



Published in final edited form as:

ACS Chem Neurosci. 2018 October 17; 9(10): 2408–2427. doi:10.1021/acschemneuro.8b00155.

Dark Classics in Chemical Neuroscience: 3,4-Methylenedioxymethamphetamine (MDMA)

Lee E. Dunlap¹, Anne M. Andrews², and David E. Olson^{1,3,4}

¹Department of Chemistry, University of California, Davis, Davis, CA 95616, USA

²Departments of Psychiatry and Chemistry & Biochemistry, Semel Institute for Neuroscience and Human Behavior, and Hatos Center for Neuropharmacology, University of California, Los Angeles, CA 90095, USA

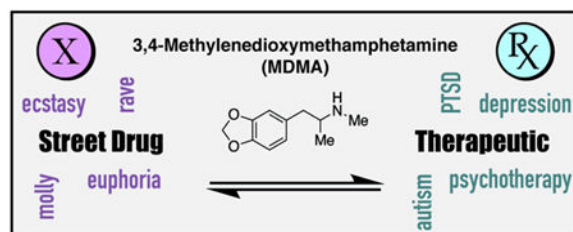
³Department of Biochemistry & Molecular Medicine, School of Medicine, University of California, Davis, Sacramento, CA 95817, USA

⁴Center for Neuroscience, University of California, Davis, Davis, CA 95616, USA

Abstract

Better known as “ecstasy,” 3,4-methylenedioxymethamphetamine (MDMA) is a small molecule that has played a prominent role in defining the ethos of today’s teenagers and young adults, much like lysergic acid diethylamide (LSD) did in the 1960s. Though MDMA possesses structural similarities to compounds like amphetamine and mescaline, it produces subjective effects that are unlike any of the classical psychostimulants or hallucinogens and is one of the few compounds capable of reliably producing prosocial behavioral states. As a result, MDMA has captured the attention of recreational users, the media, artists, psychiatrists, and neuropharmacologists alike. Here, we detail the synthesis of MDMA as well as its pharmacology, metabolism, adverse effects, and potential use in medicine. Finally, we discuss its history and why it is perhaps the most important compound for the future of psychedelic science—having the potential to either facilitate new psychedelic research initiatives, or to usher in a second Dark Age for the field.

Graphical Abstract



Correspondence to: David E. Olson.

Author Contributions

D.E.O. conceived the structure of the review. L.E.D. and D.E.O. wrote the manuscript with input from A.M.A. All authors edited the manuscript.

Notes

The authors declare no competing financial interest.

Keywords

3,4-methylenedioxymethamphetamine; MDMA; psychedelic; entactogen; empathogen

INTRODUCTION

The psychoactive compound MDMA is better known by one of its numerous street names, which include ecstasy, XTC, E, X, MDM, Adam, and EA-1475.¹ Additionally, the term “molly” is often used to refer to MDMA in the United States.² Structurally, MDMA possesses a single stereocenter, and due to its small size (freebase MW = 193.24 g/mol) and hydrophobic nature (logP = 2.050),³ MDMA readily crosses the blood-brain barrier (BBB).⁴ Chemically, MDMA is related to amphetamine (**2**), and contains the phenethylamine core structure common to this class of psychostimulants, which also includes methamphetamine (**3**), and methylphenidate (**4**) (Figure 1). The hallucinogens 2,5-dimethoxy-4-iodoamphetamine (DOI, **5**), 2,5-dimethoxy-4-bromophenethylamine (2C-B, **6**), and mescaline (**7**) are also structurally related to MDMA. As such, it is not surprising that MDMA produces effects reminiscent of both psychostimulants and hallucinogens. However, the interoceptive effects of MDMA (i.e., sense of the body’s internal state) are distinct from those produced by either of these well-known classes of psychoactive compounds.

In rodent drug discrimination studies, MDMA only partially substitutes for the stimulant *S*-(+)-amphetamine,⁵ or the ergoline hallucinogen lysergic acid diethylamide (LSD),⁶ and is unable to substitute for the phenethylamine hallucinogen 2,5-dimethoxy-4-methylamphetamine (DOM).⁷ Furthermore, when rats are trained to discriminate racemic MDMA from saline, incomplete generalization is observed using *S*-(+)-amphetamine, LSD, or DOM.⁵ The discriminative stimulus produced by MDMA seems to be modulated by 5-HT1A,⁸ 5-HT2A,⁸ and oxytocin receptors,⁹ with less involvement from D1 receptors.¹⁰ The two enantiomers of MDMA produce relatively similar discriminative stimuli.¹¹ It should be noted that while MDMA only partially substitutes for *S*-(+)-amphetamine in rats, it completely substitutes for *S*-(+)-amphetamine in rhesus monkeys.¹²

In humans, 75–150 mg of MDMA produces subjective effects that last for several hours.^{13,14,15,16,17,18,19} These include context-dependent feelings of closeness with others, reduced social inhibition, positive mood, and increased alertness.^{19,20,21,22,23,24} Regarding hallucinations, MDMA is considered to be weakly hallucinogenic.²⁵ Ingestion of MDMA does not cause auditory hallucinations and only 20% of recreational users have reported experiencing visual hallucinations.¹⁵ The visual hallucinations induced by MDMA do not tend to be well-formed, and instead, are often described as flashes of light in the peripheral visual field.¹⁵ This is in stark contrast to the profound visual disturbances experienced by most people following the administration of classical hallucinogenic agents such as LSD.^{26,27} In humans, the weak hallucinogenic effects of MDMA are blocked by ketanserin, a selective 5-HT2A antagonist.²⁵ The role of 5-HT1A receptors in the subjective effects of MDMA appears to be negligible.^{28,29,30} In addition to directly binding to 5-HT2A receptors, albeit with low affinity (vide infra), MDMA can produce subjective effects by increasing the release of monoamines such as serotonin and norepinephrine.^{17,31,32,33,34,35} The perceptual

effects of MDMA are more intense in females than in males,^{36,37} and have been shown in recent placebo-controlled studies to be clearly distinct from those produced by other psychostimulants.^{38,39}

The unique subjective effects of MDMA and related molecules such as 3,4-methylenedioxy-*N*-methyl- α -ethylphenylethylamine (MBDB, **8**) and 5,6-methylenedioxy-2-aminoindane (MDAI, **9**) led to their classification as a separate family of psychoactive compounds, distinct from both stimulants and hallucinogens (Figure 1). Due to their strong propensity to induce empathy and feelings of connectedness, these drugs were originally dubbed “empathogens” in the 1980s—a term favored by Ralph Metzner.⁴⁰ David Nichols later highlighted the ambiguous nature of the term empathogen. To avoid any negative connotations associated with “pathos” (i.e., suffering), “pathogen” (i.e., a disease producing agent), or “pathogenesis” (i.e., the development of a disease), Nichols coined the new term “entactogen,” which roughly translates from the Greek to mean that which “produces a touching within” (en = within, tactus = touch, gen = to produce).⁴¹ These terms are often used interchangeably. We will use the latter term as it more adequately captures the unique ability of these drugs to promote introspective states—a property that has been proposed to be useful in the context of psychotherapy (vide infra). Though the subjective effects of MDMA appear to be unique compared to those of LSD, both compounds tend to increase openness, promote trust, and enhance emotional empathy.^{42,43}

A major point of contention among psychopharmacologists is whether or not MDMA should be classified as a “psychedelic.” Because that term can be translated as “mind-manifesting,” we propose that MDMA, as well as more potent 5-HT_{2A} agonists like psilocybin, are appropriately placed in this category. Using this classification, psychedelics broadly defined can be subdivided into classical hallucinogens (e.g., psilocybin, LSD, mescaline) and entactogens (e.g., MDMA) on the basis of their distinct subjective effects

The prosocial and stimulant effects of MDMA led to its widespread recreational use and cemented its place in rave (dance party) culture.⁴⁴ It is estimated that MDMA has been used by 7% of the population over the age of 12.⁴⁵ This is in stark contrast to heroin, which is abused by only 2% of the population.⁴⁵ The predominant users of MDMA are teenagers and young adults, with females being more likely to use MDMA than males.⁴⁶ In people 12–25 years of age, MDMA accounts for more than 50% of all psychedelic drug use.⁴⁵ In recent years, the recreational use of MDMA by people with college degrees has been increasing.⁴⁷

Despite its popularity, MDMA is a controlled substance in the United States and many other countries making its production and sale illegal. The U.S. Drug Enforcement Administration (DEA) has classified MDMA as a Schedule I compound—the most restricted class of chemicals. Schedule I drugs are those deemed to have high abuse potential, do not have an accepted medical use, and lack accepted safety for use under medical supervision. Drugs such as heroin, LSD, gamma hydroxybutyric acid (GHB), and tetrahydrocannabinol (THC) are also classified in Schedule I. Unfortunately, the legal, financial, and political hurdles that accompany Schedule I classification significantly hinder scientific research into the effects of MDMA. As it is one of the few compounds known to reliably produce a prosocial state, MDMA may possess potential as a neurochemical tool for elucidating the mechanisms of

social behaviors and the neural underpinnings of empathy and social bonding.⁴⁸ Furthermore, MDMA may possess therapeutic potential for treating disorders associated with disruptions in social interactions such as autism spectrum disorders, social anxiety disorder, schizophrenia, and post-traumatic stress disorder (PTSD).⁴⁸

Despite its relatively simple structure, MDMA elicits robust behavioral responses by binding with high affinity to a number of neuroreceptors and transporters. Below, we discuss the synthesis of MDMA and its pharmacology, metabolism, and adverse effects. Additionally, we review the prosocial and psychoplastogenic (plasticity-promoting) properties of MDMA, the differences between its enantiomers, and its potential use in medicine. Finally, we provide brief historical context for the development of MDMA and conclude by emphasizing the important role that MDMA is expected to play in determining the trajectory of future psychedelic research.

SYNTHESIS

Racemic MDMA—the form used recreationally and in clinical trials—is typically synthesized from safrole (**10**) or piperonal (**13**). The German chemist Anton Köllisch was the first to synthesize MDMA in 1912.⁴⁹ His synthetic route began with the hydrobromination of **10** to produce **11**. Displacement of the bromide with methylamine produces MDMA.⁵⁰ A similar route was described in the peer-reviewed literature for the first time by Polish chemists Binniecki and Krajewski.⁵¹ Alternatively, MDMA can be synthesized from **10** by Wacker oxidation followed by reductive amination of **12** with methylamine and sodium cyanoborohydride.^{52,53} Compound **12** can also be accessed from **10**, following olefin isomerization to produce isosafrole, peracid oxidation to the epoxide, and acid-catalyzed epoxide isomerization to the ketone.⁵⁴

The synthesis of MDMA from piperonal (**13**) is also common, and begins with a Henry reaction between **13** and nitroethane. The key nitrostyrene intermediate formed can then be partially reduced and hydrolyzed to produce ketone **12**, or fully reduced using lithium aluminum hydride to afford 3,4-methylenedioxyamphetamine (MDA, **14**).⁵⁵ Conversion of MDA into the carbamate or formamide followed by lithium aluminum hydride reduction yields MDMA. Purification of MDMA is typically achieved following vacuum distillation of the freebase and/or crystallization of the hydrochloride salt.¹⁶ The hydrochloride salt can exist as one of several different hydrated forms.¹

While the racemate is the most commonly administered form of MDMA, recent research suggests that there are distinct differences in the pharmacology of the two enantiomers. Hence, the development of efficient asymmetric strategies for producing enantiopure MDMA is incredibly important. Traditional resolution via selective crystallization of diastereomeric salt forms has not proven the most effective route for synthesizing MDMA in high enantiomeric excess.⁵⁶ Instead, a more successful strategy has relied on the use of removable chiral auxiliaries. The first asymmetric synthesis of MDMA was reported by Nichols and co-workers (Figure 3A).⁶ Reductive amination of ketone **12** with (*S*)- α -methylbenzylamine (**15**) produced the (*S,S*) intermediate **16** following crystallization. The use of Raney nickel at 50 psi appears to be crucial for the selectivity of this reaction. In our

hands, Raney nickel catalyzed hydrogenation did not proceed under atmospheric conditions, and the use of hydride reducing agents such as NaBH₃CN yielded an inseparable 1:1 mixture of diastereomers (unpublished results). Palladium-catalyzed hydrogenolysis afforded MDA (**14**), which was converted to MDMA after reduction of the formamide. In 2014, Escubedo and co-workers reported a similar approach using Ellman's sulfonamide as the chiral auxiliary (Figure 3B).⁵⁷

The chiral pool has also been exploited to produce enantiopure MDMA. Using a method developed by Nenajdenko and co-workers,⁵⁸ (*S*)-alaninol (**23**) can be protected and converted to the aziridine **24**. Ring opening in the presence of copper(I) iodide using Grignard reagent **25** affords Ts-protected MDA (**26**). Methylation of **26** followed by deprotection yields (*S*)-MDMA.⁵⁹ The enantiomeric excess of (*S*)-mDmA produced by Huot and co-workers was not reported, but based on the stereospecific nature of the reactions employed and the fact that the stereocenter is unlikely to epimerize under these conditions, it is assumed that MDMA can be produced as a single enantiomer using this strategy. Nenajdenko and co-workers reported that this is indeed the case for related β -arylalkylamines.⁵⁸

PHARMACODYNAMICS

Effects on Monoamines.

The most well characterized effect of MDMA is its ability to increase brain levels of monoamines such as serotonin, dopamine, and norepinephrine, which is accomplished via complex mechanisms. First, MDMA binds to and inhibits the serotonin transporter (SERT), dopamine transporter (DAT), and norepinephrine transporter (NET), inhibiting monoamine reuptake and leading to increased extracellular levels of these amines.^{35,60,61,62,63} Electrophysiology experiments suggest that this inhibition results from MDMA serving as a substrate, rather than a blocker, of these transporters.⁶⁴ In contrast to (*S*)-amphetamine, racemic MDMA is a more potent inhibitor of SERT than either DAT or NET (Tables 1 and 2).⁶⁵ In addition to inhibiting the uptake of extracellular monoamines, MDMA also prevents transport of monoamines into vesicles. While, MDMA has been shown to inhibit the uptake of serotonin and dopamine into both synaptosomes and vesicles, it does not affect the cellular uptake and/or vesicular packaging of either γ -aminobutyric acid (GABA) or glutamate.⁶⁶

In addition to being a monoamine uptake inhibitor, MDMA is a potent releaser of these neurochemicals, and again, MDMA accomplishes this via several mechanisms. At the cellular membrane, MDMA reverses the flux of monoamines through their transporters, expelling intracellular serotonin, dopamine, and norepinephrine into the extracellular space. Inhibitors of SERT, DAT, and NET completely prevent MDMA-induced monoamine efflux in rat brain slices,⁶⁷ and from monoamine transporter-expressing HEK293 cells pre-loaded with radiolabeled monoamines.³⁵ However, for monoamines to reach sufficiently high cytosolic levels to be reverse transported by membrane transporters, they must first be released from synaptic vesicles into the intracellular space. By directly binding to vesicular amine transporters (VMAT), MDMA reverses the transport of molecules like serotonin.^{68,69} Additionally, as a weak base, MDMA passively diffuses across vesicular membranes to

collapse the pH gradient established by VMAT, which is necessary for maintaining high concentrations of monoamines in vesicles.^{70,71} Monoamines released from vesicles might be partially protected from degradation due to the ability of MDMA to inhibit both isoforms of monoamine oxidase.⁷² Moreover, MDMA may cause SERT internalization,⁷³ which presumably contributes to increased extracellular serotonin levels. The releasing effects of MDMA are greater for serotonin and norepinephrine, and slightly weaker for dopamine (Tables 2 and 3).⁶⁵

While much of the work elucidating the monoamine-releasing properties of MDMA have employed *in vitro* and *ex vivo* models, recently, the DA and 5-HT releasing effects of MDMA have been observed *in vivo* using microdialysis in the striatum and frontal cortex of rats.⁷⁴ There is a general consensus that MDMA increases the release of monoamines, however, there is at least one study using fast-scan cyclic voltammetry (FSCV) in brain slices that suggests that increases in monoamine concentrations following MDMA treatment might be due to inhibition of monoamine reuptake and not release *per se*.⁷⁵

Direct Effects on Receptors.

In addition to directly interacting with monoamine transporters, MDMA has been shown to bind with modest affinities to a variety of neuroreceptors including adrenergic, serotonergic, histaminergic, and muscarinic receptors.^{76,77,62} The binding profile of MDMA across much of the receptorome is shown in Table 5. The low micromolar affinities observed support the notion that MDMA induces most of its effects indirectly by modulating monoamine levels. The 5-HT_{2B} receptor is one of the few receptors that MDMA binds to with submicromolar affinity ($K_i = 500$ nM), though the role of this receptor in the effects of MDMA is unclear. For example, MDMA failed to produce a response in a 5-HT_{2B} functional assay using HEK293 cells.⁷⁸ However, it is believed that 5-HT_{2B} agonism is at least partly responsible for the 5-HT releasing effects of MDMA, as pharmacological inhibition or genetic deletion of 5-HT_{2B} receptors block MDMA-induced release of 5-HT.⁷⁹ Binding of MDMA to 5-HT_{2B} receptors was studied using a radiolabeled agonist, while many of the other receptor binding assays (e.g., 5-HT_{2A} and 5-HT_{2C}) utilized radiolabeled antagonists. Therefore, it is possible that the binding affinity of MDMA for many receptors has been underestimated. For example, it is now well established that MDMA binds directly to 5-HT_{2A} receptors, albeit with micromolar affinity, though binding assays performed with ³H-ketanserin do not capture this interaction. Furthermore, MDMA is unable to displace radiolabeled monoamine transporter inhibitors despite exhibiting nM potency in functional assays (Tables 1–4), which is consistent with its proposed role as a monoamine releaser rather than a competitive uptake inhibitor.

Trace Amine-Associated Receptor 1 (TAAR1).

The trace-amine associated receptor (TAAR1) has also been suggested as a key target mediating the effects of MDMA. Bunzow and co-workers demonstrated that MDMA acts as an agonist at rat TAAR1 receptors to increase cAMP production in a TAAR1-expressing HEK293 cell line.⁸⁰ Like MDMA, several other hallucinogens and psychostimulants have been shown to bind to and activate TAAR1 to a greater extent than neurotransmitters such as serotonin, dopamine or norepinephrine.^{80,81,82} Due to the known modulatory influence of

TAAR1 on monoamine transporter function,⁸³ it is likely that TAAR1 activation contributes to the effects of MDMA on extracellular monoamine levels. Interestingly, 4-hydroxyamphetamine proved to be a particularly potent agonist of TAAR1 (EC₅₀ = 51 nM). As MdMa is metabolized into 4-hydroxy-substituted compounds, there is the distinct possibility that metabolites of MDMA may potentially activate TAAR1. However, to the best of our knowledge, this hypothesis has not been directly tested. Finally, it is unclear if TAAR1 plays any role in the effects of MDMA in humans, as MDMA does not activate human TAAR1 in cellular assays like it does mouse and rat TAAR1.⁸⁴

Sigma-1 Receptor.

