RECENT CHALLENGES OF PSYCHOANALYTIC THERAPIES

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Whoever is interested in psychotherapic practices will not fail to hear this frequent advice coming from authors claiming to give credit to „evidence-based techniques": psychoanalysis is not „in" any more; new techniques have shown greater efficacy at lower cost. As we will see, not only have these assumption proven to be flawed, but also, this kind of viewpoint seems tightly related to the prevalence of recent tendencies in the apprehension of psychopathology. One can wonder whether theses tendencies represent a significant progress.

Until recently, psychopathology kept trying to be an adequate and a consistent domain (that is, to give an accurate description of the current knowledge about symptoms and a fair discussion of the possible aetiologies). But in the last decades, more lateral approaches have prevailed. A common trait of these approaches is that both consistency and adequacy have been discarded: the subtleties of inner pathological experiences are left aside to the profit of one-sided techniques.

Until recently, most authors accepted to discuss such fundamental theoretical frameworks as the classification models, the sydenhamian model, the process model, the continuist and discontinuist models of psychopathology; the syndromist model and the theory of clinical types; the models opposing a deep structure and phenomena; organicism, sociogenesis and psychogenesis; this is no longer the case. Psychiatric symptoms were classified in function of their severity, and their complexity inspired to clinicians a feeling of humility. Brilliant psychopathological systems, like Kraepelin's theory, had given little results; Karl Jaspers had proclaimed that it was too presumptuous, only to find that his own principles would prove insufficient to account for disorders like paranoia. Psychoanalysis has from the start accompanied the slow progress of psychopathology; almost all the neuroses and personality disorders have been defined by this discipline, which refused to proclaim the existence of a distinct

„normality", showed humility concerning its results, did not hesitate to discuss failures (including „negative therapeutic reactions"), and encouraged practitioners to envisage their own insufficiencies before charging the patients' resistances. Even if their results were quite comparable to those of organic physicians, analysts generally showed modesty and refrained from pretending to promote general happiness, conscious that this was too intimate and complex a matter to be measured by usual standards, especially in terms of the capacity of the patient to accept happiness. Even if frequent references were made to the sciences (and all of them), psychoanalytic technique was considered to be more an art than a science, a view which in no way seemed derogatory. Seven recent paradigms have attempted to put and end to this, and are currently considered as „mainstream". In the following lines, we shall examine them and discuss their pretensions to account better for the clinician's task.

1. Psychological symptoms are currently presented as industrial opportunities. What is required is the social identification of a mental suffering or disorder, and the announcement that a certain substance or technique is liable to produce a quasi miraculous healing. It is well-known that some pharmaceutical drugs have benefited from enthusiastic presentations in the US press, even if the research concerning them showed little or no difference from the effect of placebos (as in the case of SSRI antidepressants) (Kirsch) or preoccupying addictive effects (as in the case of attention-deficit disorders „enhancers") – in France some „quick methods" for treating traumatic symptoms have also benefited from a cheerful press promotion in spite of the modesty of their results. The high frequency of these journalistic promotions does not shock anybody anymore. The only limit drawn to these enterprises is the eventuality of scandals – usually, the death of patients. The peculiarities of these practices have been carefully documented by authors like David Healy or Peter Breggin, but curiously enough, the protests raised have mostly been identified with „partisan" point of views. In fact, this approach of symptoms is currently seen as inevitable; complementarily, patients are often referred to as consumers, even if a wide majority of them (especially the persons with the most severe pathologies (Narrow WE & al. 2000) refuse to be considered as such. The fact that this approach is tolerated for economical reasons should not mean that it is scientifically or even practically justified.

