

MDMA, LOVE, MOURNING AND MELANCHOLY. EXPERIENCES OF PSYCHOLOGICAL “COMPRESSION”

Finian Fallon*

Resumo: This article is an exploration of the experience of working with young adult clients who have been traumatised as a result of misusing MDMA, often combined with alcohol. A single overdose may lower psychological defences and prevent the ability to achieve a healthy repression of unconscious conflicts, resulting in an immediate or delayed existential crisis. In response there may be what is described by the author as “compression” where euphoria and dis-inhibition combine to overwhelm the psyche. The paper also explores the current use of MDMA in PTSD research and its location in contemporary culture. It incorporates Freud’s perspective from Mourning and Melancholia into the clinical approach to working with this cohort, including perspectives on mourning, loss, narcissism and displaced reproach. The compression experience may be temporarily suppressed only to emerge in depressive symptoms and suicidal ideation.

Palavras-chave: Freud; MDMA; misuse; loss; melancholy; compression; narcissism.

Introduction

This paper will attempt to outline a cultural context and tentatively suggest a clinical response to the experience of working with young adults in crisis as a result of their misuse of MDMA (full name 3,4-methylenedioxymethamphetamine), commonly known as ecstasy. It is not a paper about addiction but addresses a cultural phenomenon and offers a practical response to clinical presentations. I will first look at some current research into its use including for treatment of Post-Traumatic Stress Disorder (PTSD), in addition to viewing its location in popular culture. Then in describing the experience of MDMA overdose or misuse, I will suggest a specific term, compression, to represent the intensity of the rapid scraping away of defences and sudden emergence of repressed and developmental conflicts. Within this compression experience we may also see the intensification and manifestation of melancholic traits in addition to narcissistic regression. The complexity of the client presentation is conceptualised by me as an implosion and regression of normal developmental demands that the young adult is unable to integrate in such a brief, intense experience resulting from an altered state of mind.

It can be seen in the clinic how this experience can leave the young adult somewhat lost and experiencing what has been described as a quarter life crisis or by others as an existential crisis. These experiences can also be encountered by young adults while using other substances including marijuana, often in combination with alcohol. In my clinical response to the presenting issues explored here I often return to the basic Freudian concepts shared in *Mourning and Melancholia*.

MDMA and Research

Research into the therapeutic use of substances such as MDMA has been since the 1960s until recently beyond the pale of the research establishment. However, there is an emerging body of research into the use of so-called recreational substances in therapeutic applications. As a result we have seen the legalisation of medical marijuana in some areas of the USA and how this is causing difficulties both locally and nationally, not least for the war against drugs. Another contemporary example of this emerging field of research is the potential use of MDMA in the treatment of PTSD (Mithoefer et al 2013) which appears to hold some promise and demonstrates durability in therapeutic benefits.

In looking at the research around recreational use and misuse of MDMA there are as yet unresolved differences of opinion among researchers as to the long-term impact of misuse (Halpern et al. 2011). Its misuse may or may not be associated in research outcomes with cognitive impairment, depressive tendencies and anxious symptoms. However from clinical and anecdotal evidence it seems clear that there is a problem. For the moment, and while paying due regard to the emerging body of research, I am reliant on clinical observations, discussions with colleagues and what clients tell me about their experiences, in formulating a practical response to the difficulties presented.

MDMA and Culture

The evolving applications of previously illegal substances such as MDMA and marijuana in medical contexts provide a challenge to the maintenance of criminal punishments for illicit possession of these and other substances. There is an apparent contradiction between laws that criminalise possession and a shift from outright banning to state sanctioned control. MDMA is another substance that may traverse the divide between the illicit and the medical world. MDMA is placed firmly at the centre of youth and dance culture throughout the western world. The singer Madonna's recent efforts to ingratiate her persona

with youth culture via her reference to Molly, a slang word for MDMA, at a concert in Miami and naming her recent album MDNA are contemporary confirmations of this. In Ireland we have had the recent phenomenon of head shops appearing in high street locations, selling recreational substances in defiance of laws that until recently were unable to keep up with the new drugs being introduced. While there has been a change in legislation and a clamping down on these head shops, it was remarkable to observe queues of people stretched along the pavements of Dublin and other Irish cities. Those heading home would watch while others were queuing to get out of their heads. A googling of the term “head shops in Dublin” reveals 11 stores that are apparently still operating, including one that integrates the retail offerings of a sex shop. I believe that these head shops have contributed along with dance culture to a societal oscillation that is still resonating and which has increased the use and acceptability of MDMA and other substances among adolescents and young adults.

In Ireland we also have societal difficulties with alcohol use combined with drug taking. In the Irish context it is only very recently that our national policy on the problematic use of drugs has been integrated with our policy on alcohol. For

many years it would seem that our cultural blindness to our problems with alcohol and successful lobbying interests combined to prevent a thorough acknowledgement of our historic and contemporary difficulties with alcohol. Thankfully this is now changing. At the same time it is fascinating to observe one business in which marginally legal substances are sold, a head shop, while across the street we see a building in which another set of mind altering substances are sold openly with full state approval, and which provides substantial returns to the exchequer: a public house. It remains to be seen if we will ever square that circle.