Radioligand binding studies have shown that MDMA binds to both sigma-1 and sigma-2 receptors with K_i values in the low micromolar range, which are comparable to the affinities of MDMA for monoamine transporters.⁸⁵ Moreover, treatment with BD1063, a selective sigma-1 antagonist, blocked the effects of MDMA on rodent locomotion.⁸⁵ The sigma-1 receptor has been proposed to be a novel target for the treatment of depression and anxiety,^{86,87,88,89,90} and it is reasonable to hypothesize that this receptor plays some role in the behavioral and clinical effects of MDMA.

Hormonal Effects.

Administration of MDMA to humans leads to robust increases in plasma levels of cortisol, prolactin, dehydroepiandrosterone (DHEA), vasopressin, and oxytocin.^{18,38,91,92,93,94,95,96} It is possible that some of these hormonal changes are the result of serotonergic activity,^{97,98,99} and it is likely that they modulate some of the effects of MDMA.¹⁰⁰ For example, the rise in plasma DHEA levels was significantly correlated with feelings of euphoria.¹⁸ Furthermore, the effects of MDMA on oxytocin levels are often invoked to explain the drug's prosocial effects. Dumont and co-workers were the first to demonstrate in a controlled laboratory setting that MDMA increases oxytocin levels.⁹³ They also found that increases in blood oxytocin levels were correlated with the subjective prosocial feelings induced by MDMA more so than blood levels of the drug itself. While numerous other studies have replicated the finding that MDMA elevates oxytocin levels, they have all failed to reproduce a correlation between oxytocin levels and prosocial feelings, calling into question the relevance of this hormone for the prosocial effects of MDMA.^{100,101} As such, the role of oxytocin in the effects of MDMA is currently controversial.

Behavioral Effects in Rodents.

Like other serotonergic psychedelics, MDMA produces behavioral effects consistent with serotonin syndrome such as flat body posture, hind limb abduction, and forepaw treading.¹⁰² At lower doses, MDMA produces "amphetamine-like" hyperactivity in the open field. Both of these effects are enhanced following repeated administration of MDMA, demonstrating that MDMA is capable of producing behavioral sensitization.¹⁰³ Behavioral sensitization is correlated with the enhanced ability of MDMA to increase monoamine levels (measured via microdialysis) following repeated dosing.¹⁰⁴ The locomotor effects of MDMA are perhaps the best-studied behavioral responses in rodents, and they are modulated by a variety of neuroreceptors including 5-HT_{1B},¹⁰⁵ 5-HT_{2A},¹⁰⁶ D₁,¹⁰⁷ and D₂¹⁰⁷ receptors. Unlike amphetamine, selective serotonin reuptake inhibitors block MDMA-induced increases in

locomotion.¹⁰⁸ Furthermore, MDMA does not produce this behavioral effect in mice genetically lacking SERT, further implicating this monoamine transporter in the hyperlocomotive effects of MDMA.¹⁰⁹

In rodent models of anxiety, MDMA produces complex effects. At low acute and subchronic doses, MDMA tends to be anxiogenic in the elevated plus maze (EPM).^{110,111,112} However, at higher acute and subchronic doses, MDMA produces anxiolytic effects in the EPM. When tested in the light-dark box paradigm, MDMA does not alter preferences of mice for the two compartments.¹¹³

Some of the rodent behaviors most relevant to potential therapeutic uses of MDMA are related to social behaviors. A 5 mg/kg dose of MDMA decreased aggressive behaviors in rats and increased the time spent engaging in social behaviors such as sniffing, following, crawling under, crawling over, mutual grooming, and adjacent lying.¹¹⁴ Additionally, MDMA has been shown to induce a social conditioned place preference.¹¹⁵ Adjacent lying—a behavior in rats where two unfamiliar animals lie passively next to each other—is perhaps one of the more robust prosocial behaviors induced by MDMA in rodents.

In terms of mechanism, systemic MDMA increases plasma levels of oxytocin in rats and activates oxytocinergic neurons in the hypothalamus, as measured by Fos immunohistochemistry.⁹⁹ Increases in oxytocin levels and adjacent lying behavior induced by MDMA were abolished by treatment with a 5-HT1A antagonist, while 8-OH-DPAT (a 5-HT1A agonist) produced effects similar to MDMA.⁹⁹ This led McGregor and co-workers to propose that MDMA induces oxytocin release via stimulation of 5-HT1A receptors, and that increased adjacent lying resulted from activation of oxytocin receptors. This hypothesis was supported by the fact that intracerebroventricular administration of tocinoic acid, an oxytocin receptor antagonist, blocked MDMA-induced adjacent lying.⁹⁹ However, in a follow-up study, McGregor and co-workers could not prevent MDMA-induced adjacent lying using C25,¹¹⁶ a systemically administered non-peptidic antagonist of oxytocin receptors. In contrast, they were able to prevent this behavior using an antagonist of the vasopressin receptor 1A.¹¹⁷ There are two possibilities that might explain these contradictory results. First, tocinoic acid could have non-selective antagonistic effects at the vasopressin receptor 1A. Alternatively, C25 might not have been able to cross the blood-brain barrier.

In addition to its prosocial effects, MDMA has been shown by Howell and co-workers to promote fear extinction learning in mice.¹¹⁸ This seminal study potentially provides a mechanistic explanation for the therapeutic efficacy of MDMA in patients suffering from treatment-resistant PTSD (vide infra). Similar findings have been described for other psychedelics such as psilocybin in mice¹¹⁹ and *N,N*-dimethyltryptamine (DMT) in rats.¹²⁰ The facilitation of fear extinction memory by MDMA appears to be dependent on SeRt.¹²¹

Plasticity-Promoting Effects.

Like most psychostimulants, MDMA causes robust changes in gene expression and protein levels associated with neural plasticity.¹²² Acute treatment with MDMA (10 mg/kg) causes differential gene expression of BDNF in the frontal cortex and hippocampus of rats, with

BDNF levels increasing in the former brain region and decreasing in the latter.¹²³ The administration of 4 doses over a period of 6 h to rats led to robust increases in *BDNF* transcript levels in several cortical regions both 1 h and 7 h following dosing.¹²⁴ The largest effects were seen in the prefrontal cortex with increases in *TrkB* expression observed in that region 24 h after dosing.¹²⁴ Here, MDMA produced weaker effects on *NT3* and *TrkC* gene expression.¹²⁴ Chronic treatment with MDMA in mice¹²⁵ and subchronic administration of large doses (20 mg/kg) in rats¹²⁶ led to increases in BDNF transcription and translation in the hippocampus. The latter study also observed a reduced number of dendritic spines in the hippocampus of rats. Finally, MDMA was observed to inhibit neurite outgrowth in PC12 cells,¹²⁷ though the relevance of this cell line to studies on neural plasticity is debatable.

To date, most studies assessing the psychoplastic (plasticity-promoting) effects of MDMA have observed a reduction in dendritic branching and/or dendritic spine numbers. However, these studies are often conducted using extremely high doses of MDMA administered over extended periods of time, and probably more accurately reflect neurotoxicity resulting from overstimulation of psychoplastic receptors. More modest doses would likely yield increases, as opposed to decreases, in dendritic branching and spine density. Recently, we reported that MDMA, and several other psychedelic compounds, significantly increased the complexity of dendritic arbors in cultured cortical neurons¹²⁸ Moreover, this phenotype is not produced by all psychostimulants and drugs of abuse, as *S*-(+)-amphetamine had no effect.¹²⁸ Future studies should assess the *in vivo* effects of a single moderate dose of MDMA on dendritic branching and spine density.

METABOLISM AND PHARMACOKINETICS

The primary routes for metabolism of MDMA are *N*-demethylation and loss of the methylene bridge connecting the catechol (Figure 4), both of which are mediated by various cytochrome P450s.¹²⁹ The common metabolites of MDMA (**1**) include MDA (**14**), 3,4-dihydroxymethamphetamine (HHMA, **28**), 3,4-dihydroxyamphetamine (HHA, **29**), 4-hydroxy-3-methoxy-methamphetamine (HMMA, **30**), and 4-hydroxy-3-methoxy-amphetamine (HMA, **31**). The major metabolite of MDMA in humans is HMMA, which is mainly excreted as the glucuronic acid conjugate.¹³⁰

Recent genetic findings suggests that a variety of cytochrome P450s, including CYP2C19, CYP2B6, and CYP1A2, play a role in the demethylation of MDMA.^{131,132} Mutations in the CYP2C19 or CYP2B6 genes that reduce enzyme function have been shown to increase the ratio of MDMA/MDA but do not alter HMMA concentrations.^{131,132} Subjects with decreased CYP2C19 function also showed greater cardiovascular responses with faster onset times. Mutations in the CYP2B6 gene resulting in decreased enzyme function only influenced metabolism at later time points (i.e., 3–4 h) suggesting that it is a secondary metabolizer of MDMA.¹³¹

When MDMA is administered to humans at a dose of 100 mg, it has a half-life of approximately 8–9 h and yields plasma C_{\max} and t_{\max} values of 222.5 ng/ml and 2.3 h, respectively.¹³³ However, MDMA is known to exhibit nonlinear pharmacokinetics in both humans^{131,134,135} and squirrel monkeys.¹³⁶ This means that increasing doses of MDMA

prolong its half-life, potentially exacerbating the risk for adverse effects and neurotoxicity. The nonlinear pharmacokinetics observed following administration of MDMA is likely the result of cytochrome P450 inhibition by MDMA and its metabolites.^{131,137,138} Additionally, the enantiomers of MDMA are metabolized at different rates, with the R-enantiomer having a longer half-life than the S-enantiomer.^{139,140, 141}

ADVERSE EFFECTS

Similar to other amphetamines, MDMA produces a number of adverse effects including trismus, tachycardia, bruxism, dry mouth, palpitations, diaphoresis, and insomnia.^{15,19,36,142} Rhabdomyolysis, cardiac arrhythmias, hyperthermia, hyponatremia, and acute renal failure are the more severe side-effects and are common causes of death following MDMA intoxication.^{143,144} The more severe adverse effects of MDMA are potentially exacerbated by the intense exercise and hot environment characteristic of raves. In Long-Evans rats, slight increases in ambient temperature resulted in excessive brain hyperthermia leading to death at an MDMA dose that is significantly lower than the LD₅₀ in rats at room temperature.¹⁴⁵ Similarly, Fantegrossi and co-workers found that MDMA lethality was increased when NIH Swiss mice were housed at high densities (>6 mice per cage), which reduces the ability to dissipate body heat.¹⁴⁶ Risk for serotonin syndrome—a collection of symptoms that include high body temperature, sweating, and tremor (among others)—increases with higher doses of MDMA.¹⁴⁷

The effects of MDMA on heart function are also significant, with norepinephrine mediating a significant portion of the cardiostimulant effects observed following MDMA administration.^{34,35,148,149} In addition to increasing systolic blood pressure,^{19,36,92} the drug can induce cardiac arrhythmias and myocarditis.¹⁵⁰ Myocardial infarction can also occur following MDMA use, though this tends to happen less frequently than after cocaine or amphetamine administration.^{151,152} In the long-term, MDMA use can result in valvular heart disease,¹⁵³ which could be due to oxidative stress¹⁵⁴ or the activation of 5-HT_{2B} receptors by MDMA.⁷⁷

In terms of the addictive potential of MDMA, the data are mixed. Several people have argued that MDMA has lower abuse potential because recreational users have reported that its pleasurable effects diminish with repeated use, but its side effects increase.¹⁵ However, in animal models, MDMA does produce some of the same behavioral effects characteristic of addictive drugs like cocaine and opioids, albeit to a lesser extent. For instance, MDMA is known to produce conditioned place preference in rats¹⁵⁵ and mice,^{156,157} and MDMA is self-administered by a variety of species (e.g., rats, mice, non-human primates).¹⁵⁸ Interpretation of self-administration studies using MDMA are complicated by a variety of factors such as dose, timing, and prior exposure of the test animals to other drugs of abuse. For an overview of these issues, we refer the reader to an excellent review by Susan Schenk.¹⁵⁸ Taken together, MDMA does seem to have reinforcing properties, but these appear to be significantly weaker than those of cocaine.

Determining the adverse effects of MDMA in people who consume it recreationally is complicated by the fact that some “MDMA” sold on the street does not contain any MDMA

at all,¹⁵⁹ while other batches of illegally produced “MDMA” are adulterated.¹⁶⁰ Contaminating drugs include, but are not limited to, amphetamine, methamphetamine, MDA, pseudoephedrine, butylone, and caffeine.^{161,162} Many recreational MDMA users prefer “molly” as it is believed to be of high purity, however, a recent study employing hair follicle testing revealed that 48% of molly users tested positive for synthetic cathinones despite having reported that they had never used cathinones before.¹⁶³ Consuming MDMA as a part of a drug mixture can be extremely dangerous due to drug-drug interactions,¹⁶⁴ and has important implications for evaluating the neurotoxic potential of MDMA in humans.

Certainly, the most controversial aspect of MDMA pharmacology is its potential to induce neurotoxicity. The neurotoxic effects of MDMA have been extensively reviewed by others,^{165,166,167,168,169,170,171} and thus, we will focus only on the key studies. Additionally, we will attempt to highlight why this is such a contentious area and why the controversy is not likely to be resolved soon.

People who consume MDMA (particularly those who do so regularly, and in high doses) perform poorly on various tests related to attention, learning, and memory (e.g., working and declarative memory) when compared to MDMA-naïve controls.^{172,173,174,175} Those with a history of only moderate MDMA use do not seem to exhibit memory impairments.¹⁷⁶ However, acute MDMA intoxication produces memory deficits.¹⁷⁶ Heavy MDMA users tend to have lower cerebral spinal fluid levels of 5-hydroxyindoleacetic acid (5-HIAA)—the principle metabolite of serotonin—and thus, serotonergic toxicity has been presumed.¹⁷⁷ In general, neuroimaging studies used to assess the effects of MDMA in humans have produced mixed findings, with no clear evidence that MDMA is safe or neurotoxic.^{178,179} Finally, when compared with MDMA-naïve controls, MDMA users are more likely to be afflicted with mental illnesses including depression, psychotic disorders, eating disorders, and anxiety disorders.¹⁸⁰

While retrospective studies on MDMA-using populations are certainly important, there are several confounding factors that limit the interpretability of these data. First, MDMA produced by clandestine laboratories is often contaminated with other drugs of abuse and neurotoxic compounds such as methamphetamine. Second, recreational MDMA users are typically polydrug users.¹⁸¹ Third, recreational MDMA is often consumed at crowded dance parties (i.e., raves), where excessive activity, high temperatures, and dehydration could exacerbate any inherently neurotoxic effects of the drug. Together, these facts make it difficult, if not impossible, to distinguish the neurotoxic effects induced by MDMA itself versus those caused by impurities, drug-drug interactions, or drug-environment interactions. Furthermore, due to the retrospective nature of many human studies regarding the effects of MDMA, it is unclear if the cognitive impairments and neuropsychiatric disorders observed in groups who have used MDMA reflect a cause or consequence of MDMA use. Prospective studies are incredibly important for answering these questions. One prospective study from The Netherlands found that sensation-seeking, impulsivity, and depression did not predict future MDMA use.¹⁸² However, a much larger study from Germany concluded that MDMA users had significantly higher risk for nearly all DSM-IV mental disorders, and moreover, that the onset of these disorders typically preceded the first use of MDMA.¹⁸³

Because of the many factors that can confound human studies, researchers have turned to well controlled model systems in the laboratory to investigate MDMA neurotoxicity. However, the relevance of these models to human neurotoxicity is often questioned. Capela and co-workers found that MDMA can induce apoptotic cell death in embryonic rat cortical neurons via a 5-HT_{2A}-dependent mechanism.¹⁸⁴ Furthermore, they discovered that the metabolites of MDMA are more potent neurotoxins.¹⁸⁵ Similarly, Stumm and co-workers reported that MDMA and related amphetamines kill cultured rat cortical neurons at comparable concentrations.¹⁸⁶ It is important to note that the concentration of MDMA required to produce substantial neurotoxic effects in these studies is >200 μ M, while the maximal brain concentration of MDMA in rats following a 20 mg/kg subcutaneous dose (10x the behaviorally relevant dose) is only circa 100–200 μ M.¹⁸⁷ At a more modest concentration (10 μ M), our group determined that MDMA produced robust psychoplastogenic effects in embryonic rat cortical cultures without cell death.¹²⁸ For comparison, we have observed that several SSRIs and triptans—commonly prescribed medications—are cytotoxic to cultured rat cortical neurons in the range of 10–100 μ M (unpublished results).

In addition to studies using cultured neurons, *in vivo* animal models are frequently used to test the neurotoxic potential of MDMA. While findings dating back to 1987 suggest that MDMA has neurotoxic effects in animals,¹⁸⁸ the relevance of these models to human neurotoxicity is highly debated. Some of the contentious questions the field has to grapple with include, 1) what dosing paradigm most effectively models human use, 2) what species is most relevant, 3) is allometric scaling appropriate, 4) how should the nonlinear human pharmacokinetics of MDMA be factored in, 5) what route of administration should be utilized, and 6) how should “neurotoxicity” be defined/measured (e.g., monoamine levels, neurite degeneration, cell body loss).

In mice, MDMA tends to produce dopaminergic, but not serotonergic, neurotoxicity.^{189,190,191} This is in sharp contrast to rats, for which the opposite seems to be true. Two weeks following systemic administration of MDMA to rats (20 mg/kg, subcutaneous, twice daily for 4 d) loss of 5-HT axons (but not catecholamine axons) projecting to the forebrain was observed.¹⁹² Interestingly, axonal degeneration was not accompanied by loss of raphe cell bodies.¹⁹² As a result, serotonergic axons regenerate in rats administered MDMA, however, it is unknown how well these newly sprouted axons function.¹⁹³ Additionally, large doses of MDMA produce reductions in levels of 5-HT, 5-HIAA, and SERT.^{194,195,196} Levels of 5-HT reuptake sites in rats partially recovered 6 months following MDMA exposure and were fully recovered after 1 year.^{194,197} Similarly, 8 doses of MDMA given to rats over 4 days decreased brain 5-HT₂ receptor levels by 80% when measured 6 h after the last dose.¹⁹⁸ Receptor levels recovered to 62% after 24 h and were completely normalized after 21 days.¹⁹⁸ The MDMA-induced serotonergic neurotoxicity in rats is exacerbated by increased ambient temperature¹⁹⁹ and can be prevented by blocking SERT with fluoxetine.²⁰⁰ It should be noted that the doses of MDMA used in rats and mice to induce neurotoxicity are much higher than those often used by humans. Some researchers have justified these large rodent doses on the basis of allometric scaling²⁰¹ and the fact that experienced recreational users of MDMA often develop tolerance, leading them to ingest multiple doses in a short period of time to achieve the desired subjective effects of the drug.²⁰² Others have argued

that MDMA doses used in animals are too high, as MDMA produces behavioral effects at approximately the same dose (1–2 mg/kg) in humans and rats.¹⁶⁷ Finally, it has been posited that species differences in metabolism and neurotoxicity (e.g., dopaminergic toxicity in mice vs. serotonergic toxicity in rats) suggest that the metabolites of MDMA, and not necessarily MDMA itself, are responsible for the neurotoxic effects of MDMA.¹⁶⁸ Therefore, using model systems that more closely recapitulate the pharmacokinetics of MDMA in humans may be more useful.

