

January 1984

Letters to the Editor

Follow this and additional works at: <http://jdc.jefferson.edu/jeffjpsychiatry>

 Part of the [Psychiatry Commons](#)

[Let us know how access to this document benefits you](#)

Recommended Citation

(1984) "Letters to the Editor," *Jefferson Journal of Psychiatry*: Vol. 2 : Iss. 1 , Article 12.

DOI: <https://doi.org/10.29046/JJP.002.1.009>

Available at: <http://jdc.jefferson.edu/jeffjpsychiatry/vol2/iss1/12>

This Article is brought to you for free and open access by the Jefferson Digital Commons. The Jefferson Digital Commons is a service of Thomas Jefferson University's [Center for Teaching and Learning \(CTL\)](#). The Commons is a showcase for Jefferson books and journals, peer-reviewed scholarly publications, unique historical collections from the University archives, and teaching tools. The Jefferson Digital Commons allows researchers and interested readers anywhere in the world to learn about and keep up to date with Jefferson scholarship. This article has been accepted for inclusion in *Jefferson Journal of Psychiatry* by an authorized administrator of the Jefferson Digital Commons. For more information, please contact: JeffersonDigitalCommons@jefferson.edu.

LETTERS TO THE EDITOR

We welcome all letters to the editor, and encourage authors to reply. Input from residents and faculty on ideas presented in the *Journal* create the arena for discussion and dialogue which is the ultimate purpose of this undertaking. Please send letters to Karl Doghramji, M.D., Chief Editor, The Jefferson Journal of Psychiatry, 1015 Chestnut Street, Second Floor, Philadelphia, PA 19107.

On the First Issue of the Jefferson Journal of Psychiatry—A Resident Publication

Sir:

First let me congratulate the residents and Dr. Schwartz for an outstanding inaugural issue of the *Journal*. Each of the articles demonstrates a balance of scholarship and attention to clinical relevance.

I would like to call attention to a recurrent theme among the articles, namely, that the psychiatrist must look beyond a simple descriptive approach to diagnosis. Errors in psychiatric diagnosis are frequently made when the clinician exercises tunnel vision in the service of diagnosing a condition that he or she can treat. A typical example of this is in the approach to the patient with borderline personality disorder (BPD). The psychotherapy of BPD has received so much attention that clinicians occasionally feel less than adequate if the treatment is a drug therapy rather than analytically-oriented psychotherapy. Such a problem can cause a drug-treatable disorder to be missed. In Dr. Stanch's case study, the patient presented with a variety of nonpsychotic signs and symptoms and several failed drug trials. Dr. Stanch was able to reframe and treat the problem as a residual type of attention deficit disorder, rather than relegating the patient to an ineffective and inappropriate treatment. Similarly, in Dr. Doghramji's report, it was only after repeated examination that an organic basis was found for a patient's depression. This patient had a number of psychosocial stressors and a significant history of alcohol abuse. The clinicians had to look beyond the obvious signs of life disturbance to make the diagnosis of meningoencephalitis. This is another example how not accepting the clinical presentation at face value can open up diagnostic possibilities.

Finally, Dr. Buxbaum's discussion of the role of olfaction was intriguing. There is a growing body of evidence from neurobiology (1) that basic mood states such as anxiety may be mediated by molecular events which humans have in common with other living creatures. The example of olfaction is a cogent one, since its representation in the brain is so prominent, and its role in interpersonal dynamics and mood states is just at the threshold of clinical relevance.

Speaking as a Jefferson faculty member, it is especially gratifying to see the depth with which our residents are approaching their work. May the *Journal* have many more successful issues.

Kenneth J. Weiss, M.D.
Associate Professor of Psychiatry

1. Kandel, ER: From metapsychology to molecular biology: Explorations into the nature of anxiety. *Am J Psychiatry* 140: 1277-1293, 1983

Sir:

I found Dr. Buxbaum's article enjoyable and thought provoking. Basically, he argues that olfaction is strongly associated with human sexuality, and that the sense of smell undergoes "repression and other forms of modification by the ego" since "odors now considered repulsive were stimulating in an earlier developmental period."

I would like to suggest that this remarkable reversal serves other functions as well. For Freud, the body image represents the early prototype of the ego: The boundary of the self takes the body surface as model. Primitive introjection and projection mechanisms help to establish the ego boundary by taking in good, pleasurable sensations and ejecting the unpleasurable into the outside world. This *throwing out* makes the first cut in primary narcissism, creating the sphere of the *not me*.

Human feces initially occupy a very ambiguous place: both inside and outside, body part and piece of reality. Excrement shares in the narcissism that invests the body as a whole and the child values his products as magical objects, offering them as special gifts to the parents. In this light, the change of odor may signal a de-limiting of the self as a double awareness of separateness and limitation: the growing child no longer needs to believe his shit doesn't stink.

Incidentally, it is rather amusing to remember that Willhelm Fleiss, Freud's early confidant, was an otolaryngologist who firmly believed in the relationship of the nose to sexuality, albeit in a literal, biological sense. During the height of Freud's transference neurosis (in which Fleiss was the object) he performed several operations on Freud's nose and sinuses. The first analyzed dream in *The Interpretation of Dreams*, the Irma Dream, contains several references to nasal anatomy.

Thomas Wolman, M.D.
Clinical Assistant Professor of Psychiatry

Dr. Buxbaum replies

Sir:

Dr. Wolman's comments are appreciated. He expands the issue further though in a somewhat different direction. I would like to add that many patients with predominantly narcissistic pathology appear to be insensitive to the smell as well as the form of their own excretions, yet they are hypersensitive to the excretions of others. These

patients may have not completed the period in their development where, as Dr. Wolman states, "the change of odor may signal a de-limiting of the self as a double awareness of separateness and limitation" and remain fixed in the earlier stage where all that is theirs and produced by them is felt to be good. The *stinking shit* could only be produced by others. Globally, people appear to be more tolerant of the smell of their own excrement. This may be related to the healthy narcissism that is present in well functioning individuals.

Michael Buxbaum, M.D.
Fourth-year resident