January 1990

Letters to the Editor

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

Part of the [Psychiatry Commons](#)

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

Recommended Citation

(1990) "Letters to the Editor," *Jefferson Journal of Psychiatry*. Vol. 8 : Iss. 1 , Article 17.

DOI: <https://doi.org/10.29046/JJP.008.1.016>

Available at: <https://jdc.jefferson.edu/jeffjpsychiatry/vol8/iss1/17>

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

DR. GOTTHEIL COMMENTS ON PHARMACOLOGIC TREATMENTS OF COCAINE DEPENDENCE

To the Editor:

Dr. Knable writes that he is encouraged by the new public awareness of the cocaine problem in this country. I am encouraged by the awareness of the problem by our psychiatric residents.

This is a fine overview article. Following a brief discussion, but one which covers the basic known points, regarding epidemiology, clinical manifestations, and comorbidity, the author reviews studies of the various pharmacological agents that have been employed in the treatment of cocaine dependence and, for those whose interest has been aroused, he provides 51 references.

The section on pharmacological treatments reads like an annotated bibliography without much in the way of integration. Unfortunately, this is not the fault of the author but represents a realistic appraisal of the state of the art. As such, it represents a clear and open invitation for clinical and/or research contributions to this pervasive, puzzling, important, and interesting problem.

In looking for something to quibble about, I noticed on page 3 the use of the terms "psychosocial interventions" and "medical treatments." I would have preferred that psychosocial interventions and pharmacological interventions both be considered as forms of medical treatments.

Edward Gottheil, M.D., Ph.D.
Professor, Department of Psychiatry
and Human Behavior
Jefferson Medical College

DR. WERMAN COMMENTS ON DR. NOVALIS' ARTICLE: WHAT SUPPORTS SUPPORTIVE PSYCHOTHERAPY?

To The Editor:

Thank you for inviting me to comment on Dr. Novalis' article (1).

The first section of his article is a good review of the literature on supportive psychotherapy. I am concerned however, that the ambiguity of one statement, seemingly attributed to me, may be misread. Dr. Novalis writes that "psychodynamic psychotherapy" (what I call insight-oriented psychotherapy) "leaves out those suffering from schizophrenia, substance abuse, dementia and mental retardation, or in other words the majority of chronic mental patients" (p. 19). In my book (2) I specifically note that "The criteria for one form of treatment or the other are more important than the diagnosis assigned to the patient." Thus, "... the possibilities of treating some schizophrenic patients, when in

remission, with insight-oriented psychotherapy are well known" (p. 30). And "In and of itself, the [DSM] clinical diagnosis is not the equivalent of a therapeutic diagnosis" (p. 29). This is a critical issue because it bears directly on the nature of supportive treatment, which I shall describe later.

The second section of Dr. Novalis' article raises questions of values and ethics in the practice of supportive psychotherapy. It is undoubtedly correct that the more the therapist intervenes, the more opportunity there is for the imposition of his or her values on the patient. Unfortunately, such non-therapeutic interventions are not limited to supportive psychotherapy; they occur in all treatment modalities, and must be guarded against no less carefully than, for instance, the influence of countertransference reactions on the treatment process.

It is in the third section of Dr. Novalis' paper—"The Fundamental Difference"—that I fear the author has gone astray. An appropriate and adequate response to many of his points would be far more extensive than the limitations of this letter permit. The crux of Dr. Novalis' argument, if I understand him correctly, is that supportive psychotherapy is "primarily" a form of "behavioral" therapy, in contrast to psychoanalysis and "psychodynamic psychotherapy" which alone are truly psychoanalytic in conception and practice. In support of this curious view, Dr. Novalis contends that: "Preventing a supportive therapy patient from committing suicide would seem to be a better accomplishment, at least from the behaviorist's perspective, than giving a person insight into his unconscious dynamics while he continues to abuse his spouse" (p. 27). (I presume that the last phrase of this *non-sequitor* was intended to read something like "... while he goes ahead and commits suicide"). But this is a crude caricature of insight-oriented psychotherapy and analysis. No reasonable psychodynamically oriented therapist would be limited to "giving a person insight into his unconscious" who was actually about to commit suicide.

More significantly, however, is that although Dr. Novalis quotes frequently from my book and related articles, he does not seem to have grasped my central thesis that supportive psychotherapy is an *application* of psychoanalytic concepts to a particular group of patients—a group which is characterized precisely from a psychoanalytic perspective. In this respect, it is typically because of failures in the developmental process that many patients in this group exhibit deficiencies in reality testing, impulse control, object relations, tolerance of mental pain, possess severely maladaptive defenses, etc. Accordingly, the goal of supportive psychotherapy is to shore up these deficient functions. These patients also have neurotic conflicts but these are usually of secondary importance in the treatment process.

