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## PSYCHOTHERAPY WITH THE BORDERLINE PERSONALITY

DEAR SIR,

I would like to respond to Dr Sidney Crown's article "Contraindications and Dangers of Psychotherapy", (*Journal,* November 1983, **143,** 436–41). I do so as a general psychiatrist with some experience of psychotherapy, particularly in a University City, where we seem to see an over-representation of the so-called borderline personality disorder.

Dr Crown, in his article, suggests that working with borderline people is quite difficult and can lead to negative effects in psychotherapy. This touches on a particular dilemma for myself which I have not yet been able to resolve.

It seems to me that such individuals, in terms of Anthony Storr's article published in the same edition of the *Journal,* are suffering from early profound loss and rejection to such an extent they form as adults an anxious attachment when they believe they have found someone who may be able to help them. The very qualities of empathy, warmth and genuineness which are now held to be desirable qualities in a therapist, are the ones to which such borderline individuals respond with an anxious clinging. My experience is that even in the very first assessment interview such borderline individuals may perceive the therapist as transparent rather than opaque, as accessible rather than distant, and genuinely concerned with the "real person" which the patient feels is locked up inside themselves, to such an extent that sadly there is little room for the tactical manoeuvre Dr Crown suggests, of setting up a number of trial interviews to see whether they are really going to be able to work in therapy. I find that these people can form such an anxious attachment, even during the first interview and that any attempts to structure further contracts along the lines Dr Crown suggests are liable to be experienced by them as lack of caring or as rejection. As a result, they do put considerable pressure on the therapist to continue to be available to them, and almost at once the transference begins to develop.

The subsequent management and resolution of the transference is vital to the therapy with such patients, and as Anthony Storr points out, therapeutic work with such borderline individuals often takes a considerable period of time until they are able to incorporate the "good" aspects of the therapist, and so begin to build up their own internal self esteem. I would be interested to hear if colleagues find themselves faced with the same dilemma and if so, how they feel the dilemma might be resolved.

A. R. K. MITCHELL

*Fulbourn Hospital*
*Cambridge CB1 5EF*

## EUGEN BLEULER AND SCHIZOPHRENIA

DEAR SIR,

I would like to comment on the interesting article by Professor Hoenig (*Journal,* June 1983, **142,** 547–56).

Eugen Bleuler (my father) never thought that he had a better conception of the diagnostic criteria for schizophrenia than Emil Kraepelin, for whom he had the highest respect. Bleuler also agreed with Kurt Schneider in so far as he considered Schneider's main symptoms to be important and frequent schizophrenic symptoms. Bleuler, however, stressed the importance of a basic clinical experience more than Schneider: the experience that not a single psychopathological symptom exists which is present in every schizophrenic—and that there is no symptom in schizophrenics which might not also occur in other psychoses. Decisive for the diagnosis of schizophrenia were for Eugen Bleuler never one or several individual symptoms but the whole psychopathological picture together with the circumstances under which the syndrome had developed. To characterize the schizophrenic psychopathology in brief, Bleuler would formulate:

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|---|---|---|
| the dissociation<br>the splitting<br>the disharmony<br>the overwhelming ambitendence | in | speaking<br>thinking<br>feeling and<br>acting |

If Bleuler did not differ essentially from Kraepelin in regard to the diagnosis of schizophrenia—in what other way did he develop Kraepelin's great concept? The mere introduction of another name for the disease was certainly not important for Bleuler as some have speculated. The main contribution of Eugen Bleuler to the problem of schizophrenia was to favour the study of what was going on psychodynamically in a schizophrenic patient. He helped to introduce psychodynamics in research on schizophrenic psychoses, and therefore created a basis for a psychotherapeutic and psychosocial approach. This endeavour had its roots in a mission given to him as a boy by the simple country people around him, including his parents. They cherished the idea that some young man with their own background would be more successful in understanding the mentally sick, and feeling with them, staying with them—and helping them—than the aristocratic doctors of their time.

