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Military Sexual Trauma: Fighting a Silent War

Susana Fehr Lampley, M.D.

Since the First and Second World Wars and the Vietnam War, society has shifted toward recognizing that soldiers who experience posttraumatic stress disorder (PTSD) are not weak or malingering but are, instead, individuals enduring the residual psychological trauma of war. However, society is nowhere close to similarly recognizing PTSD associated with military sexual trauma.

In my experience, it seems that many veterans who have experienced military sexual trauma can process their combat-related PTSD relatively directly, while remaining unable to discuss the sexual trauma. Herein lies the dilemma of PTSD caused by military sexual trauma—it very often remains in hiding, including within the public sphere and in the media. These public arenas often create avenues enabling society to empathize with the experiences of others.

Therefore, if public conversations influence how trauma is conceptualized, what are we being told? Veterans often use their combat narratives as a badge of honor, and story-telling among veterans provides opportunities to process experiences in a public way. Outside of first-person narratives, films such as *Dunkirk* (2017), which grossed \$50.5 million in its opening week, create avenues for cultural empathy toward war-torn soldiers.

We cannot shift perceptions of military sexual trauma overnight.

However, these avenues do not yet exist for military sexual trauma. There are minimal public narratives available in the media to inform the general public about military sexual trauma. In fact, until the women's liberation movement of the 1970s, it was not even recognized that the most common posttraumatic disorders are found not among veterans, but among women in civilian life working through sexual trauma. Although combat-related PTSD has found its place in public conversation, PTSD caused by sexual trauma is only beginning to catch up, and military sexual trauma is lagging even further behind.

I believe that this creates significant problems for survivors processing their trauma. When one female soldier who experienced sexual trauma told me her story, she spoke quietly—her tone flat, her demeanor distant, and her eyes empty. She took no pride in her military service. Perhaps this is partially because

she knew that she would never be recognized by the general public. For instance, she will not be applauded by millions at events. Her sacrifice will never be inscribed on a wall to which millions will make a pilgrimage in her honor. She will not see her story in a film. Society has yet to acknowledge her experience. Combat-related PTSD is valorized in our culture, but sexual trauma often brings responses of discomfort, pity, and silence.

The question for psychiatrists then becomes this: how are we treating our patients who have experienced military sexual trauma? Like heroes, victims, or survivors? How are we informing the public about military sexual trauma? We cannot shift perceptions of military sexual trauma overnight—this was not even the case for war-related trauma—but we can begin to raise awareness and make efforts to recognize and push against the contrasted perceptions of PTSD and sexual trauma. I argue that the navigation of this issue shouldn't solely begin with women and/or veterans, but with our praxis as psychiatrists.

Dr. Lampley is a second-year psychiatry resident at the University of Texas Southwestern Medical Center at Dallas.

Cannabis-Induced Depersonalization-Derealization Disorder

Sean P. Madden, M.S., Patrick M. Einhorn, M.S.

An association between cannabis use and the emergence of psychotic disorders among susceptible individuals is increasingly being described in the medical literature (1). However, little is known about how cannabis use relates to other psychiatric sequelae (2). Moreover, there is a dearth of literature on the clinical characteristics of and risk factors for depersonalization-derealization disorder as precipitated by cannabis use (3).

The principal clinical features of depersonalization-derealization disorder are persistent or recurrent experiences of depersonalization or derealization (4). Depersonalization is a dissociative symptom in which one feels like an outside observer with respect to one's thoughts, body, and sensations (3). Derealization is marked by feelings of unreality and detachment from one's surroundings (4), such that one's environment is experienced as remote or unfamiliar (5). Both symptoms may be a cause of significant distress and functional impairment (4–6).

Transient episodes of depersonalization or derealization have been known to occur across a broad range of psychiatric disorders, including schizophrenia (7). However, persons with depersonalization-derealization are distinguished from those with psychotic disorders by the presence of intact reality testing regarding the dissociative disturbance (4). Whereas an individual with schizophrenia may believe that he or she is actually outside of his or her body, persons with depersonalization-derealization are aware that the dissociation is merely an uncanny sensation (5). Persons with depersonalization-derealization do not appear to be at risk for developing psychotic disorders (2, 3).

The lifetime prevalence of depersonalization-derealization disorder is ap-

proximately 2% both in the United States and worldwide (4). The average age at onset is 16 years (8), and women and men are equally affected (5). Persons with the disorder may present with comorbid psychiatric disorders, including personality disorders (8). However, it is uncommon for an individual with depersonalization-derealization disorder to have schizotypal or schizoid personality disorder (8). Personality disorders do not appear to predict symptom severity (8).

Several precipitants have been implicated in depersonalization-derealization disorder, including panic attacks (3) and recreational drugs (5). The most common psychoactive drug precipitant of the disorder is cannabis (3, 5). Although depersonalization and derealization symptoms may occur as part of a panic attack (5), persons with depersonalization-derealization disorder continue to experience symptoms following resolution of the panic attack (3). A cognitive model suggests that those predisposed to anxiety may develop fears regarding episodes of depersonalization and derealization (e.g., fear of “going mad”), which may contribute to the emergence of the symptoms following panic attacks or substance intoxication (9).

Cannabis-induced depersonalization-derealization disorder has been described in the literature for many years (10, 11). However, this type of dissociative disorder is not typically addressed in contemporary reviews focusing on the implications of cannabis use (2). Here, we examine data on prolonged experiences of depersonalization and derealization following cannabis use to provide insight into the clinical features of and risk factors for cannabis-induced depersonalization-derealization disorder.