Like rats, non-human primates experience serotonergic neurotoxicity following administration of large doses of MDMA.^{203,204} Unlike rats, these changes seem to be relatively long-lasting in most primate brain regions.^{205,206} Abnormal serotonergic innervation patterns were observed 7 years following MDMA exposure in squirrel monkeys,²⁰⁷ and these patterns seemed to result from axotomy as raphe cell bodies remained intact.²⁰⁷ In rhesus monkeys, persistent decreases in cerebrospinal fluid levels of 5-HIAA were accompanied by functional changes as measured by electrophysiology.²⁰⁸ Most of the studies assessing the neurotoxic effects of MDMA in primates administered multiple subcutaneous doses. However, humans typically consume a single oral dose of MDMA either recreationally or during MDMA-assisted psychotherapy (vide infra). To address this discrepancy, Ricaurte and co-workers compared both dose frequency and route of administration in squirrel monkeys. They found that repeated dosing and subcutaneous administration produces greater neurotoxic effects than oral dosing.²⁰⁹ Importantly, they found that a single, modest (5 mg/kg), oral dose of MDMA still produced serotonin depletion in the thalamus and hypothalamus two weeks after administration.²⁰⁹

The mechanism of MDMA-induced neurotoxicity probably involves a combination of mechanisms including glutamate-induced excitotoxicity,²¹⁰ increased oxidative stress,²¹¹ hyperthermia,²¹² mitochondrial damage, and increased inflammation.^{169,171} While the results of the numerous studies investigating MDMA-induced neurotoxicity still leave questions unanswered about the safety of MDMA administered to humans, it is reasonable to conclude that use of MDMA under common recreational conditions (e.g., high doses, multiple doses, polydrug use, high temperatures, prolonged physical activity, dehydration, etc.) is likely to cause adverse effects. However, in controlled studies in the clinic using low doses to assist psychotherapy, MDMA may be safe and well tolerated, as discussed below. When a variety of factors were considered, including physical, social, and economic factors, MDMA consistently ranked as being less harmful than illegal drugs such as heroin, cocaine, and methamphetamine, as well as legal drugs such as alcohol and nicotine.^{213,214}

POTENTIAL USE IN MEDICINE

In recent years there has been renewed interest in using psychedelic compounds like psilocybin and MDMA to treat neuropsychiatric disorders.^{215,216,217} This should not be surprising because before MDMA was placed on the Schedule I list, it was widely used by some psychiatrists to assist in treating a variety of disorders including anxiety disorders and depression. The benefits of MDMA were believed to result from increased introspection, a decrease in fear response upon accessing painful memories, and the promotion of trust between patients and their therapists.^{218,219} However, most of the work conducted during

this period yielded only anecdotal reports, and there were no placebo-controlled clinical trials conducted that adhered to current rigorous standards.

In contrast, recent clinical studies assessing the therapeutic potential of MDMA for treating PTSD are carefully controlled and well documented.^{220,221,222} First, patients are screened for medical conditions, including various neuropsychiatric disorders, that might exclude them from the study. Next, they are assessed at baseline using the Clinician-Administered PTSD Scale (CAPS). Patients then receive training sessions to establish rapport with an experienced clinician. The environment is carefully controlled so that it is aesthetically pleasing and resembles a living space rather than a medical facility. Music is often used to facilitate relaxation and/or evoke emotions. Both a male and a female therapist are present for the duration of the treatment session. After the drug is administered, there is limited verbal communication between the therapists and the patient. Instead, the patient is encouraged to explore any feelings that the experience might evoke. The therapists provide nurturing physical contact whenever necessary to help ease tension or distress. After the MDMA-session, the patient receives additional non-drug psychotherapy sessions.

An effective dosing paradigm was established by Oehen and co-workers utilizing low dose MDMA as an active placebo.²²¹ The use of an active placebo is an important part of the experimental design implemented by Oehen and co-workers. Inactive placebos, such as lactose, fail to produce physiological and psychological responses noticeable to trained clinicians or experienced MDMA users. This raises the question as to whether or not studies utilizing inactive placebos can truly be considered double-blind experiments. Patients in the experimental treatment group received an initial dose of 125 mg of MDMA followed by an additional 62.5 mg after 2.5 h. The active placebo group received an initial dose of 25 mg of MDMA followed by an additional 12.5 mg 2.5 h later. The dose of MDMA used for the active placebo group was chosen to stimulate mild but detectable psychological effects.

The most common use for MDMA in medicine is as an adjunct to psychotherapy for treating anxiety disorders.²²³ Of particular note is recent clinical work demonstrating that MDMA can produce beneficial effects in treatment-resistant PTSD patients when it is paired with psychotherapy.^{220,221,224} The beneficial effects of this treatment paradigm seemed to be relatively long-lasting, as demonstrated by follow-up studies conducted several years later.²²⁵ A recent meta-analysis determined that MDMA-assisted psychotherapy produced larger effect sizes in both clinician-observed outcomes and patient self-reports when compared to prolonged exposure therapy.²²⁶ Furthermore, fewer patients in the MDMA-assisted psychotherapy group dropped out of the study.²²⁶ These studies and others have indicated that MDMA was well tolerated when administered in a clinical setting as a single dose in the range of 75–125 mg.¹⁹ Recently, MDMA was granted “breakthrough therapy” status by the FDA for the treatment of PTSD. The phase III clinical trials are estimated to be completed within the next five years, and if the results are positive, it is anticipated that a New Drug Application for MDMA will be submitted to the FDA around 2021.²²⁷

Recent clinical work to understand the mechanism of MDMA’s therapeutic effects has revealed that this drug impacts the processing of emotionally salient information. Using functional magnetic resonance imaging (fMRI), de Wit and co-workers found that MDMA

attenuated the blood-oxygen-level dependent (BOLD) response to angry faces in the amygdala, while also enhancing the activation of the ventral striatum in response to happy faces.²²⁸ In this study, MDMA also impacted the performance of people during the Reading the Mind in the Eyes Test—a test that has participants attempt to predict what a person is thinking/feeling based on a picture of their face. Specifically, MDMA improved scores when the stimulus had a positive emotional valence. However, when the face had a negative emotional valence, MDMA-treated individuals performed poorly.²²⁹ Moreover, Carhart-Harris and co-workers found that while under the influence of MDMA, participants rated their best and worst memories as being significantly more positive and less negative, respectively.²³⁰ Related to its subjective effects, MDMA increased bilateral blood flow in the ventromedial prefrontal cortex and reduced blood flow in the left amygdala²³¹—two brain regions that play important roles in the processing of emotional stimuli and memories. Due to its general tendencies to reduce responses to threatening stimuli while enhancing responses to positive social cues, MDMA is being investigated for treating social anxiety in autistic adults,²³² and it has been suggested that MDMA may prove useful in other conditions with a significant social component.⁴⁸

Finally, MDMA may hold some promise for treating substance use disorders (SUDs).^{233,234} Initial reports suggest that MDMA might decrease substance use,²³⁵ and a pilot study conducted by Howell and co-workers demonstrated that *R*-(-)-MDMA decreased response rates during a cocaine self-administration paradigm in squirrel monkeys.²³⁶ Though very few animals were used in the latter study, the results are encouraging. While other psychedelic compounds such as LSD, psilocybin, and ibogaine have been more extensively studied than MDMA with respect to their abilities to treat SUDs, the minimal perceptual disturbances caused by MDMA may offer a distinct advantage over the classical hallucinogens.

S-(+)-MDMA VS R-(-)-MDMA

While racemic MDMA is the form used both recreationally and in clinical trials, preclinical work and some human data suggest that there are distinct differences between the *R*- and *S*-enantiomers of MDMA—the non-superposable mirror images of each other.²³⁷ The *R*- and *S*-enantiomers are sometimes referred to as the *l*- and *d*-enantiomers, respectively. An excellent review on this subject was published recently by Howell and coworkers,²³⁶ so we will only cover the highlights here.

Regarding the monoamine releasing and reuptake inhibiting properties of MDMA, there is a general consensus that the *S*-enantiomer is the more potent compound.

^{59,77,238,239,240,241,242,243,244,245,246} This is consistent with what is known about the effects of *S*-(+)-amphetamine on monoamine levels. However, *R*-(-)-MDMA appears to be a more potent direct binder of 5-HT_{2A} receptors (Table 6),^{247,248} which perhaps explains why it has a greater propensity for causing perceptual disturbances. Neither enantiomer is particularly effective at stimulating phosphatidyl inositol turnover in either 5-HT_{2A} or 5-HT_{2C} expressing cells.²⁴⁹ When rats were trained to discriminate *S*-(+)-amphetamine, LSD, and saline from each other in a 3-lever drug discrimination paradigm, *R*-(-)-MDMA and *S*-(+)-MDMA produced more hallucinogen-like and amphetamine-like discriminative stimuli,

respectively.²⁵⁰ Furthermore, experiments using mice trained to discriminate either *S*(+)-MDMA or *R*(-)-MDMA from vehicle demonstrated that the *S*-enantiomer produced more psychostimulant-like effects while the *R*-enantiomer was more hallucinogen-like.²⁵¹

In terms of their influences on hormone levels, the enantiomers of MDMA also have differential effects. Ex vivo studies utilizing rat hypothalamus tissue demonstrated that *S*(+)-MDMA is a more potent inducer of oxytocin release than the racemate, while *R*(-)-MDMA has no effect.²⁵² However, *R*(-)-MDMA was more effective at increasing the activation of hypothalamic oxytocinergic neurons, as measured by the number of c-fos positive neurons.²³⁶ Both enantiomers appear to increase vasopressin secretion comparably from the hypothalamus ex vivo.²⁵² *R*(-)-MDMA more potently increased plasma prolactin levels in rhesus macaques.²⁴⁵ Pretreatment with fluoxetine attenuated this effect, but did not block it completely. The selective 5-HT_{2A} antagonist M100907 was required to completely inhibit *R*(-)-MDMA-induced increases in prolactin, suggesting that indirect effects on 5-HT levels, as well as direct binding to 5-HT_{2A} receptors contribute to the ability of *R*(-)-MDMA to increase prolactin levels.²⁴⁶

Behaviorally, both enantiomers increase affiliative social behaviors in squirrel monkeys, and this effect seems to be dependent on activation of 5-HT_{2A} receptors.²⁵³ In mice, *R*(-)-MDMA and the racemate (but not *S*(+)-MDMA) increased social interaction and facilitated fear extinction learning, effects that could be relevant to using MDMA as a therapeutic.²⁵⁴ Furthermore, the *R*-enantiomer did not increase locomotor activity, a behavioral effect commonly produced by psychostimulants.²⁵⁴

As discussed, the primary concern for using MDMA in the clinic is its potential neurotoxicity. Most neurotoxicity studies were performed using the racemate, however, there is some evidence to suggest that the neurotoxic effects of MDMA stem from the *S*-enantiomer, with the *R*-enantiomer being relatively benign. Unlike *R*(-)-MDMA, *S*(+)-MDMA increased body temperature and promoted the activation of microglia and astroglia.²⁵⁵ However, this study employed a relatively low dose of *R*(-)-MDMA. To more definitely establish a lack of neurotoxicity following *R*(-)-MDMA administration, Howell and co-workers administered high doses of *R*(-)-MDMA (four injections of 50 mg/kg given over two days) to mice and compared effects to those produced by the racemic mixture (four injections of 20 mg/kg given over two days).²⁵⁴ These authors assessed body temperature, mortality, and markers of neurotoxicity. Unlike the racemate, high dose *R*(-)-MDMA did not influence body temperature or survival. Furthermore, the *R*-enantiomer had no effect on glial fibrillary acidic protein (GFAP) immunoreactivity, DA content, or DAT expression. The racemate significantly increased astrogliosis while decreasing both DA content and DAT expression. This study provides compelling evidence that at least in mice, the *R*-enantiomer of MDMA lacks many of the negative effects associated with the racemate, while still maintaining the ability to promote social interaction and to facilitate fear extinction learning.

Thus, *R*(-)-MDMA may be an effective pharmaceutical with an acceptable therapeutic index. However, neurotoxicity and other negative effects associated with *S*(+)-MDMA and racemic MDMA will always be associated with the acronym “MDMA,” having the potential to bias regulatory bodies, doctors, and patients. Therefore, to identify a term

suitable for common parlance, but devoid of negative connotations, we suggest the use of the alternate terms “armdma,” “esmdma,” and “racmdma” to refer to *R*-(-)-MDMA, *S*-(+)-MDMA, and (±)-MDMA, respectively. These terms are analogous to “arketamine” and “esketamine,” which refer to the *R*- and *S*-enantiomers of the fast-acting antidepressant ketamine, respectively. If armdma proves to be an effective and safe therapeutic in humans, we hope this new terminology will eliminate any potential stigma associated with using a perceived “party-drug” as a medicine.

HISTORY AND IMPORTANCE IN NEUROSCIENCE

Urban legend, rumor, and myth have clouded the true history of MDMA. Several excellent historical accounts of the discovery and development of MDMA have been reported previously,^{44,49,256,257} and thus, we only discuss the highlights here (Figure 5). First, it is a common misconception that MDMA was originally designed to be an appetite suppressor or a weight loss drug. Instead, MDMA originated from a campaign by Merck to sidestep a patent on the hemostatic drug hydrastinine held by Bayer, one of Merck’s top rivals. In fact, MDMA was first synthesized in 1912 and subsequently patented, but as it was only intended to be an intermediate en route to the desired compound, its biological activity was not assessed. It was not until 15 years after its initial synthesis that MDMA was actually tested in animal models. Merck was interested in identifying compounds that mimicked the effects of epinephrine,⁴⁹ and MDMA was one candidate tested owing to its structural similarities. Unfortunately, the results of these tests could not be found in the Merck archive.²⁵⁶

Research on MDMA appeared to stagnate until the 1950s. At that time the US military began using mescalinelike compounds, including MDMA, as part of pharmacologically-assisted interrogation programs.²⁵⁸ In essence, they were trying to identify so-called “truth drugs”—compounds capable of lowering inhibitions making people more likely to reveal secret information. The chemical warfare code of MDMA was EA-1475.⁴⁴ The methylenedioxy-containing entactogens, such as MDA and MDMA, were of particular interest to the military because these compounds tended to encourage people to speak more openly without causing overwhelming perceptual disturbances. The characteristic hallucinations produced by compounds like LSD and mescaline typically disrupted interrogation sessions. In the early 1950s, the military began testing several of these compounds on patients at the New York State Psychiatric Institute. In 1952, a patient named Harold Blauer was administered several compounds over the course of a month before succumbing to a fatal dose of MDA (450 mg).²⁵⁸ Realizing that safety data on these compounds were woefully lacking, the military contracted a group at the University of Michigan to conduct pharmacokinetic and safety studies in mice, rats, guinea pigs, dogs, and monkeys.²⁵⁹ After declassification, these data were published in 1973 and revealed that the methylenedioxy compounds were more toxic than their methoxy counterparts.²⁵⁹

The first report of the synthesis of MDMA in the peer-reviewed literature was in 1960.²⁶⁰ Afterwards, MDMA remained relatively unexplored until Alexander Shulgin learned of the unique effects of the compound and tested MDMA on himself in 1976.²⁶¹ Thereafter, Shulgin distributed it to friends and psychotherapists in northern California, who began using MDMA to facilitate psychotherapy. Shulgin and Nichols were the first to publish on

the effects of MDMA in humans in 1978.^{13,14} Though Shulgin is often credited with the rediscovery of MDMA,²⁶¹ the role of David Nichols should also be emphasized as Nichols was a co-author on these first reports of the effects of MDMA in humans. Furthermore, he was largely responsible for reclassifying MDMA and related compounds as entactogens, due to their unique qualities relative to hallucinogens and psychostimulants.⁴¹

During the period from 1978 to 1985, it is estimated that thousands of patients were treated with MDMA.²¹⁶ However, these initial studies did not adhere to the same rigorous standards that we demand of clinical trials today. As a result, the true therapeutic potential of MDMA was not captured in the scientific literature. Furthermore, the properties of MDMA that made it an effective aid to psychotherapy also led to its widespread use in social situations. During this period of time, recreational use of MDMA increased dramatically, and mounting evidence suggested that MDA, a structurally related compound, was neurotoxic. At the time, there was little data on the safety of MDMA, and thus, the DEA decided to place it on the Schedule I list in 1985 largely based on its structural similarity to MDA.²⁶² This decision was protested by a large number of scientists and therapists, and challenged in court, but ultimately, MDMA was permanently placed on the Schedule I list in 1988.

In a 2002 paper published in *Science*, Ricaurte and co-workers described experiments performed in nonhuman primates demonstrating severe dopaminergic (and to a lesser extent serotonergic) neurotoxicity of MDMA.²⁶³ These authors suggested that MDMA might put users at risk for developing Parkinson's disease. The results of the study were rapidly disseminated by the popular media, leading to the widespread public belief that administration of "recreational doses" of MDMA (3 doses of 2 mg/kg spaced over 6 hours) could have major health consequences. When Ricaurte and co-workers could not reproduce their results, they retracted their *Science* paper a year later.²⁶⁴ Further analysis revealed that animals used in the original study were likely dosed with methamphetamine, a known dopamine neurotoxin, instead of MDMA, due to a mix-up in the labeling of sample vials.

Despite its retraction, the Ricaurte study had dealt a serious blow to the credibility of MDMA as a safe therapeutic. Heated public debate ensued about the potential dangers of the drug and its government regulation. In 2009, David Nutt published an editorial where he compared the dangers of using ecstasy (1 serious adverse event in 10,000) to those of horseback riding or "equasy" (1 serious adverse event in 350).²⁶⁵ This editorial highlighted the fact that people in the scientific community felt that government agencies were not using objective criteria for assessing risk when establishing regulations for psychoactive compounds like MDMA. Since the retraction of the Ricaurte study, there have been multiple clinical trials investigating the effects of MDMA, and thus far, all data suggest that MDMA can be administered safely under these conditions.

