which emerged after the loss of her father.

I went into depression and I've been treated for that before. I've been treated for ... I'm bipolar, so I've been treated for a lot of disorders.

At the time of the interview this participant was currently taking medication for her disorders and was working. She stated “I've been on these [medications] for six months, and I've been doing really good.”

Seven of the nine participants mentioned taking medication at some point after their diagnosis. Two were still taking medication at the time of the interview and reported that the medication was beneficial. Others reported receiving effective mental health treatment. Of the nine diagnosed participants, six had received professional help from either a counselor or a psychiatrist, two participants received drug treatment and one was admitted to an institute for anxiety and depression. Avenues for diagnosis varied and included diagnosis in the military, diagnosis in prison, hospital admittance for psychological symptoms or attempted suicide or referral to the juvenile justice or child welfare services. Unlike those in the untreated or poorly-treated group, these respondents were currently using prescribed

medication or considered themselves recovered, and none was using Ecstasy or any other drug to cope with their past or present negative life situations.

DISCUSSION

A number of researchers write about MDMA use in urban areas. A majority of their research focuses on sexual and drug risk behaviors on the one hand, or the search for enjoyment and pleasure on the other. In a seminal paper, Hunt discusses what he considers to be the epidemiologic/cultural studies split in research on club drugs and youth culture, noting that epidemiologic studies focus too heavily on risk while avoiding or ignoring the pleasures associated with club attendance and so-called club drugs. Cultural studies on the other hand favor understanding drug use in the context of the quest of postmodern youth for identity and pleasure to relieve boredom and the limitations of a working or middle class lifestyle (Hunt 2009). Neither approach, however, reflects the challenges youth face in their efforts to achieve adulthood. Nowhere is this truer than with respect to urban working class and marginalized young people who suffer unduly from personal losses, prolonged exposure to violence, lack of economic resources, and stigma and discrimination associated with class, race and ethnicity in resource-poor urban environments. These chronic and acute stresses have the potential for contributing to clinical or subclinical depression, anxiety, and PTSD-like symptoms. While the association between environmental stress, violence/abuse and drug use is not new (Lansford et al. 2010; Henwood 2007; Nelson et al. 2006; Khantzian 2003, 1985; Simpson & Miller 2002), Ecstasy may be a particularly effective drug for alleviating negative psychosocial consequences of relational trauma, abuse and loss, given its observed effects in both clinical and recreational settings.

In our analysis we first isolated respondents who listed as their most salient reason for using Ecstasy their efforts to cope with a current or continuing emotional problem. We compared them to those who reported using Ecstasy for other reasons (fun, sharing with friends, going out, dancing or sex) and found that the latter group had not experienced similar negative life situations either in the past or at the time of the interview. An examination of coping participants' descriptions of their past and present situations in relation to their Ecstasy use revealed four reoccurring situations: abuse, relationship conflicts, loss, and more general lifestyle stresses related to socioeconomic security. These youth described using Ecstasy to cope with adverse emotional states associated with negative life situations primarily by blocking them out or forgetting about them.

We then reviewed more deeply the life histories of Ecstasy users who described coping with negative life situations in their Part A interviews. In the process we noted that some of them mentioned having been diagnosed with a mental health problem in the past. This led us to question the relationship of diagnosis and treatment to Ecstasy use, and to hypothesize that those diagnosed and undergoing treatment would be less likely to use Ecstasy to address their mental health problem. A comparative analysis showed that Ecstasy was used to cope with emotional problems, abuse and loss *only* by those who had not been diagnosed and treated, or who were diagnosed and treated but considered their treatment to be unsatisfactory. Most mentioned specifically that they used Ecstasy to cope with emotional stressors. Among the few who use other drugs as well, Ecstasy was their drug of choice. Slightly more than half of this group (56%) used Ecstasy occasionally (one to several times a month); the remainder were weekly (36%) or daily (8%) users and were intentional about their use. Further Ecstasy was the drug most preferred for coping purposes. The key factor differentiating those who were using Ecstasy and other illegal drugs for coping purposes and those who were not was that the latter group was either in treatment or actively seeking treatment with medication and/or counseling at the time of the interview, or had been successful in completing treatment and did not require medication. These data suggest that

both diagnosis and *effective* treatment were critical factors in avoiding self medication with Ecstasy.