PATHOGENESIS

Some individuals who use cannabis will never experience depersonalization or derealization during or after cannabis use (5). However, depersonalization and derealization remain potential side effects of cannabis (12), of which many clinicians are unaware (5). In general, cannabis-induced symptoms of depersonalization and derealization are time-locked to the period of intoxication, peaking approximately 30 minutes after ingestion and subsiding within 120 minutes of exposure to the drug (12, 13). However, among a subgroup of persons who use cannabis, symptoms of depersonalization or derealization persist for weeks, months, or years (3, 5), even after discontinuation of the substance (2, 11). Those who experience prolonged symptoms may have cannabis-induced depersonalization-derealization disorder (2, 10).

The pathogenesis of cannabis-induced depersonalization-derealization disorder can be marked by an initial dissociative disturbance with a severity that subsides but later returns in episodes that eventually become chronic (3). In other cases, onset can be more abrupt, with symptoms emerging during intoxication and persisting unremittingly for months or years (5). For other individuals, symptoms do not occur until hours or days following an episode of cannabis use (3).

RISK FACTORS

Several factors appear to be associated with risk for cannabis-induced depersonalization-derealization disorder (see box). Most affected individuals have a prior history of an anxiety disorder (6), such as panic disorder (11) or social pho-

Risk Factors for Cannabis-Induced Depersonalization-Derealization Disorder^a

Variable

- Adolescent age
- Male gender
- High-potency cannabis use
- Frequent cannabis use
- Cannabis use after trauma exposure
- Cannabis use under acute distress
- Sudden withdrawal from regular cannabis use
- Experiences of panic attacks or depersonalization or derealization during intoxication
- History of depersonalization or derealization symptoms
- History of transient cannabis-induced depersonalization or derealization disorder
- History of cannabis-induced depersonalization-derealization disorder
- History of acute anxiety or panic attacks
- History of obsessive thinking
- History of sociophobic or avoidant behavior
- Family history of depersonalization-derealization disorder
- Family history of anxiety disorders or panic attacks

^a For further details regarding factors that may be associated with risk for cannabis-induced depersonalization-derealization disorder among individuals who received a definitive diagnosis, see Hürlimann et al. (2), Szymanski (10), and Moran (11).

bia (2). Additionally, males (6) and adolescents (2) may be disproportionately affected by cannabis-induced symptoms, perhaps due to the higher rates of cannabis use among these groups (14) or to biological predisposing factors (6). Use of cannabis during periods of marked distress (11) or after exposure to trauma (10) may increase risk for cannabis-induced symptoms. Other risk factors may include sudden withdrawal from regular cannabis use (15), severe intoxication (10), and history of prior cannabis-induced symptoms (3) or prior transient substance-induced symptoms (11).

Individuals naive to cannabis or those with little previous exposure to the substance do not appear to be less prone to onset of cannabis-induced depersonalization-derealization disorder. Simeon et al. (16) examined 89 individuals who developed prolonged experiences of depersonalization and derealization following cannabis use, 28% of whom disclosed using cannabis between 100 and 500 times prior to symptom onset. Sudden emergence of the disorder among persons who use cannabis regularly may be due to life stressors that increase sensitivity to cannabis and risk for mental disorders. Moran (11) examined individuals

who used cannabis regularly while experiencing periods of marked distress, such as divorce. Cannabis use during such periods of distress appears to contribute to symptom onset among individuals with little or no prior exposure (10).

ASSOCIATION WITH ACUTE ANXIETY

There appears to be a strong relationship between acute anxiety and symptom onset in both cases of cannabis-induced depersonalization-derealization disorder (3) and depersonalization-derealization disorder unrelated to drug use (8). Persons who experience prolonged depersonalization-derealization symptoms following cannabis use often report experiencing a panic attack during intoxication (16), which may be due to altered hypothalamic-pituitary-adrenal axis functioning (17). However, the emergence of cannabis-induced depersonalization-derealization disorder is not always associated with panic (5), which suggests that cannabis may be a direct cause of symptom onset without mediation of anxiety symptoms (6).

Sierra and Berrios (18) proposed that beyond a specific threshold of anxiety, a

“left-sided prefrontal mechanism” inhibits the amygdala and, in turn, the anterior cingulate, leading to blunted autonomic arousal and feelings of detachment from the self. Concurrently, disinhibited amygdala arousal systems may activate the dorsolateral prefrontal cortex, thereby inhibiting the anterior cingulate, giving rise to other experiential features of depersonalization-derealization disorder, including mind emptiness and indifference to pain (18). Although patients with depersonalization-derealization disorder often show attenuated autonomic arousal (3), PET imaging data on transient cannabis-induced symptoms do not support this model (13). Elucidating how cannabis may be associated with symptom onset is challenging, given the varying strains of cannabis and chemical compounds that are currently available (19).

While acute anxiety is known to be involved in the emergence of depersonalization-derealization disorder symptoms, less is known about why such symptoms may persist following cannabis use. Rather than a direct pharmacologic effect, persistent symptoms have been thought to be associated with causal attributions and fears regarding an episode of dissociation (20). Some patients have attributed their symptoms to brain damage (11), while others have refused pharmacological intervention due to the fear of such intervention worsening their symptoms (11). In light of the consistent relationship between anxiety and symptoms of depersonalization-derealization disorder (3, 5), it is possible that such beliefs or fears about symptom episodes may perpetuate otherwise transient substance-induced symptoms (20). It would be less likely that prolonged symptoms are due to residual drug effects, given that tetrahydrocannabinol is typically eliminated from the body within a few weeks (2).

CONCLUSIONS

We reviewed data on prolonged experiences of depersonalization or derealization following cannabis use to provide insight into the clinical features of and risk factors for cannabis-induced depersonalization-derealization disorder. Most risk factors were derived from cases of indi-

viduals who received a definitive diagnosis of depersonalization-derealization disorder after using cannabis (2, 10, 11). The most significant risk factor appears to be a history of pathological anxiety (3, 5), which may be contributory to both symptom onset (14) and the persistent nature of the syndrome (20). Anxiety-prone young males who use cannabis may be at ultra-high risk for cannabis-induced depersonalization-derealization disorder, particularly when cannabis is used under marked distress.

