

‘Weddings, parties, anything...’, a qualitative analysis of ecstasy use in Perth, Western Australia

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Abstract

This study investigates the patterns of use, the meanings associated with use, the perception of risk and the strategies adopted to reduce these risks for a sample of ecstasy users in Perth, Western Australia. The sample was purposively chosen to represent the heterogeneous nature of ecstasy users in Perth. Data were collected from 31 ecstasy users and 157 h of participant observation in a variety of settings. The study found that users exhibited a reasonable degree of control over their consumption, incorporating a series of risk reduction strategies. Application of these strategies was inconsistent, with a large percentage of the sample indulging in occasional binges, spontaneous purchases, polydrug use and purchasing from unknown individuals in clubs/pubs. As users became more experienced, they tended to become less concerned about the risks associated with use and exhibited greater risk taking behaviour. Understanding the beliefs and events that influence the adoption (or non-adoption) of harm reduction strategies and the heterogeneous nature of ecstasy users is important for future health promotion interventions and policy. © 2001 Elsevier Science B.V. All rights reserved.

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Introduction

Ecstasy consumption has been primarily linked through research and the popular media to youth and the rave/dance music scene. Numerous authors have presented repeated

evidence of a strong association between raves/dance parties, youth and ecstasy consumption (Forsyth, 1995, 1996, 1997; Adlaf, 1997; Boys et al., 1997; Shucksmith and Hendry, 1998; Kreiner et al., 1999; Lenton and Davidson, 1999; Sherlock and Conner, 1999). Most studies to date have been either descriptive statistical/questionnaire data or biomedical studies focussing on animal experimentation and pharmacological analyses

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(McCann, 1993; Ricaurte, 1996; Adlaf, 1997; Forsyth, 1997; Gerra et al., 1998; Parrott, 1998). Earlier research largely focussed on the rave subculture; however, as dance music has become increasingly mainstream, research into ecstasy use has broadened to include nightclubs where dance music is played (Measham et al., 1998). Despite this, research has remained focussed on youth and dance music settings (Forsyth, 1997; Kreiner et al., 1999; Lenton and Davidson, 1999; Pedersen and Skron-dal, 1999; Sherlock and Conner, 1999). Most research of this kind has included questionnaire data aimed at highlighting levels of use and association with dance music settings. As such there has been limited in-depth research on ecstasy users, their patterns of use and the diverse settings/events where ecstasy is consumed.

There is some evidence that recreational use of ecstasy occurs outside the rave/dance music scene (Moore, 1993; Beck and Rosenbaum, 1994; Handy et al., 1998; Pedersen and Skron-dal, 1999). Data from recent Australian research suggested that ecstasy was increasingly being consumed by a more demographically diverse group of people than has been previously recorded (Topp et al., 1998). This trend was also evident in data taken from Western Australia. (Australian Institute of Health and Welfare, 1999; National Drug Strategy Household Survey, 2000). The majority of self-reported ecstasy users were aged between 20–29 years of age; however, a significant number of users were aged thirty years and above, with approximately 11% of users belonging to the 40+ age group (National Drug Strategy Household Survey, 2000). All age groups, except the 30–39 years group, revealed little to no variation in the number who reported having ever used and having

used in the past year. This suggests that there is a small but dedicated number of ‘older’ (forty-plus) ecstasy users within the Perth community. Despite this evidence, much of the research and many of the intervention programs have focussed on the rave/dance music scene and youth, thus ignoring a significant ‘hidden’ population of ecstasy users. This study purposively selected a sample of ecstasy users to represent the pattern of age use in Western Australia, with the intention of broadening the current understanding of popular recreational ecstasy use in community settings.

Ethnographic methods of participant observation (excluding actual drug use) and in-depth interviewing were used in this study. This approach is a recognised form of investigation of drug-using populations (Becker, 1953; Power, 1989; Moore, 1993; Dear, 1995). Immersing oneself in the life of those involved in the study allows for minimal disruption to the normal sequence of events and therefore enables insight into the meanings, circumstances and behaviour that surround drug use. Moore (1993) (p. 71), succinctly captured this when he wrote that ethnographers are ‘ideally positioned to describe and interpret the social processes which underlie drug use, the social meanings of drug use fashioned during the social interaction and the harm minimisation practices currently employed by drug users to reduce drug-related harm’. An interpretative framework based upon symbolic interactionism was used to guide data analysis (Charon, 1992; Reynolds, 1993).

For the purposes of this paper, ‘ecstasy’ is used to refer to the substance(s) that have been bought and consumed purporting to be 3,4 Methylenedioxymethamphetamine (MDMA).

Methodology

Data were collected through a range of strategies including participant observation, semi-structured in-depth interviews, follow-up semi-structured and structured telephone interviews, and numerous informal conversations. Data were collected from a total of 31 participants between July 1998 and February 2000. Key informants ($n = 7$) were longitudinally followed for up to an 18 month period, with each informant being contacted fortnightly. A total of 13 semi-structured interviews were conducted with an additional 18 field contacts providing information via observation and verbal feedback/verification. In addition to the 31 participants that were directly involved in this study, others were indirectly involved through their presence at observational periods/events. Participants who were interviewed were subsequently contacted via telephone on at least one occasion; however, seven were contacted on numerous occasions over a 6–18 month period. The information obtained included a brief history of licit and illicit drug use; knowledge of the drug; the level of planning that was involved in use (specific events only or a regular weekend binge); supply sources; type of use (novice, long-term); the meanings associated with the drug; distribution and supply networks; users' perception of harm and information relating to other recreational drug use. Interviewed participants were subsequently contacted via telephone pre- and post- use event, with data being collected on the preparation, planning and actual event.

