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Letters to the Editor

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Letters to the Editor

IN RESPONSE TO DR. JONAS

In reply to Dr. Jonas' letter about my discussion of the paper, "Bulimia as a Masturbatory Equivalent," by Dr. Eric Levin: The symptoms of bulimic anorexia nervosa mask an underlying personality disorder which should be the central focus of treatment. Control studies are not possible in the neuroses because of the multiple unconscious conflicts that determine symptoms. Regarding outcome, I have followed certain cases for twenty years from a severe regressive bulimic state through marriage, childbirth, and motherhood. In recent years at the meetings of the Psychosomatic Discussion Group of the American Psychoanalytic Association, of which I am chairman, the successful analyses of bulimic anorexics have been presented. It is true that standard psychoanalytic technique is not effective with most bulimics. However, we have developed a definite modified psychoanalytic approach that we detail in our book, *Fear of Being Fat: The Treatment of Anorexia Nervosa and Bulimia* (1). Dr. Charles C. Hogan, Dr. Ira Mintz, and I have another book in press on the analytic treatment of anorexia nervosa and bulimia. These volumes should go far to correct the impression that psychoanalysis is ineffective with bulimics. In the great majority of our cases, analysis achieved both a clearing of the bulimic anorexic symptoms and a resolution of the underlying personality disorder. In cases seen in consultation and supervision, as well as cases presented to the Psychosomatic Study Groups, therapeutic impasses with bulimics have been resolved by: 1) a deeper psychodynamic understanding; 2) a review of the countertransference conflicts of the therapist; and 3) an exploration of the often subtle treatment sabotage on the part of the patient's parents who frequently are unable to accept self-assertive behavior by the enmeshed bulimic anorexic. The importance of engaging the adolescent's parents in conjoint treatment in order to disentangle their relationship with the patient cannot be emphasized enough.

In regard to etiology, it is a central hypothesis of my research that bulimic anorexic symptoms are caused by an overwhelming fear of being fat that is primarily an identification with a parent or parents who have a similar fear of being fat and that bulimic anorexia nervosa—bulimic fat phobia—is secondarily reinforced by the general irrational fear of being fat of most other women and many men in our culture. Psychodynamic research with the families of over 100 anorexia nervosa and bulimic patients revealed a parental psychological profile that appeared to be etiologic in establishing the personality disorder in their children that later manifests itself in anorexic or bulimic symptoms.

To understand and treat bulimic anorexics, it is necessary to understand the impulse disorders, the addictive personality structure (2,3), and the habits of childhood that are frequently the developmental forerunners of bulimia. I have emphasized that bulimia is a food phobia—an addiction. In bulimics I have noted the frequent occurrence of thumb-sucking, nail-biting, cuticle chewing and eating, head banging, hair pulling and eating, and other childhood impulse disorders such as encopresis and enuresis. In certain cases there is a childhood history of excessive good behavior. However, therapy uncovers isolated episodes of rebelliousness. The ego utilizes the same defense in its struggle with a childhood habit or a childhood impulse disorder as it uses later in trying to cope with bulimic anorexia nervosa or the other eating disorders. Thus the defenses of denial,

splitting, displacement, externalization, withholding, and lying are deeply ingrained in the ego structure of the bulimic anorexic. In some cases we see a chaotic ego structure, as when a childhood habit co-exists with bulimia and an addiction.

The Use of Antidepressant Medication. The treatment of bulimics has to be guided by the psychodynamic diagnosis of the individual case and the presenting clinical situation (1).

There are additional reasons why my colleagues and I (1,4), along with other psychoanalysts (5) do not agree that it is "archaic and cruel to allow patients to experience their eating disorder to gain insight." On the contrary, precipitous symptom relief can be dangerous to the patient's life and to their mental functioning. If symptoms are relieved by any method (supportive therapy, medication, etc.) before there has been sufficient change in the underlying personality disorder and object relationships, the defective defensive structure of the bulimic ego (1,6) may break down and self-destructive acting out (1) and/or alternate neurotic, psychosomatic or psychotic symptom formation can occur. The psychoanalytically trained psychiatrist should be in charge of treatment as a split transference can interfere with treatment (8,9). Of course, internists, pediatricians, and other specialists work with us to monitor the patient's health and we are constantly aware that these self-destructive patients may force us to interrupt dynamic therapy and intervene for life-saving purposes. Many bulimic anorexic nervosa's are addicted to alcohol and/or drugs and we are confronted with all the therapeutic problems encountered in the treatment of the impulse disorders. This dilemma I explore at length in Chapter 8 of our book, *Fear of Being Fat: The Treatment of Anorexia Nervosa and Bulimia*.