Depersonalization-derealization disorder has been considered a hardwired coping mechanism through which feelings of unreality and detachment from one's self and one's surroundings help one to cope with acute distress (3). Episodes of depersonalization or derealization associated with cannabis use are typically time-locked to the period of intoxication (12). However, in susceptible individuals who use cannabis, "external stressors and intrapsychic factors may contribute to its continued use as a defense mechanism," as described by Syzmanski (10). Interventions aimed at mitigating anxiety and targeting intrapsychic factors may prove to be useful in treating cannabis-induced depersonalization-derealization disorder (20).

Prolonged symptoms following cannabis use have been associated with psychotic syndromes in some case reports (10, 11). However, persons who meet diagnostic criteria for depersonalization-derealization disorder present with intact reality testing and do not have a psychotic disorder (2, 4). Although symptoms of depersonalization-derealization disorder may occur in the prodrome of schizophrenia (3), validated instruments used in the assessment of early- and late-prodromal schizophrenia have not revealed any evidence of risk for psychosis among patients with cannabis-induced depersonalization-derealization disorder (2). It is noteworthy that in our review, individuals who did not show signs of prodromal schizophrenia reported experiencing some of the more severe clinical features of depersonalization and derealization, including sensations of physical separation from their bodies and agency (2). Prolonged and se-

KEY POINTS/CLINICAL PEARLS

- Cannabis-induced depersonalization-derealization disorder is characterized by persistent or recurring episodes of depersonalization or derealization.
- Cannabis-induced depersonalization-derealization disorder is distinguished from psychotic disorders by the presence of intact reality testing; patients with cannabis-induced depersonalization-derealization disorder do not appear to be at risk for developing psychotic disorders.
- Symptoms of cannabis-induced depersonalization-derealization disorder are typically time-locked to the period of intoxication, although marked anxiety regarding dissociation may contribute to the symptomatic presentation of the disorder.
- Active treatment of cannabis-induced depersonalization-derealization disorder should incorporate treatment of patients' anxiety regarding dissociation symptoms.

vere dissociation following cannabis use may, therefore, not always be an indication of evolving psychosis.

Distinguishing cases of cannabis-induced psychosis from cases of cannabis-induced depersonalization-derealization disorder may be critical in guiding appropriate diagnosis and treatment of this distressing dissociative disorder.

Sean P. Madden and Patrick M. Einhorn completed this study as students in the Department of Biobehavioral Sciences, Teachers College, Columbia University, New York.

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Inhalant Abuse: The Wolf in Sheep's Clothing

Alexandru I. Cojanu, M.D.

Recent efforts aimed at analyzing new forms of substance abuse have led to identification of risks associated with electronic cigarettes (1) and synthetic cannabinoids (2). Additionally, guidelines pertaining to low-risk cannabis use have been established (3). However, less focus has been placed on the forgotten but commonplace use of readily available inhalants as a means of achieving a “high” and its relationship with comorbid mental disorders.

DSM-5 defines inhalant use disorder as a “problematic pattern of use of a hydrocarbon-based inhalant substance leading to clinically significant impairment or distress” (4). Estimates show that 11% of high school students use inhalants as a form of achieving a “high” (5). Current data also suggest that the lifetime prevalence of inhalant use among persons aged 18–25 years is 13.1% and 9.6% among those aged ≥26 (6). Furthermore, it is estimated that 70% of persons with inhalant use disorder meet criteria for at least one lifetime mood, anxiety, or personality disorder (7). Due to the lack of readily available diagnostic tools for detecting inhalant use, this commonplace practice of substance abuse goes largely undetected.

The case report below provides insight into inhalant use disorder in the context of comorbid depressive disorder. The discussion that follows provides definitions of various forms of inhalants, as well as description of the practice of inhalant abuse, including associated terminology (“street names”), popular culture cameos, and possible clinical adverse effects. To aid clinicians in identifying this behavior, initial diagnostic and management approaches, as well as guidelines for psychiatric comorbidity screening, are also discussed.

CASE

“Steve” is a 20-year-old young man who was brought to the emergency department after being found in an altered mental state in his apartment during a safety check. The patient’s urine drug screen was negative for cocaine, methadone, opiates, propoxyphene, benzodiazepines, barbiturates, and amphetamines. His ethanol screen was also negative, and his vital signs were within normal ranges, except for a blood pressure reading of 150 mmHg/100 mmHg. His initial medical workup did not reveal any abnormalities. A consult with the psychiatric service was ordered due to the patient’s history of depression and clinical presentation.

During the psychiatric evaluation, the patient was tearful, withdrawn, and somewhat weak and unsteady. He reported “huffing” approximately nine cans of computer-keyboard dust cleaner daily over the past 3 months. He revealed that he lived alone, had lost his part-time job, and had been dismissed from his college courses, and he endorsed increasing isolation from his family. He was on probation following an arrest for attempting to steal computer-keyboard dust cleaner from a local hardware store. He denied active suicidal ideations. However, he did endorse an overall depressed mood, poor sleep, lack of appetite, and loss of interest in any activity that did not involve huffing, and he expressed guilt related to his continued use of inhalants and the negative consequences. He denied use of any other illicit substance.

The patient was admitted to the inpatient psychiatric unit for his safety and started on mirtazapine for his depression, sleep deprivation, and appetite loss. After a short hospitalization, he was enrolled in a dual-track treatment program

aimed at treating both his mood and substance use disorders. At a 3-month follow-up, the patient reported not having abused inhalants during this period, and his mood symptoms were markedly improved.