In 2011, the first completed clinical trial evaluating the potential of MDMA-assisted psychotherapy for alleviating treatment-resistant PTSD was published.²²⁰ The results were positive, and in 2017, MDMA was granted "breakthrough therapy" status by the FDA. This designation helps to expedite the review and potential approval process for promising therapeutics. Phase III clinical trials are currently being planned, and if the results of those trials warrant approval by the FDA, a bona fide accepted medical use for MDMA will have

been established. This would necessitate the removal of MDMA from the Schedule I list, a regulatory change that could have profound implications for the field of psychedelic medicine. Schedule I status has severely hampered access to psychedelics for research purposes. In sum, this trajectory is perhaps why MDMA is the most influential compound for the future of psychedelic research. However, MDMA is also a highly divisive compound having the potential to swing public opinion against general use of psychedelics in medicine.

Since 2012, there has been an upswing in the numbers of songs and pop culture references to “molly,” a trend that parallels that seen for LSD in the 1960s and 1970s. Extensive proselytizing about the non-medical uses of LSD contributed to the creation of the Controlled Substance Act of 1970. This legislation has been a huge barrier to legitimate scientific research on the effects of these drugs and led to the first “Dark Age” for the field—the period of time from roughly 1970 to 1994 when relatively little psychedelic research was conducted. If public discourse on MDMA takes a similar course to that of LSD, we may be doomed to repeat the mistakes of the past. This would be unfortunate as MDMA is an important neurochemical tool for elucidating the neural mechanisms of social behaviors and empathy, and it has the potential to offer real relief to people suffering from PTSD and other anxiety disorders. However, because of its history and neurotoxic potential, MDMA may never achieve clinical and/or societal acceptance. Perhaps the true potential of MDMA lies in its use as a lead structure for the development of safer and more efficacious alternatives.

Acknowledgments

Funding

This work was funded in part by a UC Davis Science Translation and Innovative Research (STAIR) Grant and the National Institute on Drug Abuse (DA045550).

REFERENCES

1. Shulgin AT (1986) The background and chemistry of MDMA. *J. Psychoactive Drugs*. 18, 291–304. [PubMed: 2880943]
2. Palamar JJ (2017) What's in a name? Correlates of ecstasy users knowing or agreeing that molly is ecstasy/MDMA. *J. Psychoactive Drugs* published online 9 22, 2017. DOI: 10.1080/02791072.2017.1369200.
3. Calculated using advanced chemistry development (ACD/Labs) Software V11.02 via SciFinder Scholar.
4. Pajouhesh H, and Lenz GR (2005) Medicinal chemical properties of successful central nervous system drugs. *NeuroRx* 2, 541–553. [PubMed: 16489364]
5. Oberlender R, and Nichols DE, (1988) Drug discrimination studies with MDMA and amphetamine. *Psychopharmacology (Berl)* 95, 71–76. [PubMed: 2898791]
6. Nichols DE, Hoffman AJ, Oberlender RA, Jacob P, and Shulgin AT (1986) Derivatives of 1-(1,3-benzodioxol-5-yl)-2-butanamine: representatives of a novel therapeutic class. *J. Med. Chem.* 29, 2009–2015. [PubMed: 3761319]
7. Glennon RA, Young R, Rosecrans JA, and Anderson GM, (1982) Discriminative stimulus properties of MDA analogs. *Biological Psychiatry* 17, 807–814. [PubMed: 6126227]
8. Mori T, Uzawa N, Kazawa H, Watanabe H, Mochizuki A, Shibasaki M, Yoshizawa K, Higashiyama K, and Suzuki T (2014) Differential substitution for the discriminative stimulus effects of 3,4-methylenedioxymethamphetamine and methylphenidate in rats. *J. Pharmacol. Exp. Ther.* 350, 403–411. [PubMed: 24917544]

9. Broadbear JH, Tunstall B, and Beringer K (2010) Examining the role of oxytocin in the interoceptive effects of 3,4-methylenedioxymethamphetamine (MDMA, 'ecstasy') using a drug discrimination paradigm in the rat. *Addiction Biology* 16, 202–214. [PubMed: 21070509]
10. Harper DN, Crowther A, and Schenk S (2011) A Comparison of MDMA and amphetamine in the drug discrimination paradigm. *The Open Addiction Journal* 4, 22–23.
11. Baker LE, Broadbent J, Michael EK, Matthews PK, Metosh CA, Saunders RB, West WB, and Appel JB Assessment of the discriminative stimulus effects of the optical isomers of ecstasy (3,4-methylenedioxymethamphetamine; MDMA). *Behav. Pharmacol.* 6, 263–275. [PubMed: 11224335]
12. Kamien JB, Johanson CE, Schuster CR, and Woolverton WL (1986) The effects of (+/-)-methylenedioxymethamphetamine and (+/-)-methylenedioxyamphetamine in monkeys trained to discriminate (+)-amphetamine from saline. *Drug Alcohol Depend.* 18, 139–147. [PubMed: 2877841]
13. Anderson GM, Braun G, Braun U, Nichols DE, and Shulgin AT (1978) QUASAR: Quantitative structure activity relationships of analgesics, narcotic antagonists, and hallucinogens. *NIDA Res. Monogr. Ser* 22, 1–487.
14. Shulgin AT, and Nichols DE (1978) Characterization of three new psychotomimetics In *The Psychopharmacology of Hallucinogens*. (New York), p. 74–83, Pergamon Press, New York.
15. Peroutka SJ, Newman H, and Harris H (1988) Subjective effects of 3,4-methylenedioxymethamphetamine in recreational users. *Neuropsychopharmacology* 1, 273–277. [PubMed: 2908020]
16. Shulgin A, and Shulgin AT (1991) *PiHKAL: A Chemical Love Story*. 1st ed Transform Press, Berkeley.
17. Liechti ME, and Vollenweider FX (2001) Which neuroreceptors mediate the subjective effects of MDMA in humans? A summary of mechanistic studies. *Hum. Psychopharmacol.* 16, 589–598. [PubMed: 12404538]
18. Harris DS, Baggott M, Mendelson JH, Mendelson JE, and Jones RT (2002) Subjective and hormonal effects of 3,4-methylenedioxymethamphetamine (MDMA) in humans. *Psychopharmacology (Berl)* 162, 396–405. [PubMed: 12172693]
19. Vizeli P, Liechti ME (2017) Safety pharmacology of acute MDMA administration in healthy subjects. *J. Psychopharmacol.* 31, 576–588. [PubMed: 28443695]
20. Bershak AK, Miller MA, Baggott MJ, de Wit H (2016) The effects of MDMA on socio-emotional processing: does MDMA differ from other stimulants? *J. Psychopharmacol.* 30, 1248–1258. [PubMed: 27562198]
21. Kamilar-Britt P, Bedi G (2015) The prosocial effects of 3,4-methylenedioxymethamphetamine (MDMA): controlled studies in humans and laboratory animals. *Neurosci. Biobehav. Rev.* 57, 433–446. [PubMed: 26408071]
22. Cami J, Farre M, Mas M, Roset PN, Poudevida S Mas A, San L, de la Torre R (2000) Human pharmacology of 3,4-methylenedioxymethamphetamine ("ecstasy"): psychomotor performance and subjective effects. *J. Clin. Psychopharmacol.* 20, 455–466. [PubMed: 10917407]
23. Kolbrich EA, Goodwin RS, Gorelick DA, Hayes RJ, Stein EA, Huestis MA (2008) Physiological and subjective responses to controlled oral 3,4-methylenedioxymethamphetamine administration. *J. Clin. Psychopharmacol.* 28, 432–440. [PubMed: 18626271]
24. Vollenweider FX, Gamma A, Liechti ME, Huber T (1998) Psychological and cardiovascular effects and short-term sequelae of MDMA ("ecstasy") in MDMA-naïve healthy volunteers. *Neuropsychopharmacology* 19, 241–251. [PubMed: 9718588]
25. Liechti ME, Saur MR, Gamma A, Hell D, Vollenweider FX (2000) Psychological and physiological effects of MDMA ("Ecstasy") after pretreatment with the 5-HT(2) antagonist ketanserin in healthy humans. *Neuropsychopharmacology* 23, 396–404. [PubMed: 10989266]
26. Nichols DE (2004) Hallucinogens. *Pharmacol. Ther.* 101, 131–181. [PubMed: 14761703]
27. Nichols DE (2016) Psychedelics. *Pharmacol. Rev.* 68, 264–355. [PubMed: 26841800]
28. Hasler F, Studerus E, Lindner K, Ludewig S, Vollenweider F (2009) Investigation of serotonin-1A receptor function in the human psychopharmacology of MDMA. *J. Psychopharmacol.* 23, 923–935. [PubMed: 18635693]

29. Kuypers KP, de la Torre R, Farre M, Yubero-Lahoz S, Dziobek I, Van den Bos W, Ramaekers JG (2014) No evidence that MDMA-induced enhancement of emotional empathy is related to peripheral oxytocin levels or 5-HT1a receptor activation. *PLoS One* 9, e100719. [PubMed: 24972084]
30. Van Wel JH, Kuypers KP, Theunissen EL, Bosker WM, Bakker K, Ramaekers JG (2012) Effects of acute MDMA intoxication on mood and impulsivity: role of the 5-HT2 and 5-HT1 receptors. *PLoS One* 7, e40187. [PubMed: 22808116]
31. Farre M, Abanades S, Roset PN, Peiro AM, Torrens M, O'Mathuna B, O'Mathúna B, Segura M, de la Torre R (2007) Pharmacological interaction between 3,4-methylenedioxymethamphetamine (ecstasy) and paroxetine: pharmacological effects and pharmacokinetics. *J. Pharmacol. Exp. Ther.* 323, 954–962. [PubMed: 17890444]
32. Liechti ME, Baumann C, Gamma A, Vollenweider FX (2000) Acute psychological effects of 3,4-methylenedioxymethamphetamine (MDMA, "Ecstasy") are attenuated by the serotonin uptake inhibitor citalopram. *Neuropsychopharmacology* 22, 513–521. [PubMed: 10731626]
33. Tancer M, Johanson CE (2007) The effects of fluoxetine on the subjective and physiological effects of 3,4-methylenedioxymethamphetamine (MDMA) in humans. *Psychopharmacology* 189, 565–573. [PubMed: 17047932]
34. Hysek CM, Simmler LD, Ineichen M, Grouzmann E, Hoener MC, Brenneisen R, Huwyler J, Liechti ME (2011) The norepinephrine transporter inhibitor reboxetine reduces stimulant effects of MDMA ("ecstasy") in humans. *Clinical pharmacology and therapeutics* 90, 246–255. [PubMed: 21677639]
35. Hysek CM, Simmler LD, Nicola V, Vischer N, Donzelli M, Krähenbühl S, Grouzmann E, Huwyler J, Hoener MC, Liechti ME (2012) Duloxetine inhibits effects of MDMA ("ecstasy") in vitro and in humans in a randomized placebo-controlled laboratory study. *PLoS One* 7, e36476. [PubMed: 22574166]
36. Liechti ME, Gamma A, and Vollenweider FX (2001) Gender differences in the subjective effects of MDMA. *Psychopharmacology (Berl)*. 154, 161–168. [PubMed: 11314678]
37. Vizeli P, Liechti ME (2017) Safety pharmacology of acute MDMA administration in healthy subjects. *J Psychopharmacol.* 31, 576–588. [PubMed: 28443695]
38. Dolder PC, Muller F, Schmid Y, Borgwardt SJ, Liechti ME (2018) Direct comparison of the acute subjective, emotional, autonomic, and endocrine effects of MDMA, methylphenidate, and modafinil in healthy subjects. *Psychopharmacology (Berl)*. 235, 467–479. [PubMed: 28551715]
39. Schmid Y, Hysek CM, Simmler LD, Crockett MJ, Quednow BB, Liechti ME (2014) Differential effects of MDMA and methylphenidate on social cognition. *J. Psychopharmacol.* 28, 847–856. [PubMed: 25052243]
40. Yensen R, Metzner R, Shakespeare W, and Nichols DE (1993) The Great Entactogen - Empathogen Debate. *Newsletter of the Multidisciplinary Association for Psychedelic Studies* MAPS 4, 47–49.
41. Nichols DE (1986) Differences between the mechanism of action of MDMA, MBDB, and the classic hallucinogens. Identification of a new therapeutic class: entactogens. *J. Psychoactive Drugs* 18,305–313. [PubMed: 2880944]
42. Dolder PC, Schmid Y, Mueller F, Borgwardt S, Liechti ME (2016) LSD acutely impairs fear recognition and enhances emotional empathy and sociality. *Neuropsychopharmacology* 41, 2638–2646. [PubMed: 27249781]
43. Schmid Y, Enzler F, Gasser P, Grouzmann E, Preller KH, Vollenweider FX, Brenneise R, Muller F, Borgwardt S, Liechti ME (2015) Acute effects of lysergic acid diethylamide in healthy subjects. *Biol. Psychiatry* 78, 544–553. [PubMed: 25575620]
44. Pentney AR (2001) An exploration of the history and controversies surrounding MDMA and MDA. *J. Psychoactive Drugs.* 33, 213–221. [PubMed: 11718314]
45. SAMHSA. (2015) National Survey on Drug Use and Health, 2002-2014. Rockville, MD <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.pdf>.
46. Wu P, Liu X, Pham TH, Jin J, Fan B, and Jin Z (2010) Ecstasy use among US adolescents from 1999 to 2008. *Drug Alcohol Depend.* 112, 33–38. [PubMed: 20570447]

47. Palamar JJ, Mauro PM, Han BH, and Martins SS (2017) Shifting characteristics of ecstasy users ages 12-34 in the United States, 2007-2014. *Drug Alcohol Depend.* 181, 20–24. [PubMed: 29028555]
48. Heifets BD, and Malenka RC (2016) MDMA as a probe and treatment for social behaviors. *Cell.* 166, 269–272. [PubMed: 27419864]
49. Karch SB (2011) A historical review of MDMA. *The Open Forensic Science Journal.* 4, 20–24.
50. Renton RJ, Cowie JS, and Oon MC (1993) A study of the precursors, intermediates and reaction byproducts in the synthesis of 3,4-methylenedioxyamphetamine and its application to forensic drug analysis. *Forensic Sci. Int.* 60, 189–202. [PubMed: 7901132]
51. Biniecki S, and Krajewski E (1960) Preparation of dl- 1-(3,4- methylenedioxyphenyl)-2-(methylamino)propane and dl-(3,4- dimethoxyphenyl)-2-(methylamino)propane. *Acta Poloniae Pharmaceutica* 17, 421–425.
52. Cox M, and Klass G (2006) Synthesis by-products from the Wacker oxidation of safrole in methanol using rho-benzoquinone and palladium chloride. *Forensic Sci Int.* 164, 138–147. [PubMed: 16442765]
53. Braun U, Shulgin AT, and Braun G (1980) Centrally active N-substituted analogs of 3,4-methylenedioxyphenylisopropylamine (3,4-methylenedioxyamphetamine). *J. Pharm. Sci.* 69, 192–195. [PubMed: 6102141]
54. Heather E, Shimmom R, McDonagh AM (2015) Organic impurity profiling of 3,4-methylenedioxyamphetamine (MDMA) synthesised from catechol. *Forensic Sci. Int.* 48, 140–147.
55. Parker M, Marona-Lewicka D, Kurrasch D, Shulgin AT, and Nichols DE (1998) Synthesis and pharmacological evaluation of ring-methylated derivatives of 3,4-(methylenedioxy)amphetamine (MDA). *J. Med. Chem* 41, 1001–1005. [PubMed: 9526575]
56. Pizarro N, de la Torre R, Farré M, Segura J, Llebaria A, and Joglar J (2002) Synthesis and capillary electrophoretic analysis of enantiomerically enriched reference standards of MDMA and its main metabolites. *Bioorg. Med. Chem.* 10, 1085–1092. [PubMed: 11836119]
57. Llabres S, García-Ratés S, Cristóbal-Lecina E, Riera A, Borrell JI, Camarasa J, Pubill D, Luque FJ, and Escubedo E (2014) Molecular basis of the selective binding of MDMA enantiomers to the alpha4beta2 nicotinic receptor subtype: synthesis, pharmacological evaluation and mechanistic studies. *Eur. J. Med. Chem.* 81, 35–46. [PubMed: 24942641]
58. Nenajdenko VG, Karpov AS, and Balenkova ES (2001) A new convenient approach to chiral -aryl(heteroaryl)alkylamines. *Tet. Asymmetry* 12, 2517–2527.
59. Huot P, Johnston TH, Lewis KD, Koprlich JB, Reyes MG, Fox SH, Piggott MJ, and Brotchie JM (2011) Characterization of 3,4-methylenedioxyamphetamine (MDMA) enantiomers in vitro and in the MPTP-lesioned primate: R-MDMA reduces severity of dyskinesia, whereas S-MDMA extends duration of ON-time. *J. Neurosci.* 31, 7190–7198. [PubMed: 21562283]
60. Iversen L, Gibbons S, Treble R, Setola V, Huang XP, and Roth BL (2013) Neurochemical profiles of some novel psychoactive substances. *Eur. J. Pharmacol.* 700, 147–151. [PubMed: 23261499]
61. Jones DC, Lau SS, and Monks TJ (2004) Thioether metabolites of 3,4-methylenedioxyamphetamine and 3,4-methylenedioxyamphetamine inhibit human serotonin transporter (hSERT) function and simultaneously stimulate dopamine uptake into hSERT-expressing SK-N-MC cells. *J. Pharmacol. Exp. Ther.* 311, 298–306. [PubMed: 15169827]
62. Simmler L, Buser T, Donzelli M, Schramm Y, Dieu LH, Huwyler J, et al. (2013) Pharmacological characterization of designer cathinones in vitro. *Br. J. Pharmacol.* 168, 458–470. [PubMed: 22897747]
63. Han DD, Gu HH (2006) Comparison of the monoamine transporters from human and mouse in their sensitivities to psychostimulant drugs. *BMC Pharmacol.* 6, 6. [PubMed: 16515684]
64. Sandtner W, Stockner T, Hasenhuettl PS, Partilla JS, Seddik A, Zhang YW, Cao J, Holy M, Steinkellner T, Rudnick G, Baumann MH, Ecker GF, Newman AH, Sitte HH (2016) Binding Mode Selection Determines the Action of Ecstasy Homologs at Monoamine Transporters. *Mol. Pharmacol.* 89, 165–175. [PubMed: 26519222]

