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Keynote Address

"Chronicle of a death foretold": the end of psychotherapy.

By Paul Verhaeghe

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Abstract

My generation has lived in the heyday of psychotherapy and we may see the demise of it as well. The confluence of three issues threatens the vitality of psychotherapy and may prove lethal: The rise of protocol-based treatments makes psychotherapy much less efficient and will reinforce a pharmacological approach; The contemporary social discourse installs the idea that everyone should receive everything without a personal effort (just think of the ads saying "because you deserve it"); Finally and most importantly, contemporary psychopathology has changed in such a way that in many cases, psychotherapy doesn't work. If we want to avoid our disappearance, it is time to think about action.

Chronicle of a death foretold": the end of psychotherapy

By Paul Verhaeghe

About 40 years ago, the anti-psychiatry movement denounced the labelling and stigmatizing effect of so-called diagnoses and the abuse of medication and electro-shock therapy. Thomas Szasz published his book on the myth of mental illness and demonstrated how psychiatry was used to control and limit deviance from society's norms. In the wake of this revolutionary movement, psychotherapy became more and more important, together with a pleading for a more scientific approach in psychiatry. As a result, we have lived the heydays of psychotherapy in combination with the human sciences becoming more and more scientific. Today, almost half a century later, we can draw the balances, and the results are not very good. On the contrary, the possibility that psychotherapy might disappear, is real. There are at least three issues that threaten its vitality and whose confluence may prove lethal. The first one has to do with a perverse twist in the need for more science in matters of diagnosis and treatment. The second one concerns a strange idea in the contemporary social discourse. Finally, a genuine change in contemporary psychopathology makes most psychotherapeutic approaches inefficient.

Firstly, let us consider the effects of the plea for a scientific approach in matters of psychodiagnosis and treatment. The antipsychiatry had demonstrated very clearly that the psychodiagnostic labelling of that time was arbitrary and had no scientific basis whatsoever. Treatment came down to the prescription of chemical straightjackets, and if need be, a couple of electroshocks could finish the job. The answer of the scientific community to these critics resulted in several attempts to produce objective diagnostic systems and tests. I won't go into the details, but the final result today is the DSM, the Diagnostical and Statistical Manual as the supposedly new bible in matters of psychiatric diagnosis. The trouble with this DSM is that from a scientific point of view, it is just rubbish. In spite of all the efforts, it is nothing but a scientific hoax. I could demonstrate this in detail, but that would be quite boring, so I will skip that part (see Verhaeghe, 2004). The strange thing is that this is generally known, and that it doesn't provoke much reaction. Every one of us continues as if we didn't know that the emperor is naked.

What is even worse is that it is also rubbish from a clinical point of view. About half of the patients cannot be diagnosed using the DSM, because their problems do not fit in any category (Howard et al. 1996; Messer, 2001). And in case they do fit into one – and usually into two or three – of the many categories, the result is not much better, because there is no intrinsic link whatsoever with a particular treatment.

This missing link is very important because it testifies to the philosophy that underscores the DSM. By and large, this approach is a very classic medical one, operating via a supposedly objective observation and aiming at the delineation of syndromes (called disorders) in a patient. The therapist is nothing but a neutral observatory, his subjectivity is irrelevant. This kind of approach is even outdated in contemporary medicine, but for one reason or another, it is still very much alive in the DSM. It becomes especially obvious in what I called the missing link. There is no link between a particular DSM-diagnosis and a particular psychotherapy, because the hope is that this therapy would be a medical one, meaning a new drug or even a neurological intervention.