DISCUSSION

What Are Inhalants?

Inhalants include solvents, aerosol sprays, gases, and nitrites found in low-cost, legally sold, easily accessible household items. They typically contain hydrocarbons (aliphatic, aromatic, or halogenated), nitrous oxide (a gas), and nitrites (amyl, butyl, and isobutyl). *DSM-5* distinguishes between these substances, with only hydrocarbon-based inhalants included under the inhalant use disorder diagnosis and nitrous oxide and nitrites assigned to the “other” diagnostic class (4). Terms commonly used by patients to describe inhalant abuse are presented in Table 1. In popular culture, inhalant abuse has been depicted in film. In the 2003 movie *Thirteen*, two protagonists are seen inhaling from a can of computer dust cleaner.

Common Clinical Adverse Effects

Persons who engage in inhalant abuse rarely seek immediate medical attention. Due to their high lipid solubility, inhalants are rapidly absorbed across pulmonary membranes and into the bloodstream. Lipophilic hydrocarbons have high volatility, allowing them to readily cross the blood-brain barrier. They promote an initial feeling of euphoria, with an effect lasting between 15 and 45 minutes, leading to CNS depression. Symptoms include lethargy, somnolence, headache, ataxia, stupor, and possible seizures. The mechanism by

TABLE 1. Street Terminology and Common Laboratory/Diagnostic Tests for Inhalant Abuse

| Method of Abuse | Substances of Abuse | Laboratory/Diagnostic Tests |
|-----------------|---------------------|---------------------------------------|
| Huffing | Air blast | EKG |
| Sniffing | Whiteout | CBC and comprehensive metabolic panel |
| Bagging | Poppers | Urine drug screen |
| Dusting | Whippets | Urinalysis |
| Whipping | Highball | Rapid blood glucose |
| Nagging | Poppers | Continuous pulse oximetry |
| Glading | Bullet bolt | Arterial blood gas analysis |

which CNS depression occurs has not yet been fully elucidated; however, experts have postulated noncompetitive, reversible inhibition of the *N*-methyl-D-aspartate receptor; activation of the mesolimbic dopaminergic pathway; and increased GABA receptor activation (8).

Continued use and toxicity are associated with pulmonary, gastrointestinal, renal, neurologic, and cardiovascular adverse effects. Inhalant-associated “sudden sniffing death” refers to sudden cardiovascular collapse as a result of arrhythmia, occurring after the inhalation of halogenated hydrocarbons (containing chloride or fluoride), which are commonly found in degreasers and spot removers. Additionally, inhaling nitrous oxide from an inflated balloon or a whipped cream can (“whipping”) can result in neurotoxicity manifesting as polyneuropathy, ataxia, and even psychosis (9).

Making the Diagnosis

Standard five- and seven-panel drug screens do not enable identification of inhalant abuse but should be used to rule out intoxication with other substances. An experimental study conducted in Sweden showed that inhaled 1,1,1,2-tetrafluoroethane, found in aerosol freezer sprays, resulted in a 0.002% postexposure urinary excretion of the inhaled amount, with an average half-life of only

58 minutes (10), suggesting that detection proves to be difficult even for just this one substance.

Where available, more extensive testing can include urinary trichloroethanol (for chlorinated hydrocarbons), urinary hippuric acid (for toluene exposure), or blood and exhaled toluene levels. However, these tests represent limitations to diagnostic strategy, since they are expensive and not readily available at most facilities. Characteristic odors can reveal recent inhalant abuse, including sweet solvent odor (halogenated hydrocarbons) and petroleum distillate odor (kerosene).

Differential diagnoses include intoxication with other substances (e.g., alcohol, cannabis, salicylates, opioids, benzodiazepines, barbiturates, nonbenzodiazepine sleep medications, carbon monoxide, and cyanide) that can cause CNS depression. Metabolic disturbances such as hypoglycemia, as well as misuse of medications such as metformin and isoniazid, should be ruled out.

Management and Further Screening

While inhalant intoxication usually resolves spontaneously, emergency treatment strategies should begin with advanced cardiac life support protocols, with the patient’s airway, breathing, and circulation stabilized first. Basic medical workup, laboratory tests, and monitoring

should follow, as summarized in Table 1. Differential diagnoses should be ruled out, including consideration of the use of antidotes such as naloxone and flumazenil. Consulting the local poison control center is prudent. Patients with mild to moderate respiratory distress typically benefit from the use of supplemental oxygen and beta-2 bronchodilators (albuterol), and seizures should be managed with intravenous benzodiazepines.

Once the patient is medically stable, a thorough psychiatric evaluation is required. This will enable clinicians to establish a diagnosis while screening for comorbid psychiatric illness, given that 70% of persons who abuse inhalants meet criteria for at least one lifetime mood (48%), anxiety (36%), or personality (45%) disorder (7).

CONCLUSIONS

Clinicians should maintain a high index of suspicion for inhalant abuse when encountering young, intoxicated patients with relatively normal medical and laboratory workup, negative urine drug screen, and negative alcohol screen. However, clinicians should understand the limitations associated with making the diagnosis of inhalant use disorder, including lack of readily available diagnostic laboratory tests. Screening for comorbid psychiatric illness should be prompt, along with treatment interventions. In summary, inhalant abuse remains a dangerous behavior among young adults and warrants the label of a “wolf in sheep’s clothing” due to easy access to commonplace household items used as a form of substance abuse.

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The patient’s name and other identifying details in the above case have been changed to protect the patient’s privacy.