2. Psychological symptoms are considered in terms of risks: this view, initiated by health insurances specialists, has immensely percolated into public preoccupations. From this point of view, psychopathological symptoms have no kind of specificity, and they are simply envisaged alongside cardiovascular diseases, drug or alcohol consumption, cancer, etc. The only questions asked are how much is this bound to cost, who will take responsibility for the expenses, how

it is predictable, and consequently more or less preventable. Although these issues are quite fascinating, the prevalent view is that the „risk" cannot be anything else than a factor of economical benefit or loss. Consequently, the idea has prevailed that ready-made comparisons can be done: clinicians were encouraged to promote the techniques promising the fastest and cheapest recovery. A huge proportion of the research on psychotherapies focused on „evidence-based" studies, centered on virtual therapeutic situations assimilated to drug prescriptions, discarding the more demanding investigation on realistic processes in actual psychotherapies. In the meanwhile, „cognitive techniques" drawing on simplified psychoanalytic models (Kandel 1998) had been promoted; they were initially classified together with „psychodynamic therapies", but finally their promoters chose to merge them with behavioral techniques; these techniques included procedures in which patients were persuaded to evaluate their own sufferings according to ready-made scales and to adhere to the values advocated by their „trainers". In the flow of publications produced along these lines, manualized cognitive-behaviour therapies were presented as doing comparatively better than psychodynamically oriented treatments, until researchers tried to know whether the alleged results were enduring. Several „fast techniques" have thus been shown to be of modest efficacy. In an extensive 2005 investigation on long-term outcomes of patient with anxiety and psychotic disorders benefiting from BCT, Durham et al (National Health Service, UK) found that the alleged favourable results did not persist in the long run, that the ameliorations were at best modest in anxious cases and practically impalpable in psychotic cases, and that the number of relapses had been heavily underestimated. An increase in the number of sessions brought no overall improvement. On the other hand, research on the outcome of long-term treatments of similar patients with psychodynamic therapies showed favourable results (Leuzinger-Bohleber).

3. Within the framework of the sociological school of Chicago (Erving Goffman), mental symptoms came to be understood in terms of social stigma, characteristic of an extreme class of disadvantaged individuals; stigmatization was understood to be a means of maintaining a sort of „military reserve", in the terms of Friedrich Engels. This concept has undergone various modifications as it was inserted in the domain of cognitive psychosociology (Corrigan) and medical sociology (Link & Phelan). Whatever the merits of theses elaborations may be at the service of ailing individuals and disadvantaged groups, it is quite clear that their connection with psychopathology is somewhat loose, as they content themselves with the evaluation of social acceptability or rejection, i.e. the empowerment of stigmatized individuals, usually avoiding to evaluate the respective momentum of social versus purely psychopathological factors, let alone the possible interference between both. The immense popularity of

„self-diagnosis" on the basis of so-called „internet information", inviting surfers to self-label what they may be suffering of, has changed many „self-help groups" into lobbies craving for social recognition.

Individuals are publicly invited to join survivors associations, most of the time at the expense of personal privacy and sound psychopathological science. Many of these lobbies have been instrumentalized by commercial and industrial interests, happy to see that the drugs or techniques they propose can thus find a ready list of consumers. Several controversial labels, such as „multiple personalities" (Sauvagnat 2001), Attention Deficit with hyperactivity, etc., have thus been operationalized by powerful industrial interests (Breggin), and a growing number of „survivors" nowadays confront clinicians with unwarranted but highly structured demands.

4. Diagnosis has become a perilous exercise at a time when the categories of the DSM are publicly voted for or against by assemblies of the American Psychiatric Association influenced by various lobbies (Vedantam), instead of being carefully documented by scrupulous research. As a result, the significance of categories that took decades to be carefully elaborated has been lost sight of and new categories have been hailed inconsiderately. Neuroses have been declared inconsistent and sliced into „personality disorders" and „disorders"; some categories, like „pervasive development disorders", have pervaded into an uncontrollable spectrum, to such a point that it is not unusual to see, in the U.S., judges decide who shall or shall not receive the corresponding diagnosis and financial support. Childhood bipolar disorders have become a frequent diagnosis in the same geographical regions, whereas this category is seen as aberrant in other continents, where the prescription of thymo-regulators before teen age is conceived as a dangerous practice. And most of all, the issue of co-morbidity has been totally underestimated. It is not rare to see most of the DSM categories present a co-morbidity of more than 50%, a figure that can well exceed 80% in the case of ADHD.