65. Rothman RB, Baumann MH, Dersch CM, Romero DV, Rice KC, Carroll FI, and Partilla JS (2001) Amphetamine-type central nervous system stimulants release norepinephrine more potently than they release dopamine and serotonin. *Synapse* 39, 32–41. [PubMed: 11071707]
66. Bogen IL, Haug KH, Myhre O, and Fonnum F (2003) Short- and long-term effects of MDMA ("ecstasy") on synaptosomal and vesicular uptake of neurotransmitters in vitro and ex vivo. *Neurochem. Int.* 43, 393–400. [PubMed: 12742084]
67. Fitzgerald JL, and Reid JJ (1990) Effects of methylenedioxymethamphetamine on the release of monoamines from rat brain slices. *Eur J Pharmacol.* 191, 217–220. [PubMed: 1982265]
68. Rudnick G, and Wall SC (1992) The molecular mechanism of "ecstasy" [3,4-methylenedioxymethamphetamine (MDMA)]: serotonin transporters are targets for MDMA-induced serotonin release. *Proc. Natl. Acad. Sci. USA.* 89, 1817–1821 [PubMed: 1347426]
69. Mlinar B, Corradetti R (2003) Endogenous 5-HT, released by MDMA through serotonin transporter- and secretory vesicle-dependent mechanisms, reduces hippocampal excitatory synaptic transmission by preferential activation of 5-HT_{1B} receptors located on CA1 pyramidal neurons. *Eur. J. Neurosci* 18, 1559–1571. [PubMed: 14511335]
70. Schuldiner S, Steiner-Mordoch S, Yelin R, Wall SC, and Rudnick G (1993) Amphetamine derivatives interact with both plasma membrane and secretory vesicle biogenic amine transporters. *Mol. Pharmacol.* 44, 1227–1231. [PubMed: 7903417]
71. Sulzer D, and Rayport S (1990) Amphetamine and other psychostimulants reduce pH gradients in midbrain dopaminergic neurons and chromaffin granules: a mechanism of action. *Neuron* 5, 797–808. [PubMed: 2268433]
72. Leonardi ET, and Azmitia EC (1994) MDMA (ecstasy) inhibition of MAO type A and type B, comparisons with fenfluramine and fluoxetine (Prozac). *Neuropsychopharmacology* 10, 231–238. [PubMed: 7945733]
73. Kittler K, Lau T, and Schloss P (2010) Antagonists and substrates differentially regulate serotonin transporter cell surface expression in serotonergic neurons. *Eur. J. Pharmacol.* 629, 63–67. [PubMed: 20006597]
74. Golembiowska K, Jurczak A, Kamińska K, Noworyta-Sokołowska K, and Górska A (2016) Effect of some psychoactive drugs used as 'legal highs' on brain neurotransmitters. *Neurotox. Res* 29, 394–407. [PubMed: 26501352]
75. Irvani MM, Asari D, Patel J, Wieczorek WJ, and Kruk ZL (2000) Direct effects of 3,4-methylenedioxymethamphetamine (MDMA) on serotonin or dopamine release and uptake in the caudate putamen, nucleus accumbens, substantia nigra pars reticulata, and the dorsal raphe nucleus slices. *Synapse* 36, 275–285. [PubMed: 10819905]
76. Battaglia G, Brooks BP, Kulsakdinun C, and De Souza EB (1988) Pharmacologic profile of MDMA (3,4-methylenedioxymethamphetamine) at various brain recognition sites. *Eur. J. Pharmacol.* 149, 159–163. [PubMed: 2899513]
77. Setola V, Hufeisen SJ, Grande-Allen KJ, Vesely I, Glennon RA, Blough B, Rothman RB, and Roth BL (2003) 3,4-methylenedioxymethamphetamine (MDMA, "Ecstasy") induces fenfluramine-like proliferative actions on human cardiac valvular interstitial cells in vitro. *Mol. Pharmacol.* 63, 1223–1229. [PubMed: 12761331]
78. Rickli A, Hoener MC, Liechti ME (2015) Monoamine transporter and receptor interaction profiles of novel psychoactive substances: para-halogenated amphetamines and pyrovalerone cathinones. *Euro. Neuropsychopharmacol.* 25, 365–376.
79. Doly S, Valjent E, Setola V, Callebert J, Herve D, Launay JM, and Maroteaux L (2008) Serotonin 5-HT_{2B} receptors are required for 3,4-methylenedioxymethamphetamine-induced hyperlocomotion and 5-HT release in vivo and in vitro. *J. Neurosci.* 28, 2933–2940. [PubMed: 18337424]
80. Bunzow JR, Sonders MS, Arttamangkul S, Harrison LM, Zhang G, Quigley DI, Darland T, Suchland KL, Pasumamula S, Kennedy JL, Olson SB, Magenis RE, Amara SG, and Grandy DK (2001) Amphetamine, 3,4-methylenedioxymethamphetamine, lysergic acid diethylamide, and metabolites of the catecholamine neurotransmitters are agonists of a rat trace amine receptor. *Mol. Pharmacol.* 60, 1181–1188. [PubMed: 11723224]

81. Borowsky B, Adham N, Jones KA, Raddatz R, Artymyshyn R, Ogozalek KL, Durkin MM, Lakhilani PP, Bonini JA, Pathirana S, Boyle N, Pu X, Kouranova E, Lichtblau H, Ochoa FY, Branchek TA, and Gerald C (2001) Trace amines: Identification of a family of mammalian G protein-coupled receptors. *Proc. Natl. Acad. Sci* 98, 8966–8971. [PubMed: 11459929]
82. Accorroni A, and Zucchi R (2016) Trace Amine-Associated Receptors: Ligands and putative role in the central nervous system (Farooqui A Ed.), pp 151–164. Academic Press, San Diego.
83. Miller GM (2011) The emerging role of trace amine-associated receptor 1 in the functional regulation of monoamine transporters and dopaminergic activity. *J. Neurochem.* 116, 164–176. [PubMed: 21073468]
84. Simmler LD, Buchy D, Chaboz S, Hoener MC, Liechti ME (2016) In vitro characterization of psychoactive substances at rat, mouse, and human trace amine-associated receptor 1. *J. Pharmacol. Exp. Ther.* 357, 134–144. [PubMed: 26791601]
85. Brammer MK, Gilmore DL, and Matsumoto RR, (2006) Interactions between 3,4-methylenedioxymethamphetamine and σ 1 Receptors. *Eur. J. Pharmacol.* 553, 141–145. [PubMed: 17070798]
86. Cobos EJ, Entrena JM, Nieto FR, Cendan CM, and Del Pozo E (2008) Pharmacology and therapeutic potential of sigma(1) receptor ligands. *Curr. Neuropharmacol* 6, 344–366. [PubMed: 19587856]
87. Hayashi T (2015) Sigma-1 receptor: the novel intracellular target of neuropsychotherapeutic drugs. *J. Pharmacol. Sci.* 127, 2–5. [PubMed: 25704011]
88. Maurice T, and Su T-P (2009) The pharmacology of sigma-1 receptors. *Pharmacol. Ther.* 124, 195–206. [PubMed: 19619582]
89. Villard V, Meunier J, Chevallier N, and Maurice T (2011) Pharmacological interaction with the sigma(1) (σ 1)-receptor in the acute behavioral effects of antidepressants. *J. Pharmacol. Sci.* 115, 279–292. [PubMed: 21427517]
90. Stahl SM (2008) The sigma enigma: can sigma receptors provide a novel target for disorders of mood and cognition? *J. Clin. Psychiatry* 69, 1673–1674. [PubMed: 19200426]
91. Grob CS, Poland RE, Chang L, Ernst T (1996) Psychobiologic effects of 3,4-methylenedioxymethamphetamine in humans: methodological considerations and preliminary observations. *Behav. Brain. Res* 73,103–107 [PubMed: 8788485]
92. Mas M, Farre M, de la Torre R, Roset PN, Ortuno J, Segura J, Cami J (1999) Cardiovascular and neuroendocrine effects and pharmacokinetics of 3,4-methylenedioxymethamphetamine in humans. *J Pharmacol. Exp. Ther* 290, 1–10 [PubMed: 10381752]
93. Dumont GJ, Sweep FC, van der Steen R, Hermsen R, Donders AR, Touw DJ, van Gerven JM, Buitelaar JK, and Verkes RJ (2009) Increased oxytocin concentrations and prosocial feelings in humans after ecstasy (3,4-methylenedioxymethamphetamine) administration. *Soc. Neurosci.* 4, 359–366. [PubMed: 19562632]
94. Seibert J, Hysek CM, Penno CA, Schmid Y, Kratschmar DV, Liechti ME, Odermatt A (2014) Acute effects of 3,4-methylenedioxymethamphetamine and methylphenidate on circulating steroid levels in healthy subjects. *Neuroendocrinology* 100, 17–25. [PubMed: 24903002]
95. Henry JA, Fallon JK, Kicman AT, Hutt AJ, Cowan DA, Forsling M (1998) Low-dose MDMA ("ecstasy") induces vasopressin secretion. *Lancet* 351, 1784. [PubMed: 9635954]
96. Wolff K, Tsapakis EM, Winstock AR, Hartley D, Holt D, Forsling ML, Aitchison KJ (2006) Vasopressin and oxytocin secretion in response to the consumption of ecstasy in a clubbing population. *J. Psychopharmacol.* 20, 400–410. [PubMed: 16574714]
97. Lefebvre H, Contesse V, Delarue C, Feuilloley M, Hery F, Grise P, Raynaud G, Verhofstad AA, Wolf LM, and Vaudry H (1992) Serotonin-induced stimulation of cortisol secretion from human adrenocortical tissue is mediated through activation of a serotonin-4 receptor subtype. *Neuroscience* 47, 999–1007 [PubMed: 1374544]
98. Prescott RW, Kendall-Taylor P, Weightman DR, Watson MJ, and Ratcliffe WA (1984) The effect of ketanserin, a specific serotonin antagonist on the PRL, GH, ACTH, and cortisol responses to hypoglycaemia in normal subjects. *Clin. Endocrinol.(Oxf)* 20,137–142 [PubMed: 6325044]

99. Thompson MR, Callaghan PD, Hunt GE, Cornish JL, and McGregor IS (2007) A role for oxytocin and 5-HT(1A) receptors in the prosocial effects of 3,4-methylenedioxymethamphetamine ("ecstasy"). *Neuroscience* 146, 509–514. [PubMed: 17383105]
100. Parrott AC (2016) Oxytocin, cortisol and 3,4-methylenedioxymethamphetamine: neurohormonal aspects of recreational "ecstasy". *Behav. Pharmacol* 27, 649–658. [PubMed: 27681116]
101. Kuypers KPC, Dolder PC, Ramaekers JG, Liechti ME (2017) Multifaceted empathy of healthy volunteers after single doses of MDMA: a pooled sample of placebo-controlled studies. *J. Psychopharmacol* 31, 589–598. [PubMed: 28372480]
102. Fox MA, Andrews AM, Wendland JR, Lesch KP, Holmes A, and Murphy DL (2007) A pharmacological analysis of mice with a targeted disruption of the serotonin transporter. *Psychopharmacology (Berl)*. 195, 147–166. [PubMed: 17712549]
103. Spanos LJ, and Yamamoto BK (1989) Acute and subchronic effects of methylenedioxymethamphetamine [(+/-)MDMA] on locomotion and serotonin syndrome behavior in the rat. *Pharmacol. Biochem. Behav* 32, 835–840. [PubMed: 2572003]
104. Kalivas PW, Duffy P, and White SR (1998) MDMA elicits behavioral and neurochemical sensitization in rats. *Neuropsychopharmacology* 18, 469–479. [PubMed: 9571655]
105. Scearce-Levie K, Viswanathan SS, and Hen R (1999) Locomotor response to MDMA is attenuated in knockout mice lacking the 5-HT1B receptor. *Psychopharmacology (Berl)*. 141, 154–161. [PubMed: 9952039]
106. Kehne JH, Ketteler HJ, McCloskey TC, Sullivan CK, Dudley MW, and Schmidt CJ (1996) Effects of the selective 5-HT2A receptor antagonist MDL 100,907 on MDMA-induced locomotor stimulation in rats. *Neuropsychopharmacology* 15, 116–124. [PubMed: 8840347]
107. Risbrough VB, Masten VL, Caldwell S, Paulus MP, Low MJ, and Geyer MA (2006) Differential contributions of dopamine D1, D2, and D3 receptors to MDMA-induced effects on locomotor behavior patterns in mice. *Neuropsychopharmacology* 31, 2349–2358. [PubMed: 16855533]
108. Callaway CW, Wing LL, and Geyer MA (1990) Serotonin release contributes to the locomotor stimulant effects of 3,4-methylenedioxymethamphetamine in rats. *J. Pharmacol. Exp. Ther* 254, 456–464. [PubMed: 1974635]
109. Bengel D, Murphy DL, Andrews AM, Wichems CH, Feltner D, Heils A, Mossner R, Westphal H, and Lesch KP (1998) Altered brain serotonin homeostasis and locomotor insensitivity to 3, 4-methylenedioxymethamphetamine ("ecstasy") in serotonin transporter-deficient mice. *Mol. Pharmacol.* 53, 649–655. [PubMed: 9547354]
110. Lin HQ, Burden PM, Christie MJ, and Johnston GA (1999) The anxiogenic-like and anxiolytic-like effects of MDMA on mice in the elevated plus-maze: a comparison with amphetamine. *Pharmacol. Biochem. Behav* 62, 403–408. [PubMed: 10080230]
111. Navarro JF, and Maldonado E (2002) Acute and subchronic effects of MDMA ("ecstasy") on anxiety in male mice tested in the elevated plus-maze. *Prog. Neuropsychopharmacol. Biol. Psychiatry*. 26, 1151–1154.
112. Ho YJ, Pawlak CR, Guo L, and Schwarting RK (2004) Acute and long-term consequences of single MDMA administration in relation to individual anxiety levels in the rat. *Behav. Brain. Res* 149,135–144. [PubMed: 15129777]
113. Maldonado E, and Navarro JF (2000) Effects of 3,4-methylenedioxy-methamphetamine (MDMA) on anxiety in mice tested in the light-dark box. *Prog. Neuropsychopharmacol. Biol. Psychiatry* 24, 463–472. [PubMed: 10836493]
114. Morley KC, and McGregor IS, (2000). (±)-3,4-Methylenedioxymethamphetamine (MDMA, 'Ecstasy') increases social interaction in rats. *Eur. J. Pharmacol* 408, 41–49. [PubMed: 11070182]
115. Ramos L, Hicks C, Caminer A, Goodwin J, and McGregor IS (2015) Oxytocin and MDMA ('Ecstasy') enhance social reward in rats. *Psychopharmacology (Berl)*. 232, 2631–2641. [PubMed: 25772337]
116. Brown A, Brown TB, Calabrese A, Ellis D, Puhalo N, Ralph M, and Watson L (2010) Triazole oxytocin antagonists: Identification of an aryloxyazetidone replacement for a biaryl substituent. *Bioorg. Med. Chem. Lett* 20, 516–520. [PubMed: 19963374]
117. Ramos L, Hicks C, Kevin R, Caminer A, Narlawar R, Kassiou M, and McGregor IS (2013) Acute prosocial effects of oxytocin and vasopressin when given alone or in combination with 3,4-

methylenedioxyamphetamine in rats: involvement of the V1A receptor. *Neuropsychopharmacology* 38, 2249–2259. [PubMed: 23676791]

118. Young MB, Andero R, Ressler KJ, and Howell LL (2015) 3,4-Methylenedioxyamphetamine facilitates fear extinction learning. *Transl. Psychiatry* 5, e634. [PubMed: 26371762]
119. Catlow BJ, Song S, Paredes DA, Kirstein CL, and Sanchez-Ramos J (2013) Effects of psilocybin on hippocampal neurogenesis and extinction of trace fear conditioning. *Exp. Brain Res* 228, 481–491. [PubMed: 23727882]
120. Cameron LP, Benson CJ, Dunlap LE, Olson DE (2018) Effects of N,N-dimethyltryptamine (DMT) on rat behaviors relevant to anxiety and depression. *ACS Chem. Neurosci* ASAP.
121. Young MB, Norrholm SD, Khoury LM, Jovanovic T, Rauch SAM, Reiff CM, Dunlap BW, Rothbaum BO, and Howell LL (2017) Inhibition of serotonin transporters disrupts the enhancement of fear memory extinction by 3,4-methylenedioxyamphetamine (MDMA). *Psychopharmacology* 234, 2883–2895. [PubMed: 28741031]
122. Nyberg F (2014) Structural plasticity of the brain to psychostimulant use. *Neuropharmacology* 87, 115–124. [PubMed: 25018041]
123. Martinez-Turrillas R, Moyano S, Del Rio J, Frechilla D, (2006) Differential effects of 3,4-methylenedioxyamphetamine (MDMA, “ecstasy”) on BDNF mRNA expression in rat frontal cortex and hippocampus. *Neuroscience Letters* 402, 126–130. [PubMed: 16644117]
124. Hemmerle AM, Dickerson JW, Herring NR, Schaefer TL, Vorhees CV, Williams MT, 1, and Seroogy KB (2012) (±)3,4-Methylenedioxyamphetamine (“Ecstasy”) treatment modulates expression of neurotrophins and their receptors in multiple regions of adult rat brain. *J. Comp. Neurol* 520, 2459–2474. [PubMed: 22237931]
125. Abad S, Camarasa J, Pubill D, Camins A, and Escubedo E (2016) Adaptive plasticity in the hippocampus of young mice intermittently exposed to MDMA could be the origin of memory deficits. *Mol. Neurobiol.* 53, 7271–7283. [PubMed: 26687233]
126. Abad S, Fole A, del Olmo N, Pubill D, Pallàs M, Junyent F, Camarasa J, Camins A, Escubedo E (2014) MDMA enhances hippocampal-dependent learning and memory under restrictive conditions, and modifies hippocampal spine density. *Psychopharmacology (Berl)*. 231, 863–874. [PubMed: 24158501]
127. Kaizaki A, Tanaka S, Tsujikawa K, Numazawa S, Yoshida T (2010) Recreational drugs, 3,4-Methylenedioxyamphetamine(MDMA), 3,4-methylenedioxyamphetamine (MDA) and diphenylprolinol, inhibit neurite outgrowth in PC12 cells. *J. Toxicol. Sci* 35, 375–381. [PubMed: 20519846]
128. Ly C, Greb AC, Cameron LP, Wong JM, Barragan EV, Wilson PC, Burbach KF, Dunlap LE, Soltanzadeh Zarandi S, Sood A, Paddy MR, Duim WC, Dennis MY, McAllister AK, Ori-McKenney KM, Gray JA, and Olson DE (2018) Psychedelics promote structural and functional neural plasticity. *Cell Rep.* 23, 3170–3182. [PubMed: 29898390]
129. Kreth K, Kovar K, Schwab M, and Zanger UM (2000). Identification of the human cytochromes P450 involved in the oxidative metabolism of “Ecstasy”-related designer drugs. *Biochem. Pharmacol* 59, 1563–1571. [PubMed: 10799653]
130. Shima N, Kamata H, Katagi M, Tsuchihashi H, Sakuma T, and Nemoto N (2007) Direct determination of glucuronide and sulfate of 4-hydroxy-3-methoxyamphetamine, the main metabolite of MDMA, in human urine. *J. Chromatogr. B. Analyt. Technol. Biomed. Life Sci* 857, 123–129.
131. Vizeli P, Schmid Y, Prestin K, Meyer zu Schwabedissen HE, Liechti ME (2017) Pharmacogenetics of ecstasy: CYP1A2, CYP2C19, and CYP2B6 polymorphisms moderate pharmacokinetics of MDMA in healthy subjects. *Euro. Neuropsychopharmacol* 27, 232–238.
132. Schmid Y, Vizeli P, Hysek CM, Prestin K, Meyer zu Schwabedissen HE, Liechti ME (2016) CYP2D6 function moderates the pharmacokinetics and pharmacodynamics of MDMA in a controlled study in healthy subjects. *Pharmacogenet. Genom* 26, 397–401.
133. de la Torre R, Farré M, Roset PN, Lopez CH, Mas M, Ortuño J, Menoyo E, Pizarro N, Segura J, and Camí J (2000) Pharmacology of MdMa in humans. *Ann N. Y. Acad. Sci* 914, 225–237. [PubMed: 11085324]