Recruits were mature adults (18–41 years) and were obtained using a combination of theoretical purposive sampling and the chain link referral or snowball technique (Silverman et al., 1990; Gifford, 1996). Initial contact with subjects was initiated through known associates and advertisements at a

university. Using a snowball technique these contacts eventually lead to key informants. Purposive sampling involved matching specific individuals for age to reflect the use patterns in Perth, Western Australia. The snowball technique was then used to connect the researchers with other ecstasy users that matched the age profile being sought. To qualify for the study, each individual had to have used ecstasy at least once in the previous 6 months. Although several participants had attended rave/dance parties, none of the sample identified themselves as belonging to the rave/dance music scene.

Participant observation

Using a combination of covert and overt observation methods the researcher spent a total of 157 hours observing participants and events. The combination of these two methods is an acceptable form of data collection (Power, 1989). The researcher used overt methods when engaged in observations at private dwellings and other use settings where the subjects were aware that they were being observed. Covert observation refers to those times when the subjects under observation may not have been aware that they were being observed. Participant observations served to both enrich and verify the interview data, allowing greater insight into the function and the meanings derived from drug use. It involved the researcher being immersed in the participants' lives, which required long hours of informal interaction in addition to attending social activities and ecstasy purchasing opportunities, and conducting interviews.

Observational data were collected from a diverse range of settings including several different nightclubs (four) and pubs (eight) in the Perth metropolitan area, participants' homes (five), a wedding, the Gay and Lesbian

Pride party, a taxi ride, private parties (six) and a rave. Additional data on previous settings was obtained in the interviews and at participant observation sessions, via conversations with the participants and other voluntary informants. The interviews were generally conducted in informal settings of the participant's choice. The researcher also accompanied two of the participants to their place of purchase (the dealer's home), as well as being present at several spontaneous purchases (private home, party, pub and club) and unsuccessful attempts to purchase. Due to the nature of the research, the researcher was not always able to make immediate field notes during some observational periods. In such instances a dictated record of the observed events was recorded into a tape recorder at the earliest possible time.

Data integrity and validity

The use of qualitative data collection methods required the researchers to account for data integrity and validity (Bogdan and Taylor 1975; Gifford, 1996). Data integrity refers to the verity of the data from a subjective perspective and the integrity of the methods used to collect the data. This was accounted for by the creation of detailed field notes immediately after the observational events so as to minimize the researcher's subjective recall, and creating verbal recordings of observations. All interviews were audio recorded and full transcriptions completed. The researcher was regularly debriefed after engaging in fieldwork. Further, over time researcher sensitivity was developed and used to check the verity of the data (Jick, 1979; Power, 1989; Silverman et al., 1990; Strauss and Corbin, 1990; Gifford, 1996).

Data validity was accounted for by convergence of data sources (triangulation). This

included comparison between interviews, pre- and post-event interviewing and comparison with observational data. On occasions, discrepancies between data sources were identified and used to direct further data collection. Often, subjects were invited to comment upon discrepancies identified between interview and observational data.

Problems encountered in the field

Qualitative research methods, particularly when researching illicit drug use, involves a variety of potential risks to both the researcher and the research subjects (Lee, 1995; Stewart-Clevidence and Goldstein, 1996). During this investigation the researcher experienced a number of problems associated with the fieldwork. Issues of researcher integrity, blurring of boundaries and the risks associated with researching an illicit act needed to be addressed. During the observational periods the researcher was offered a variety of drugs. The offer of drugs commonly occurred when subjects tried to initiate the researcher into their social group. Often this represented a blurring of the boundaries by the subjects. The researcher also encountered sexual advances and the potentially dangerous situation of being driven in a vehicle by someone who had recently consumed ecstasy. Attempts to minimize the potential for sexual advances included using social sponsors who introduced the researcher into the groups. Additional risks involved in this research include those associated with the observation and recording of illegal activity, particularly the purchase of illicit drugs. Knowledge about dealers and their modus operandi posed potential ethical and legal risk to the researcher; however, no problems were encountered with regards to these potential risks.

Generalisability

The choice of purposive sampling limits the generalisability of the findings. In addition, the sample size is small and thus the findings can not be said to be reflective of general ecstasy consumption. The purpose of this research is not however to produce generalisable results. Rather, it is to describe the diverse settings and social circumstances in which ecstasy is used, the relationship that exists between the event/setting and user behaviour, and the meaning that ecstasy has for both the individual and their social group. Thus whilst these data will not be widely generalisable, they will have relevance to members of particular user sub groups of users within the Perth community.

Data analysis

An interpretative framework based upon symbolic interactionism was used to guide data analysis. The interpretative framework required the issue to be investigated and analysed from the participants' perspectives. Data were coded and placed into categories according to emerging themes, for example the meaning of ecstasy. All data were managed using the Non-numerical, Unstructured, Indexing, Searching and Theorising (NUD.IST) computer program (NUD.IST, 1995). Using a constant comparative process further data were collected and categories refined as the interrelationships and interdependence between categories became evident (Strauss and Corbin 1990; Glaser, 1992). This constant comparative process continued until the data had sufficient depth to explain the issues under investigation.