Psychoanalytically oriented psychotherapists do not ignore or demean behavior (if one includes, as I do, expressed thoughts, feelings, dreams and fantasies, as well as perceptible acts). In fact, it is essentially by means of behavior that we make inferences about "the mind." I have explored this matter at length elsewhere (3).

Finally, Dr. Novalis' wish to set supportive psychotherapy apart from the insight-oriented modalities of treatment collapses under the reality that most psychotherapy, as he seems to realize, cannot be neatly dichotomized into supportive and insight-oriented modes. Both modalities are derived from the same psychoanalytic concepts: dynamic unconscious processes; drives and the consequent conflicts between pleasure and the demands of reality; an epigenetic developmental view; self and object representations; the ubiquity of transference reactions, etc.

There is much more that can and perhaps should be said about these issues, but as a guest I do not wish to overstay my invitation. I only wish to commend Dr. Novalis for bringing the subject of supportive psychotherapy to the attention of your readers.

David S. Werman, M.D.
Professor of Psychiatry
Duke University Medical Center

REFERENCES

1. Novalis, PN: What supports supportive psychotherapy? *Jefferson Journal of Psychiatry* 7(2):17-29, 1989
2. Werman, DS: *The practice of supportive psychotherapy*. New York, Brunner/Mazel, 1984
3. Werman, DS: The idealization of structural change. *Psychoanalytic Inquiry* 9(1):119-39, 1989

DR. NOVALIS RESPONDS TO DR WERMAN'S COMMENTS

To the Editor:

Dr. Werman's pioneering work on supportive psychotherapy is responsible for my own interest in the subject and has contributed to the national resurgence of interest on the topic. Therefore, it is an honor to receive his comments on my paper (1). At the risk of paying homage and taking umbrage in the same breath, however, I must respond to some of the challenges he raises.

First, I did not attribute to Dr. Werman the statement that psychodynamic psychotherapy leaves out the majority of chronic mental patients. However, I did think it was a rather direct consequence of the "recognized paradox" which he himself drew attention to in his book. Restated, one might say the best patients get much better and the worst patients get a little better. I agree with Dr. Werman that some schizophrenic patients (especially those in remission, as he mentions) can be treated with psychodynamic therapy. Despite some claims to success in this area (such as in (2)), the results of more carefully constructed studies (3) show a general advantage to supportive modes of treatment in most measures of outcome.

Second, Dr. Werman and I seem to agree that the ethical problems of supportive psychotherapy are not unique to that mode of therapy but are surmountable. I certainly did not wish to imply that psychoanalysis and psychodynamic therapy are value-free. Rather I wished to emphasize the dangers of supportive work in which the therapist rather directly imposes values upon the patient.

When I wrote this paper I recognized that my application of a behavioral label to supportive psychotherapy would be ideologically controversial. However, I do not feel it represents either a "curious view" or proof that I have "gone astray," as Dr. Werman contends. For example, my analogy of the suicidal patient and the spouse-abusing patient was not misprinted, and was meant to represent the unfortunate attitude of many psychodynamic therapists that intellectual insight is more important than (and a necessary prerequisite to) behavioral change. This analogy led to my concluding argument. It

is the primary emphasis on behavioral change which gives supportive psychotherapy its orientation.

Dr. Werman says that I have not grasped his "central thesis that supportive psychotherapy is an *application* of psychoanalytic concepts to a particular group of patients." He implies that if I had grasped it, I would have agreed with it. Perhaps I look and do not see, but I grasp it and disagree. There are fundamental theoretical differences between psychodynamic and behavioral approaches, the most obvious being the former's approach of referring behavioral dysfunction to the operation of conflicts within a specified psychic apparatus. Instead of treating psychopathology from the inside out by unraveling the mental end of the patient's "Gordian knot," the behavioral therapist attempts to work with the exterior strand. There is only one knot and one rope, but the approaches are quite different.

Since it is unlikely that we will unravel our ideological controversy in this brief exchange of letters, I will stop at this point with the hope that our differences have underscored the importance of further work on the techniques and basis of supportive psychotherapy.

Peter N. Novalis, M.D., Ph.D

REFERENCES

1. Novalis PN: What supports supportive psychotherapy? *Jefferson Journal of Psychiatry* 7(2):17-29, 1989
2. Karon BP, VandenBos GR: *Psychotherapy of Schizophrenia: The Treatment of Choice*. New York, Jason Aronson, 1981
3. Gunderson JG, Frank AF: Effects of Psychotherapy in Schizophrenia. *Yale J of Biology and Medicine* 58:373-381, 1985