Unfortunately enough, this has been already more or less realised with children. The so-called *Pervasive Developmental Disorders* are everywhere, together with the *Attention-Deficit and Disruptive Behavior Disorders*. Just to give you an idea: last June, I was in Canada for a conference, and the weekend edition of a major Canadian newspaper ran an article on the alarming rise in drug prescription for children (*The Globe and Mail*, June 9, 2007). Based on official information from the government, they concluded that in four years time, prescription for Ritalin rose almost 50%, whilst those for the new generation of antipsychotic medication nearly doubled. I picked the Canadian statistics purely by chance, but the same thing is obvious in every western country. This is a perfect although tragic illustration of the social construction of a disease. It is not only tragic, it is also very ironic because this social construction comes down to the idea that the social has no importance whatsoever. Anyone today who has the guts to say that ADHD or PDD might have social and psychological causes, that developmental disorders might be caused by those who are responsible for the development, runs the risk of becoming banned from the scientific community. The causes have to be neurological or genetic, and the only thing we need is a kind of neurological training program in combination with a super pill. Unfortunately, in most cases, this super pill has not been found, but – as the saying goes – the results are very promising. In the meantime, we have to make do with a bit of social support here, a bit of psychotherapy there and please give us some more money for our research program.

The fact that the DSM-diagnoses are social constructs becomes even clearer if we look at the adult section. Let me remind you that a DSM-diagnosis has to be exclusively based on objective observation; a conceptually-driven diagnosis is out of the question. As a consequence, every DSM-diagnosis has to fall back on a social norm, in order to decide whether an observed behaviour is normal or not. The idea of *ab – normal* has to be understood in a literal sense: that which does not follow the social norm. Consequently, the therapy that follows this kind of diagnosis has only one aim: to cure the patient of his bad symptoms and to turn him into a respectable citizen who follows the norms. This is the case for almost every so-called personality disorder, with of course the borderline personality disorder and the anti-social personality disorder on top of the list.

In other words, compared to the sixties, we are back at square one. This is a perfect illustration of what Freud would have called "a return of the repressed". Contemporary psycho-diagnostical labelling is not more scientific than the previous systems; it is a social construction aiming at social control, and it cherishes the idea that a genuine treatment should be a pharmacological one. The main difference between the contemporary system and the previous ones is the uniformity of the DSM compared to the multiplicity of the former, meaning that every administration loves it.

Apparently, the plea for a scientific approach in matters of psychodiagnostics has met with a failure. Let us take a look now at the growing contemporary demand for psychotherapies to prove that they are both scientific and effective. Nobody of a sound mind can be against such a requirement. The trouble is that this has ended in

a very perverse reversal that might mean the end of psychotherapy. As this might sound very surprising, it needs explaining.

If someone wants to research whether a certain kind of therapeutic approach is useful or not, he will almost certainly use the methods that were originally developed for medical and pharmacological treatments. This means that he will take the utmost care to compose at least two large groups of exactly the same patients, who will be treated with two different methods, one of them being the new approach, whilst the other group receives the standard treatment. In order to make the comparison possible, the therapy given within one group has to be completely identical, hence the need for manualised treatments – the therapist has literally to follow the book. This is the philosophy of *Evidence Based Medicine* and *Randomized Control Trials*: identical patients, identical therapists, identical treatments.

Such an approach has enormous implications, because it means that a psychotherapeutic method can only be researched on its effectiveness if it meets at least two criteria beforehand. Firstly, it must be possible to standardize the treatment completely, in order to rule out the impact of the individual therapists. Secondly, the treatment has to be short; ideally it takes only 6 to 16 sessions, in order to rule out other influences. I think it is obvious for everyone that only a very limited number of psychotherapies meet these criteria, **meaning that all the other forms cannot be measured within this approach**. On top of that, this research design can only be applied to a very limited number of patients as well, because of another inherent requirement. Indeed, the patients that can be used in this kind of research are only allowed one diagnosis, co-morbidity is out of the question.

Let us take a closer look at these requirements. First is the need for a manualised treatment based on a protocol-like approach. This means that the therapist is reduced to an executive who has to follow the book – as a matter of fact, he or she is turned into a research assistant who is not allowed to take any initiative during the treatment. In the ironic words of Westen: "A good clinician in an efficacy study (and, by extension, in clinical practice […]) is one who adheres closely to the manual, does not get sidetracked by material the patient introduces that diverges from the agenda set forth in the manual, and does not succumb to the seductive siren of clinical experience." (Westen, 2004, pp. 638-39). Anyone with clinical experience knows that therapy doesn't work this way, that each individual treatment is different because each client is different. A couple of years ago, there was a big conference in my country at the occasion of 25th anniversary of the organisation for psychiatry and psychotherapy. I was one of the keynote speakers, each speaker representing a different psychotherapeutic approach. In spite of our different backgrounds, we had one thing in common. During the panel discussion, it became obvious that not one of us followed his or her own book, let alone a manualised one. The explanation was very simple: we can't predict beforehand what will be important, and a good therapy is always to a certain extent tailor made to a particular client.