Findings

The sample

A total sample of 31 participants, consisting of 13 females and 18 males, were directly involved in this study, with an additional number being indirectly involved through their presence at observational periods/events. The semi-structured in-depth interview sample consisted of eight males and five females, with an average age of 24 years for males (range 18–38) and 27 years for females (range 22–41). This study purposively sought to obtain a sample that reflected the heterogeneous profile of ecstasy users in Perth. Thus, although the majority of participants were aged from 20–29 years, one-third of the interviewed sample and one-sixth of the total sample were aged over 30 years, which was consistent with the 1998 survey data (National Drug Strategy Household Survey, 2000). The sample included both frequent and infrequent users of ecstasy, male and female, homosexual and heterosexual, singles and couples, professionals, students and blue-collar workers. Some were regular users, while others had only tried ecstasy once prior to participating in the study.

Occupationally, participants included 12 white-collar workers (engineering, banking, psychology, teaching, physiotherapy and dentistry), 11 part-time and full-time students, three blue-collar workers (electrician, painter, mechanic) and two single mothers. The remaining participants worked in the security and personal fitness industries. All of the interview participants, except two, had successfully completed year 12 (final school year), with the majority having completed, or working towards completing, a university degree ($n = 20$).

History and patterns of use

The participants demonstrated a wide variation in the duration and frequency of use. Some had been using for only 7 months prior to interview while others had been using for over 10 years. The majority began using in the previous 5 years, with the average length of time that ecstasy had been used being 3.5 years. The actual frequency of use was erratic, numerous factors being influential in determining use patterns. The majority of this sample were not currently consuming ecstasy at regular intervals (weekly, bi-weekly), with most describing their use as erratic and irregular. All participants indicated that there were typically periods of high and low use; all illustrated a high level of consistent use around special occasions and events, particularly the festive Christmas/New Year period. When initially interviewed all, bar three, of the participants indicated an intention to continue to use ecstasy in the future. Despite their initial assertions, these three participants all sought to use ecstasy on several occasions during the observational period. Follow-up interviews revealed that two of the 31 participants had ceased use. Although both had indicated during the interview process that they intended to continue to use in the long term, external circumstances (medical and legal) had forced a re-evaluation of use and ultimately a decision to cease. Both, however, viewed this situation as temporary and indicated an intention to resume use in the future.

Initial use was restricted to no more than one ecstasy tablet for all of the participants. Typically, this involved half a tablet. A smaller number of the participants indicated that they had consumed two consecutive halves on their initiation. This involved taking half a tablet and waiting to feel the

effect before progressing to an additional half. A minority revealed that they had consumed a whole tablet on their first use episode. Generally, females were slightly more conservative in their initial use, with the majority only consuming half an 'e' (ecstasy tablet) on their first attempt. In contrast, a half of the male participants consumed an entire tablet on their first ecstasy experience.

Similar to the findings recently described by Shewan et al. (2000), the data revealed that users were aware of the influence of drug, set and setting on their ecstasy experiences. Furthermore, they had developed a range of harm minimisation strategies incorporating these factors.

The decision to use ecstasy was based upon a complex series of interactions that continued to change over time. Issues relating to the drug such as purity, route of administration and the meanings derived from the use were not constant. Users were taught about what to expect from the drug and how to interpret the sensations they received; for example, when discussing the nausea and paranoia that some people experienced, Adam made the following observation:

'It's all a bit of mind over matter. You have to learn to let your fears go, to relax and just take in the experience. All drugs, all drug taking is about mood and setting' (Adam, aged 26).

The users identified that the setting, the availability of other drugs and their expectations all combined to influence their decision to use and their drug use experience.

Making the decision to use

‘I’d seen other people on it and it just seemed all right. And like I sort of weighed up the risk factors and it seemed pretty good. And I heard that you’ve got more chance of dying on the way to a rave in a car accident that actually taking ecstasy. So I thought I’d give it a go’ (Barry, aged 18).

A range of factors was important when making the decision to use, however the friendship groups and social support network were revealed to be of particular importance. All participants initiated their use in the company of close friends, partners or a relative. These friends were either fellow initiates or they were previously experienced and thus, were accorded the role of guide and mentor. In this role they were responsible for reducing feelings of anxiety, monitoring the effects (physical and psychological) and enhancing the experience of the new user. Feeling comfortable, relaxed and secure were universally reported as essential to ensuring a positive introductory experience. The presence of friends in itself did not, however, serve to meet those needs. Typically, the initiate sought out information concerning the effects, risk of adverse events and strategies to minimise those risks from experienced acquaintances prior to making the decision to use. This was either done directly, by asking experienced individuals or through observation of users in situ.

‘I don’t have any real concerns because I’ve always weighed what I’ve considered to be the pros and cons of what I do and at the end of the day I make that choice. I don’t know what alcohol is doing to my

liver but every time I have a glass of wine I’m not going to do myself in over the fact. I’m going to rely on the fact that my consumption of all the drugs that I choose to take is sufficiently moderate that, for me, that is worth the risks that I know to be associated with those drugs’ (Bob, aged 38).

The above quote was typical of the experienced user. Experienced users tended to exhibit a level of nonchalance in relation to the potential health risks associated with use of the drug, which can be largely attributed to the absence of significant adverse events in their own personal experiences. It was interesting to note, however, that all of the participants indicated that regardless of the amount consumed on their first occasion, they would advise initiates to only consume half a tablet as they considered this to be the safe level of use for first timers.

Meaning and function

‘I just like the feeling of power, of speed, of complete oneness with your body. Just all the senses come alive. It’s like, have you ever had a fruit tingle? You feel that tingle on your tongue when you have a few fruit tingles. It’s like you’re one big wet fruit tingle. And you’re just effervescing. It’s just brilliant.’ (Adam, aged 26).

