Please note: The following article is based entirely on the fictional character of Howard Hughes as portrayed in the movie, The Aviator. It is not an official diagnostic opinion of the historical individual.

As portrayed in The Aviator, Howard Hughes presents an efflorescence of psychiatric diagnoses. For any psychiatrist in the audience, the movie is a busman's holiday. We first encounter the adult Howard Hughes as the supreme instance of a narcissistic personality disorder for whom the sky is no limit. Oblivious to the needs and feelings of others, he pushes through one grandiose scheme after another and accomplishes amazing feats, whether of aeronautic design, flying, corporate manipulation, or movie-making. But soon we learn that he can't enjoy the celebration of success. As his euphoric employees toast their shared achievement, he is driven by agonizing perfectionism to disrupt the party, to demand one more modification or revision, to push on for even greater triumph. His torment brings to our diagnostic mind obsessive-compulsive disorder, an impression reinforced by a host of rituals and avoidances, down even to his inability to dress appropriately for his elegant party. And in crucial situations he demonstrates uncontrollable tics and utterances, and falls apart in full-blown panic attacks—so we add panic disorder and maybe Tourette's to the list.

The grandiosity and omnipotence drive him on relentlessly. His boundless energy and total disregard for reasonable limitations, whether financial, mechanical, or human, begin to spell out mania in our minds. He ignores the strict instructions of his engineers in test flights that end disastrously. Miraculously he survives, though severely injured in the second spectacular crash that is portrayed in excruciating detail. Perhaps a terrible guilt associated with success, we wonder, could be driving him to glorious self-destruction. His profound, regressive major depressions complete the diagnostic cycle and we think this has to be a full-blown bipolar disorder.

A growing paranoia compounds the picture—hallucinations appear, along with persecutory ideas and delusional states. Is he schizoaffective? we wonder, especially as he deteriorates to a naked, primitive, reclusive self-imprisonment, drinking bottle after bottle of milk and filling the empty bottles with urine. Then, from his terrorized, wildly obsessive-compulsive, probably delusional, regressed state—under the tender but firm direction of Ava Gardner, one of the women who unaccountably love him—he emerges to defend himself brilliantly against a powerful, predatory senator in the full glare of public attention. From almost certain defeat he snatches triumph. On he goes to another grandiose scheme, the largest airplane in the world—built of wood. We leave him in a regressed state again after its maiden and only flight, and we anticipate that his story ends badly.

But our diagnostic thinking does not end there. Glimpses of his childhood relationship with his mother suggest insatiable longing for maternal admiration and nurturing. Women respond to his grandiosity and seductiveness, and several genuinely care for him, leaving only when they can no longer stand his self-absorption and cruel indifference to their needs. Those of us who are psychoanalytically inclined think about his array of primitive defenses and his developmental arrest somewhere along the way from phallic narcissism to longed-for and dreaded oedipal triumph, with its dangers of vengeful emasculation or loss of self through merger with the mother in an infantile narcissistic state. Indeed, the movie gives us flagrant evidence of his mother's seductive, adoring behavior with him and his grandiose promise to her as a child to build the biggest airplane, make the greatest movie, and become the richest man in the world. Fulfilling those promises in real life provokes extreme reaction formations that account for his self-punitive behavior that destroys the celebrations. New meaning also accrues to his compulsive hand-washing, a repetition from childhood even to using the same soap dish that his mother used when she warned him of being in danger of infection from other

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people—which also relates to his paranoid expectations that people will attack him. Katherine Hepburn stumbles onto this while washing his injured foot, as she forewarns him of the dangers of being famous. This and her telling of her brother’s suicide prompt him to reveal that he has sometimes had hallucinations, a rare moment of insight. Her leaving him for Spencer Tracy precipitates an acute psychotic episode. The symptoms now have meaning in the context of his life-long history of emotional relationships; they are no longer just signs of a biological aberration.

The whole exercise makes us mindful of the limitations of DSM-IV. Does this man suffer from five or six different Axis I disorders plus a severe Axis II disorder? Does he have six diseases or one? Does anything on that list really tell us about this suffering human being and how his illness works? We of course handle this dilemma with the concept of comorbidity, but this still implies the impracticality of six comorbid disorders. DSM-IV or its predecessor is a way to describe or categorize the patient, but it does not capture the unitary nature of a complex, coherent, evolving psychopathological process manifested by a host of symptoms and behaviors. It certainly gives no clue to the biological, psychological, and environmental forces that underlie those symptoms and behaviors. A meaningful formulation of Howard Hughes’ illness would have to be a complex, multifactorial, and highly individualized thesis. Reducing such a patient to a single specific diagnosis for which there is a specific treatment is clinically unworkable. An integrated basis for treatment must address the whole person with a fundamental process producing a plethora of symptoms and behaviors.