The second requirement concerns the need for a limited and preferably fixed number of therapeutic sessions. The insurance companies love this idea. Well, follow-up

research has demonstrated what every experienced clinician knows: the effect of a psychotherapy is among other things determined by its length (Westen, 2004, p. 633), and although most short term psychotherapies might initially be successful, there is an enormous relapse within one year. Again, the conclusion is quite clear: it doesn't work that way.

The third requirement is even more baffling, because the exclusion of every patient who suffers from co-morbidity means that about two thirds of the potential clients are excluded from these studies. I am always wondering where they find these kinds of clients, I never see them! The moment you start listening to a patient with a supposedly "simple phobia" or an isolated "panic disorder", things very quickly get more complicated, and the idea of "single" or "isolated" disappears quite fast. Moreover, the whole idea of co-morbidity is a weird artefact of the DSM. It is because of their need for a clear cut classification that the DSM task force has assumed the existence of pure categories that might add up in rare cases. Let me tell you a big secret: these pure categories exist only on paper, and the moment you enter the real world, you meet real people who have real problems.

Let us now return to the contemporary obligation for psychotherapy to prove its effectiveness. For the time being, the most accepted way to test it, is by using the Evidence Based methodology. As I explained, this methodology can only be applied to a very limited number of psychotherapies and even then, for only a very limited number of patients. It is at this point that we meet a perverse twist with a disastrous effect. Instead of concluding that this methodology is too limited to do the job, the message is that those therapies that cannot be tested by RCT are simply not scientific nor effective. This is what I called the perverse reversal and the perversity doesn't stop there, on the contrary. The next step is that the insurance companies refuse to refund those therapies that are not tested; next and consequently, the teaching institutes tend to focus nowadays almost exclusively on those few therapies that do match the criteria of the Evidence Based approach!

As a result, a large number of psychotherapies are banned from the forum and a very limited number of short term and protocol-based psychotherapies are promoted as the only reliable ones. As they are short term and protocol-based, they are easy to teach and easy to apply, and indeed, today, they are everywhere.

There is only one tiny problem: they don't work. First of all, they don't work because they are used with the wrong patients, meaning: with real patients. Remember: these methods were tested with those very rare clients who have only one problem. In real life, what in these studies is called "the naturalistic treatments", half of the clients don't fit DSM-diagnoses and about two-third of them suffer from so-called co-morbidity. Secondly, there is growing evidence that by 18 months post-treatment, the initial positive outcome of brief psychotherapy is indistinguishable from a placebo-effect. The irony of this finding is that it has lead the authors of a particular study in this respect to the conclusion that patients need repetitions of this short-term treatment, in order to keep up the initial positive effect (Westen, 2004, p.641). Advocating a long-term treatment is obviously a bridge too far…

In summary, the scientific testing of psychotherapeutic effectiveness has resulted in an impoverishment of psychotherapy to protocol-based short term treatments. The growing evidence that the initial positive effects of the latter don't last, is leading more and more to the perverse conclusion that psychotherapy as such doesn't work. This is perverse, because the correct conclusion is that firstly, the larger part of psychotherapies cannot be tested with the RCT-methodology because of the limits of that methodology, and secondly, that the larger part of our clients cannot be treated by those treatments that can be tested via RCT.

Nevertheless, the damage has been done and the perverse conclusion operates as a self-fulfilling prophecy. I am afraid that in the near future the deception with psychotherapy – that is, with EB Therapies – will increase and that salvation will be more and more expected from a pharmacological or even a neurological intervention. This will be all the more the case, because the latter idea is already inscribed in the set up of the DSM diagnostics and the RCT-methodology. Indeed, both of them belong to a bio-medical approach, meaning that researchers develop a new diagnosis and a new medication or treatment in the laboratory, which is then marketed by pharmaceutical companies and teaching institutes. The marketing is directed to physicians and therapists who have to apply these new products or methods. Notice that in this line of reasoning, the clients are the physicians and the therapists, not the patients.