From a clinical perspective it is surprising to encounter the apparently increasing prevalence of MDMA and other non-traditional substances in client presentations. In the past alcohol and cannabis would have been the usual suspects. Another feature of the Irish context is the combination of alcohol with other mind altering substances which perhaps increases the impact on users, especially when located in social situations in which the normalcy of drug taking appears to be thoroughly established. In essence younger people are entering early adulthood in an environment in which drug use is increasingly prevalent and acceptable. This is combined

with a cultural acceptability in Ireland of, if not a cultural insistence on, excessive consumption of alcohol. While one-off experimentations with these substances might be more often safely integrated into developmental rites of passage of young adults, in the future repeated and long-term usage of alcohol combined with other mind altering substances as part of a general cultural trend may pose a significant challenge for mental health resource provision in Ireland. I will now outline the clinical presentations representing the overuse of MDMA as this paper moves towards a clinical response to the presenting problem.

MDMA Overdose, Misuse and “Compression”

MDMA is “an entactogen - a substance that enhances empathy, intimacy, loquacity and an elevated positive mood.” (Gunja 2012, p.563) In overdose it causes physical symptoms of bruxism, palpitations, hypertension and diaphoresis, delirium, tremor, autonomic instability, seizures and other effects (ibid.) We are familiar with overdoses of water intake resulting from hyperthermia. There may also be hypotension and paranoia. Clients have reported, as has been reported for many other substances, a dissociation from reality occasionally leading to the experience of a bad trip on MDMA. This negative experience may include feeling sad, fearful or terrorised with

anxiety levels sometimes ranging from mild to severe. In its aftermath individuals can be left feeling severely down for days or weeks, or years in my clinical experience. I observe that some of these bad experiences and ongoing use of MDMA (with or without alcohol) lead to fundamental alterations in the world view of clients seeking psychotherapy. These shifts could be described as existential crises. A quarter life crisis is another description that may be apt in these examples. While alcohol is clearly implicated in a significant proportion of completed suicides in Ireland it remains to be seen what part MDMA and other substance use has to play in the incidence of self-destruction.

From a psychoanalytic perspective the MDMA overdose experience seems to manifest a combination of euphoric feeling with dis-inhibition of repressed conflicts around parents, family, friends and self. Guilt and self-hatred may be instantly brought into consciousness. The young adult MDMA user, who it seems is often socially awkward, is looking for some connection via their ingestion of the substance (the nickname “Bump” is one of many used in an Irish context which suggests a desire for intimate and physical contact with others). It seems that normally repressed conflicts related to how the young adult esteems themselves erupt back into consciousness. Self-doubts that may have been adequately managed cry out again,

seeking immediate reassurance which is often unavailable in situations where everyone is out of it. This is the experience that I describe as “compression”: temporarily euphoric feelings of dis-inhibition combined with rapid uncovering of repressed conflicts, regression and anxiety in a short period of time as a result of the excessive or prolonged ingestion of mind altering substances.

Clinically, clients presenting with compression often appear to have some background pathology within their family structures in which there is insufficient affection, attention and intimacy. There may be a family system that appears adequate however on exploration, after the usual resistance and guilt about critiquing one’s family has been overcome, I often hear of a much colder and isolated family experience than initial client responses would suggest. Perhaps a lack of adequate affection, attention and intimacy in families is the norm rather than the exception. There is often a sense that these clients have not encountered the impact of being thoroughly loved. From Freud’s account we can see that it is perhaps no coincidence that MDMA pills are orally ingested to help the user love and be loved, to touch and be touched. In considering these elements from a clinical aspect we can return to ideas proposed by Freud in his

writings and in particular in *Mourning and Melancholia* which seem to capture many of the psychological features of the compression experience.

Mourning and Melancholia

In writing about *Mourning and Melancholia* Freud wonders whether “a purely narcissistic blow to the ego... may not suffice to produce the picture of melancholia and whether an impoverishment of ego-libido directly due to toxins may not be able to produce certain forms of the disease” (1917 p.252). Perhaps we can see in this statement a confirmation of the dangers of a narcissistic culture. The use of the word melancholia by Freud refers to the loss of an unconscious love object (p.243) Freud describes the features of melancholia as:

a profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment (1917 p.243).

As outlined by Freud a difficulty in abandoning the loved object persists. In compression the client often finds it difficult to emerge into their adulthood while so many developmental challenges have been relaunched into their conscious field. There is a denial of the need to abandon a

“hallucinatory wishful psychosis” (ibid.) related to an idealised past and family context. Much like losses associated by Freud with melancholia, in the clinical setting therapeutic change is difficult and may take a long time.