Bulimic anorexics experience hyperactive states. In these anxiety conditions they gorge and vomit endlessly, but also will disobey monoamine oxidase dietary restrictions, inducing dangerous side effects, and may ingest dangerous amounts of prescribed medication. Supervised cases attempted suicide with aspirin, acetaminophen, ipecac, imipramine, and amitriptyline. A colleague's case experienced a resolution of bulimic symptoms following the administration of phenelzine but developed a toxic manic psychosis, became noncommunicative, and acted out sexually. Dangerous overdose with laxatives is a manifestation of the either/or nature of their ego functioning (1,8). Bulimics, for example, resort to extremes of exercise to relieve anxiety and take off weight. Only a psychodynamic approach can change this neurotic behavior. Because of unresolved oral conflicts, the bulimic patient believes in magical solutions to problems, is intolerant of delay, and is ambivalent about such a lengthy learning process as analytic therapy. The temporary removal of symptoms can eventuate in premature termination of treatment.

The crucial therapeutic force is the transference neurosis. Patients must reexperience in the transference the dyadic relationship with the mother and understand depression and rage at not being able to control the therapist as they did the mother. Likewise, later in therapy, the triadic Oedipus complex emerges and can be analyzed in the transference neurosis. If the patient is on medication, the transference loses its intensity and the therapist's interpretations become diluted and intellectual. From the ego and psychodynamic point of view, a paradox emerges. Only those bulimics who are well motivated and have stronger egos can be medicated without the risk of alternate symptom development or acting out; however, it is just such healthier patients who have the most favorable psychotherapeutic prognosis.

In those situations where the use of medication, particularly antidepressants, is necessary, that is, medical crises or when patients cannot be motivated for psychotherapy,

in treatment stalemates, or where cost and therapist availability are problems, the use of drugs is a trade-off with potentially disadvantageous consequences. Therapeutic stalemates can occur in cases of chronic bulimia where there has been long-term resistance to insight and change in analytic therapy.

While medication in some intractable case may facilitate therapy, we have found that, even in severe regressed states, knowledgeable interpretations have resolved the impasses. Before resorting to medication, one is well advised to try consultation and/or supervision. In cases seen in consultation and supervision, therapeutic impasses have been resolved by a deeper psychodynamic understanding, a review of the countertransference conflicts of the therapist, and an exploration of the often subtle treatment sabotage on the part of the parents, who frequently are unable to accept self-assertive behavior by the enmeshed bulimic anorexic. It must be kept in mind that at best medication may make the patient more amenable to dynamic therapy, but it cannot change the underlying impulsive, masochistic personality disorder.

C. Philip Wilson, M. D.

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DR. WOLMAN COMMENTS ON "PSYCHOANALYSIS: SCIENCE OR FICTION"

Sir:

Dr. Garcia's thought provoking article, "Psychoanalysis: Science or Fiction?" (1) shows the vehemence with which Freud held to the scientific Weltanschauung. Permit me to share some of my own reflections on Freud and the scientific status of psychoanalysis.

To begin with a clinical example, consider the case of a college student with a phobia for all kinds of laboratory work. In analysis, this student wants to stay as far away as possible from the phobic stimuli. To this end, he constructs a wishful fantasy that renders experiment unnecessary by making theory omnipotent. In effect, he says to the analyst, "let's talk about *the* dream, *the* Unconscious, *the* Oedipus complex. But the analyst must reply, "what about *your* dream, *your* Unconscious, *your* Oedipus?" He must demonstrate, over and over again, that theorizing is useless here—it's like trying to swim without getting in the water. He must show the student how to use analysis as a down-to-earth laboratory, much like the others he fears, and not like a philosophic starship. Not surprisingly, analysis and laboratory work share the same insecurities: unpredictability of results, unwieldy equipment, accidental injuries, and temporary chaos and disorientation.