The appeal for ecstasy users appears to be controlled freedom, a loss of inhibitions, affirmation of friendships and, as Adam describes in the above quote, a range of sensory sensations linked to enjoyment and pleasure. Ecstasy is the drug of choice because it provides the fun, confidence and companionship that the users seek without the negative consequences associated with other recreational

drugs. In fact, a significant proportion viewed ecstasy as an alternative to alcohol and preferred its effects. The preferred effects included the lack of aggression (physical and sexual), the sense of retaining control, the absence of a hangover, the positive feelings experienced during the ecstasy high, the loss of inhibitions (in particular dance-related inhibitions for men), the sense of intimacy and the desire to dance. Essential to the popularity of ecstasy is the sense of control that the users maintain, as the following quote highlights:

‘I don’t like being not in control. I’ve always whenever I’ve had stuff before I’ve always been able to control what I’m doing. With ‘e’s you always know what you’re doing. You can always remember what you did.’ (A.J., aged 23).

Ecstasy was viewed by users as a facilitator of particular social activities and therefore was viewed as having a functional role. While viewed as a facilitator it was not, however, viewed in any way as an addictive substance.

‘I mean like this party that I was telling you about. Everyone was friends. They went there to do this-to take ‘e’s and just have a good time together. None of them were really abusing the drug. It was more of a fun thing, a social thing. All of them have jobs and ... it’s just a recreational thing. A party thing.’(A.J., aged 23).

Limiting use

Each of the 31 participants indicated that they had adopted some form of self-limitation in relation to their use of ecstasy. These

limitations included the self-imposed controls of the amount, frequency and intensity of use. Reasons given for these self-limitations included monetary factors (cost), quality factors (inconsistency/variability in the quality of ecstasy), social factors (issues relating to employment, parenthood and friendship networks) and the potential health risks associated with use of ecstasy.

The financial cost was the predominant reason given for limiting use. Although other factors (such as friends, availability and health risk) were considered, it was ultimately the financial burden that determined level of use. Interview and observational data revealed that the majority of participants, when presented with an opportunity for a free ‘e’ took it, regardless of their position prior to the offer. A.J.’s experience is typical, her initial experience with ecstasy left her feeling disappointed and she had therefore decided that she would not use it again. But, ‘when it was free I thought, well it didn’t do anything last time so it’s not going to matter if I take it this time.’ (A.J., aged 23).

Bingeing

While all of the participants typically used between half to one and a half tablets in a single ecstasy use period, 70% of those interviewed indicated that they had on occasions ‘binged’ on at least 2 and up to as many as 5 tablets in one single use period. The majority of participants indicated that they would use more frequently and for some, at greater levels of intensity, if the cost of purchasing ecstasy were less. The participants recognised that due to the positive experience associated with the use of ecstasy, the desire to take more once the initial supply had been consumed was significant. Adam’s response was typical: ‘I think the major risk is taking too many.’ (Adam, aged 26).

Observational and interview data revealed that participants frequently attempted to obtain additional tablets regardless of the actual effect of the drug. That is, the desire to take more occurred both when the experience was particularly good and on the occasions where the user's expectations had not been met. The following response reflects the observed attitude and behaviour of the participants in relation to unplanned 'additional' use:

'But the thing is, when you've forked out some money there's this certain expectation that it will have a certain effect and when that effect doesn't happen you take more.'
(Anne, aged 41)

Patterns of other drug use

There has been much speculation about ecstasy's potential role as a gateway drug. Recent research suggests, however, that this speculation is unfounded (Pedersen & Skrondal 1999). The participants in this study revealed mixed drug-use histories. Drugs consumed by interview participants prior to initiation to ecstasy included alcohol (13/13); tobacco (7/13); marijuana (13/13); LSD (lysergic acid diethylamide) (7/13); speed/amphetamine (7/13); cocaine (2/13); heroin (1/13); magic mushrooms (2/13) and dexamphetamine (1/13).

Drugs consumed post-ecstasy initiation included duramine (1/13); amyl nitrate (bulbs) (2/13); LSD (3/13); speed/amphetamine (3/13); cocaine (5/13, of which 3 had only used once or twice, the remaining 2 had used regularly); heroin (1/13, once only); magic mushrooms (2/13, once only) and dexamphetamine (1/13). Thus while some participants had consumed additional drugs post-ecstasy, others had not.

Some participants used pharmaceuticals such as Valium and Rohypnol although few included these when asked to detail the drugs they had used both prior to and post-initiation to ecstasy. Observational data revealed that a number of participants used these substances to ease the comedown and to facilitate sleep after an ecstasy-using event. The majority of participants held strong views against other illicit drug use, particularly LSD, heroin and cocaine, while a small number were opposed to the use of pharmaceuticals.

'I take drugs for a reason. For fun. If I've got something wrong with me I've got my immune system to correct it. Not drugs.'
(Peter, aged 28).

Perhaps more significant than ecstasy's potential as a gateway drug was the evidence of a general trend towards polydrug use. Previous studies have suggested that the 'pure' ecstasy user is a rarity, citing significant polydrug consumption patterns (Forsyth, 1996; Boys et al., 1997; Sherlock et al., 1999; Shewan et al., 2000). Initiates and inexperienced users tended to use ecstasy in isolation from other drugs, with the exception of alcohol, which was typically consumed in moderation or not at all. It was universal that as users became more experienced, they exhibited a pattern of use that included the consumption of greater amounts of ecstasy and an increasing combination of other drugs. Whether this pattern is a result of physical or psychological tolerance, or simply an experiential expansion along the drug use continuum, is difficult to say without further research. Significantly, it was universally agreed that ecstasy was the preferred drug (even above alcohol), but that the cost, availability and inconsistency of the product made use of other drugs necessary.

