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Letters to the Editor

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LETTERS TO THE EDITOR

We welcome any and all letters. Using this forum we hope to encourage the kind of communication that is so vital to our continued growth as professionals. Please send any letters to: Jeffery Sarnoff, M.D., Editor, *The Jefferson Journal of Psychiatry*, 1015 Chestnut Street, Second Floor, Philadelphia PA 19107.

BIO-PSYCHO-SOCIAL ALCOHOLISM

Sir:

It was with sharp interest that I read the interdisciplinary article by Blumenthal, et al, "Intractable Alcoholism in a Patient with a Levine Shunt." In my estimation, this is truly a teaching case and I believe that its recording is a step in the right direction to see that recognition is being given to the bio-psycho-social, hence, interdisciplinary nature of the *disease* of alcoholism. This case further highlights the point that treatment efforts should not be isolated in any one specialty area, be it internal medicine or psychiatry.

As can be seen in the case of Mr. J., of all the diseases that are treated in medicine, alcohol abuse/alcoholism is one that certainly knows no special boundaries. Unfortunately, as a disease it is all too frequently placed in the bailiwick of the "other guy," who should be responsible for caring for this difficult patient. Medically, this approach can offer the patient some temporary symptomatic relief from the physical sequelae of drinking (from a broken arm to liver disease). However, without recognition and resolution of the psycho-social issues there is a very high likelihood of continuing non-compliance (Mr. J.), a resumption of drinking, and ultimately worsening medical problems.

This interdisciplinary case report certainly focuses on the myriad of medical, psychological, and social problems that characterize chronic alcoholism. The teaching significance of this case is in highlighting first that some meaningful intervention (albeit of limited long term impact) is possible with an interdisciplinary approach; and, secondly, that earlier recognition and intervention is needed to help stop the disease process before it reaches the advanced state presented by this patient.

Stephen P. Weinstein, Ph.D.
Clinical Associate Professor
Department of Psychiatry

"DISEASE MY EYELASHES! HE'S DOING IT ON PURPOSE."

Sir:

Dr. Gottheil points out in your interdisciplinary case conference that alcoholism is still not widely regarded as a disease. He might have added that thirty years have elapsed since Jellinek and Alcoholics Anonymous first promulgated the idea that it was. It makes sense to look into the reason for such sustained public resistance.

We do not have to look far, at least as far as the public is concerned. When any of us have tried to explain the disease concept to relatives of alcoholics, they often as not say, "Disease my eyelashes! He's doing it on purpose." And indeed he is. Elbow bending is not a conditioned reflex. Nor is it a totally preemptive motive. This patient will inhibit his drinking as long as you actually stand and watch him. Under some circumstances you can actually pay him not to drink (Cohen, et al, 1971). He simply tends, in more circumstances than are good for him, to want to drink more than the rest of us.

"Well," the relative says, "I like to drink sometimes, too, but I recognize an obligation to restrain myself. Why should this guy get away with something I take pains to avoid?"

"But," we say, "controlled drinking is not particularly hard for most of us. We're not dying to drink, just moderately interested. After we've had enough, we usually stop because we feel like it. The alcoholic's *disease* consists of an exceptional *motive to drink*. This does not come from a flaw in his character, as people

used to think. Future alcoholics are no more 'oral' than anybody else (Vaillant, 1980). Perhaps they are slightly more extroverted than average (Kammeier, et al, 1973), but that is also true of future cigarette smokers (Stepney, 1982). On the contrary, exceptional motivation to drink is inborn, and occurs much more often in the children of alcoholics adopted at birth than in the children of nonalcoholics adopted at birth by alcoholics (Goodwin, 1979). So the fact that he can choose whether to drink or not on any given occasion does not mean that he is free of disease. The person with pneumonia can choose not to cough, in the sense that he can resist the urge to cough at any given moment, but everyone is willing to say he coughs because of his disease."