As it happened, Freud faced similar conflicts when he undertook his self-analysis. One of his dreams of the period (2) nicely describes what he was going through—it is quite a macabre scene: Freud dissecting his own pelvis. But the expected gruesomeness is absent. Freud wonders if the missing affect belongs with his queasy discomfort at making public his most private affairs. Certainly this would not have been necessary in his early experimental work on the nervous system of fishes, also alluded to in the dream. That work, carried out under the mentorship of a distinguished male scientist, contrasts with an association to the book "She" by Rider Haggard, in which a woman serves as guide through treacherous, boggy terrain. Perhaps the dream's latent message is: If only psychoanalysis was more like my early scientific work—orderly, objective, and socially accepted—in other words as far removed as possible from a woman's subjectivity, with its strange feelings and intuitions.

The college student *wishes* psychoanalysis was more humanistic; Freud *wishes* it was more scientific. Both, I believe, are reacting to the ambiguous identity of the "impossible profession" even at its inception. Only a man like Freud could have initially withstood the contradictions that lie at the heart of the analytic endeavor. Yet every analyst must stand in Freud's shoes when tolerating ambiguity and uncertainty, whether in the clinical setting or elsewhere.

We easily fall prey to the temptation to resolve the paradox of analysis through an either/or mentality. If it's not a science, then it must be a pseudo-science, argues the scientific establishment. If it's not a science, it must belong to the humanities, argue some analysts, provoking other analysts to defend its scientific status to the end. The resulting endless debate should show that the question, thus posed, is unresolvable.

Given the pressures, internal and external, to present a familiar visage to the world, it will be hard for the psychoanalytic movement to maintain its precarious position on the crossroads of science, art and religion. But if it fails to do so, I believe it will have gained social prestige at the expense of its unique perspective, and will be diminished accordingly.

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Jefferson Medical College

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DR. GARCIA RESPONDS

Sir:

I thank Dr. Wolman for his comments on psychoanalysis and science, but I must take issue with them.

First, the "paradox of analysis" to which Dr. Wolman alludes remains a mystery to me. Psychoanalysis has its share of ambiguities and uncertainties, as do all other sciences, but like the rest it has the capability of discovering truths, and it sets about its search in as systematic and objective a manner as is humanly possible. This may not be saying all that much, given man's constitutional unfitness for scientific enterprise (1), but it is this which separates analysis from such essentially unscientific pursuits as Jungian psychology—and from all religious systems as well.

As for Freud's adherence to the scientific *Weltanschauung*, what else is there for mature man? Certainly a return to the illusory and often destructive world-view of religion would constitute a terrible regression.

True, psychoanalysis has been under great pressure to make itself palatable to the general population. To deny the scientific birthright of analysis is one way of surrendering to this pressure, the consequences of which would be devastating. But it is certainly in keeping with these decidedly anti-Freudian times.

Emanuel E. Garcia, M.D.

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DR. WERMAN RESPONDS TO THE REVIEW OF "THE PRACTICE OF SUPPORTIVE PSYCHOTHERAPY"

Sir:

Thank you for your thoughtful review of my book, *The Practice of Supportive Psychotherapy* (Brunner/Mazel, 1984), as well as for the invitation to respond to your review. I appreciate your bringing my book to the attention of your fellow residents, because my aim in writing the book was to stimulate interest and critical thought in a much undervalued and poorly conceptualized, although widely prescribed and practiced, form of treatment. Accordingly, in writing the book, I had in mind the large number of clinicians, from a wide variety of disciplines, who practice supportive psychotherapy.

The Practice of Supportive Psychotherapy is meant to be a basic text with only enough theory to place the clinical matters in a conceptual framework; my goal was clearly to stress practice and to be free of jargon and inflexible theoretical formulations. I have considered a later volume, which would deal at greater length with both technical and theoretical issues, but first things first.