These developments are quite recent and they are anything but innocent because their consequences lead exactly to those situations that were denounced by the anti-psychiatry. Nevertheless, there is at least one important difference: we don't seem to care that much about it. Even on the contrary, there is a certain shift in the social discourse in that direction. This is the second issue that I want to consider as being dangerous for the existence of psychotherapy.

Psychotherapy is without any doubt deeply embedded in the sixties and seventies, meaning that both the therapists and the clients shared the same social discourse without even being aware of it. This discourse was emancipating itself from an often very strict religious normativity within a patriarchal authoritarian society. Consequently, patients were not only suffering from guilt and frustration and longing for freedom and autonomy. Besides that and precisely because of that, they were deeply convinced of their personal responsibility and implication in their problems – just remember the catholic "*mea culpa, mea culpa, mea maxima culpa*". Of course, this links up perfectly with the implicit expectation of every classic psychotherapy, i.e. that the patient has a sense of illness, that he has "insight" in his or her own problem – basically, this means that he or she has a sense of guilt and is prepared to try to change a number of things in his or her own way of life.

Today, these ideas have changed dramatically. Guilt has become an obscene word, and if something goes wrong, the cause has to be looked for in some external agency. Just to give you an illustration: a couple of years ago, Fonagy and his colleagues conducted an informal study in an outpatient child community mental health clinic. They asked parents about the likely cause of their child's problem. The

most frequent answer was brain chemistry, followed by bad genes and bad friends. Explanation number four was food additives and finally, as fifth probable causality, came early life experiences. The message is clear: we – the parents – have nothing to do with the problem of our children, it is something in the machinery that went wrong, don't blame us (Fonagy, 2002, p.98). This idea goes even that far today that the one who used to be the victim, might get the blame. If a youngster steals your cell phone and gets caught with it, the usual answer will be something like this: "It's your fault, what do you expect, leaving your cell phone like that! You were just asking for it!".

Obviously, the whole idea of guilt and personal implication has changed radically, even that radically that we meet nowadays with the exact opposite thesis. You are not to be blamed, no, on the contrary, you should receive everything you want. As usual, we can find the best illustrations in the advertisement business, because the whiz kids of the publicity business keep their finger on the pulse. One of the new slogans selling whatever product runs the following lines: "Because you deserve it!"; "Because your body deserves it!". The last variant that I have read was "Because your dog deserves it!". This is the new credo, replacing the old fashioned "mea culpa".

And guess what happens when someone who has been raised in this kind of discourse, develops a number of psychological problems and asks for our help. This kind of client expects us to solve his or her problems without a serious effort from his or her part. The moment that we make it clear to him that it doesn't work that way, he or she will quickly loose interest and will turn to someone who has something better to offer. More often than not, this offer will be – again – a pharmacological one. That's so much easier – "I have a depression, my therapist told me that it's probably genetic, and now I have to take these little pills", case closed. This kind of reasoning is becoming more and more widespread today, because it fits very well into the contemporary social discourse. On top of that, it dovetails perfectly with the perverse conclusion that psychotherapy doesn't work anyway, so why bother? Take a pill and be happy.

This brings me to the third issue that threatens psychotherapy. As a matter of fact, this issue is quite closely associated to the previous one. In the last few decades, there has been an obvious shift in the kind of problems that we are presented with in our clinical practice. The classic symptoms seem to be disappearing, and we are facing a new kind of pathology.

Indeed, instead of phobias, we meet with panic disorders. Instead of conversion symptoms, we find somatization disorder. Instead of hysterical nausea, there are eating disorders. With some exaggeration, it can be said that yesterday's docile psychoneurotic patient who dreamt of forbidden sexual activities resulting in massive feelings of guilt that lead to phobic and obsessional symptoms, that this patient has almost disappeared. Instead of that, we are confronted with the promiscuous, aggressive borderline patient who combines eating disorders with addictions and self

mutilation. More often than not, he or she claims our help while at the same time refusing it.