There were several other important differences between the individuals who were diagnosed and treated versus those who were either diagnosed and poorly treated or undiagnosed altogether including gender, and race/ethnicity. For example, three of the four diagnosed and treated males were Caucasian (75%); only one male was not Caucasian; both males that were once diagnosed but poorly treated were also Caucasian. Undiagnosed males were more racially/ethnically diverse, and were primarily African American and Latino. The primary means of obtaining a mental health diagnosis and treatment were parental intervention or through institutional intervention. Institutional interventions included removal from the family and placement in a foster home or institution, hospitalization, or imprisonment or detention due to illegal activity (Bhui et al. 2003). Only a few individuals sought treatment on their own.

Our research on Ecstasy suggests that it serves an important function in the lives of urban youth facing stressful life situations including past and present trauma. These individuals exert agency in drug decision making, carefully considering how, why, when and under what circumstances they use Ecstasy. Most of the time respondents using MDMA to cope with emotional stress report that the drug is producing the desired effect and their drug experiences and perceptions of MDMA are generally positive. They report that Ecstasy dulls their pain, reduces tension, improves communication, and helps them to avoid undesired arguments with people important to them. Further, they report that Ecstasy dims the memory of past trauma, helps youth experiencing PTSD-like symptoms to sleep at night, and enables them to get on with their daily lives. These explanations, which address relational problems, differ from those given for the use of other drugs.

At the same time, they recount that Ecstasy does produce undesired effects from time to time, and there is widespread awareness among users that Ecstasy can contribute to mental health problems (Singer & Schensul 2011). Research has shown that Ecstasy has been associated with cognitive impairment, attention deficits, long lasting neurotoxicity as well as a range of mental disorders (Lieb et al. 2002; McCann et al. 1999; Parrott and Lasky 1998). Because of its status as a Schedule I drug, there is currently no control over the quality or content of MDMA purchased illegally and used for self-medication or recreational purposes. The content of these pills is unknown and they may be adulterated with dangerous ingredients or fillers. Despite the many precautions youth report in trying to obtain safe pills, most youth in this study could report at least one negative instance of Ecstasy use, often in association with other drugs including alcohol. In our study sample, these observations and even respondents' own initial negative experiences with Ecstasy did not deter them from continuing to use the drug to try to solve their problems.

Our overall study findings show that young people in our primarily urban study sample are using Ecstasy both to seek and increase pleasure (Singer & Schensul 2011; Hunt, Moloney & Evans 2009; Singer et al. 2004), and to cope with emotional pain. If the primary purpose of use is pain alleviation, youth are taking unnecessary risks, with potential negative consequences. Our study and others (Abram et al. 2008; Cause et al. 2002) have shown that many youth suffering from mental health problems do not actively seek assistance due to financial barriers, lack of trust of providers and stigmatization of mental health disorders. Low rates of treatment-seeking found among our participants are consistent with studies showing that minority youth in particular are less likely to seek professional help for mental health problems (Cauce et al. 2002; Bui & Takeuchi 1992), are less likely to be covered by either public or private insurance policies (Collins et al. 2006), and are less likely to receive culturally competent care (Vo & Park 2008). With appropriate treatment including

counseling and the discretionary inclusion of appropriate anti-anxiety or antidepressant medication, we believe that young people could and would make a decision to shift away from self-medication with Ecstasy in favor of more effective controlled medication and counseling. There is a pressing need for publicly-funded, developmentally and culturally appropriate mental health care for young people, in order to reduce stigma associated with diagnosis and treatment and to address the systemic factors leading to the observed need for self-medication among urban, minority and low-income youth.