Polydrug use

Polydrug use was a significant feature in the participants' consumption patterns, particularly for special events (binges, all night events with a recovery party the next day). Certain drugs were frequently consumed in conjunction with ecstasy, the typical cocktail being 1–2 tabs of ecstasy, and a cone or two of marijuana to facilitate the comedown. For more advanced/intense users, 1–2 points of speed were generally included in the typical consumption patterns. Adam spoke of a combination termed the 'Candy Flip', which consisted of 'LSD or a trip, plus speed, plus ecstasy all at once or in close proximity to one another.' Speed (amphetamine) was generally used to prolong the up feeling, to heighten energy levels or to 'kick start the 'e''. Almost universally, marijuana was used to ease the come down experience. Alcohol consumption was generally kept to a minimum; however, as users became more experienced, alcohol consumption (pre-, post- and during) tended to increase.

Changes in use

Significant changes in use patterns were generally linked to a change in life circumstances. Such changes included new employment/financial situation, relocation, parenthood, physical injury (unrelated), police intervention (criminal investigation) and new relationships. For example, two of the participants had in the past used ecstasy weekly, in some instances peaking at more than three times a week, while employed in the clubbing/hospitality industry. Since leaving that industry, both had markedly decreased their level of consumption. Billy's level of use had changed significantly since leaving the clubbing industry.

'My priorities have changed. It's not all about doing that anymore. It's good to go out and do that but obviously time's a factor as well. You know I just had a lot more time then. And not many responsibilities. Whereas now I have less time and more responsibilities.' (Billy, aged 25).

When asked if he could envisage returning to a higher level of use, Billy responded:

'If I was single I might. Because again less responsibility.' (Billy, aged 25).

Users expressed the notion that certain changes in life circumstances would result in a re-evaluation of their ecstasy use. In particular, several users noted that the 2 days required for the typical ecstasy experience (use and recovery) might not be viable in the future. The older and more experienced users indicated that although patterns of use, particularly frequency, intensity and choice of use settings, might change in the future, their use would continue.

The following quote from an experienced user illustrates the issue of availability, the significance of setting, and illustrates how changes to physical and social environments impact upon use patterns:

'Being in [country town] does sort of slow you down a bit. There's not so many wild parties and that sort of thing, plus there's not so many people that I know here that take them.' (Adam, aged 26).

Adam had recently been relocated to a country town. He indicated that the responsi-

bility associated with his new employment was a major determinant in his decision to abstain. However, this abstinence did not include smoking marijuana, which he continued to do on a regular basis. Significantly, it was the change in setting (physical and social), not the issues of availability or opportunity that prevented him from using. He viewed his use of ecstasy as a 'treat', an activity that was closely intertwined with friendship networks. While away from Perth and his friends Adam abstained from using ecstasy; however, upon his return to Perth (at regular intervals of 3–4 months), he would quickly revert to his pre-relocation use patterns.

All of the participants adopted some form of cost-benefit analysis to their use of ecstasy. For the majority of participants, the positive effects derived from use of ecstasy outweighed the negative. As long as this equation remained in favour of ecstasy, then the participants would continue to consume. This is exemplified by the experiences of three of the participants. Follow-up interviews revealed that in the months proceeding the in-depth interviews Barry, J.J. and Craig altered their perception of the risks and the costs associated with ecstasy use and thus had altered their use patterns. Barry had been involved in an accident that resulted in serious head injuries, Craig had been questioned by the police in relation to an unrelated drug incident and felt that the risk of being caught was now higher and J.J. felt that the ecstasy she had purchased in recent times had not fulfilled her expectations. All three felt that the benefits derived from ecstasy were no longer greater than the associated economic, legal and health costs. When contacted several months after the follow up interviews, J.J. revealed that she had used again as it had been offered to her as a gift.

Risk

'Sure some people are going to have problems on it, but people are going to have problems on anything. Caffeine and cigarettes and alcohol, three legal drugs that cause a shit load of problems.' (Adam, aged 26).

This quote is typical of participants' responses to their perception of risks. All participants were aware of a range of risks associated with ecstasy use. The participants were questioned on negative experiences, perceived risks and risk reduction measures. Perceived risks included ignorance concerning the actual contents of the tablet/capsules, overheating, potential effects from polydrug use, legal risks associated with couriership, distributing and bulk purchasing, and the potential long term health risks. When asked about risks, all participants recognised the immediate risks associated with ecstasy use. These included overheating, dehydration, grinding teeth and gums, disorientation, nausea, blurred vision and increased heart rate. A number of strategies were adopted to minimise the potential for negative or adverse outcomes. These included controlling for the factors of drug, set and setting.

Confirming results from recent studies conducted in Wales, UK, the participants used the notion of 'acceptable safeguards' (Shewan et al., 2000), or steps that provide an acceptable level of protection. For example, using only when with friends; using only after someone else has tried it; using a regular supplier; controlling the amount consumed; controlling the amount of other drugs consumed; monitoring others (for physical and psychological harm); guiding initiates; limit-

ing one's supply and use; and using only when in a positive mood. This said, however, observational data revealed that the majority exhibited a willingness to circumvent these safety strategies. Examples observed included making spontaneous purchases, purchasing and consuming more tablets than intended, using despite a self-imposed moratorium, bulk purchasing, using when drunk, using on a work evening, bingeing and driving when under the influence. Their behaviour revealed a disparity between what they claimed to do and what they recognised as safe, and what they were actually doing.