134. de la Torre R, Farre M, Ortuno J, Mas M, Brenneisen R, Roset PN, Segura J, and Cami J (2000) Non-linear pharmacokinetics of MDMA ('ecstasy') in humans. *Br. J. Clin. Pharmacol* 49, 104–109. [PubMed: 10671903]
135. Kolbrich EA, Goodwin RS, Gorelick DA, Hayes RJ, Stein EA, and Huestis MA. (2008) Plasma pharmacokinetics of 3,4-methylenedioxymethamphetamine after controlled oral administration to young adults. *Ther. Drug Monit* 30, 320–332. [PubMed: 18520604]
136. Mueller M, Peters FT, Maurer HH, McCann UD, and Ricaurte GA, (2008) Nonlinear pharmacokinetics of (+/-)3,4-methylenedioxymethamphetamine (MDMA, "Ecstasy") and its major metabolites in squirrel monkeys at plasma concentrations of MDMA that develop after typical psychoactive doses. *J. Pharmacol. Exp. Ther* 327,38–44. [PubMed: 18591215]
137. Delaforge M, Jaouen M, and Bouille G (1999) Inhibitory metabolite complex formation of methylenedioxymethamphetamine with rat and human cytochrome P450. Particular involvement of CYP2D. *Environ. Toxicol. Pharmacol* 7,153–158. [PubMed: 21781921]
138. Yang J, Jamei M, Heydari A, Yeo KR, de la Torre R, Farré M, Tucker GT, Rostami-Hodjegan A (2006) Implications of mechanism-based inhibition of CYP2D6 for the pharmacokinetics and toxicity of MDMA. *J. Psychopharmacol* 20, 842–849. [PubMed: 16714321]
139. Pizarro N, Farre M, Pujadas M, Peiró AM, Roset PN, Joglar J, and de la Torre R (2004) Stereochemical analysis of 3,4-methylenedioxymethamphetamine and its main metabolites in human samples including the catechol-type metabolite (3,4-dihydroxymethamphetamine). *Drug Metab. Dispos* 2, 1001–1007.
140. Fallon JK, Kicman AT, Henry JA, Milligan PJ, Cowan DA, and Hutt AJ (1999) Stereospecific analysis and enantiomeric disposition of 3, 4-methylenedioxymethamphetamine (Ecstasy) in humans. *Clin. Chem* 45,1058–1069. [PubMed: 10388483]
141. Steuer AE, Schmidhauser C, Schmid Y, Rickli A, Liechti ME, Kraemer T (2015) Chiral Plasma Pharmacokinetics of 3,4-Methylenedioxymethamphetamine and its Phase I and II Metabolites following Controlled Administration to Humans. *Drug Metab. Dispos* 43, 1864–1871. [PubMed: 26395866]
142. Liechti ME, Vollenweider FX (2000). The serotonin uptake inhibitor citalopram reduces acute cardiovascular and vegetative effects of 3,4-methylenedioxymethamphetamine ('Ecstasy') in healthy volunteers. *J. Psychopharmacol* 14, 269–274. [PubMed: 11106307]
143. Henry JA, Jeffreys KJ, and Dawling S (1992) Toxicity and deaths from 3,4-methylenedioxymethamphetamine ("ecstasy") *Lancet* 340, 384–387. [PubMed: 1353554]
144. Henry JA (1992) Ecstasy and the dance of death. *BMJ* 305, 5–6. [PubMed: 1353390]
145. Brown PL, and Kiyatkin EA (2004) Brain hyperthermia induced by MDMA (ecstasy): modulation by environmental conditions. *Eur. J. Neurosci* 20, 51–58. [PubMed: 15245478]
146. Fantegrossi WE, Godlewski T, Karabenick RL, Stephen JM, Ullrich T, Rice KC, and Woods JH (2003) Pharmacological characterization of the effects of 3,4-methylenedioxymethamphetamine ("ecstasy") and its enantiomers on lethality, core temperature, and locomotor activity in singly housed and crowded mice. *Psychopharmacology (Berl)*. 166, 202–211. [PubMed: 12563544]
147. Spanos LJ, and Yamamoto BK (1989) Acute and subchronic effects of methylenedioxymethamphetamine [(+/-)MDMA] on locomotion and serotonin syndrome behavior in the rat. *Pharmacol. Biochem. Behav* 32, 835–840. [PubMed: 2572003]
148. Schmid Y, Rickli A, Schaffner A, Duthaler U, Grouzmann E, Hysek CM, Liechti ME (2015) Interactions between bupropion and 3,4-methylenedioxymethamphetamine in healthy subjects. *J. Pharmacol. Exp. Ther* 353, 102–111. [PubMed: 25655950]
149. Hysek CM, Fink AE, Simmler LD, Donzelli M, Grouzmann E, Liechti ME (2013) Alpha-adrenergic receptors contribute to the acute effects of MDMA in humans. *J. Clin. Psychopharmacol* 33, 658–666. [PubMed: 23857311]
150. Badon LA, Hicks A, Lord K, Ogden BA, Meleg-Smith S, Varner KJ (2002) Changes in cardiovascular responsiveness and cardiotoxicity elicited during binge administration of Ecstasy. *J. Pharmacol. Exp. Ther* 302, 898–907. [PubMed: 12183645]
151. Furst SR, Fallon SP, Reznik GN, and Shah PK (1990) Myocardial infarction after inhalation of methamphetamine. *N. Engl. J. Med* 323, 1147–1148. [PubMed: 2215590]

152. Qasim A, Townend J, and Davies M (2001) Ecstasy induced acute myocardial infarction. *Heart* 85, e10. [PubMed: 11359764]
153. Bhattacharyya S, Schapira AH, Mikhailidis DP, and Davar J (2009) Drug-induced fibrotic valvular heart disease. *Lancet* 374, 577–585. [PubMed: 19683643]
154. Shenouda SK, Varner KJ, Carvalho F, and Lucchesi PA (2009) Metabolites of MDMA induce oxidative stress and contractile dysfunction in adult rat left ventricular myocytes. *Cardiovasc. Toxicol* 9, 30–38. [PubMed: 19333788]
155. Bilsky EJ, Hubbell CL, Delconte JD, and Reid LD (1991) MDMA produces a conditioned place preference and elicits ejaculation in male rats: a modulatory role for the endogenous opioids. *Pharmacol Biochem Behav.* 40, 443–447. [PubMed: 1687169]
156. Daza-Losada M, Rodríguez-Arias M, Aguilar MA, and Miñarro J (2009) Acquisition and reinstatement of MDMA-induced conditioned place preference in mice pre-treated with MDMA or cocaine during adolescence. *Addiction Biology*, 447–456. [PubMed: 19740367]
157. Vidal-Infer A, Roger-Sanchez C, Daza-Losada M, Aguilar MA, Minarro J, and Rodríguez-Arias M (2012) Role of the dopaminergic system in the acquisition, expression and reinstatement of MDMA-induced conditioned place preference in adolescent mice. *PLoS One* 7, e43107. [PubMed: 22916213]
158. Schenk S (2009) MDMA self-administration in laboratory animals: a summary of the literature and proposal for future research. *Neuropsychobiology* 60,130–136. [PubMed: 19893330]
159. Coelho Neto J, Faraco RFP, Alves CF, Castro SMM, and Machado Y (2018) Genuine sildenafil tablets sold in Brazil disguised as MDMA. *Forensic Sci Int.* 283, e8–12. [PubMed: 29295746]
160. Saleemi S, Pennybaker SJ, Wooldridge M, Johnson MW (2017) Who is 'Molly'? MDMA adulterants by product name and the impact of harm-reduction services at raves. *J. Psychopharmacol* 31, 1056–1060. [PubMed: 28693371]
161. Milroy CM, Clark JC, and Forrest AR (1996) Pathology of deaths associated with "ecstasy" and "eve" misuse. *J. Clin. Pathol* 49, 149–153. [PubMed: 8655682]
162. Giraudon I, and Bello PY (2007) Monitoring ecstasy content in France: results from the National Surveillance System 1999-2004. *Subst. Use Misuse* 42, 1567–1578. [PubMed: 17918027]
163. Palamar JJ, Salomone A, Vincenti M, and Cleland CM (2016) Detection of "bath salts" and other novel psychoactive substances in hair samples of ecstasy/MDMA/"Molly" users. *Drug Alcohol Depend* 161, 200–205. [PubMed: 26883685]
164. Yuki F, Rie I, Miki K, Mitsuhiro W, Naotaka K, and Kenichiro N, (2013) Warning against coadministration of 3,4-methylenedioxymethamphetamine (MDMA) with methamphetamine from the perspective of pharmacokinetic and pharmacodynamic evaluations in rat brain. *Eur. J. Pharm. Sci* 49, 57–64. [PubMed: 23395913]
165. Moratalla R, Khairnar A, Simola N, Granado N, Garcia-Montes JR, Porceddu PF, Tizabi Y, Costa G, and Morelli M (2017) Amphetamine-related drugs neurotoxicity in humans and in experimental animals: Main mechanisms. *Prog. Neurobiol* 155, 149–170. [PubMed: 26455459]
166. Gouzoulis-Mayfrank E, and Daumann J (2009) Neurotoxicity of drugs of abuse - the case of methylenedioxy amphetamines (MDMA, ecstasy), and amphetamines. *Dialogues Clin. Neurosci* 11, 305–317. [PubMed: 19877498]
167. Baumann MH, Wang W, and Rothman RB (2007) Methylenedioxyamphetamine (MDMA) neurotoxicity in rats: a reappraisal of past and present findings. *Psychopharmacology (Berl)*. 189, 407–424. [PubMed: 16541247]
168. Green AR, King MV, Shortall SE, and Fone KC (2012) Lost in translation: preclinical studies on 3,4-methylenedioxyamphetamine provide information on mechanisms of action, but do not allow accurate prediction of adverse events in humans. *Br. J. Pharmacol* 166, 1523–1536. [PubMed: 22188379]
169. Halpin LE, Collins SA, and Yamamoto BK (2014) Neurotoxicity of methamphetamine and 3,4-methylenedioxyamphetamine. *Life Sci.* 97, 37–44. [PubMed: 23892199]
170. Steinkellner T, Freissmuth M, Sitte HH, and Montgomery T (2011) The ugly side of amphetamines: short- and long-term toxicity of 3,4-methylenedioxyamphetamine (MDMA, 'Ecstasy'), methamphetamine and D-amphetamine. *Biol. Chem* 392, 103–115. [PubMed: 21194370]

171. Lyles J, and Cadet JL (2003) Methylenedioxymethamphetamine (MDMA, Ecstasy) neurotoxicity: cellular and molecular mechanisms. *Brain Res. Brain Res. Rev* 42,155–168. [PubMed: 12738056]
172. Schilt T, de Win MM, Koeter M, Jager G, Korf DJ, van den Brink W, and Schmand B (2007) Cognition in novice ecstasy users with minimal exposure to other drugs: a prospective cohort study. *Arch. Gen. Psychiatry* 64, 728–736. [PubMed: 17548754]
173. Wunderli MD, Vonmoos M, Furst M, Schadelin K, Kraemer T, Baumgartner MR, Seifritz E, and Quednow BB (2017) Discrete memory impairments in largely pure chronic users of MDMA. *Eur. Neuropsychopharmacol* 7, 987–999.
174. McCann UD, Mertl M, Eligulashvili V, and Ricaurte GA (1999) Cognitive performance in (+/-) 3,4-methylenedioxymethamphetamine (MDMA, "ecstasy") users: a controlled study. *Psychopharmacology (Berl)*. 143, 417–425. [PubMed: 10367560]
175. Gouzoulis-Mayfran E, Daumann J, Tuchtenhagen F, Pelz S, Becker S, Kunert H, Fimm B, and Sass H (2000) Impaired cognitive performance in drug free users of recreational ecstasy (MDMA) *J. Neurol. Neurosurg. Psychiatry*. 68, 719–725. [PubMed: 10811694]
176. Kuypers KP, Theunissen EL, van Wel JH, de Sousa Fernandes Perna EB, Linssen A, Sambeth A, Schultz BG, and Ramaekers JG (2016) Verbal memory impairment in polydrug ecstasy users: A clinical perspective. *PLoS One* 11, e0149438. [PubMed: 26907605]
177. McCann UD, Ridenour A, Shaham Y, and Ricaurte GA (1994) Serotonin neurotoxicity after (+/-)3,4-methylenedioxymethamphetamine (MDMA; "Ecstasy"): a controlled study in humans. *Neuro. Psycho. Pharmacol* 10,129–138.
178. Mueller F, Lenz C, Steiner M, Dolder PC, Walter M, Lang UE, Liechti ME, and Borgwardt S (2016) Neuroimaging in moderate MDMA use: A systematic review. *Neurosci. Biobehav. Rev* 62, 21–34. [PubMed: 26746590]
179. Garg A, Kapoor S, Goel M, Chopra S, Chopra M, Kapoor A, McCann UD, and Behera C (2015) Functional magnetic resonance imaging in abstinent MDMA users: A Review. *Curr. Drug. Abuse Rev* 8, 15–25. [PubMed: 25731754]
180. Schifano F, Di Furia L, Forza G, Minicuci N, and Bricolo R (1998) MDMA ('ecstasy') consumption in the context of polydrug abuse: a report on 150 patients. *Drug Alcohol Depend.* 52, 85–90. [PubMed: 9788011]
181. Gouzoulis-Mayfrank E, Daumann JJ (2006) The confounding problem of polydrug use in recreational ecstasy/MDMA users: a brief overview. *Psychopharmacol.* 20,188–193.
182. de Win MM, Schilt T, Reneman L, Vervaeke H, Jager G, Dijkink S, Booij J, and van den Brink W (2006) Ecstasy use and self-reported depression, impulsivity, and sensation seeking: a prospective cohort study. *J. Psychopharmacol* 20, 226–235. [PubMed: 16510480]
183. Lieb R, Schuetz CG, Pfister H, von Sydow K, and Wittchen H (2002) Mental disorders in ecstasy users: a prospective-longitudinal investigation. *Drug Alcohol Depend.* 68, 195–207. [PubMed: 12234649]
184. Capela JP, Ruscher K, Lautenschlager M, Freyer D, Dirnagl U, Gaio AR, Bastos ML, Meisel A, and Carvalho F (2006) Ecstasy-induced cell death in cortical neuronal cultures is serotonin 2A-receptor-dependent and potentiated under hyperthermia. *Neuroscience.* 139,1069–1081. [PubMed: 16504407]
185. Capela JP, Meisel A, Abreu AR, Branco PS, Ferreira LM, Lobo AM, Remião F, Bastos ML, and Carvalho F (2006) Neurotoxicity of Ecstasy metabolites in rat cortical neurons, and influence of hyperthermia. *J. Pharmacol. Exp. Ther* 316, 53–61. [PubMed: 16183702]
186. Stumm G, Schlegel J, Schäfer T, Würz C, Mennel HD, Krieg JC, and Vedder H (1999) Amphetamines induce apoptosis and regulation of bcl-x splice variants in neocortical neurons. *FASEB J.* 13, 1065–1072. [PubMed: 10336889]
187. Chu T, Kumagai Y, DiStefano EW, and Cho AK (1996) Disposition of methylenedioxy methamphetamine and three metabolites in the brains of different rat strains and their possible roles in acute serotonin depletion. *Biochem. Pharmacol* 51, 789–796. [PubMed: 8602874]
188. Commins DL, Vosmer G, Virus RM, Woolverton WL, Schuster CR, and Seiden LS (1987) Biochemical and histological evidence that methylenedioxy methylamphetamine (MDMA) is toxic to neurons in the rat brain. *J. Pharmacol. Exp. Ther* 241, 338–345. [PubMed: 2883295]

Biochemical and histological evidence that methylenedioxyamphetamine (MDMA) is toxic to neurons in the rat brain.