The relative is by no means silenced. "If extra temptation is a disease, it's certainly not limited to alcoholics. Speaking of smoking, I gave it up last year, and it was the hardest thing I have ever done in my life. I understand fewer smokers reform than alcoholics, if you go by percentages. Now I also know people who never get the slightest kick out of smoking, so I guess I have one of your motivational diseases. There are a lot of us. What about the people who eat too much, or gamble too much? People who can't hold onto a dime? Workaholics, or the fancy new name for them, Type A Personalities? What about people who can't stop committing crimes? Is that supposed to be a disease too?"

"Sure. The same kind of study that showed an alcoholic tendency to be inborn has also shown a criminal tendency to be inborn (Hutchings and Mednick, 1974). Apparently, many differences in what we are tempted by are determined by our genes. Not many habits, good or bad, have been studied by this kind of research. But I once heard Seymour Kety say that while he was studying the hereditary nature of schizophrenia in Danish adoptees, he ran several comparison groups, including one on the trait of being a doctor. He said that you could predict that, too, better by knowing about the biological parents than the adoptive parents. Still, I don't see why that negates what I said about alcoholism as a disease."

"I guess it doesn't as far as science goes. But when you tell me he has a disease, it sounds like you're saying I can't blame him for anything he does. That's not fair. Almost everybody has some temptation that's hard to control. People in a family are supposed to try to at least curb their temptations, even intense ones, like I did with my smoking. This guy just isn't trying very hard."

"But motivation is what you try *with*. If someone has a disease of motivation, it's hard for you to tell if he's trying as hard as he can."

"That's true, Doc, I can't tell for sure, but you can't either; maybe even less that I can, because you don't live with him. I just want to be free to settle this matter according to my intuition, without some outsider coming in and imposing his theory."

It seems to me that this opinion has to be respected. Even allowing for the different burden he carries, the person with a motivational disease is still blameworthy sometimes, and his family members would probably find it downright spooky to be with him if they were convinced to the contrary. The disease concept tells us something about alcoholics, but it does not tell us how to intervene in the subtle bargaining process by which family members assign blame to one another. Perhaps it would gain more currency if we made that point clearer.

This argument does not invalidate Dr. Gotthel's message, which is not aimed at family members, but doctors—sometimes, by chance, the same people—but in a different role. Doctors are not hired to be judges of virtue, and speculation as to a patient's blameworthiness is self-indulgent. For doctors, the disease concept makes a technical point: diseases are not cured by exhortation. Alcoholic patients are ambivalent, just like the ones with anxiety attacks, and will respond to the skills we have learned as ambivalence—sometimes, and sometimes not, as with our other patients. It should not be necessary to establish our patients as blame free before trying to make alliances with them.

REFERENCES

1. Goodwin DW: Alcoholism and heredity: a review and a hypothesis. *Arch Gen Psych* 36: 57-61, 1979
2. Hutchings B, Mednick S: Registered criminality in the adoptive and biological parents of registered male adoptees, in *Genetics, Environment, and Psychopathology*. Edited by Mednick S, Schulsinger F, Huggins J, Bell. Amsterdam, Elsevier, 1974

3. Kammeier, Hoffman H, Toper R: Personality characteristics of alcoholics as college freshmen and at time of treatment. *Quart J Stud Alc* 34: 390-399, 1973
4. Stepney R: Human smoking behavior and the development of dependence on tobacco smoking. *Pharm and Therapeut* 15: 183-206, 1982
5. Vaillant G: Natural history of male psychological health, VIII: antecedents of alcoholism and morality. *Am J Psych* 137: 181-186, 1980

George Ainslie, M.D.
Assistant Professor of Psychiatry
Director of Resident Education
Coatesville VA Medical Center

DR. GOTTHEIL REPLIES

Sir:

As usual, George Ainslie's remarks are thought provoking. How can we explain that alcoholism is a disease to the alcoholic's family? A difficult task, indeed, when we cannot really define disease. Dorland's Medical Dictionary defines it as a "definite morbid process having a characteristic train of symptoms; it may affect the whole body or any of its parts, and its etiology, pathology, and prognosis may be known or unknown." So far so good. Alcoholism seems to fit; but what is a morbid process? Returning to Dorland, we find that morbid is defined as a) "pertaining to, affected with, or inducing disease," and b) "unhealthy or unwholesome, as a morbid disease or fear." Again, while alcoholism seems to fit, what is established is unclear. A disease seems to be a morbid process which is unhealthy and being unhealthy is having a disease. Most families of alcoholic persons would not find Dorland very convincing.