Over time, individuals appeared to become more relaxed about their use and at this stage, additional behaviours such as purchasing off the street, spontaneous purchases, increasing the volume consumed and including 'outsiders' to the use group began to occur. Users appeared to become less anxious about potential adverse effects as they became more experienced. Bob describes the anxiety cycle:

'Certainly in the early days of taking ecstasy on a regular basis there was always this level of anxiety amongst the group. It would be this level of anxiety of, I suppose, the safety of the pill in the initial phase. Then, what it was going to be like. I don't have that anymore because for me I've rationalised the drug taking and that if it's a bad pill it's going to be a bad pill.' (Bob, aged 38).

As Bob became more experienced the anxiety he felt was related less to safety than to the experiential quality of the drug. This is evidence of the shift in risk perception that occurs. As the user becomes more experienced their perception of the risk of adverse health consequences is superseded by the risk of getting a 'dud' (poor) experience.

Inexperienced users intimated that if they knew the chemical content of their purchase and it was not MDMA, then they probably would not consume it. In contrast, the more experienced users indicated that they wouldn't want to know as the uncertainty was considered 'part of the process' (Anne, aged 41). There was an acceptance among users that they would at some point experience bad or 'dud' ecstasy. This acceptance was evident in their rationalisation of such experiences:

'Well I've had one bad one out of four or five. So that's not a bad effort. I've probably bought one bad car out of five but that doesn't stop me buying cars.' (Peter, aged 28).

Several participants reported they had driven either while 'e'ing or on the morning following an evening where ecstasy had been consumed. All of those who had driven in these circumstances believed that their driving ability was affected, with one participant suggesting although driving would be considered a risk taking behaviour, he loved the experience and often volunteered to drive home. Research from Western Australia (Lenton and Davidson, 1999) has identified driving as a potential risk associated with ecstasy consumption; however, further investigation is required to fully determine the level of risk.

The perception of risk due to ecstasy consumption was influenced by personal and peer experiences.

Interviewer: 'So have either of you ever experienced negative effects or a bad 'e'?'

Bob: 'Is there a bad 'e'?'

Anne: 'We've never had a bad 'e' in terms of having incredibly dire consequences.'

Bob: 'I've never had any negative side effects, that I am aware of, at all from ecstasy.'

(Bob, aged 38 and Anne, aged 41)

The participants, with the exception of one, recounted no 'significant' negative experiences, and despite his experiences he continued to use. Although the majority of users indicated an awareness of the potential adverse health consequences, the perceived risk to health remained minimal. This was largely due to the fact that none, except Billy, had personal knowledge of anyone having experienced a significant adverse reaction. The majority of negative experiences were attributed to mood, emotional state, setting, or adulterants present in the tablet. Short-term adverse effects such as vomiting, nausea and overheating held most salience. The majority of participants indicated an awareness of potential adverse long-term health effects, although none viewed this as particularly significant.

Similarly, they tended to view the legal risks as negligible and displayed a considerable lack of concern in relation to their consumption of ecstasy when in a public place, often consuming the tablet while in the open.

'I've become very complacent about it. I used to be very paranoid about it. Make sure no one sees. But now I don't really care. You're taking a tablet, what's anyone going to say to you? You know what you're taking? Oh, aspirin. It doesn't really bother me. Anywhere I'll take it. But especially when you're having a beer at the pub it's very easy to take one out of your pocket, put it down and have a drink. Very simple.' (Adam, aged 26).

Again, experienced users tended to display a more relaxed attitude than those less experienced users. This said, however, it was common practice, particularly among female

participants, to use the toilets as a place of consumption. The role of the toilets was two-fold: firstly, they were perceived as providing safety from detection, and secondly, the toilets provided a place for social interaction with other ecstasy users. Toilets are often used as a place to consume drugs and, for females, they often represent a safe space. In the case of an adverse reaction, the toilets provide a place away from flashing lights, booming music and masses of people, where friends could monitor each others' progress and bring them back to a positive mindset.

Routes of administration

Reported routes of administration included snorting and swallowing. Initial consumption of ecstasy was universally oral. The majority maintained this route of administration, however a number of participants indicated that as they became more experienced users, they progressed to snorting. This was never to the exclusion of swallowing and, for the majority, it remained the preferred mode of administration. This was reported as being for ease of administration (versatility and convenience), its inconspicuous nature (easy to slip one down with a drink without anyone noticing) and the length of the effect, which is reflected in the following quote:

'The thing is if you mix it in a drink and drink it, it comes up slowly and lasts longer. You snort it and it comes up a little quicker and it doesn't last as long.' (Peter, aged 28).

In contrast however, Renae loved to snort.

'I just like the feeling. ... I like the gross taste in the back of your throat because you know you're going to get high in a

minute... It's that sort of naughtiness as well.' (Renaë, aged 23).

Swallowing was universally considered the safest mode of consumption, both in relation to health and legal risks. Despite the apparent absence of overt concern for the health and legal risks associated with ecstasy use, all of the participants incorporated risk reduction behaviours, as highlighted by their preferred method of consumption.

'I've taken it as tablets obviously. I've never injected anything into my body, so I've never done that. I've heard of people that inject 'e's, crush them down and then do it. But I don't believe in injecting stuff into my body. I sort of think you've gone a bit too far if you do that. I've crushed them and snorted them. That seems to be all right. Injecting is not but snorting is — go figure.' (He laughs) (Adam, aged 26).