That brings us to treatment. Despite his narcissistic and often unintentionally cruel lifestyle, Howard Hughes—the man—evokes compassion and concern. Some psychiatrists in the audience were undoubtedly murmuring, “I’m glad he’s not mine!”—while others may have thought about how much tragedy and waste of genius could have been avoided with the effective treatment they could have provided, and most of us probably reacted in both ways. The foundation of such treatment would have to have been a strong, enduring therapeutic relationship, no small feat either to establish or to maintain with this man. The first huge challenge would have been to achieve a degree of insight—realistic confrontation with the fact that he is ill and needs treatment.

But specificity is no more meaningful a concept for treatment than for diagnosis. Even the medications we would consider are nonspecific. Antipsychotic medications would be valuable whether he had bipolar disorder, schizoaffective illness, or paranoia. Among the mood stabilizers, only lithium is really specific to one disorder—bipolar—although it is sometimes used off-label to augment the treatment of depression. The array of other mood stabilizers started their pharmaceutical life as treatment for seizure disorders. Would we consider a selective serotonin reuptake inhibitor or a serotonin norepinephrine reuptake inhibitor for his depressions, managed carefully to avert rebound mania? They would also be useful for his obsessive-compulsive disorder and his panic attacks. In fact, if they are specific treatments at all, they are specific for a common cluster of symptom states—depression, anxiety states, and obsessive-compulsive features—that perceptive psychiatrists of a previous generation collectively called neurosis (ah! the N-word!) Future generations are starting to think of disorders in terms of neural circuitry and neurotransmitter malfunction—a whole new kind of specificity—in which malfunction may be a result of genetic inheritance or the effects of faulty emotional development or neural damage resulting from stressful life events. The specificity of DSM-IV thinking is a crude and superficial approximation of what really defines the essence of a patient’s fundamental illness. In a spectrum of real-world people with psychiatric disorders, I suspect that more of our patients lie towards Howard Hughes’ end of it than at the opposite end where one finds the carefully scrubbed patients with one diagnosis and no comorbidities for whom the efficacy of “specific” treatments is assessed.

In recent years, a series of well-designed studies have established the efficacy of specific psychotherapies for specific disorders—for example, cognitive-behavioral therapy and interpersonal therapy for depression or dialectic behavior therapy for borderline personality disorder. Tweaking these structured treatments that focus on conscious mental life to apply to other specific disorders has shown that they are helpful—in the short-term at least—in modifying a variety of conditions. Because the studies are designed according to the standard randomized, manual-based, controlled, double-blind formula for highly selected patients, these treatments now appear as evidence-based treatments for specific disorders in practice guidelines.

Psychodynamic therapy does not fare so well, because the preferred randomized controlled trials have not been done. (Exceptions: one such study of manual-based psychiatric treatment of panic disorder is underway, after a highly successful open trial, and psychodynamic therapy is recognized in the APA practice guideline as a specific treatment for borderline personality disor-
Extensive studies have shown that short-term psychotherapy is effective, but that significant differences in efficacy between specific psychotherapies for a variety of conditions cannot be demonstrated. It would be appropriate for evidence-based guidelines to take those findings into account. Longer-term efficacy of psychodynamic therapy gets tested every day in real-life practice as we keep our more chronic neurotic patients functioning and help them gradually overcome their illness, but no one has figured out how to design a randomized, controlled study that covers many years of treatment. Controlled evaluation of the long-term efficacy of any specific treatment administered over many years of chronic mental illness presents huge challenges in design and funding.

The great advantage of psychodynamic approaches is their flexibility, supported by a multidimensional theoretical framework that adapts to the immense variety of human mental life. For example, with some of my bipolar patients, I need only to provide them with a relationship, medication, psychoanalytically informed education and support, and most importantly to be there when they begin to sense the onset of an episode. With others, the supportive relationship is profound, and many hours of psychotherapy are needed to deal with emotional issues of long standing that aggravate and interact with the bipolar disease.

The widely practiced psychotherapies have much in common with each other. Ingenious studies by Ablon et al. have demonstrated that the efficacious elements in a psychotherapy are not necessarily those that the practitioners of a particular type of psychotherapy identify as the essential elements of that therapy. Freud used what we would call behavioral techniques in the treatment of phobias, and CBT therapists sometimes help patients see the roots of their maladaptive automatic thoughts in their earlier life history. The important thing is that psychotherapy be available to every patient in need of it, individualized to the particular qualities of that patient.

But what about Howard Hughes? Could you or I have caught him in one of his more distressed extreme states and persuaded him to use therapy to feel better and preserve his relationships and his ambitious projects? Might medication have brought him enough under control to engage reasonably in talk therapy, which could calm his torment, unravel his fears, help him understand and curtail his repetitive, self-destructive episodes, or even allow him to enjoy success? Could he have worked through the relationship with his obsessive, fearful, seductive mother enough to put it in the past and have a stable and mutually caring relationship with a woman? Could he have been content with anything less than the idealized “greatest in the world”? What products of his brilliant mind and powerful leadership might then have emerged to benefit mankind? We’ll never know, of course.

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References