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KEY POINTS/CLINICAL PEARLS

- Inhalants are found in common, low-cost, legally sold household products and provide fast-acting euphoria, ultimately leading to CNS depression.
- Lifetime prevalence of inhalant abuse is 13.1% among persons aged 18–25 and 9.6% among persons aged ≥26.
- Seventy percent of persons who abuse inhalants have a lifetime prevalence of comorbid psychiatric disorders, including mood (48%), anxiety (36%), and personality (45%) disorders.

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MDMA in Psychiatry: Past, Present, and Future

Michael Cooper, M.D., Anna Kim, M.D.

3,4-Methylenedioxymethamphetamine (MDMA), commonly referred to as “Ecstasy,” is a ring-substituted phenethylamine that is structurally similar to both mescaline and methamphetamine. MDMA is characterized by its unique subjective effects, including euphoria, a feeling of love for others, and a sense of being at peace with the world, while not significantly affecting visual perception or cognition (1).

Its idealized, publicized, “Zen”-like impact poses a stark contrast to a largely controversial history. Merck first synthesized the substance in 1912 in a search for a precursor to hydrastinine, a hemostatic drug, to which archrival Bayer already held the patent. Records of subsequent animal studies were destroyed in Allied bombing raids during World War II. It was not until the 1950s that interest in MDMA was rekindled by the U.S. Army in hopes that it could be used as a form of mind control or a weapon. The United States lost interest once it was found that the effects of the drug were not much different from the effects of other stimulants (2).

Research on MDMA took a turn once curious chemists in university and industry settings realized its potential therapeutic properties. Alexander Shulgin, a former Dow Chemical employee, resynthesized the compound as part of an intellectual musing in 1965 and eventually tried MDMA himself 2 years later. In mental health and academic circles, word spread of the many positive experiences individuals had using the drug, namely in response to its striking effects on empathy and communication. Due

to concerns over its potential for abuse and increasing availability on the street, however, it was designated as a schedule I substance in 1985 (2). To this day, discussions about its therapeutic use continue among academics, sparking novel ideas and inciting firmly held opinions and debate.

Despite the potential therapeutic use of MDMA, it is not without possible health consequences. Neuroimaging studies have found evidence for decreased serotonin transporter binding in abstinent MDMA users, which may contribute to deficits in attention, executive function, and memory among this population (3). Another potential risk of MDMA use is that of deep-seated thoughts and feelings facilitated by the drug that might emerge in the course of a therapeutic session, which may be overly distressing, particularly with inexperienced therapists. A period of non-drug therapy may then be required to resolve the newly emerged problems (4).

Potential health consequences notwithstanding, results from recent phase II studies suggest that MDMA-assisted psychotherapy might be a promising new treatment for posttraumatic stress disorder (PTSD). In addition to enhancement of bonding and trust, it is hypothesized that defenses against certain themes may be diminished while under the influence of MDMA, thereby facilitating more active therapeutic work. One of the studies included in a meta-analysis by Amoroso and Workman (5) revealed that participants who ingested MDMA reported that their worst memories were less negative compared with

those who had not ingested the drug, suggesting that the drug could be well suited for treating PTSD.

MDMA has an undeniably checkered history, and its use is not without risks. However, its unique subjective effects, when paired with psychotherapy, hold promise as a novel therapeutic intervention for PTSD and potentially for other psychiatric disorders.

Dr. Cooper is a third-year resident in the Department of Psychiatry at New York University, New York.

Dr. Kim is a third-year resident in the Department of Psychiatry at the Icahn School of Medicine, Mount Sinai Medical Center, New York. She is also Deputy Editor of the *American Journal of Psychiatry Residents' Journal*.

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Not There Yet

Shapir Rosenberg, M.D.

“Lilly,” an 86-year-old woman residing in an assisted-living facility, wasn’t acting her usual self. An ambulance brought her to the hospital, and she was admitted to the geriatric psychiatry service. She had dementia and severe hearing loss, and she was on an antidepressant.

On my evening intake, Lilly occupied a small portion of her large “geri-chair” recliner. She was small and frail. Her piercingly beautiful blue eyes looked above her glasses, which sat low on her nose. She looked away silently as I posed questions. Though when I amplified my voice to inquire whether she knew where she was, she shouted, “Lilly!” When I touched her hand, she screamed, “Don’t!” so a physical examination was deferred. I ordered routine laboratory workups to identify common causes of altered mentation in the elderly, typed an admission note, and went home.

The next day I called Lilly’s only child, her daughter, Debra, a nurse. Debra related that Lilly began showing signs of memory loss some years ago and that she had urged her mother to sell her home in the Vermont woods in order to move closer to her. Lilly had been living in her current facility for a year. Her daughter stated, “We know the neighborhood hospitals well.” Knowledge of local hospitals is often the case among elder-care facility residents and their family members, with infection, constipation, and falls leading to emergency department visits, each time with a different doctor cast and nursing crew. Indeed, Debra knew well the ambulances’ hospital bypass protocols and had her “favorite” emergency departments.

Debra said that in the past 12 months, her mother had become less conversant, more confused, and forgetful of her own daughter’s identity. But because no acute etiology for her impaired state was found, I told Debra that we would moni-

I was struck by the
challenge that dying
poses for doctors—
even geriatric
psychiatrists.

tor her mother and consider further tests to exclude other diagnoses. At the end of the conversation, I inquired, “At present, your mom’s code status is ‘full,’ is that still your wish?” She answered, “Yes.”

In the ensuing days, at the behest of my supervising psychiatrist, “Dr. G,” no fewer than five specialty teams were brought on board to evaluate Lilly. The internist recommended demarcating an area of redness on her left wrist to track possible cellulitis, and a rheumatologist expressed concern for upper-extremity gout. The latter recommended a wrist aspiration to exclude infection. This required an orthopedic surgeon to sedate and restrain Lilly and then “tap” her joint. Concurrently, a brain MRI hinted at the possibility of normal pressure hydrocephalus as the source of her acute cognitive slide. The neurologist felt that an empiric trial of acetazolamide would be more palatable than the requisite large-volume lumbar puncture, which was needed to definitively make the diagnosis. Neurosurgery deferred involvement until there was diagnostic clarity.