Eugen Bleuler's main conclusion from his experience with schizophrenics was that it was possible to

understand the hallucinations, delusions, and thoughts of schizophrenics; in fact, all their psychotic symptoms, in connection with their wishes, hopes, fears and their whole personality development. This understanding helped him in his psychotherapeutic and psychosocial work with schizophrenics. Yet, although Eugen Bleuler reached a psychological understanding of the psychopathology of the individual patient, he was too modest and critical to maintain that he had discovered the real nature, origin and etiology of schizophrenia. He agreed with Kraepelin that at that time all this was very enigmatic. I personally am convinced that today (after half a century of new research since Eugen Bleuler's and Kraepelin's time) the nature, origin and etiology of schizophrenic psychoses have become much less enigmatic and are much better understood. This is not the place, however, to discuss the overview of present-day knowledge.

Stressing the interest in the psychodynamics of schizophrenics and in the possibility of psychotherapeutic and psychosocial help was Eugen Bleuler's main contribution to the problems of schizophrenia. We must not forget, however, that he introduced still other and important trends in the discussion: he rebutted the dogmatic idea that schizophrenia was a disease entity. He showed that what was called the "dementia" of schizophrenics could be understood by the patient's life experience and in particular by the reactions of healthy people to the patient's condition. He also introduced the concepts of ambivalence and autism which became important both for the psychopathology of the schizophrenic and for general psychopathology and psychology.

M. BLEULER

*Bahnhofstrasse 49*
*CH-8702 Zollikon/Zürich*
*Switzerland*

DEAR SIR,

Professor Manfred Bleuler throws new light on his father's motivations for taking his particular approach to the study, interpretation and treatment of schizophrenia. I was pleased to find that he, from his personal knowledge of the background, could confirm my own conclusions gleaned only from the literature about the essence of E. Bleuler's work. He (Eugen), his family and most of the local people had little confidence in the "aristocratic city doctors", because they felt these doctors could not communicate with the patients, mostly humble local people, nor understand them. They were more interested in brain anatomy and pathology at the expense of the general human concerns of the patient.

To overcome this deficiency he concerned himself more with the psychology of his patients, and so developed his own concept of the illness. Large aspects of the illness—not only the patients as people—became to him psychologically understandable. So much so that his new concept was criticized as an overextension of the method of empathic understanding.

Perhaps so; but there can be little doubt that Bleuler's work had opened doors and was stimulating. Professor Stengel once reminded us how much Swiss psychiatry had contributed to the study of schizophrenia, and few more so than the two Bleulers. I have never heard schizophrenia called the "Swiss illness", although this would indeed have its justification, but I have more than once heard it referred to as "Bleuler's disease".

J. HOENIG

*Clarke Institute of Psychiatry*
*250 College Street*
*Toronto M5T IR8*

## HEADACHES, DEPRESSION AND 5-HYDROXYTRYPTAMINE

DEAR SIR,

Garvey *et al,* (*Journal,* December 1983, **143,** 544–7) reported that patients with a major depressive disorder had a significantly higher headache rate than the same patients in a euthymic phase. The incidence of headache in these patients was similar to the incidence observed in a group of normal controls. The authors suggested that the association of headaches and depression might be related to abnormalities of 5-hydroxytryptamine (5-HT). These results prompted us to examine retrospectively several separate lines of research that we have undertaken. We have not been able to show a significant difference in the incidence of headache between drug-free patients suffering from a major depressive illness and normal controls (Abou-Saleh and Coppen, 1983). The only patients in a euthymic phase whom we have studied are those who have suffered from recurrent affective illness and who, at the time of testing, were receiving prophylactic lithium treatment. These patients complain significantly less of headache than the drug-free depressed patients and even than controls. These findings are in agreement with reports (Mathew, 1977; Kudrow, 1977) that lithium might be useful in the treatment of migraine and cluster headache.

Garvey *et al* have suggested that 5-HT abnormalities may be responsible for the association between headaches and depression, and we have experimental evidence from studies in patients with a major depressive disorder and in patients with migraine to suggest that such abnormalities exist in both depression and migraine.