

listened to their own heartbeats, developed exquisitely sensitive hearing and smell, or concentrated on their pain. Patients reported that their depersonalization and loss of self became more severe when they were not "allowed" pain (because of the narcotic administration). Four patients had had visual and auditory hallucinations (e.g., a deceased mother returning from the grave to sit at the bedside), but retrospectively it was difficult to tell whether these phenomena were directly related to the patient's being paralyzed or if they were secondary to the delirium accompanying physical illness.

The posttraumatic stress disorders were characterized by screaming nightmares, intrusive recollections, irritability, suspiciousness toward caretakers, anger at the hospital and consenting relatives, withdrawal from visitors, suppressed and shameful memories of "having gone crazy," and a reluctance to return for aftercare. Four patients had had suicidal ideation without immediate intent; they linked this ideation to the depressive realization that they had the capacity to lose control of their minds. Only one patient was grateful for what he considered a "lifesaving" procedure; the other five said they would rather die than go through it again.

The prevalence of panic during pancuronium administration and of iatrogenic posttraumatic stress disorder is unknown and requires further investigation. Based on our evaluation of these six patients, we suggest that diazepam be generously prescribed during the procedure, that staff and relatives continually touch and talk to the patients, that tape-recorded explanations from staff and reassurances from family be played when more personal contact is not available, and that, following the treatment, patients be assessed and, if necessary, treated for posttraumatic stress disorder. Our six patients responded to the psychotherapeutic interventions described by Horowitz (1).

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#### Information on "Ecstasy"

SIR: We read with interest Richard J. Alexander, M.D.'s request for information regarding the drug "Ecstasy" (June 1985 issue).

"Ecstasy" is the street name for 3,4-methylenedioxymethamphetamine (MDMA), a psychoactive phenylisopropylamine, synthesized in Germany in the early twentieth century. It was investigated by the U.S. Army as a potential psychotoxic compound in the mid-1950s (1).

MDMA has been labeled a psychedelic drug, but the scant published literature comparing the subjective effects of this compound to those of the "classic" psychedelic drugs, such as LSD, psilocybin, mescaline, or dimethyltryptamine, does not clearly support the placement of MDMA in this category (2). Anecdotal clinical reports describe a lack of the disorientation, ego disruption, perceptual distortions, and transient psychotic states that can occur with the more powerful psychedelics, when MDMA is used in a controlled environment with careful supervision (Greer, 1983 unpublished manuscript; Downing, 1984 unpublished manuscript;

Kuony, 1980 unpublished manuscript). Greer described one case (out of 80) of a man with a prior history of panic attacks who experienced a recurrence of the symptoms after using MDMA; his symptoms resolved after he reentered psychotherapy. Generally, subjects describe an increase in mood and in the ability to communicate in individual and conjoint psychotherapy, and enhanced introspective ability.

MDMA has a brief duration of action (4-6 hours), is usually administered in a dose of 75-150 mg orally as an adjunct to psychotherapy, and has acute side effects that are primarily sympathomimetic in nature.

MDMA has been placed in schedule I (with heroin and LSD) on an emergency basis by the U.S. Drug Enforcement Agency (DEA). This apparently was done because of the increasing frequency of street use and because of concerns that MDMA's chemical similarity to methylenedioxyamphetamine (MDA), another schedule I drug, bespoke similarities in clinical effects. An unpublished manuscript that described serotonergic terminal degeneration in the CNS was quoted from by the DEA in making its decision. However, that study used MDA, not MDMA. Even in the best of circumstances, establishing a direct causal relationship between the use of a psychoactive drug and subsequent "adverse reactions" is quite difficult (3). Abuse of a drug of unknown purity, strength, and contaminants, in combination with any number of other drugs and alcohol, in unprepared subjects with an unknown degree of psychopathology in an uncontrolled setting is not a test of whether or not the drug has any potential therapeutic use or even high potential for abuse.

A number of psychotherapists who use MDMA as an adjunct to their psychotherapeutic practice, as well as a number of other concerned parties, have called on the DEA for an administrative law hearing with regard to classifying MDMA as a schedule I substance. These hearings are now in progress and will not be completed until next year, when a final decision will be made.

We hope the furor in the media and legislatures that made research with psychedelic compounds so difficult (if not impossible) to pursue in the 1960s will not have the same effect on further rational inquiry into the mechanisms of action and clinical utility of MDMA.

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#### Common Misconceptions About the Mental Status Examination

SIR: As examiners for part II of the American Board of Psychiatry and Neurology examination, we have observed year after year that candidates misconstrue the intent of many