With time, the outer aspect of Lilly’s wrist attained a normal hue without antibiotics, and the inner part was deemed microbiologically unremarkable. An attempted lumbar puncture was halted, owing to Lilly’s wiggling and squirming. Aside from transient electrolyte derangement due to poor hydration and a 2-day stupor, which the team believed to be a reaction to an antipsychotic admin-

istered for agitation, Lilly remained in her recliner for most of her hospitalization, glasses askew, generally mute, and only intermittently screaming her name during diaper changes.

Two weeks in, I requested a family meeting with Debra and the unit’s social worker and case manager. I wanted to discuss remaining treatment options and the likelihood that Lilly had arrived at a new cognitive baseline and would require round-the-clock nursing, a level of care higher than what she was previously receiving. I called Dr. G to discuss the meeting’s intended agenda. After a review of her hospital course and my discharge plan, I said, “I’d also like to explore Lilly’s goals of care and code status; she’s an elderly lady with advanced dementia who is making frequent trips to emergency rooms.” Dr. G, a senior psychiatrist on the inpatient service, replied, “Hold off on that. I don’t think—no, we’re not there yet.”

In the ensuing meeting, Debra said that she wasn’t willing to consent to her mother undergoing a repeat lumbar puncture. Even if the findings were suggestive, a surgically placed shunt to drain fluid accumulating in Lilly’s brain would likely offer minimal restoration of her cognitive abilities and pose intolerably high risk. She tearfully concurred that her mother needed full-time care.

Debra again recounted their frequent emergency department visits and their exacting tolls. As an oncology nurse, Debra said that she had counseled many families over the years in similar situations. When a patient’s clinical picture isn’t improving, when further intensive tests like blood draws are more upsetting than therapeutic, and when repeated hospital trips impinge on a person’s limited days, reconsideration of the point of it all seems necessary. Yet Debra stopped

short of doing so. Fearful of Dr. G's admonishment, so did I.

I did not suggest the possibility of changing Lilly's code status. Nor did I share my feelings regarding the appropriateness and likely benefit of hospice care at this juncture. Rather, Debra concluded the meeting by saying that she would take time that week to visit nursing homes in geographic proximity and provide the social worker with a ranked list to facilitate placement.

Debra, a medical professional, was also Lilly's daughter, and in the midst of crisis couldn't be expected to maintain

a clinical perspective about a decision that inherently acknowledged the approaching end of her mother's life. But I too was complicit, despite a keen awareness of the need for physicians to initiate goals-of-care discussions. My own mother's death, when I was just 12 years old, came during an era when little attention was given to such conversations and when patients were subjected to aggressive, and often futile, "treatments," which those in the field of palliative care now strive to avoid.

I felt sad for Lilly and Debra, angry at Dr. G, and disappointed in myself. I was

struck by the challenge that dying poses for doctors—even geriatric psychiatrists. In modern health care, a struggle persists to acknowledge, talk about, and cope with loss and to help patients and surrogates assign value to limited time. In a gently incriminating, tragically absurd, and unintentionally astute way, Dr. G captured it: we are not there yet.

Dr. Rosenberg is a third-year resident at the University of Maryland Medical Center, Baltimore.

Competency in Combining Pharmacotherapy and Psychotherapy Integrated and Split Treatment, Second Edition

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Michelle B. Riba, M.D., M.S., Richard Balon, M.D., and Laura Weiss Roberts, M.D., M.A.
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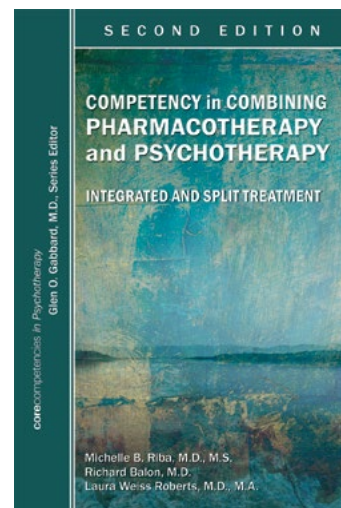
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Call for Applications to Join the 2018 Editorial Board

The *American Journal of Psychiatry—Residents' Journal* is now accepting applications to join the 2018–2019 Editorial Board for the following positions:

SENIOR DEPUTY EDITOR (SDE) POSITION

Job Description/Responsibilities

- Frequent correspondence with *AJP-Residents' Journal* Editorial Board and *AJP* editorial staff, including conference calls.
- Frequent correspondence with authors.
- Peer review manuscripts on a weekly basis.
- Make decisions regarding manuscript acceptance.
- Work with *AJP* editorial staff to prepare accepted manuscripts for publication to ensure clarity, conciseness, and conformity with *AJP* style guidelines.
- Coordinate selection of book review authors and distribution of books with *AJP* editorial staff.
- Recruit authors and guest editors for the journal.
- Manage the *Test Your Knowledge* questions on the *Residents' Journal* Facebook and Twitter pages and work closely with authors in developing Board-style review questions for the *Test Your Knowledge* section.
- Fulfill the responsibilities of the Editor-in-Chief when called upon, including forming issue lineup.
- Collaborate with the Editor-in-Chief in selecting the 2019 SDE, Deputy Editor, and Associate Editors.
- Attend and present at the APA Annual Meeting.
- Commitment averages 10–15 hours per week.