When I talk to individuals unsympathetic to the alcoholic's plight, whether family, physician, or other, the most frequent and perplexing issue is that of resolving the paradox that diseases are supposed to cause pain while alcohol gives pleasure. Certainly, the nonalcoholic and the alcoholic before becoming an alcoholic derive pleasure from alcohol. But once the individual has become an alcoholic, losing friends, jobs, family, health, and self-esteem in the process, drinking is no longer for the purpose of pleasure but to avoid pain. When studied, we find that alcoholics who say that they drink to feel good, relax, sleep better, and become more sociable, do not—instead they become more tense, anxious, depressed, and unsociable (Mendelson JH, LaDow J, and Solomon P: Experimentally induced chronic intoxication and withdrawal in alcoholics. *Quart J St Alc Suppl* 2, 1964). But even more to the point, when we see an alcoholic who is depressed, spitting up blood from gastritis, or going through the horror of D.T.s swear never to drink again and then go back and drink, can we really believe that he/she is looking for pleasure? Even when this happens again and again? This, I believe, is the behavior that is morbid, entirely contrary to one's best interest and desires, and is what defines the disease process in alcoholism.

I am hesitant to describe alcoholism as a motivational disease. It sounds too willful and could serve to exacerbate family members' negative feelings. This is especially likely in those who conceive of disease as a physical, structural change and challenge the disease concept on this basis. In discussing this issue I tend to use depression and allergy as accepted models of disease in which no gross structural defects are observed.

If we accept alcoholism as a disease, then, must the family accept unacceptable behavior? Should the individual be understood, excused from blame, and considered irresponsible for past, current, and all future behavior? Not at all. People react differently to illnesses. Some, following the loss of a hand, a myocardial infarction, or the development of diabetes become immobilized, dependent, and a burden on their families. Others compensate and go on about their lives, learning to write with their toes, or taking appropriate care of their medical conditions and functioning quite well. Behavior patterns, even abnormal ones such as depression and hypersensitivity, can be treated and modified even though the underlying predispositional tendency may continue to exist and may again manifest itself from time to time. It should also be noted that treatment results with alcoholic patients are quite good, but that is a separate topic.

Ed Gottheil, M.D.
Professor of Clinical Psychiatry

CHILD PSYCHIATRY

Sir:

I was delighted to see Child Psychiatry represented so well in the latest issue of *The Jefferson Journal of Psychiatry*.

Dr. Marti illustrates a basic caveat to those who fail to see the "forest" of deprivation, loss, conflict, and trauma that frequently antedates the "trees" of acute trauma that so commands our clinical attention with the sexually abused child. She has in addition underscored the overriding importance of a biopsychosocial model for the clinical diagnosis and treatment of children.

Dr. Doenlen aptly illustrates the vicissitudes of the separation/individuation process as it unfolds in twins and demonstrates how an appreciation of these developmental-adaptational dynamics sharpens one's clinical insights and becomes the theoretical underpinnings of treatment goals and strategy.

I want to thank these Child Fellows for "breaking the ice" and hope that others will soon follow.