If we consider these differences schematically, they can be summarised in three points. First of all, these new symptoms have nearly always to do with the body in a direct, unmediated way. Just think of somatization and eating disorders, but also of addiction, self-mutilation and enactment. In case the traditional symptoms had an effect on the body, it was almost always in an indirect way. Moreover, more often than not, the classic symptoms had an inhibitory effect on the body.

Almost immediately following this, we find a second characteristic, again in contrast to the traditional neurosis. Most of the new symptoms are performative ones, not in the theatrical meaning of the word, but in the sense that they imply actions. Whilst the Freudian neurotic was endlessly dreaming of things that he or she could do but of course never did, his contemporary counterpart does not dream any more, he or she prefers to act, and their acts are directed towards the body, be it the own body or that of the other and we are confronted with aggression and promiscuity in the real.

A third difference is less visible, especially because it concerns something that is not there. In contrast to the traditional symptoms, the new ones seem to be devoid of meaning, they are just what they are. The most obvious example is a panic attack – for the patient, it is just panic, there are no hidden meanings to it, as in the case of a phobic construction. Moreover, this panic attack seems to be unrelated to the personal history of the patient, it comes out of the blue just as it disappears without an obvious reason.

Finally, it has to be said that these three differences are staged within a totally different relational setting as well. By and large, the classic, Woody Alan look-alike neurotic subject has a basic trust towards the other. He comes to see us in the conviction that we are willing to help him and even more so, that we have the power to offer help. It seems as if the new patient takes the opposite position. He starts with a basic *distrust* towards the other and he is not prepared to make an exception for the therapist. He demands help and insists on it, but at the same time, he is more hostile than cooperative. Moreover, he is not prepared to take the blame for any failure, even on the contrary – it is the other's fault.

These recurring differences testify to the shift in contemporary clinical praxis, meaning that something must have changed in the psychodynamic history of these patients as well. The link with my previous issue, that is, the shift in social discourse, is obvious, but this does not mean that these changes are easy to understand or to explain, on the contrary. For the last couple of years, we have been working on these issues at Ghent University and our main conclusion so far is that for an ever growing number of people, something has changed in their developmental history. To put it in Lacanian terms, something went wrong during the mirror stage, that is, the period where the identity formation starts in combination with the drive regulation. It seems as if the contemporary Other – meaning the parents, but also the symbolic order – is failing more and more in taking on his/her mirroring function. The result is that the

child does not develop a psychological, meaning a representational way of handling his drives and the accompanying arousal. Moreover, the identity formation as such is hampered as well.

Consequently, the processing of the drives remains stuck at the somatic level, that is, the original level of the Real. This explains why the symptoms address the body in an unmediated and even in a performative way. It explains their lack of meaning as well, they are much closer to a meaningless "Abreaction" than to whatever kind of defense mechanism. In my reasoning, this leads to what Freud has called **actual neurosis**. For lack of time, I can't elaborate on our contemporary interpretation of Freud's theory; suffice it to say that the main characteristic of actual neurosis is the failure to process the drive arousal via representations (see Verhaeghe, 2004). In the light of Lacan's theory on the mirror stage and Freud's theory on identity development, this failure of the representational capacity has to be understood via a failure in the relationship with the primordial Other. Normally, that is: in classic psychoneurosis the drive arousal obtains a representational coating and finds a symbolic expression via meaningful and classically analyzable symptoms. In case of actual neurosis this representational process is seriously hampered. The effect with regard to the clinical picture is an absence of 'meaningful' symptoms combined with the preponderance of panic attacks and anxiety related somatic phenomena, the latter being expressions of the original arousal. Consequently, the excitation obtains excessive proportions and finds an outlet via actions that are either directed towards the own body or towards the other.