Requirements

- Must be an APA resident-fellow member.
- Must be starting as a PGY-3 in July 2018, or a PGY-4 in July 2018 with plans to enter an ACGME fellowship in July 2019.
- Must be in a U.S. residency program.

Selected candidate will be considered for a 2-year position, including advancement to Editor-in-Chief in 2019.

DEPUTY EDITOR (DE) POSITION

Job Description/Responsibilities

- Frequent correspondence with *Residents' Journal* Editorial Board and *AJP* editorial staff, including conference calls.
- Frequent correspondence with authors.
- Peer review manuscripts on a weekly basis.
- Make decisions regarding manuscript acceptance.
- Work with *AJP* editorial staff to prepare accepted manuscripts for publication to ensure

clarity, conciseness, and conformity with *AJP* style guidelines.

- Prepare a monthly *Residents' Resources* section for the journal that highlights upcoming national opportunities for medical students and trainees.
- Recruit authors and guest editors for the journal.
- Collaborate with the Editor-in-Chief in selecting the 2019–2020 Editorial Board.
- Attend and present at the APA Annual Meeting.
- Commitment averages 10 hours per week.

Requirements

- Must be an APA resident-fellow member.
- Must be a PGY-2, PGY-3, or PGY-4 resident starting in July 2018, or a fellow in an ACGME fellowship in July 2018.
- Must be in a U.S. residency program or fellowship.

This is a 1-year position only, with no automatic advancement to the SDE position in 2019. If the selected candidate is interested in serving as SDE in 2019, he or she would need to formally apply for the position at that time.

ASSOCIATE EDITOR (AE) POSITIONS (two positions available)

Job Description/Responsibilities

- Peer review manuscripts on a weekly basis.
- Make decisions regarding manuscript acceptance.
- Recruit authors and guest editors for the journal.
- Collaborate with the SDE, DE, and Editor-in-Chief to develop innovative ideas for the journal.
- Attend and present at the APA Annual Meeting.
- Commitment averages 5 hours per week.

Requirements

- Must be an APA resident-fellow member
- Must be a PGY-2, PGY-3, or PGY-4 resident in July 2018, or a fellow in an ACGME fellowship in July 2018.
- Must be in a U.S. residency program or fellowship

This is a 1-year position only, with no automatic advancement to the DE or SDE position in 2019. If the selected candidate is interested in serving as DE or SDE in 2019, he or she would need to formally apply for the position at that time.

MEDIA EDITOR (ME) POSITION

Job Description/Responsibilities

- Manage the *Residents' Journal* Twitter and Facebook accounts.
- Oversee podcasts.
- Collaborate with the AEs to decide on content
- Collaborate with SDE, DE, and Editor-in-Chief to develop innovative ideas for the journal.
- Attend and present at the APA Annual Meeting.
- Commitment averages 5 hours per week.

Requirements

- Must be an APA resident-fellow member.
- Must be an upcoming PGY-2, PGY-3, or PGY-4 resident in July 2018, or a fellow in an ACGME fellowship in July 2018.
- Must be in a U.S. residency program or fellowship.

This is a 1-year position only, with no automatic advancement to the Deputy Editor or Senior Deputy Editor position in 2019. If the selected candidate is interested in serving as Deputy Editor or Senior Deputy Editor in 2019, he or she would need to formally apply for the position at that time.

CULTURE EDITOR (CE) POSITION

Job Description/Responsibilities

- Collaborate with SDE, DE, and Editor-in-Chief to develop innovative ideas for the journal.
- Attend and present at the APA Annual Meeting.
- Commitment averages 5 hours per week.

Requirements

- Must be an APA resident-fellow member.
- Must be an upcoming PGY-2, PGY-3, or PGY-4 resident in July 2018, or a fellow in an ACGME fellowship in July 2018.
- Must be in a U.S. residency program or fellowship.

This is a 1-year position only, with no automatic advancement to the DE or SDE position in 2019. If the selected candidate is interested in serving as DE or SDE in 2019, he or she would need to formally apply for the position at that time.

For all positions, e-mail a CV and personal statement of up to 750 words, including reasons for applying and ideas for journal development, to oliver.glass@emory.edu. The deadline for applications is March 2, 2018.

Residents' Resources

Here we highlight upcoming national opportunities for medical students and trainees to be recognized for their hard work, dedication, and scholarship.

To contribute to the Residents' Resources feature, contact Anna Kim, M.D., Deputy Editor (anna.kim@mountsinai.org).