5. An important proportion of the historical research in the domain of medical sociology has repetitively followed the „paradigm" of „institutional motives". Ignoring the fact that clinicians will usually try to heal their patients, and inspired by R Kuhn's triumphant theories, theses researchers have decided that the use of clinical categories or therapeutic techniques is mainly a question of power. Individual motives were thus considered as being of little relevance, as compared to the idea that competition between „scientific groups" and downright ambition will always structure the personal implication of a man, no matter what his scientific engagements may be. As a result the history of clinical categories, for instance monomania, has been drained of their practical significance; the human conflicts have been seen solely as conflicts of

power, to such an extent that the succession of concepts has become an inconsistent series, „full of noise and fury". It doesn't seem to occur to some of these historians that the original definition of monomania, i.e. partial madness, could have some sort of practical and clinical meaning. The history of clinical research and practices is now seen as an evolutionist domain, and the survival of the fittest is conceived as its only prevailing law. History, at the turn of the 19th century, had become a critical domain, in the sense of the Neo-kantians; a century later, it seems to have become the mere justification of industrial strategies. Amazingly few clinicians (for instance Berrios) dare to counter these unwarranted pretensions.

6. A curious alternative has recently appeared on the scene: as the personal motives of clinicians and researchers were no longer understandable, could they not simply be understood as evil? A curious sect has recently come forth, pompously dubbing themselves „Freud scholars", who pretended to track down the real motives of the creator of psychoanalysis: Freud simply wanted his patients to get worse. Animated by tenebrous instincts, craving to win social recognition, devoid of minimal human sensitivity, Freud is portrayed as having lied on his results and on the biographies of his patients. The complexity of cases, the complexity of symptoms, could thus be reduced and simplified into an all-pervading doubt. Hasn't he expressed doubts on his own capacity as a therapist? Hasn't he declared that he was „like Moses"? Freud's doubts could then be reduced to a horrible secret, that of a wicked man. Nowhere have the „resistances against psychoanalysis" expressed themselves so crudely as in the recent conspirationist prose of the „Freud bashers". But the very fact that most of them come from a precise cultural domain can be taken as a precious indication of the value of their criticism. In a famous book, a Canadian historian of psychiatry, Edward Shorter, remarked that psychoanalysis has never really been welcome in the USA, and that in spite of what has been frequently stated, it has never been deeply accepted outside „Jewish and Feminist circles". The gross exaggerations that are so frequent in the rhetoric of the Freud-bashers can rightfully be considered as a trademark of a certain form of ethnocentrism, especially in some North-American protestant circles. Freud's insistence on the role of sexual drives, the way he valued confession, his attacks on religions, his views on ethics, frontally contradicted this puritan and predestinationist tradition. The very fact that other cultural domains avoided to criticise his theories too frontally, and even, in the case of West-European liberal Christianity (French Catholic and Reformed and recent German Katholische and Evangelische Kirche), significant portions have repetitively tried to reconcile their doctrines with Freudianism, can also be seen as a confirmation of this suspicion.

7. Biological research has dramatically developed in the last decades, opening new fields of research but giving little unambiguous results. In a domain that traditionally overlapped psychological and biological research, psychosomatic symptomatology, it has become usual to consider disorders in terms of neuro-psycho-endocrino-immunology, as the main regulation systems of the human body have proven to be deeply connected with each other. But such a complex approach probably sounded discouraging to researchers eager to touch a wide public, and the reductionist approaches, popularized by the mass-media (the „discoveries" of dozens of „candidate genes" have been trumpeted to be the „cause" of mental diseases in the last two decades, with hardly more positive result than ideological discourses encouraging political deciders to pour more funds into biological research) have failed to demonstrate clear-cut causalities in most cases. A notable quantity of biological research has therefore adopted a „lateral" strategy, in their attempts to establish a „forced relationship" between a psychopathological phenomenon and a single biological mechanism. In this kind of reductionist approach, researchers content themselves with establishing a link between the activation or inactivation of a certain cerebral region and a known pathology to declare that they have found the biological cause of this disorder, which should eliminate alternative explanations. This „result" is then „proclaimed" by an opportunistic press campaign. Recently, a researcher has claimed to have discovered that autistic individual showed a characteristic activation of the temporal region, discarding at least four already available alternative explanations, and even considering that her „results" should allow political deciders to fund „ sensory training programmes" of autistic children, and refuse such fundings to psychotherapies aiming at establishing intersubjective relationships and better emotional regulation. In this case, this researcher clearly considered that she had a right to „prescribe" certain techniques, even if their evaluations had already proven that they were flawed.