David S. Brashear, M.D.
Professor of Child Psychiatry

POPULAR CAUSES, TWIN CLINICS, AND IDIOSYNCRACY

Sir:

The two articles related to child psychiatry in the January 1985 issue of *The Jefferson Journal of Psychiatry* underscore a very important issue in psychiatry: namely, we treat *people*, not syndromes. The article by Dr. Marti on the importance of an overall assessment for child victims of sexual abuse is most timely. Unfortunately, the sexual abuse of children is currently "in," the darling of the media, the popular press, and those who write television "dramas;" as a result the phenomenon is being subjected to the same effects that any faddish phenomenon experiences: over simplification, mass hysteria, and the creation of all kinds of activists who claim the divine duty to protect us all from whatever the latest scourge might be. The same fate befell (plain old regular) abuse about a decade ago, the diagnostic category of "borderline personality" over the past twenty years, the effects of divorce on children over the past decade, manic-depressive psychosis once lithium was discovered about a decade ago, et cetera. In each instance "junk food" treatment services went into business to profit from these "fads," television talk-show guests managed to feed the flames, more articles appeared in the popular press than in the professional journals, and, of course, the statistical incidence of these conditions sky-rocketed in order to justify the outlay of funds to support research and service. Just this past week I heard of a latency age child who was subjected in school to a group of visitors who presented to the student body a "class" in the recognition of and defense against sexual abuse; he reported detailed accounts of uncles putting hands down their nieces' pants, camp counsellors playing "secret games," et cetera. From the child's response, it was clear that the classroom presentation *itself* was an example of sexual abuse, something that I am sure the well-meaning presenters totally missed. I am reminded of Eric Hoffer's book on "True Believers" and how dangerous they are; we often need protection from those committed to do us "good" as they see it.

In such a climate the temptation to see no further than the label is great, to bring out the latest ritualized "treatments" for each presumed "victim" in the spirit of the Procrustean couch. As psychiatrists our major protection against such offenses is our truly humanistic concern for the whole person; one of the positive aspects of DSM-III is its appreciation of the fact that symptoms occur in the context of a character structure, in a person with assets and liabilities, strengths and weaknesses, in a specific setting.

Although Dr. Doenlen is less specific about it than Dr. Marti, his case report on an identical twin evokes the time some thirty years ago when "twinning" was all the rage among behavioral scientists. His clinical material makes clear that there were many factors at work with his patient above and beyond her twinship. The infantile neurosis material was clear in the thinly disguised masturbatory equivalent of eye-lash pulling (and later finger nail biting) and in the primal scene curiosity equivalent of the terrifying face looking in her bedroom window. Her competition with her twin was most surely in part a typical displaced oedipal struggle. And in her insistence that it's okay to pull out eye-lashes and bite nails as they grow back we surely see the

expression of a very common defense against castration anxiety. In other words, she had a classical neurosis of childhood, in the broader context of her "twinning" character trait. And further, there was evidence of marital conflict between the parents to further fan the flames. In other words, a Twin Clinic, like a Sexual Abuse Clinic (and there are, of course, some of the latter; I have not heard of the former) can be a disservice to the patient if its circumscribed title is accompanied by a circumscribed clinical perspective. The psyche is just too complex to be so fractionated.

Finally, a word about Dr. Dorn's Tower of Babel, the psychiatric reading list. In a sense it comments upon the points I endeavored to make above. The practice of psychotherapy is a very solitary event; with the exception of varieties of group therapy with two or more therapists, we do what we do alone with our patients. It is inevitable that we grow to some extent idiosyncratic in our practice. We are restrained by the limited repertoire of human psychic activity, and by the theories, mental models, and clinical techniques we have evolved over time from our teaching, practice, reading, and our own treatment. But one's professional identity and "knowledge," especially with the passage of time and accumulation of experience, cannot readily be disentangled from our person. Our skills include more than simply technical data; they also include such personal qualities as our capacity for empathy, our value systems, our socio-political perspectives, our level of professionalism; we are our only professional piece of equipment, which may be why psychopharmacology often serves first and foremost as a means of lightening our sense of *personal* responsibility for our work with our patients; clearly all too often a prescription is the acting out of the countertransference. The reading list, I believe, reflects this, for it is indeed idiosyncratic, not in the few "basic texts" that most agree should be included in a basic bibliography, but in all the publications with but one vote for inclusion. The literary and philosophical items listed speak for the importance for all clinicians to develop the wisdom, the ironic perspective on human existence that can be fostered by such reading; hopefully, it can help protect one from the over-simplified, good guy/bad guy, narrow field of vision that can interfere with our capacity to see the broader picture.