In explaining my position on compression I have one point of departure from Freud’s description of melancholia which does not diminish his position but merely utilises his work in the particular context of the experience that I am writing about. Freud describes melancholia as involving an impoverishment of the ego but not of the world (p. 245). I would argue that the compression experience may often result in both a diminution in ego strength and in the client’s view of the world, for the self-worthlessness revealed in the clinic is often accompanied by a disappointment with the world and the future (as well as a fear of poverty referred to by Freud (p.250)). In addition to often sleeping poorly Freud also says that in relation to melancholia the client experiences “what is psychologically very remarkable... an overcoming of the instinct which compels every living thing to cling to life. (p.245)” Clinically I often observe suicidal ideation which is present and acknowledged by the client but not active in terms of performing the act. It is as if the client just doesn’t care whether they live or die.

Freud also confirms the clinical experience of clients being truthful in their understanding of what might be described now as an existential worldview but in a way that causes difficulty for them. It can be seen clinically that, as Freud writes, the conscience itself has become ill and split off from the ego (p.247) and he goes on to say that, “an object loss was transformed into an ego-loss... between the critical activity of the ego and the ego as altered by identification” (p.248) and that this loss operates as “an identification of the ego with the abandoned object” causing a “shadow of the object” to fall on the ego rather than the energy being diverted into a new love object (ibid.) The client may live in the shadow of the loss.

The freshness and apposite writing of Freud remains remarkable to me. It fits the clinical picture so well and where my clinical experience differs it is only in minor categorisations: the insights offered by Freud still demand attention and consideration in my clinical response. He also wrote about how the melancholic reaction is somewhat connected to his ideas around narcissistic regression which is outlined below.

Narcissistic Regression

Freud writes that “melancholia... borrows some of its features... from the process of regression from narcissistic object-choice to narcissism” (1917 p.249). Earlier he had written:

He is not willing to forgo the narcissistic perfection of his childhood; and when, as he grows up, he is disturbed by the admonitions of others and by the awakening of his own critical judgement, so that he can no longer retain that perfection, he seeks to recover it in the new form of an ego ideal... the substitute for the lost narcissism of his childhood in which he was his own ideal. (Freud 1914, p.93)

We can also see in the taking of illicit substances that these may be egodystonic behaviours that contradict the ego-ideal or super-ego of clients introjected from their families, resulting in further self-recrimination and loathing. There may well be some recrimination against a failed love-object contained in the sadistic/masochistic identification diverted to the ego. As Freud writes, “... the patients usually still succeed, by the circuitous path of self-punishment, in taking revenge on the original object and in tormenting their loved one through their illness, having resorted to it in order to avoid the need to express their hostility to him openly” (p.250) In this way the displaced reproach for disappointment with parents or family is redirected back onto the client.

Combining the possibility of narcissistic regression, dystonic guilt and displaced reproach we can see how the client may have returned to narcissistic polarities of right and wrong or black and white thinking. These polarities are perhaps a return to a Kleinian paranoid-schizoid state of mind which must be worked through carefully in the clinical setting which I will now explore.

Clinical Response

In outlining a clinical response to this complex presentation the first thing to be aware of is the unique presentation of each client. This paper is offered not as a prescriptive approach to responding to these presentations but as tentative thoughts for consideration when working with this type of cohort. In practical terms there may also be active-directive elements to the treatment of clients in these circumstances where, for example, isolation has increased as a result of the compression aftermath. Many of the techniques I use are not classical psychoanalytic approaches but are used with the intention of getting the client to eventually speak in a psychodynamic framework, if they wish. However I would agree with the Adlerian view that therapy is sometimes a call to action, especially in the face of such debilitating positions held by the client particularly in relation to suicide

and depressive behaviours.

When working with this group my initial goal is to establish a good rapport with the client. This can be difficult with clients who are grappling with narcissistic regression and who may look down on and despise the therapist at the same time as they seek help. I have seen the use of humour, selective self-disclosure and story-telling to be useful in helping the client believe that they are not alone in their suffering. The use of philosophical discussion or discussions about the normal vicissitudes of life in general can prove effective in shaking up the acquired rigidities in the client's thinking as well as generating rapport. The establishment of rapport is both constructive and reparative in its intent. Where clients present who are clearly anxious I will often begin with simple breathing exercises and relaxation techniques to calm the client and at the same time hopefully earn their trust by showing them that they can learn to relax and self-soothe with practice. In all of this I have in mind the benefit of the Freudian approach of remembering, repeating and working through. The clinical must take place in an authentic context for the work, as being formulaic or repetitive in my approach to different clients may endanger the development of a working attachment or transference with the client.

In this paper I have outlined a cultural and clinical context for the excessive use of MDMA and have suggested compression as a term to describe excessive use of this and other substances. I have used the work of Freud to illustrate a theoretical framework that can be used to conceptualise the presenting issues and therapeutic frame. I conceptualise the work as unpacking the compression experience and facilitating the client to reorganise their thinking via speech, insight, action and the expression of their desires. It can take a long time and there are difficulties in containing and holding young adults who have been traumatised by their risky attempts to engage with enjoyment and life.

NOTES

* Finian Fallon is an accredited psychotherapist working in Ireland. He holds an MA in Addiction Studies and is completing a Doctorate in Psychotherapy at Dublin City University.

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