We can easily divide these paradigms in two kinds: some are tainted with relativism, others can rightfully be called reductionist. Reductionism has allowed organic medicine to boast significant results, for instance in the domain of neurology and oncology; but to what extent can it be applied to psychopathology? As long as the neurosciences do not yield more uncontroversial outcome in this latter domain, there is no sound reason to consider that the more realistic „bio-psycho-social" model (Engel), and its psychosomatic correlate, neuro-psycho-socio-immunology, or the Lacanian models integrating the highly individualistic issue of jouissance (intimate, sexual body-structuration) and the psychopathological effects of social discourses should be discarded. Psychic matters in general resists to reductionism, especially in the psychotherapeutic domains. Rigid prescriptive psychotherapeutic programmes ("trainings") achieve little success and are frontally confronted to negative therapeutic reac-

tions, as Durham's groundbreaking research has shown. Nevertheless, they continue to be hailed and prescribed for perfectly cultural reasons. For instance, in the case of adolescent psychopathology, North-American practitioners are encouraged to prescribe drugs (generally prohibited in the UK), and to apply behaviour-cognitive programmes of desensitization, self-esteem improvement and aggressivity control, although these have proven to be less effective than antidepressants, which in their turn have shown to produce less results than…placebo! The fact that the more versatile psychodynamic psychotherapies have proven to produce better effects (Fonagy & Target 1998) is curiously not taken in consideration, and it would be difficult not to admit that cultural motives do not play here a predominent role.

Such cultural factors are even more striking in the case of Attention Deficit with Hyperactivity. In the US, practitioners have been encouraged to prescribe Ritalin (a substance close to cocaine) to children presenting with this sort of disorders, and even to shift to mood regulators in case of failure, the practice of cognitive-behavioural therapies being presented as optional. In the UK practitioners are discouraged to give attention-regulating drugs to the children and encouraged to send the parents to behavioural „parenting programmes"… (Sauvagnat 2006)

To these two current mottoes, relativism and reductionism, we would like to oppose two others: complexity and socio-cultural determination, two traits constantly underscored by European psychoanalysis. A psychopathological theory that does not acknowledge a sufficient degree of complexity in the human psyche simply misses its goals, and does not prove anything else than the narrowness of its own socio-cultural determinations. The stress currently put on „control" in „manualized" psychotherapeutic practices has shown its limits. The focalization on „social risks" has tended to silence the fact that clinical terminology is nowadays socially determined and prescribed, as F Erős has demonstrated about holocaust trauma, the labelling decisions may have very little to do with the intensity of the ailments (Erős 2006). The same restrictions have also tried to silence the fact that behind and alleged symptomatology, a huge diversity of subjective fantasies and unconscious positions can be found. As J Lacan (inspired by the founder of the theory of probabilities, Blaise Pascal) has shown in his seminar D'un Autre à l'autre, a subject should be seen as a gambler, as a pawn in the game of the Other, as a stake within his family, as a party in an ordeal trial. This is what unconscious fantasies are about. There is absolutely no reason to consider that patients should be any simpler than poker players.

If the use of simplified methods has always been an admissible practice, one should not oversimplify human subjectivity; conscionable clinicians should not pretend that simplifying methods will simplify humans. As Kandel has shown, practically all simplified psychotherapies have been inspired by psychoanalysis

– at least for ethically acceptable psychotherapies – in an attempt to respond to social demands. But symptoms are also a protest against social demands. There is no sound reason why conscionable practitioners should not turn to psychoanalytic strategies that have not been manualized.