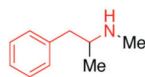
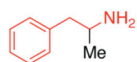
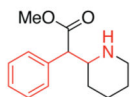
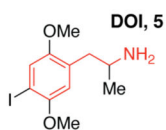
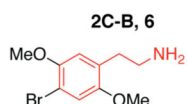
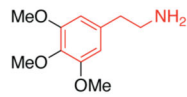
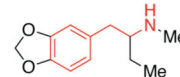
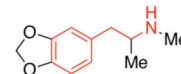
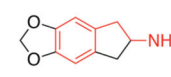
189. Logan BJ, Laverty R, Sanderson WD, and Yee YB (1988) Differences between rats and mice in MDMA (methylenedioxyamphetamine) neurotoxicity. *Eur. J. Pharmacol* 152, 227–234. [PubMed: 2906000]
190. Granado N, O'Shea E, Bove J, Vila M, Colado MI, and Moratalla R (2008) Persistent MDMA-induced dopaminergic neurotoxicity in the striatum and substantia nigra of mice. *J. Neurochem* 107, 1102–1112. [PubMed: 18823368]
191. O'Callaghan JP, and Miller DB (1994) Neurotoxicity profiles of substituted amphetamines in the C57BL/6J mouse. *J. Pharmacol. Exp. Ther* 270, 741–751. [PubMed: 8071867]
192. O'Hearn E, Battaglia G, De Souza EB, Kuhar MJ and, Molliver ME (1988) Methylenedioxyamphetamine (MDA) and methylenedioxyamphetamine (MDMA) cause selective ablation of serotonergic axon terminals in forebrain: immunocytochemical evidence for neurotoxicity. *J. Neurosci* 8, 2788–2803. [PubMed: 2457659]
193. Molliver ME, Berger UV, Mamounas LA, Molliver DC, O'Hearn E, and Wilson MA (1990) Neurotoxicity of MDMA and related compounds: anatomic studies. *Ann. N. Y. Acad. Sci* 600, 649–661. [PubMed: 1979216]
194. Battaglia G, Yeh SY, and De Souza EB (1988) MDMA-induced neurotoxicity: parameters of degeneration and recovery of brain serotonin neurons. *Pharmacol. Biochem. Behav* 29, 269–274. [PubMed: 2452449]
195. Xie T, Tong L, McLane MW, Hatzidimitriou G, Yuan J, McCann U, and Ricaurte G (2006) Loss of serotonin transporter protein after MDMA and other ring-substituted amphetamines. *Neuropsychopharmacology* 31, 2639–2651. [PubMed: 16452989]
196. Schmidt CJ, Wu L, and Lovenberg W (1986) Methylenedioxyamphetamine: a potentially neurotoxic amphetamine analogue. *Eur. J. Pharmacol* 124, 175–178. [PubMed: 2424776]
197. Scanzello CR, Hatzidimitriou G, Martello AL, Katz JL, and Ricaurte GA (1993) Serotonergic recovery after (+/-)-3,4-(methylenedioxy) methamphetamine injury: observations in rats. *J. Pharmacol. Exp. Ther* 264, 1484–1491. [PubMed: 7680719]
198. Scheffel U, Lever JR, Stathis M, and Ricaurte GA (1992) Repeated administration of MDMA causes transient down-regulation of serotonin 5-HT₂ receptors. *Neuropharmacology*. 31, 881–893. [PubMed: 1359444]
199. Malberg JE, and Seiden LS (1998) Small changes in ambient temperature cause large changes in 3,4-methylenedioxyamphetamine (MDMA)-induced serotonin neurotoxicity and core body temperature in the rat. *J. Neurosci* 18, 5086–5094. [PubMed: 9634574]
200. Sanchez V, Camarero J, Esteban B, Peter MJ, Green AR, and Colado MI (2001) The mechanisms involved in the long-lasting neuroprotective effect of fluoxetine against MDMA ('ecstasy')-induced degeneration of 5-HT nerve endings in rat brain. *Br. J. Pharmacol* 134, 46–57. [PubMed: 11522596]
201. McCann UD, and Ricaurte GA (2001) Caveat emptor: editors beware. *Neuropsychopharmacology* 24, 333–336. [PubMed: 11256359]
202. Parrott AC (2005) Chronic tolerance to recreational MDMA (3,4-methylenedioxyamphetamine) or Ecstasy. *J. Psychopharmacol* 19, 71–83. [PubMed: 15671132]
203. Ricaurte GA, Forno LS, Wilson MA, DeLanney LE, Irwin I, Molliver ME, and Langston JW (1988) (+/-)-3,4-Methylenedioxyamphetamine selectively damages central serotonergic neurons in nonhuman primates. *JAMA*. 260, 51–55. [PubMed: 2454332]
204. Insel TR, Battaglia G, Johannessen JN, Marra S, and De Souza EB (1989) 3,4-Methylenedioxyamphetamine ("ecstasy") selectively destroys brain serotonin terminals in rhesus monkeys. *J. Pharmacol. Exp. Ther* 249, 713–720. [PubMed: 2471824]
205. Ricaurte GA, Martello AL, Katz JL, Martello MB (1992) Lasting effects of (+/-)-3,4-methylenedioxyamphetamine (MDMA) on central serotonergic neurons in nonhuman primates: neurochemical observations. *Primates: Neurochemical Observations. J. Pharmacol. Exp. Ther* 261, 616–622. [PubMed: 1374470]

206. Scheffel U, Szabo Z, Mathews WB, Finley PA, Dannals RF, Ravert HT, Szabo K, Yuan J, and Ricaurte GA (1998) In vivo detection of short- and long-term MDMA neurotoxicity--a positron emission tomography study in the living baboon brain. *Synapse*. 29, 183–192. [PubMed: 9593108]
207. Hatzidimitriou G, McCann UD, and Ricaurte GA (1999) Altered serotonin innervation patterns in the forebrain of monkeys treated with (+/-)3,4-methylenedioxymethamphetamine seven years previously: factors influencing abnormal recovery. *J. Neurosci* 19, 5096–5107. [PubMed: 10366642]
208. Taffe MA, Weed MR, Davis S, Huitrón-Resendiz S, Schroeder R, Parsons LH, Henriksen SJ, and Gold LH (2001) Functional consequences of repeated (+/-)3,4-methylenedioxymethamphetamine (MDMA) treatment in rhesus monkeys. *Neuropsychopharmacology* 24, 230–239. [PubMed: 11166514]
209. Ricaurte GA, DeLanney LE, Irwin I, and Langston JW (1988) Toxic effects of MDMA on central serotonergic neurons in the primate: importance of route and frequency of drug administration. *Brain Res.* 446, 165–168. [PubMed: 2897228]
210. Miller DB, and O'Callaghan JP (1995) The role of temperature, stress, and other factors in the neurotoxicity of the substituted amphetamines 3,4-methylenedioxymethamphetamine and fenfluramine. *Mol. Neurobiol* 11, 177–192. [PubMed: 8561961]
211. Jayanthi S, Ladenheim B, Andrews AM, and Cadet JL (1999) Overexpression of human copper/zinc superoxide dismutase in transgenic mice attenuates oxidative stress caused by methylenedioxymethamphetamine (Ecstasy). *Neuroscience*. 91, 1379–1387. [PubMed: 10391444]
212. Johnson EA, Sharp DS, and Miller DB (2000) Restraint as a stressor in mice: against the dopaminergic neurotoxicity of D-MDMA, low body weight mitigates restraint-induced hypothermia and consequent neuroprotection. *Brain Res.* 875, 107–118. [PubMed: 10967304]
213. Nutt D, King LA, Saulsbury W, and Blakemore C (2007) Development of a rational scale to assess the harm of drugs of potential misuse. *Lancet* 369, 1047–1053. [PubMed: 17382831]
214. Nutt DJ, King LA, and Phillips LD (2010) Drug harms in the UK: a multicriteria decision analysis. *Lancet* 376, 1558–1565. [PubMed: 21036393]
215. Kyzar EJ, Nichols CD, Gainetdinov RR, Nichols DE, and Kalueff AV (2017) Psychedelic drugs in biomedicine. *Trends Pharmacol. Sci* 38, 992–1005. [PubMed: 28947075]
216. Mithoefer MC, Grob CS, and Brewerton TD (2016) Novel psychopharmacological therapies for psychiatric disorders: psilocybin and MDMA. *Lancet Psychiatry* 3, 481–488. [PubMed: 27067625]
217. Sessa B, and Nutt D (2015) Making a medicine out of MDMA. *Br. J. Psychiatry.* 206, 4–6. [PubMed: 25561485]
218. Grinspoon L, and Bakalar JB (1986) Can drugs be used to enhance the psychotherapeutic process? *Am. J. Psychother* 40, 393–404. [PubMed: 2876654]
219. Riedlinger TJ and Riedlinger JE (1994) Psychedelic and entactogenic drugs in the treatment of depression. *J. Psychoactive Drugs* 26, 41–55. [PubMed: 7913128]
220. Mithoefer MC, Wagner MT, Mithoefer AT, Jerome L, and Doblin R (2011) The safety and efficacy of (+/-)3,4-methylenedioxymethamphetamine-assisted psychotherapy in subjects with chronic, treatment-resistant posttraumatic stress disorder: the first randomized controlled pilot study. *J. Psychopharmacol. (Oxf, Engl)* 25, 439–452.
221. Oehen P, Traber R, Widmer V, and Schnyder U (2013) A randomized, controlled pilot study of MDMA (+/-3,4-methylenedioxymethamphetamine)-assisted psychotherapy for treatment of resistant, chronic post-traumatic stress disorder (PTSD). *J. Psychopharmacol. (Oxf, Engl)* 27, 40–52.
222. Mithoefer MC (2011) MDMA-Assisted Psychotherapy for the Treatment of Posttraumatic Stress Disorder: A Revised Teaching Manual. http://www.maps.org/research/mdma/Manual_MDMAPTSD_30Nov11.pdf (accessed Jun 12, 2018).
223. Johansen PO, and Krebs TS (2009) How could MDMA (ecstasy) help anxiety disorders? A neurobiological rationale. *J. Psychopharmacol. (Oxf, Engl)* 23, 389–391.

224. Bouso JC, Doblin R, Farre M, Alcazar MA, and Gómez-Jarabo G (2008) MDMA-assisted psychotherapy using low doses in a small sample of women with chronic posttraumatic stress disorder. *J. Psychoactive Drugs* 40, 225–236. [PubMed: 19004414]
225. Mithoefer MC, Wagner MT, Mithoefer AT, Jerome L, Martin SF, Yazar-Klosinski B, Michel Y, Brewerton TD, and Doblin R (2013) Durability of improvement in post-traumatic stress disorder symptoms and absence of harmful effects or drug dependency after 3,4-methylenedioxyamphetamine-assisted psychotherapy: a prospective long-term follow-up study. *J. Psychopharmacol. (Oxf, Engl)* 27, 28–39.
226. Amoroso T, and Workman M (2016) Treating posttraumatic stress disorder with MDMA-assisted psychotherapy: A preliminary meta-analysis and comparison to prolonged exposure therapy. *J. Psychopharmacol* 30, 595–600. [PubMed: 27118529]
227. Feduccia AA, Holland J, and Mithoefer MC (2018) Progress and promise for the MDMA drug development program. *Psychopharmacology (Berl)*. 235, 561–571. [PubMed: 29152674]
228. Bedi G, Phan KL, Angstadt M, and de Wit H (2009) Effects of MDMA on sociability and neural response to social threat and social reward. *Psychopharmacology (Berl)*. 207, 73–83. [PubMed: 19680634]
229. Hysek CM, Domes G, and Liechti ME (2012) MDMA enhances “mind reading” of positive emotions and impairs “mind reading” of negative emotions. *Psychopharmacology (Berl)*. 222, 293–302. [PubMed: 22277989]
230. Carhart-Harris RL, Wall MB, Erritzoe D, Kaelen M, Ferguson B, De Meer I, Tanner M, Bloomfield M, Williams TM, Bolstridge M, Stewart L, Morgan CJ, Newbould RD, Feilding A, Curran HV, and Nutt DJ (2014) The effect of acutely administered MDMA on subjective and BOLD-fMRI responses to favourite and worst autobiographical memories. *Int. J. Neuropsychopharmacol* 17, 527–540. [PubMed: 24345398]
231. Gamma A, Buck A, Berthold T, Hell D, and Vollenweider FX (2000) 3,4-Methylenedioxyamphetamine (MDMA) modulates cortical and limbic brain activity as measured by [H215O]-PET in healthy humans. *Neuropsychopharmacology* 23, 388–395. [PubMed: 10989265]
232. Danforth AL, Struble CM, Yazar-Klosinski B, and Grob CS (2016) MDMA-assisted therapy: a new treatment model for social anxiety in autistic adults. *Prog. Neuro-Psychopharmacol. Biol. Psychiatry* 64, 237–249.
233. Jerome L, Schuster S, and Yazar-Klosinski BB (2013) Can MDMA play a role in the treatment of substance abuse? *Curr. Drug Abuse Rev* 6, 54–62. [PubMed: 23627786]
234. Sessa B (2017) Why MDMA therapy for alcohol use disorder? And why now? *Neuropharmacology*. Published online 11 7, 2017. doi: 10.1016/j.neuropharm.2017.11.004.
235. Greer G, Tolbert R (1986) Subjective reports of the effects of MDMA in a clinical setting. *J. Psychoactive Drugs* 18, 319–327. [PubMed: 2880946]
236. Pitts EG, Curry DW, Hampshire KN, Young MB, and Howell LL (2018) (±)-MDMA and its enantiomers: potential therapeutic advantages of R(–)-MDMA. *Psychopharmacology (Berl)*. 235, 377–392. [PubMed: 29248945]
237. Anderson GM, 3rd, Braun G, Braun U, Nichols DE, Shulgin AT (1978) Absolute configuration and psychotomimetic activity. *NIDA Res. Monogr* 22, 8–15.
238. Nichols DE, Lloyd DH, Hoffman AJ, Nichols MB, and Yim GK (1982) Effects of certain hallucinogenic amphetamine analogues on the release of [3H]serotonin from rat brain synaptosomes. *J. Med. Chem* 25, 530–535. [PubMed: 7086839]
239. Johnson MP, Hoffman AJ, and Nichols DE (1986) Effects of the enantiomers of MDA, MDMA and related analogues on [3H]serotonin and [3H]dopamine release from superfused rat brain slices. *Eur. J. Pharmacol* 132, 269–276. [PubMed: 2880735]
240. Schmidt CJ, Levin JA, and Lovenberg W (1987) In vitro and in vivo neuro-chemical effects of methylenedioxyamphetamine on striatal monoaminergic systems in the rat brain. *Biochem. Pharmacol* 36, 747–755. [PubMed: 2881549]
241. Steele TD, Nichols DE, and Yim GKW (1987) Stereochemical effects of 3,4-methylenedioxyamphetamine (MDMA) and related amphetamine derivatives on inhibition

- of uptake of [3H] monoamines synaptosomes from different regions into of rat brain. *Biochem. Pharmacol* 36, 2297–2303. [PubMed: 2886126]
242. Verrico CD, Miller GM, and Madras BK (2007) MDMA (ecstasy) and human dopamine, norepinephrine, and serotonin transporters: implications for MDMA-induced neurotoxicity and treatment. *Psychopharmacology* 189, 489–503. [PubMed: 16220332]
243. Hiramatsu M, and Cho AK (1990) Enantiomeric differences in the effects of 3,4-methylenedioxyamphetamine on extracellular monoamines and metabolites in the striatum of freely-moving rats: an in vivo microdialysis study. *Neuropharmacology* 29, 269–275. [PubMed: 1691459]
244. Acquas E, Pisanu A, Spiga S, Plumitallo A, Zernig G, and Di Chiara G (2007) Differential effects of intravenous R,S-(+/-)-3,4-methylenedioxyamphetamine (MDMA, ecstasy) and its S(+)- and R(-)-enantiomers on dopamine transmission and extracellular signal regulated kinase phosphorylation (pERK) in the rat nucleus accumbens shell. *J. Neurochem* 102, 121–132. [PubMed: 17564678]
245. Murnane KS, Fantegrossi WE, Godfrey JR, Banks ML, and Howell LL (2010) Endocrine and neurochemical effects of 3,4-methylenedioxyamphetamine and its stereoisomers in rhesus monkeys. *J. Pharmacol. Exp. Ther.* 334, 642–650. [PubMed: 20466795]
246. Murnane KS, Kimmel HL, Rice KC, and Howell LL (2012) The neuropharmacology of prolactin secretion elicited by 3,4-methylenedioxyamphetamine (“ecstasy”): a concurrent microdialysis and plasma analysis study. *Horm. Behav* 61, 181–190. [PubMed: 22197270]
247. Lyon RA, Glennon RA, and Titeler M (1986) 3,4-Methylenedioxyamphetamine (MDMA): stereoselective interactions at brain 5-HT1 and 5-HT2 receptors. *Psychopharmacology (Berl)*. 88, 525–526. [PubMed: 2871581]
248. Toll L, Berzetei-Gurske IP, Polgar WE, Brandt SR, Adapa ID, Rodriguez L, Schwartz RW, Haggart D, O'Brien A, White A, Kennedy JM, Craymer K, Farrington L, and Auh JS (1998) Standard binding and functional assays related to medications development division testing for potential cocaine and opiate narcotic treatment medications. *NIDA Res. Monogr* 178, 440–466. [PubMed: 9686407]
249. Nash JF, Roth BL, Brodtkin JD, Nichols DE, and Gudelsky GA (1994) Effect of the R(-) and S(+) isomers of MDA and MDMA on phosphatidyl inositol turnover in cultured cells expressing 5-HT2A or 5-HT2C receptors. *Neurosci. Lett* 177, 111–115. [PubMed: 7824160]
250. Baker LE, and Taylor MM (1997) Assessment of the MDA and MDMA optical isomers in a stimulant-hallucinogen discrimination. *Pharmacol. Biochem. Behav* 57, 737–748. [PubMed: 9259001]
251. Murnane KS, Murai N, Howell LL, and Fantegrossi WE (2009) Discriminative stimulus effects of psychostimulants and hallucinogens in S(+)-3,4-methylenedioxyamphetamine (MDMA) and R(-)-MDMA trained mice. *J. Pharmacol. Exp. Ther* 331, 717–723. [PubMed: 19684254]
252. Forsling ML, Fallon JK, Shah D, Tilbrook GS, Da C, Kicman AT, and Hutt AJ (2002) The effect of 3,4-methylenedioxyamphetamine (MDMA, 'ecstasy') and its metabolites on neurohypophysial hormone release from the isolated rat hypothalamus. *Br. J. Pharmacol* 135, 649–656. [PubMed: 11834612]
253. Pitts EG, Minerva AR, Chandler EB, Kohn JN, Logun MT, Sulima A, Rice KC, and Howell LL (2017) 3,4-Methylenedioxyamphetamine increases affiliative behaviors in squirrel monkeys in a serotonin 2A receptor-dependent manner. *Neuropsychopharmacology* 42, 1962–1971. [PubMed: 28425496]
254. Curry DW, Young MB, Tran AN, Daoud GE, and Howell LL (2017) Separating the agony from ecstasy: R(-)-3,4-methylenedioxyamphetamine has prosocial and therapeutic-like effects without signs of neurotoxicity in mice. *Neuropharmacology* 128, 196–206 [PubMed: 28993129]
255. Frau L, Simola N, Plumitallo A, and Morelli M (2013) Microglial and astroglial activation by 3,4-methylenedioxyamphetamine (MDMA) in mice depends on S(+) enantiomer and is associated with an increase in body temperature and motility. *J. Neurochem* 124, 69–78. [PubMed: 23083295]
256. Freudenmann RW, Oxler F, and Bernschneider-Reif S (2006) The origin of MDMA (ecstasy) revisited: the true story reconstructed from the original documents. *Addiction* 101, 1241–1245. [PubMed: 16911722]

257. Adam D (2006) Origins of ecstasy an urban myth. *Nat. Rev. Drug Discov* 5, 806–807.
258. Passie T, and Benzenhofer U (2018) MDA, MDMA, and other "mescaline-like" substances in the US military's search for a truth drug (1940s to 1960s). *Drug Test Anal.* 10, 72–80. [PubMed: 28851034]
259. Hardman HF, Haavik CO, and Seevers MH (1973) Relationship of the structure of mescaline and seven analogs to toxicity and behavior in five species of laboratory animals. *Toxicol. Appl. Pharmacol* 25, 299–309. [PubMed: 4197635]
260. Biniecki S, and Krajewski E (1960) Production of d,1-N-methyl-beta- (3,4-methylenedioxyphenyl)-isopropylamine and d,1-N- methyl-beta-(3,4-dimthoxyphenyl)-isopropylamine. *Acta. Polon. Pharm* 17, 421–425.
261. Benzenhöfer U, and Passie T (2010) Rediscovering MDMA (ecstasy): the role of the American chemist Alexander T. Shulgin. *Addiction* 105, 1355–1361. [PubMed: 20653618]
262. Climko RP, Roehrich H, Sweeney DR, and Al-Razi J (1987) Ecstasy: a review of MDMA and MDA. *Int. J. Psychiatry Med* 16, 359–372.
263. Ricaurte GA, Yuan J, Hatzidimitriou G, Cord BJ, and McCann UD (2002) Severe dopaminergic neurotoxicity in primates after a common recreational dose regimen of MDMA ("ecstasy"). *Science* 297, 2260–2263. [PubMed: 12351788]
264. Ricaurte GA; Yuan J, Hatzidimitriou G, Cord BJ, and McCann UD (2003) Retraction: Severe dopaminergic neurotoxicity in primates after a common recreational dose regimen of MDMA ("ecstasy"). *Science* 301, 1479.
265. Nutt DJ (2009) Equasy- an overlooked addiction with implications for the current debate on drug harms. *J. Psychopharmacol* 23, 3–5. [PubMed: 19158127]

Psychostimulants**Amphetamine, 2****Methamphetamine, 3****Methylphenidate, 4****Hallucinogens****DOI, 5****2C-B, 6****Mescaline, 7****Entactogens****MDMA, 1****MBDB, 8****MDAI, 9****Figure 1.**

Structural relationships between MDMA and other psychoactive compounds. The common phenethylamine core is highlighted in red. Compounds are classified as psychostimulants, hallucinogens, or entactogens based on the behavioral responses they produce in experimental animals and their subjective effects in humans.