In the examples we have given, youth consistently describe the use of Ecstasy as a numbing agent (Sindicich, Degenhardt & Hall 2010) and a way to cope with past emotional and physical abuse (Wu, Liu & Fan 2010; Singer et al. 2004). That participants in our study reported re-experiencing traumatic life events and a compounding of previous and current problems suggests that the “forgetting” or “numbing” effect they described while on Ecstasy is more palliative than restorative. Individuals using Ecstasy to self-medicate in these contexts do so with no professional guidance or knowledge of how to progress through personal problems in ways that will lead to long-term resilience. Their continued use of Ecstasy and expressed desire to continue taking the drug with no proximate plans for cessation are further evidence that self-medication without supervision may not effectively capitalize on the potential therapeutic properties of Ecstasy when used in more controlled settings. Research to date (e.g. Sindicih, Degenhardt & Hall 2010) shows that the use of MDMA under controlled conditions can do more than simply help one numb or forget his/her problems, and that with the appropriate guidance, Ecstasy may facilitate treatment for PTSD and other trauma-related mental health problems by lowering anxiety and fear, thereby allowing individuals to revisit and gain new perspectives on traumatic experiences without eliciting the strong negative emotions associated with them. Doblin (2002) and other proponents of MDMA use in therapy suggest, and are attempting to show, that controlled doses can help to reduce incapacitating symptoms of trauma such as avoidance and hyperactivation (e.g. anxiety and fear), allowing more constructive approaches to recovery.

Researchers concerned about the therapeutic value of Ecstasy have obtained permission to test it in clinical settings for treatment of PTSD and cancer-related pain (Morris 2008; Doblin 2002). A number of clinical trials funded by the Multidisciplinary Association for Psychedelic Studies (MAPS) are currently underway to test the utility of MDMA as a therapeutic tool to assist psychotherapy for the treatment of PTSD and other trauma-related illnesses, including those stemming from sexual assault, war, violent crimes and other traumas. The results of these studies have been sufficiently successful for researchers to receive permission from the FDA to train psychotherapists to deliver counseling in association with MDMA prescription to patients (MAPS 2011). Although the results of clinical tests seem promising, some researchers warn that altering levels of serotonin in individuals with already low levels can exacerbate preexisting depressed mood states and lead to worsening of symptoms and perhaps increased suicide risk (Degenhardt & Hall 2010; Parrott 2001). Careful screening measures can help to identify individuals most likely to benefit from therapeutic use of Ecstasy, along with contextual factors most likely to facilitate treatment.

In sum, urban youth in our study lack access to mental health services and counseling that would alleviate their psychological pain, relieve their stress, and improve their quality of life, health and relationships. Thus they turn to coping strategies such as the use of Ecstasy and other drugs that are illegal, or diverted from their prescribed purpose, in order to reduce emotional distress and pain resulting from stressful life situations and past or current abuse, to improve their mood, and to enable them to function more effectively in daily interaction with friends and loved ones. Further research is needed to demonstrate that improving access to appropriate mental health treatment and medication reduces the use of Ecstasy or

other drugs for self medication. Finally, research is needed to explore the potential of Ecstasy administered under controlled conditions to reduce pain stemming from exposure to violence and abuse in childhood or early adolescence, and enhance capacity for building rewarding sustainable relationships even in difficult life circumstances.

Limitations

The study has some limitations. The sample used for it was drawn from a study which focused on elucidating the relationship between Ecstasy and sexual risk. Hence, not all participants were asked specific details pertinent to the subject matter of this study such as if they had ever used Ecstasy for coping or if they had a history of mental health diagnosis. Additionally, given the subject matter of this article, some participants may not have been comfortable discussing past traumatic events which may have been the impetus for their Ecstasy use or a history of mental health diagnosis or problems. Further, the study was localized to the Hartford and greater Hartford area, thus participants may not be representative of the general population of urban Ecstasy users. Lastly, the inclusion criteria, of individuals who had used Ecstasy within the past four months, did not allow us to fully explore the possibility of finding individuals who were once using Ecstasy to cope and were no longer using the drug or individuals who stopped using Ecstasy due to either adverse effects or problem resolution.

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