Like Adam, none of the participants had injected ecstasy, although several indicated that they knew of people who did. Most of the participants held a strong anti-injecting view and tended to view injecting drug users as 'junkies'. There was universal agreement that injecting transforms one's drug use from recreational into the realm of the problematic. Three of the participants had previously injected other drugs—namely speed and heroin. Although the heroin experiences had been a 'one-off', the participant who had injected speed identified herself as having been an addict for approximately 18 months.

Rituals of use

Typically, ecstasy use involved a certain level of planning and organisation, although

a majority of participants had at some stage participated in unplanned, spontaneous ecstasy use events. The frequency of these spontaneous events was linked to the amount of ecstasy consumed, previous ecstasy experiences, friendship groups and supply networks (availability). Use was very much influenced by external factors such as special events (reunions, celebrations, Gay Pride festival); festive occasions (birthdays, Christmas, New Year); availability and cost, as highlighted in the following quote from Adam:

'When they are available. When I've got the money. When I feel like it. There's no real one factor that says yep I'm going to take an 'e'. A lot of times it's a spur of the moment decision. A lot of times if it's a big event coming up then it's a planned decision. It depends.' (Adam, aged 26).

The whole ecstasy experience is made up of events that surround the drug. Beginning with the decision to purchase, 'scoring' (the purchase of the drug); preparations for use; 'popping the tab'; the comedown and the inevitable 'eckkie blues' (the recovery phase that often includes mild to moderate, and in some individuals, intense, feelings of depression). The phases involved specific rituals that culminated in the actual use event. Each served to heighten user anticipation and expectations, which combined to create the overall ecstasy experience. These rituals included purchasing chubba chubbs/lollipops (to reduce the effects of gum chewing), mints, menthol drops or nasal sprays (to heighten the experience) and marijuana (for the comedown), organising music (specific to each stage), co-ordinating consumption and monitoring the group's progress.

The phases themselves were often spread out over a period of time, sometimes weeks and even months, while for spontaneous use events, the phases were completed within a very short time frame. This appeared to have some effect on the experiential outcome. The physical setting (club, pub, home, beach), also tended to affect the organisational process and the various rituals involved, and therefore significantly affected the end experience.

Minimising the negative effects

The majority of users indicated that they were prepared to pay more for ecstasy if they could be guaranteed ‘the right effect’. That is, if they could be sure that it was MDMA that they were purchasing. While recognising that this was impossible, there were several recognised strategies that users adopted to maximise the quality of the ecstasy and thus their experience. These strategies included only using ones that had been recommended by others, scoring from a regular source, pre-purchasing, bulk/multiple purchases and developing a reciprocal relationship of trust with the supplier.

There existed a genuine belief among the users that the dealers/suppliers were generally trustworthy and there was a perception that they would look after the users. The dealers were not viewed as ‘drug’ dealers, rather as acquaintances doing a friend a good turn. If a ‘dud’ was purchased, it was generally accepted as ‘bad luck’:

‘Yeah we just had a joke about it, you know. He (supplier) goes ‘yeah sorry about that’. Cause everyone, you know you can’t do anything about it you know. He had one as well, so yeah. It’s just bad luck.’ (Barry, aged 18).

Some participants viewed the initial feeling of nausea as a negative aspect of the drug. However, the majority of users, particularly the more experienced users, viewed this as an indication that the MDMA content is high and therefore the expectations about the impending experience were raised:

Renae was the first to come on. She said that it was pretty strong as she was feeling quite vomitous. Adam replied that that was the sign of a good ‘e’, which had the effect of lifting her mood to a new level. Her expectations were now raised; the anticipation of a good ‘e’ experience was already making her happy. (Field notes from observational session, 1998)

The veracity of this physical effect of MDMA is yet to be proven. However, whether the alleged effect is true or not is largely irrelevant, as the users are socialized to interpret signs and symptoms. The creation of ‘user folklore’ has the effect of maximising potential enjoyment and building expectation (despite an unpleasant feeling), as well as reducing potential anxiety in new users. The very success of this process is evidenced in the fact that this initial feeling of nausea is viewed as an integral part of the ecstasy experience and was therefore embraced to the point where it became ritualised:

‘We used to do ridiculous things like get so excited by the prospect of taking like Lemon Saline (a fizzy drink used to settle stomach acid) and stuff before we went out. And that was all part of the ritual. And it was a part of the experience.’ (Anne, aged 41).

The comedown/recovery phase also featured as part of the folklore/mythology that is an integral part of the ecstasy experience.

Affectionately labeled ‘the eckkie blues’, this phase was regarded by a number of participants as negative, while others embraced the experience, stating that it provided the opportunity for personal reflection and emotional release.

‘I actually don’t mind it. It’s actually an emotion that I don’t often come into. So it’s kind of enjoyable even though it’s a down state of mind.’ (S.E., aged 24).

Regardless of the users’ experience of this phase, it was given a positive status as it served to validate the whole ‘ecstasy’ experience. No ‘eckkie blues’ means that there was no ecstasy. Thus users tended to embrace the negativity and listlessness of the day after. This was best summated by Luke when he stated that the ‘blues’ were an indication that ‘You’ve given it your all. You’ve got no more to give.’ (Luke, aged 37).

The majority of participants indicated an awareness of potential adverse long-term health effects, although none viewed this as particularly significant. Despite this, there was evidence of attempts to moderate use and thus to minimise the potential threat of long term effects. The self-imposition of ecstasy-free weekends and the spacing of ecstasy use are examples of this.