In regard to the headings of the subsections, which you found "frustrating," I should point out that these were edited in to allow practioners to refer to the topics as needed, as a useful reference. Continuity was sacrificed, to some extent, in favor of accessibility, a decision which you perhaps had not discerned. Thus, you note that in my discussion of object relations I do not sufficiently explore the matter of transference. But the reader of your review would have no way of knowing that the subsection of which you write occurs in a chapter devoted to the evaluation of patients for therapy. That is why I pointedly

began the sentence you quoted by saying, "It is enough at this point to note that . . ." (a phrase you omitted) so that the reader of the book would realize that the issue of transference would be treated more fully in a subsequent chapter.

Of more importance, however, is the potentially useful comparison you make between Kernberg's article on supportive psychotherapy and my book. Unfortunately, you did not highlight the fundamental differences between us, nor I might add, our many points of agreement. These matters deserve some clarification. Kernberg's view of supportive psychotherapy is based on the techniques used in treatment (following Bibring's schema), and chiefly on a specific patient population: severe borderline personality disorders. In contrast, my view is based on utilizing any technique available that will shore up those psychological functions the patient lacks. In respect to the patient population for which supportive psychotherapy is indicated, I believe that it consists of that vast number of patients who are seen in mental health centers and clinics throughout the country. The diagnoses carried by these patients extend from one end of the diagnostic spectrum to the other, and this includes such diverse categories as the neuroses, serious drug and alcohol dependence, all matter of psychotic disorders, and chronic brain syndromes.

It is also to the beleaguered clinicians who deal with these most difficult patients that my book is addressed. These people are too frequently relegated to the category of second class therapists. They often receive little support—financial, emotional, educational, or social—for the work they are doing. Issues of morale, feelings of competence, and community approval are frequent problems among these mental health professionals. As you can see, my book does have quite different goals from those advanced in Kernberg's article, which primarily is concerned with the techniques to be used in working with patients with severe character disorders.

Despite the foregoing differences, if that is what they are, your review has the great merit of casting a bright light on the issue of supportive psychotherapy. It is through such discussions and the clarification of the issues at stake, that supportive psychotherapy will be better understood and better practiced, and I should like to commend you for bringing these matters to the attention of your readers.

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DR. MILLER COMMENTS ON "THE NEUROPSYCHIATRIC SYNDROME OF
A PSYCHOMOTOR SEIZURE DISORDER IN SHAKESPEARE'S *OTHELLO*, *THE
MOOR OF VENICE*"

Sir:

Thank you for making me aware of Dr. Alan J. Cohen's interesting article, "The Neuropsychiatric Syndrome of a Psychomotor Seizure Disorder in Shakespeare's *Othello*, *the Moor of Venice*." The paper will make a good reference for the course I have taught on "Medicine in Shakespeare."

This is another in a long list of articles and books attesting to Shakespeare's knowledge of the medicine of his time. The remarkable amount of medical information he displayed in the dramas and poems was no doubt gained by observation and reading, as well as his association with the physician, John Hall, who became Shakespeare's son-in-law.

In writing about Shakespeare's knowledge of a disorder such as epilepsy, it is important to keep separate what he might have understood about it in the seventeenth century and what is known today. Shakespeare may have been aware of the association of head trauma and seizures. He knew about the aura, unconsciousness, foaming at mouth, and post-seizure confusion. He seemed to understand that sufferers are often suspicious or even paranoid by nature. Of course he could not have known that he was describing temporal lobe psychomotor epilepsy. It is amazing that his portrayal fits the syndrome so well, as Dr. Cohen makes plain.

Shakespeare used epilepsy again in "Julius Caesar" as Casca describes how Caesar fell down in the market place and foamed at mouth, and was speechless:

Brutus: 'Tis very like: he hath the falling sickness. (I, 2, 252-4)

In "The Merchant of Venice" musicogenic epilepsy is mentioned as Shylock says:

And others, when the bagpipe sings in the nose; Cannot contain their urine. (IV, 1, 49-50).

It was a pleasure to read Dr. Cohen's interesting paper.

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