MARCH DEADLINES

| Fellowship/Award | |
|--|--|
| American Association of Psychiatric Administrators (AAPA) Best Resident/Fellow Paper in Administrative Psychiatry Award | |
| Organization | AAPA/Journal of Psychiatric Administration and Management (JPAM) |
| Deadline | March 30, 2018 |
| Brief Description | The Journal publishes peer-reviewed, original articles and also welcomes conceptual essays, commentaries, observations, and opinion pieces. Trainees may submit papers related to their administrative experience such as being Chief Resident, serving on committees, quality improvement or patient safety initiatives, or participating in a research project. The winner will have the opportunity to present at the APA, will receive a \$250 cash prize, and will be invited to serve as an executive member on the AAPA Early Career Development Committee. |
| Eligibility | Must be a resident or fellow; manuscript may not be submitted elsewhere for publication unless first declined by JPAM (2,500 word limit). |
| Contact and Website | E-mail: francesrotonbell@gmail.com • Web: https://www.novapublishers.com/catalog/product_info.php?products_id=20782&osCsid |
| Fellowship/Award | |
| American Academy of Child and Adolescent Psychiatry (AACAP) Pilot Research Award for General Psychiatry Residents | |
| Organization | AACAP, supported by Pfizer |
| Deadline | March 30, 2018 |
| Brief Description | Offers \$15,000 for general psychiatry residents who have an interest in beginning a career in child and adolescent mental health research. Recipients have the opportunity to submit a poster presentation on their research for the AACAP's 66th Annual Meeting in Chicago, October 14–19, 2019. The award also includes the cost of attending the AACAP Annual Meeting for 5 days. |
| Eligibility | Candidates must be enrolled in a general psychiatry residency; must not have any previous significant, individual research funding in the field of child and adolescent mental health; and must be an AACAP member. |
| Contact and Website | E-mail: research@aacap.org • Web: http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Pilot_Research_Award.aspx |
| Fellowship/Award | |
| AACAP Pilot Research Award for Junior Faculty and Child and Adolescent Psychiatry Fellows | |
| Organization | AACAP |
| Deadline | March 30, 2018 |
| Brief Description | Offers \$15,000 for child psychiatry residents, fellows, and junior faculty who have an interest in beginning a career in child and adolescent psychiatry research. Recipients have the opportunity to submit a poster presentation on their research for the AACAP's 66th Annual Meeting in Chicago, October 14–19, 2019. The award also includes the cost of attending the AACAP Annual meeting for 5 days. |
| Eligibility | Enrolled in a child psychiatry residency or fellowship or have a faculty appointment in an accredited medical school but no more than 2 years of experience following graduation from training. Candidates must not have any previous significant, individual research funding in the field of child and adolescent mental health and must be an AACAP member. |
| Contact and Website | E-mail: research@aacap.org • Web: http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/Pilot_Research_Award_Child_Psychiatry_Residents_Junior_Faculty.aspx |
| Fellowship/Award | |
| AACAP Pilot Research Award for Learning Disabilities | |
| Organization | AACAP, supported by AACAP's Elaine Schlosser Lewis Fund |
| Deadline | March 30, 2018 |
| Brief Description | Offers \$15,000 for child and adolescent psychiatry residents and junior faculty who have an interest in beginning a career in child and adolescent mental health research. The recipient has the opportunity to submit a poster presentation on his or her research for the AACAP's 66th Annual Meeting in Chicago, October 14–19, 2019. |
| Eligibility | Enrolled in a child psychiatry residency or fellowship or have a faculty appointment in an accredited medical school but no more than 2 years of experience following graduation from training. Candidates must not have any previous significant, individual research funding in the field of child and adolescent mental health and must be an AACAP member. |
| Contact and Website | E-mail: research@aacap.org • Web: http://www.aacap.org/AACAP/Awards/Resident_and_ECP_Awards/AACAP_Pilot_Research_Award_for_Learning_Disabilities.aspx |
| Fellowship/Award | |
| American Psychiatric Association (APA) Resident Recognition Award | |
| Organization | APA |
| Deadline | March 31, 2018 |
| Brief Description | The Resident Recognition Award is presented annually to outstanding psychiatry residents or fellows from each department or institution who exemplify one or more APA values. Multiple awards are given each year. |
| Eligibility | Must be a resident or fellow; must be an APA member; and must be in good standing in a general psychiatry or fellowship program. |
| Contact and Website | E-mail: cvanwagner@psych.org • Web: https://www.psychiatry.org/psychiatrists/awards-leadership-opportunities/awards/resident-recognition-award |

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The Residents' Journal accepts manuscripts authored by medical students, resident physicians, and fellows; attending physicians and other members of faculty cannot be included as authors.

To submit a manuscript, please visit http://ajp.psychiatryonline.org/ajp_authors_reviewers, and select a manuscript type for *AJP Residents' Journal*.

- 1. Commentary:** Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.
- 2. History of Psychiatry:** Provides a historical perspective on a topic relevant to psychiatry. Limited to 500 words and five references.
- 3. Treatment in Psychiatry:** This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2–4 multiple-choice questions based on the article's content. Limited to 1,500 words, 15 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.

- 4. Clinical Case Conference:** A presentation and discussion of an unusual clinical event. Limited to 1,250 words, 10 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.
- 5. Original Research:** Reports of novel observations and research. Limited to 1,250 words, 10 references, and two figures. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.
- 6. Review Article:** A clinically relevant review focused on educating the resident physician. Limited to 1,500 words, 20 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.
- 7. Drug Review:** A review of a pharmacological agent that highlights mechanism of action, efficacy, side-effects and drug-interactions. Limited to 1,500 words, 20 references, and one figure. This article type should also include a table of Key Points/Clinical Pearls with 3–4 teaching points.

- 8. Perspectives in Global Mental Health:** This article type should begin with a representative case or study on psychiatric health delivery internationally, rooted in scholarly projects that involve travel outside of the United States; a discussion of clinical issues and future directions for research or scholarly work should follow. Limited to 1,500 words and 20 references.
- 9. Arts and Culture:** Creative, nonfiction pieces that represent the introspections of authors generally informed by a patient encounter, an unexpected cause of personal reflection and/or growth, or elements of personal experience in relation to one's culture that are relevant to the field of psychiatry. Limited to 500 words.
- 10. Letters to the Editor:** Limited to 250 words (including 3 references) and three authors. Comments on articles published in the *Residents' Journal* will be considered for publication if received within 1 month of publication of the original article.
- 11. Book and Movie Forum:** Book and movie reviews with a focus on their relevance to the field of psychiatry. Limited to 500 words and 3 references.

Upcoming Themes

If you are interested in serving as a **Guest Section Editor** for the *Residents' Journal*, please send your CV, and include your ideas for topics, to Rachel Katz, M.D., Editor-in-Chief (rachel.katz@yale.edu).

Prevention and Primary Care in Psychiatry
Neuropsychiatry
Advances in Treating Personality Disorders

Rachel Katz, M.D.
rachel.katz@yale.edu