Guiding and initiation

The data suggest that initial and ongoing use of ecstasy is highly centred around close friendship networks. A specific issue that was raised by a number of respondents was trust and its association with their level of anxiety, particularly on their initiation. Indeed a number of participants indicated that use would only occur with this specific cluster of associates.

‘Like I know people who have had them and felt sick and felt really bad and have got really... It’s a lot to do on your own perception and who you’re with. You might feel really alone and sort of scared about how you’re feeling and not knowing how to cope. A lot of people who take them for the first time feel like that. They feel like they can’t cope, they don’t know what’s happening.’ (A.J., aged 23).

Initiation involved mainly informal steps to guiding new users, but followed similar pathways. The following response was typical and reflected the attitudes and behaviour observed in the field. Bob indicated that he felt a level of responsibility towards the new initiate:

‘Particularly if they are doing it because of something I have done or talked about. I feel quite strongly that they should have as much information as possible.’ (Bob, aged 38).

This information would include the likely physical and emotional effects of the drug, tips to reduce nausea and overheating, reassurance as to the safety of the drug and reinforcement of the fun experience that they were about to embark upon. The experienced user would stay close to the initiate and monitor their progress asking if they were feeling this or that effect, lifting their mood (and also their own), ensuring that water consumption was adequate and that they weren’t overheating. Several initiations were witnessed, and on each occasion the experienced user closely monitored the initiate’s body temperature levels, to the point of removing them from the dance-floor to cool off. This was despite the fact that they were

themselves 'e'ing at the time. Several participants revealed that this behaviour was not entirely selfless, as there is a somewhat voyeuristic pleasure to initiating people. Essentially, they used such opportunities to relive the heady days of their own initial use.

'It was so nice to just watch somebody... its soo good. Because, like I said before it's either the drug or yourself that sort of knows the feeling and you get excited about it, but being with someone else for the first time just like go wow or whatever. And to just see the different emotions in them it's great. I love it. I could be a virgin 'e' person-giving them out to 'e' virgins.' (Renaë, aged 23).

Summary and conclusions

The purpose of this paper was to investigate and report on the patterns of use, the meanings associated with use, perceptions of risk and strategies adopted to reduce these risks for a sample of ecstasy users purposively chosen to reflect the heterogeneous nature of ecstasy users in Perth, Western Australia. Despite the limited sample size, the research provides detailed insight into a group of ecstasy users that have not been previously considered. As this sample were purposively selected, their experiences of ecstasy, particularly in relation to set and setting, were more diverse than those generally reported in previous research. This study found users exhibited a reasonable degree of control over their consumption, incorporating a series of risk reduction strategies.

The participants attempted to exert control over set (expectation, risk perception, mood) and setting (physical surroundings), and although it was impossible to control for the

drug, they adopted measures such as using a regular supplier and having pre-taste tests as methods of semi-control. New users were initiated into the ecstasy-using experience by more experienced users who helped the new initiates to interpret the symptoms they experienced during the drug use. The data revealed evidence of user folklore and myths that served to define and influence the overall drug experience. Users came to accept certain 'norms' about the effects, benefits and harms associated with their use of ecstasy. Using this knowledge they become more expert at manipulating drug, set and setting to maximise the experience and reduce the potential risks. Thus, despite the evidence of occasions of unplanned and spontaneous use, the participants revealed highly ritualised and largely controlled behaviour in relation to their ecstasy use.

Though users identified a wide range of harm reduction strategies the application of these strategies was inconsistent, with a large number of the sample indulging in occasional binges, spontaneous purchases, polydrug use and purchasing from unknown individuals in clubs/pubs. As users become more experienced, their perception of the risks associated with use tended to diminish and they exhibited greater risk taking behaviour. The majority of participants indicated an intention for prolonged future use; however, they recognised that changes to life circumstances could serve to alter their use patterns. This suggests that the cost-benefit analysis conducted by the users is a constant process and one that is periodically reviewed. It may be that interventions could be developed that alter the cost-benefit analysis so as to increase the costs while decreasing the benefits.

Although aware of some of the potential long-term adverse health effects, the participants did not perceive these risks as particularly salient. These data imply that the

evidence linking use to long-term negative outcomes has had little impact upon levels of use. This suggests that greater emphasis on the negative short-term effects of use is required if changes to use patterns are to be achieved. Future interventions could adopt strategies similar to recent Western Australian programs directed towards the reduction of smoking and consumption of alcohol, which focused upon adverse short-term effects.

The study points to other aspects associated with ecstasy use that need further research and careful consideration with regard to intervention programs. The socialization associated with use has potential to be used as an intervention route; however, it would be necessary for individuals to be able to distinguish between signs of ecstasy consumption and consumption of a product that could cause even more harm. The inconsistent application of the identified harm reduction strategies would require further research to investigate the efficacy of peer-led harm reduction interventions. The disparity between expressed harm reduction strategies and the observed action of the users reinforces the need for multiple data collection methods and the need for constant comparison between data sets.

Further research is required to identify optimum intervention methods. For example, this study found evidence that as users became more experienced they appeared to be willing to engage in behaviour that they had previously identified as being risky. This has implications for the salience of intervention methods.

Finally, the issue of polydrug use needs to be considered with regard to future research, the interactions between commonly used drugs and intervention messages. A number of the interviewed subjects initiated use of other drugs, with particular emphasis on

polydrug use, once they had initiated ecstasy use. This phenomena needs further investigation: firstly, to determine the processes involved in making the decisions to use other drugs and secondly, to determine the most appropriate health intervention messages. If polydrug use is the norm, then programs targeting only one drug may not be relevant to this population.

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