I apologize for going on at such length; perhaps you can take it as an indicator of the success of your Journal that it can be so provocative! I look forward to future issues.

J. Alexis Burland, M.D.-P.C.
Professor of Child Psychiatry

SURVIVORS OF SUDDEN DEATH

Sir:

I have read with interest the article, "Caring for Survivors of Sudden Death in the Emergency Ward," by Jeffery Sarnoff, M.D., in the January 1985 issue of *The Jefferson Journal of Psychiatry*. Dr. Sarnoff's points are well taken and well said. The article serves as a clear guideline to the management of survivors of sudden death in the Emergency Department and as such will be a significant aid for those training in Emergency Medicine.

I commend you for the high quality of offerings of this sort in your journal.

Joseph A. Zeccardi, M.D.
Director
Division of Emergency Medicine

SELLING THE STAGES OF GRIEF

Sir:

Reading Dr. Sarnoff's article in *The Jefferson Journal of Psychiatry* reminded me that I recently saw an old news photograph of survivors of the Coconut Grove fire (1942). This extraordinary picture, which was being used to illustrate psychologic shock or some such thing, consists of an image of two women transfixed by their catastrophe. Eyes unfocused, expressions blank, postures lax, they appear as if narcotized, and indeed, as we know now, must have been flooded with endorphins. (It is possible to perform considerable

surgery on people in this state without eliciting complaints of pain.) I enjoyed Dr. Sarnoff's article, but felt that he slighted several points. Although loss is a distinct type of trauma in life, there is no psychology of grief separate from other human psychology. The person in mourning is governed by the same laws of nature as in other traumatic circumstances. Not every writer in this area recognizes this fact. I thought that Dr. Sarnoff did not make sufficiently clear the important difference between human responses to sudden and gradually unfolding losses, which are two very different situations, and call up very different kinds of responses from people. It seems as if the psychic defenses function like an old car that needs a warm up period to function smoothly. The time factor is essential in determining not only cognitive and perceptual function, which one might expect, but also effect which I always think of as a mercurial mental phenomena. It was in gradually unfolding loss that Kubler-Ross observed, incorrectly, I must add, her five stages of mourning. Her genius was in selling an incorrect observation to the field and public. Defenses in grief are actually fluid and shifting, and do not go through a set sequence of stages. To say that little appeared in the literature between Lindemann and Kubler-Ross seems unfair to such careful works as Weissman, Schneidman, and Ver Wordt who were more important, if less sensational, contributions to thanatology.

It is a crying shame that the burden of informing the loved ones of a sudden death falls upon those least prepared to deal with the psychological complexities, the most junior house staff. This system assures the maximum psychic trauma to both parties with greatest unfortunate consequences for the future of both doctor and family. Since we seem unable to change the hospital system, there is a crying need for some sort of manual for managing the effects of sudden loss which could be distributed to all beginning residents. Dr. Sarnoff's thorough and comprehensive review article would be an excellent basis for such a guide.

Howard Field, M.D.
Professor of Psychiatry
Director
Division of Consultation and Liaison

"OVER AND ABOVE"

Sir:

I read and enjoyed the latest issue and all other issues of the residents' *Jefferson Journal of Psychiatry*.

The articles have been multidisciplinary and reflective of a wide latitude of academic exposure afforded to our residents in their teaching program. This knowledge and acumen is reflected in their patient care.

The Journal has become a major contribution of the department. It is "over and above" what is usually forthcoming from residency training, and as such deserves meritorious praise and recognition.

It is also of note that a contributor has been the recipient of the Kenneth Appel Award, a prestigious award granted by the Philadelphia Country Medical Society to a psychiatric resident for the best paper regarding his or her experience in treatment or research, last year, and this year, one of the contributors has received honorable mention.

I will look forward to the next issue of the Journal.

Paul J. Poinard, M.D.
Emeritus Professor of Psychiatry