REFERENCES

American Psychiatric Association (1994), *DSM-IV R*.

BREGGIN, P.–BREGGIN, G. (1994). *Talking Back to Prozac.* New York: St. Martin's Press.

DAVIDOFF, F.–HAYNES, B.–SACKETT–SMITH, R. (1995): Evidence-based medicine, *British Medical Journal*, 310: 1085–1086 (29 April).

DURHAM, R. C.–CHAMBERS, J. A.–POWER, K. G.–SHARP, D. M. (2005): Macdonald RR, Major KA, Dow MGT & Gumley A: *Long-term outcome of cognitive behaviour therapy clinical trials in Central Scotland, Health Technology Assessment*, NHS R&D HTA Programme, November.

ERŐS. F. (2006): Effets psychologiques a long terme du trauma de l'holocauste: resultants de recherché et choses vécues, to appear in *Psychologie clinique*, Numéro thématique Le trauma, aspects cliniques, éthiques et politiques, nov.

FONAGY, P.–TARGET, M. (1998): *The outcome of psychodynamic therapy: the work of the Anna Freud Centre*. Invited public lecture, London, England, September.

HEALY, D. (1997): *The antidepressant era*. Cambridge (MA): Harvard University Press.

KANDEL, E. R. (1999): Biology and the future of psychoanalysis: A new intellectual framework for psychiatry revisited. *Amer. J. Psychiat*. 156: 505–524.

KIRSCH, I.–MOORE, T. J.–SCOBORIA, A.–NICHOLLS, S. S. (2002): The Emperor's New Drugs: An Analysis of Antidepressant Medication Data Submitted to the U.S. Food and Drug Administration*, Prevention & Treatment*, Volume 5, Article 23, July 15, 2002 American Psychological Association.

KIRSCH, I.–SAPIRSTEIN, G. (2002): Listening to Prozac but hearing placebo: a meta-analysis of antidepressant medication, *Prevention and Treatment*, American Psychological Association, Vol 1, article 2002a.

KUHN, T. S. (1962). *The Structure of Scientific Revolutions*. Chicago: University of Chicago Press.

LACAN, J.: *D'un Autre à l'autre*, Paris, Seuil.

LEUZINGER-BOHLEBER, M.: Stuhr, U.; Rüger, B.; Beutel, M. (2001): Langzeitwirkungen von Psychoanalysen und Psychotherapien. Eine multiperspektivische, repräsentative Katamnesestudie. *Psyche – Z Psychoanal* 55: 193–276

NARROW, W. E.–REGIER, D. A. (2000): Norquist G Rae DS, Kennedy C, Arons B: Mental Health service Use by American with Severe Mental Illnesses, *Soc Psychiatr Psychiatr Epidemiol,* 35: 147–155.

SACKETT–RICHARDSON (1996): EBM: what it is and what it is not, *BMJ* 1996, 312:71–72.

SANDELL, R.–BLOMBERG, J.–LAZAR, A. (1997): When reality doesn't fit the blueprint: doing research on psychoanalysis and long-term psychotherapy in a public health service program. *Psychotherapy Research*, 7, 333–344

SANDELL, R. (1996): *Repeated Follow-up of Long-term Psychotherapy*, Stuttgart Kolleg. February.

SAUVAGNAT, F. (2001): *Divisions subjectives et personnalités multiples*, Rennes, Presses Universitaires de Rennes.

SAUVAGNAT, F. ET AL. (2004): *Principios de psicopatologia psicoanalitica*, Madrid, editorial sintesis, 790 p.

SAUVAGNAT, F. (2005): Recent tendencies in the psychopathology of disturbed children, to appear in *Proceedings of the Conference of the European Society for the History of Psychiatry*, Paris, november.

SHORTER, E. (1997): *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*. New York: John Wiley & Sons.

VEDANTAM, S.: *Experts Defining Mental Disorders Are Linked to Drug Firms*, Washington Post.