The psychodynamic history of these patients permits us to understand these differences with the traditional psychoneurotic. The crucial thing in actual neurosis is the combination between an ambivalent position towards the Other and the absence of the representational coping with the drive arousal. Consequently, the focus remains very much on the real of the body and on acting-out. It is important to understand that this acting-out does not have a hidden meaning that can be interpreted. The only aim of this acting-out is to get rid of the inner tension. Anxiety and depression are not rare, but again, they are different compared to the psychoneurotic version. They are much more elementary, there are no underlying layers to them. This brings us to the typical transference. The actual neurotic stance towards the other is quite contradictory. On the one hand, this other is needed, because the subject is demanding an answer. On the other hand, this patient does not expect too much from the other, because the primordial Other did not present much help either. [1]

I won't go into the reasons why these changes have taken place, because I don't know the answers. Anyhow, it is quite obvious that this change has a number of implications for psychotherapy, whatever form the treatment might take. I will give you the most important implication right away. Traditional psychotherapy does not

[1] I elaborated these ideas in a book (Verhaeghe, 2004) as well as in recent conceptual papers (see: Verhaeghe & Vanheule, 2005, in press; Verhaeghe, Vanheule, & De Rick, in press). Researchers from my department empirically validated a number of the ideas posited there (see: De Rick & Vanheule, in press; Vanheule, 2006, 2007a, 2007b, 2007c).

work with this kind of patient. Even worse: traditional psychotherapy runs the risk of reinforcing this actual neurosis. Of course, this adds up to the contemporary idea that psychotherapy as such is not useful.

This unexpected result comes about as follows. The actual neurotic patient has a problem, and he expects an answer from the other. The thing is that he does not present his problem in the way we expect him to, because as psychotherapists, we are looking for meaningful symptoms and for signifying material that we can interpret. One step further and we consider this impossibility to represent the inner experience as a form of resistance to the treatment. Well, this is exactly the repetition of the original problem: the child presented a problem to the other, but this other failed in his or her mirroring reaction and did not present an answer, let alone a solution. The patient presents his problem in a way that does not suit our expectations. He gets frustrated and finds his expectation confirmed: the other does not help him. The therapist gets frustrated as well: this client does not cooperate, does not want our help and goes even so far as to accuse us of not being very helpful. Both parties harden their positions and the therapeutic process is not therapeutic at all, on the contrary.

At this point, we can return to Freud's wise conclusion: the psychoanalytic technique in its original form doesn't work. That is, free association is very hard and interpretation is not very useful, because of the typical characteristics of actual neurosis. As a matter of fact, I can even enlarge Freud's conclusion: most traditional psychotherapies won't work, because most psychotherapies operate via what I would call *deconstruction*, and this goes even for cognitive behavioural therapy. In case of actual neurosis there is nothing to deconstruct, and that is precisely their problem. With some exaggeration, I can say that we have to treat these patients with a kind of therapy that is diametrically opposed to the classic treatment. Instead of deconstruction and analysis, we have to aim for construction and synthesis, both in matters of symptoms and transference. The trouble is that we are not trained to do so, and that in most cases we don't even see the problem, the only thing we see is yet another client who doesn't want to cooperate… But as their number is growing and growing, this might very well end in the opposite conclusion, namely that we, the therapists, don't cooperate, that the resistance is ours – incidentally, this is something Lacan said some twenty years ago ("the only resistance is the resistance of the analyst"). From my point of view, it is very possible to treat these clients with psychotherapy, provided that we rethink the therapeutic goals and the methods to reach them.

It is time to come to my conclusion. As I have explained, there are three issues threatening the vitality of psychotherapy, and if we want to survive, we need to face them. This threat is all the more real, because these three issues tend to reinforce each other.

First of all, instead of fighting each other and trying to prove that our approach is the best, the different schools of psychotherapy should fight the DSM-infantilization and the accompanying shift towards pharmacology and pseudo-neurology. Consequently,

we should take a much more active part in the contemporary social discourse and tell the public that there are no easy answers.

Secondly, we need to develop genuine scientific methods of our own to test the effectiveness of real psychotherapies with real patients.

Thirdly, we need to be fully aware of the changes in contemporary psychopathology, we need to study the reasons for these changes and we need to adapt our psychotherapeutic methods accordingly. From my point of view, this last issue is the most interesting and challenging one, but if we fail to address the two former issues, there will be no challenge left…

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