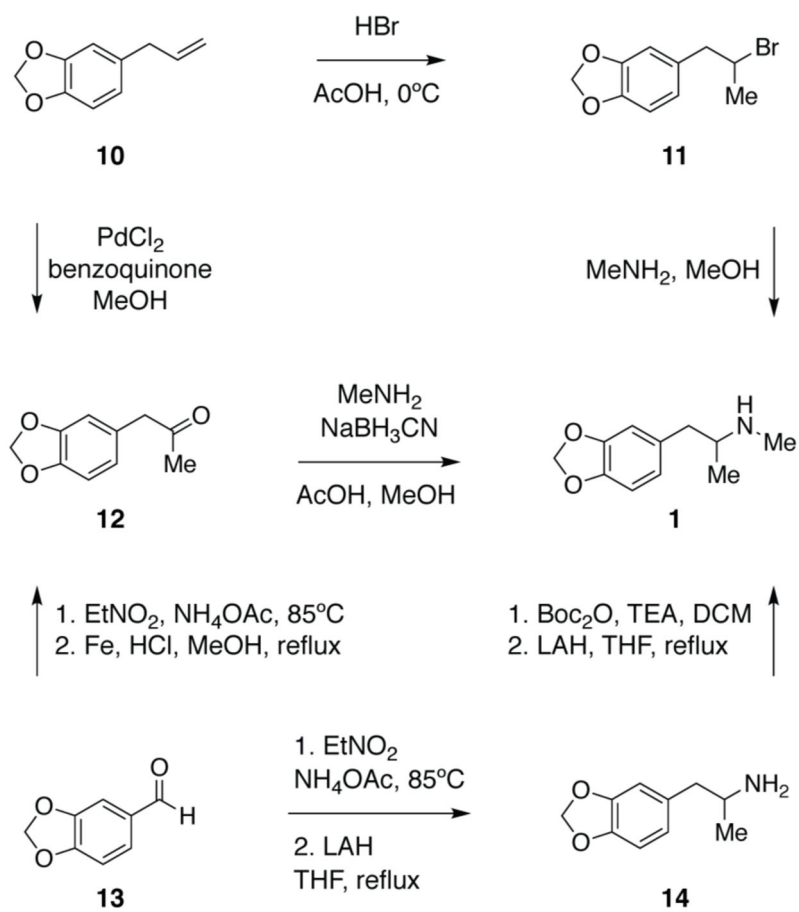


Figure 2.
Common synthetic strategies used to produce racemic MDMA.

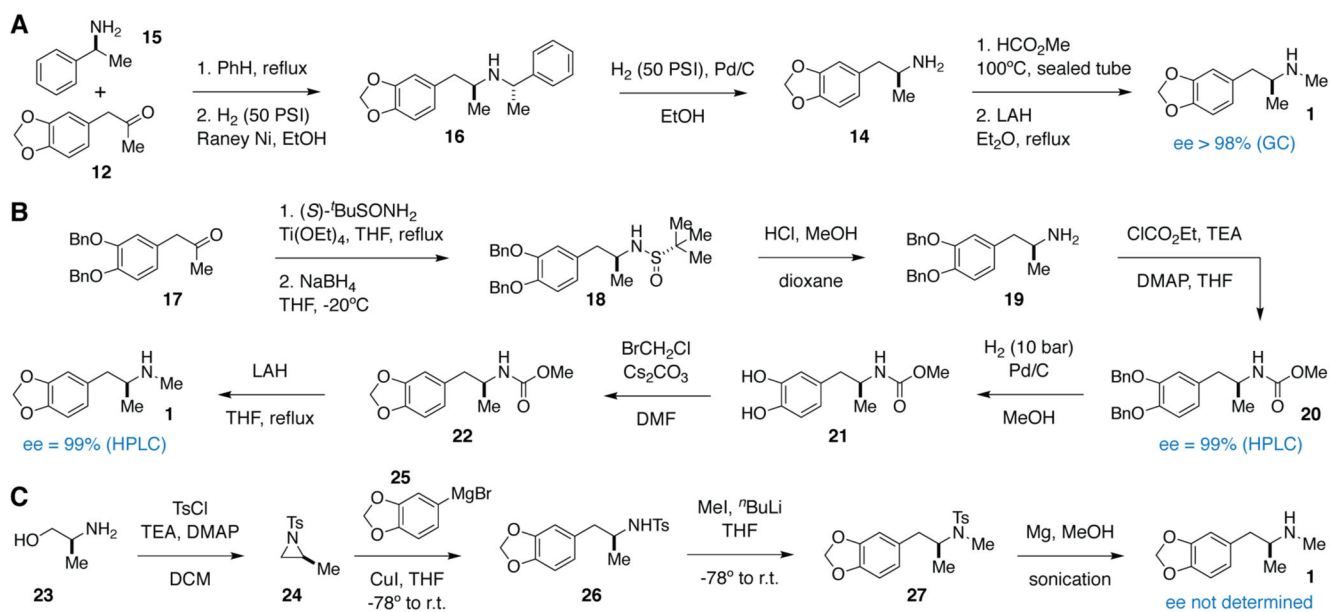


Figure 3. Synthetic strategies used to synthesize enantiopure MDMA. (A) Reductive amination using (*S*)- α -methylbenzylamine (B) Reductive amination using Ellman's sulfinamide (C) Ring opening of an (*S*)-alanine-derived-aziridine.

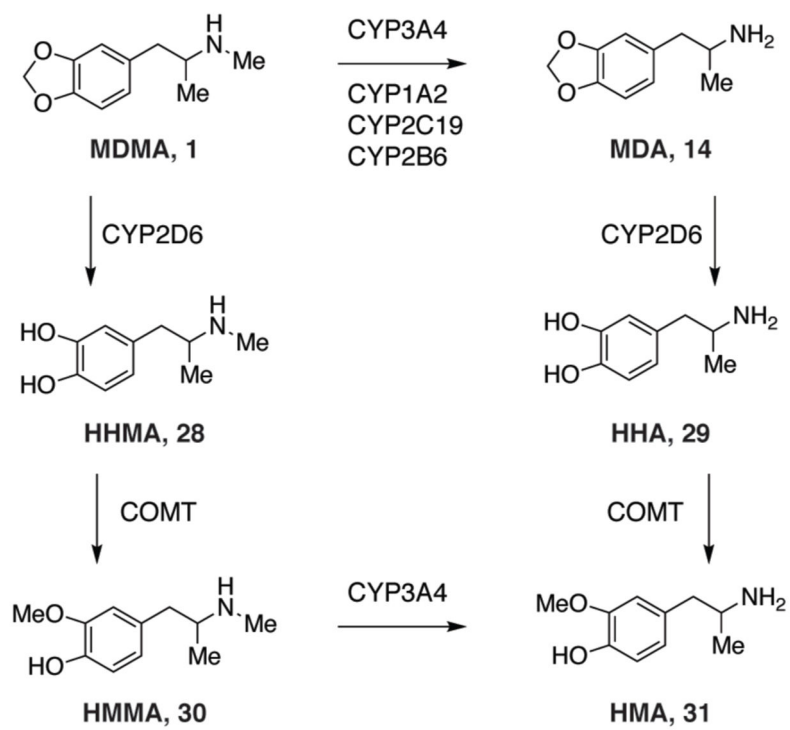


Figure 4. Common metabolites of MDMA. CYP = cytochrome P450; COMT = catechol-O-methyltransferase.

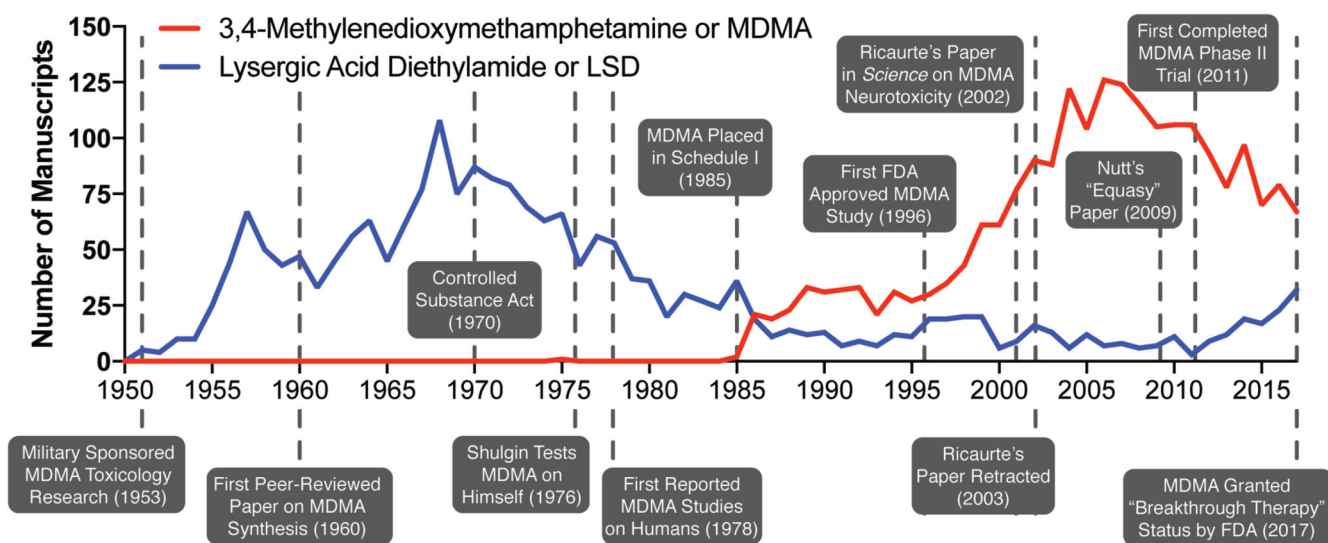


Figure 5. Timeline of important events related to research on MDMA and classical psychedelics. Note the different peaks for research on MDMA and LSD. The data were obtained from a PubMed search for papers having titles that contained the search terms “3,4-methylenedioxymethamphetamine or MDMA” and “lysergic acid diethylamide or LSD” conducted on March 20, 2018.

Table 1.

Effects of MDMA on monoamine reuptake using synaptosomes prepared from rat brains. Values for K_i (nM) are reported \pm standard deviations.⁶⁵ NE = norepinephrine; DA = dopamine; 5-HT = serotonin.

Compound	NE Uptake	DA Uptake	5-HT Uptake
S-(+)-Amph	38.9 \pm 1.8	34 \pm 6	3,830 \pm 170
(\pm)-MDMA	462 \pm 18	1,572 \pm 59	238 \pm 13

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 2.

Effects of MDMA on monoamine transport inhibition using HEK293 cells stably expressing human monoamine transporters. Values for IC₅₀ (μM) are reported with 95% confidence intervals in parentheses.⁶² NE = norepinephrine; DA = dopamine; 5-HT = serotonin.

Compound	NE Uptake	DA Uptake	5-HT Uptake
<i>S</i> (+)-Amph	0.094 (0.06–0.14)	1.30 (0.83–2.0)	>10
(±)-MDMA	0.447 (0.33–0.60)	17 (12–24)	1.36 (1.0–2.0)

Table 3.

Effects of MDMA on monoamine release using synaptosomes prepared from rat brains. Values for EC₅₀ (nM) are reported \pm standard deviations.⁶⁵ NE = norepinephrine; DA = dopamine; 5-HT = serotonin.

Compound	NE Release	DA Release	5-HT Release
<i>S</i> -(+)-Amph	7.07 \pm 0.95	24.8 \pm 3.5	1,765 \pm 94
(\pm)-MDMA	77.4 \pm 3.4	376 \pm 16	56.6 \pm 2.1

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 4.

Effects of MDMA on monoamine release using monoamine-preloaded HEK293 cells stably expressing human monoamine transporters. Values for EC₅₀ (μM) are reported with 95% confidence intervals in parentheses.⁶²

NE = norepinephrine; DA = dopamine; 5-HT = serotonin.

Compound	DA Release	5-HT Release
<i>S</i> -(+)-Amph	1.76 (1.1–2.9)	>33
(±)-MDMA	22 (8.9–53)	5.63 (3.5–9.2)

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 5.

Binding affinity profile for (\pm)-MDMA with values for K_i reported in nM. Radioligand binding assays were performed using stably or transiently expressing cell lines (HEK, HEKT, or CHO) unless noted otherwise.

Receptor	Radiolabeled Ligand	Ligand Classification	Species	K_i (nM)	Reference
5-HT1A	^3H -8-OH-DPAT	Agonist	Human	>10,000	77
5-HT1A	^3H -8-OH-DPAT	Agonist	Human	12,200	62
5-HT 1B	^3H -GR-125743	Antagonist	Human	>10,000	77
5-HT 1D	^3H -GR-125743	Antagonist	Human	>10,000	77
5-HT 1E	^3H -5-HT	Agonist	Human	>10,000	77
5-HT2A	^3H -Ketanserin	Antagonist	Rat	>10,000	77
5-HT2A	^3H -Ketanserin	Antagonist	Human	7,800	62
5-HT2B	^3H -LSD	Agonist	Human	500	77
5-HT2C	^3H -Mesulergine	Antagonist	Rat	>10,000	77
5-HT2C	^3H -Mesulergine	Antagonist	Human	>13,000	62
5-HT3	^3H -Zacopride	Antagonist	Human	>10,000	77
5-HT5	^3H -LSD	Agonist	Human	>10,000	77
5-HT6	^3H -LSD	Agonist	Human	>10,000	77
5-HT7	^3H -LSD	Agonist	Human	>10,000	77
Alpha1A	^{125}I -HEAT	Antagonist	Human	>10,000	77
Alpha1A	^3H -Prazosin	Inverse Agonist	Human	>6,000	62
Alpha1B	^{125}I -HEAT	Antagonist	Human	>10,000	77
Alpha2A	^3H -Clonidine	Agonist	Human	2,532	77
Alpha2A	^3H - Rauwolscine	Antagonist	Human	15,000	62
Alpha2B	^3H -Clonidine	Agonist	Human	1,785	77
Alpha2C	^3H -Clonidine	Agonist	Human	1,123	77
Beta1	^{125}I -Pindolol	Partial Agonist	Rat	>10,000	77
Beta2	^{125}I -Pindolol	Partial Agonist	Rat	>10,000	77
CB1	^3H -CP-55940	Agonist	Rat (brain)	>10,000	77
M1	^3H -QNB	Antagonist	Human	>10,000	77
M2	^3H -QNB	Antagonist	Human	>10,000	77
M3	^3H -QNB	Antagonist	Human	1,851	77
M4	^3H -QNB	Antagonist	Human	8,245	77
M5	^3H -QNB	Antagonist	Human	6,339	77
Nicotinic Alpha1Beta2	^3H -Epibatidine	Agonist	Human	>10,000	77
Nicotinic Alpha2Beta2	^3H -Epibatidine	Agonist	Human	>10,000	77
Nicotinic Alpha2Beta4	^3H -Epibatidine	Agonist	Human	>10,000	77

Receptor	Radiolabeled Ligand	Ligand Classification	Species	K _i (nM)	Reference
Nicotinic Alpha3Beta2	³ H-Epipatidine	Agonist	Human	>10,000	77
Nicotinic Alpha3Beta4	³ H-Epipatidine	Agonist	Human	>10,000	77
Nicotinic Alpha7	³ H-Epipatidine	Agonist	Human	>10,000	77
D1	³ H-SCH23390	Antagonist	Human	>10,000	77
D1	³ H-SCH23390	Antagonist	Human	>13,600	62
D2	³ H-NMSP	Antagonist	Human	>10,000	77
D2	³ H-Spiperone	Antagonist	Human	25,200	62
D3	³ H-NMSP	Antagonist	Human	>10,000	77
D3	³ H-Spiperone	Antagonist	Human	>17,700	62
D4	³ H-NMSP	Antagonist	Rat	>10,000	77
D5	³ H-SCH23390	Antagonist	Human	>10,000	77
GABA A	³ H-Muscimol	Agonist	Rat (forebrain)	>10,000	77
GABA B	³ H-Baclofen	Agonist	Rat (forebrain)	>10,000	77
NMDA	³ H-MK-801	Antagonist	Rat (forebrain)	>10,000	77
H1	³ H-Pyrilamine	Antagonist	Human	2,138	77
H1	³ H-Pyrilamine	Antagonist	Human	>14,400	62
H2	³ H-Pyrilamine	Antagonist	Human	>10,000	77
Prostaglandin EP3	³ H-PGE2	Agonist	Human	>10,000	77
Prostaglandin EP4	³ H-PGE2	Agonist	Human	>10,000	77
NET	³ H-Nisoxetine	Inhibitor	Human	>10,000	77
NET	³ H-Nisoxetine	Inhibitor	Human	30,500	62
DAT	³ H-GBR 12935	Inhibitor	Human	>10,000	77
DAT	³ H-WIN35,428	Inhibitor	Human	6,500	62
SERT	³ H-Citalopram	Inhibitor	Human	>10,000	77
SERT	³ H-Citalopram	Inhibitor	Human	13,300	62
TAAR1	³ H-RO5166017	Agonist	Rat	370	62
TAAR1	³ H-RO5166017	Agonist	Mouse	2,400	62

Table 6.

Binding affinity profile for (\pm)-MDMA, *R*-(-)-MDMA, and *S*-(+)-MDMA with values for K_i reported in nM \pm SEM.²⁴⁷

Receptor	Hot Ligand	Hot Ligand Activity	(\pm)-MDMA	<i>R</i> -(-)-MDMA	<i>S</i> -(+)-MDMA
5-HT 1	³ H-5-HT	Agonist	6,850 \pm 1,300	4,200 \pm 500	>10,000
5-HT2	³ H-Ketanserin	Antagonist	8,300 \pm 1,100	3,310 \pm 140	>10,000
D2	³ H-NMSP	Antagonist	>10,000	>10,000	>10,000

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript