EVALUATION

BLOG-NOTES: THE PSYCHOPATHY OF EVALUATION

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The way in which health systems have redefined the juridical fiction of *habeas corpus* determines a politics: my body is not only a juridical fiction, it has to be in good health too. From an ethical point of view, the field of health has long been managed by professional medical communities. Economic concerns have now made managerial and administrative control of primary importance and relegated professional ethics. In the 21st century the managerial formula has been standardised: funding agencies, suppliers required to compete with each other, the setting-up of a market more or less regulated by private regimes (American HMOs)[1] or by a public service regime (English and continental European systems) – all immersed in the rhetoric of evaluation. The apparent uniformity of these solutions conceals, in fact, a great heterogeneity in the performance of health systems.

The American economist Paul Krugman has turned himself into an efficacious denunciator of the so-called benefits of privatisation. He exposes the calamitous performance of the American health system by showing the profound inadequacy of privatising resources in the field of health, a strategy which results in making access to health "a privilege rather than a right." And he emphasises that "This attitude turns out to be as inefficient as it is cruel" [2] In fact, clients in a position of weakness are being discarded between the various "agencies" operating within the health market. And this at the moment when health systems are faced with a spectacular increase in the demand for care, which is linked not only to the fact of having a body, but also to that of having a mind: *habeas mentem*.

Maintaining the psyche in good health is an imperative underlined by the WHO: "The World Health Organisation […] draws attention to the increase in the demand for care for psychical problems. Indeed, one person in four is confronted with serious psychical or psychiatric disturbances in the course of their existence, and depressive problems are about to become the 21st century's most striking illness."[3] Faced with this explosion in the demand for psychical health, the WHO is the harbinger of good tidings. In

keeping with the example of somatic treatments, the efficacy of which is proved according to the standards of *evidence-based medicine* (EBM), psychotherapies henceforth submitted to the same criteria. Psychotherapies, which constitute a specific mode of treatment, are thus scientifically recognised as an efficient treatment. Let us be quite clear about this: nothing new has been invented. We have simply managed to insert psychotherapies into the rhetoric of managerial evaluation, by saying, for example: "Encouraging facts have recently been established to support the cost/efficiency ratio of psychotherapeutic approaches to the treatment of psychosis, various kinds of mood disorder and those disorders linked to stress - together with, or as an alternative to, pharmacotherapy. Research results indicate that psychological interventions lead to greater satisfaction and an acceptance of treatment, which can contribute significantly to a reduction in relapse rates, hospitalisation and unemployment. […] The additional cost of psychological treatment is compensated for by the restricted use of other health resources." [4]

As we can see, the WHO is not being sentimental. It is in the name of a neo-liberal perspective that it pleads for psychotherapies with such compassion. The field of psychotherapies is distributed between diverse orientations: psychoanalytic, cognitive-behavioural, systemic or relational therapy. If recourse to the psychotherapies is to be encouraged, their form is left to each individual's taste. From the managerial point of view, the question of choice between psychotherapies boils down to the question of their evaluation and their utility. All methods of evaluation begin from a limit encountered in measuring the efficacy of the above mentioned psychotherapies: this limit can be named the problem of the "dodo bird verdict".

The problem of the "dodo bird verdict" & the bid for power by RCT [5]

The recent report of the Belgian Conseil Supérieur d'Hygiène, produced to enable the establishment of a law to regulate psychotherapies, articulated the problem thus:[6] "The handbook by Bergin and Garfield, *Handbook of Psychotherapy and Behaviour Change* (Lambert, 2004), which is in its fifth edition, gives an outline of the empirical studies that have been undertaken in the last sixty years. It shows that psychotherapy is

efficacious and that it enjoys considerable effects which match, on average, those of somatic and medical treatments. There are, in general, few or no differences between the serious therapies (the famous *Dodo bird verdict,* Luborsky et *al., [*2002*]*), especially after corrections are made, which aim to take into account the allegiance of the principal researcher. The interpersonal processes (like the construction of a working alliance), the person and the expertise of the therapist (without taking into account the orientation to which the latter belongs) turn out to have more impact on the variance of the effects than the specific techniques used.

The "dodo bird verdict" debate dates back thirty years. It's a homage to Lewis Carroll.[7] In the second chapter of *Alice in Wonderland,* the heroine shrinks and finds herself plunged in a pool formed by the tears she'd shed when she was 2.75 metres tall. A mouse joins her, then various animals: "There was a duck and a dodo bird, a lory and an eaglet, and a number of other bizarre creatures". In fact, this group of animals brings together the usual entourage of the author and Alice. In "*duck",* we should understand the name of Lewis Carroll's school friend, Robinson Duckworth; in "*lory*" (parrot), and "*eagle*", the names of Alice's sisters, Lorina and Edith Lidell, and in "dodo", the author's name (Dodgson). It is worth noting that the dodo bird is an animal that is extinct, that Alice was published in 1865 and that Charles Darwin's *The Origin of Species* dates from 1859. The dodo, a Darwinian homage, is an emblematic animal for Mauritius, which died out around 1680, a victim of evolution. This name without a reference marks him out in *Alice* as the one who will present the prizes following the open competition to find out how to get dry again. The mouse proposes a semantic process, a historical account: "I'll soon make you dry enough," says the mouse, "this is the driest thing I know." The dodo then proposes an asemantic process, "a caucus race",[8] the rules of which no one knows. Each person interprets it in their own way and begins to run. When "they had been running half an hour or so, and were quite dry, the dodo suddenly called out: "The race is over!" "But who has won?" they cried. "*EVERYBODY* has won, and *all* must have prizes."

In order to reach this brilliant solution, the dodo thought long and hard, "it sat for a long time with one finger pressed upon its forehead (the position in which you usually see Shakespeare, in pictures of him), while the rest waited in silence." [9] His thinking displayed no melancholy. This

elegant solution to a test whose exact contents no one knows (in which the information is unequally distributed and is dissymmetrical, but in which each person emerges a winner) anticipates the elaboration of a problem which will occupy logicians and mathematicians in the following century.

Do games without losers exist, in other words, non zero-sum games, that can be mathematically formulated? John Nash was to settle this question at the end of the 1950s. Indeed, the "Nash equilibriums" designate possible economic non zero-sum games. All the participants win. Are *"bona fide"* therapies a phenomenon of this order? When measured, their efficacy turns out to be more or less equivalent. "In general terms, the majority of studies, meta-analyses and meta-meta-analyses indicate that there is little difference in the results obtained among the "bona fide" psychotherapies, in other words those guided by a coherent, theoretical structure, which have been practiced widely and have theirs foundations in research", "as is the case for cognitive-behavioural, systemic, psychoanalytic psychotherapies", or for relational therapy. [10] It is the will, the *hubris*, to go beyond this limit that has produced the astonishing exception of Inserm's expert evaluation report. [11] The Belgian report pinned it down as such: "One remarkable exception is that of the recent Inserm report (2004), which is presented as the first comparative piece of research to show (personality disorders apart) the superiority of cognitive behavioural therapies over psychotherapies. However, the methodological bias that led to such results has been made widely explicit". [12]

They have not been made sufficiently explicit. Two years after this bid for power by Inserm, which was followed by other expert evaluation reports (one focusing on the psychological post-mortem of suicide and one on behavioural disorders in children and adolescents), we can better understand what is at stake. It became apparent to a group of scientists that the only way to force the issue of the problem of the "dodo bird verdict" was to use a very particular method, one constructed on the model of comparative clinical trials used to authorise the release of medicines on the market.

In order to do this, they had to propose an equivalence between psychotherapy and medication — this alone makes it possible to justify the sole use of this method. As one expert from the cognitive-behavioural therapies (CBT) says: "Since the 1980s, the third generation of research in

psychotherapy uses the model of controlled clinical trials stemming from pharmaco-therapy, *DSM* diagnoses, and manuals which precisely describe treatments used".[13] Rather than a "third generation", it is a certain way of doing things, a way of biasing the results. Let us examine these multiple biases.

For medical trials, the method consists in obtaining perfectly homogenous groups of patients, according to a biological model that defines the cause of illness. Patients are then divided according to an extremely standardised, random protocol, administering either the medicine to be tested in strictly defined dosages or a placebo or "reference" treatment. The person prescribing does not know what he is distributing. This method was invented to control the pharmaceutical industry; it has henceforth been presented as a ready-packaged machine for administering psychotropic medicines, and is characterised by the absence of a confirmed biological causality for mental illnesses. Thus, Philippe Pignarre emphasises that this "biology of biochemical receptors in the brain […] brings to a triumphant conclusion the fact that a modern medication is always the penultimate medication. It always precedes another that is more efficacious, more usable and less toxic. This insubstantial biology willingly adorns itself in the clothes of actual biology, whilst its ambitions are limited to the perfection of new penultimate medicines".[14] One English psychiatrist is even more precise about the absence of a biological model, when he notes that the dopamine "model" boils down to a mode of reasoning inspired by the following logic: aspirin relieves headaches, so headaches are caused by a deficiency in acetylsalicylic acid.[15]

The interpretation of RCTs on the disinhibitory effects of antidepressants in adolescents has particularly provoked polemics, scandals and prescription bans. That is why the results of a study[16] sponsored by a national body – the *National Institute of Mental Health (NIMH)* – and not by a laboratory, were especially awaited. Now, the results of this study, comparing the treatment of depressed adolescents using psychotherapy and/or Prozac, are paradoxical. On the one hand, they reassure doctors fearful of legal action in the case of bad practice: the fact that pharmacotherapy alone has been effective in over 60% of cases proves that their prescription was effective too. On the other hand, the

study spoils the hopes engendered by the expert evaluations like Inserm's. Indeed, cognitive behavioural therapy, presented as a "psychotherapy", and as a "talking therapy", does not prove to be any more effective than the placebo treatment. Cognitive behavioural therapy as "psychotherapy" is thus practically disqualified as a preventative treatment for suicide.

Since the publication of the results, an article in the *New York Times* has given an outline of the concerns spreading across the milieu. How can patients and their parents be reassured, how can they be helped to decide between the risks that are presented by antidepressants and the inefficiency of "psychotherapies", as represented by CBT? One would hope to reassure the parents of depressed adolescents by noting that experts emphasise that the results are less discouraging than they appear to be.[17] After all, although the results are not significant, psychotherapy by CBT had an effect on 43% of patients, which is slightly above the 35% who had some improvement with the placebo. The American universities have mobilised. They are putting statistics that do not take individual variations into account back where they belong, and then emphasising that in fact the results depend far more on particular cases and on therapists than on general statistics. In short, you again find the usual interpretation of the "dodo bird verdict". Some people suspect that adolescents are too eaten up by their emotions to have the aptitude for self-observation that CBT demands: they do not apply themselves as much to the note-taking homework and continuous self-observation that's required. To bring things to a close and in order to calm people's minds, they conclude that it is necessary to have regular interviews with adolescents, especially on account of the suicide risks.

It is in this context that we also need to note the disparity between the rules for the prescription of antidepressants in different countries (discrepancies that are difficult to justify) and the difficulty in establishing guidelines for good practice which are supposed to resolve all the contradictions. We are referring to the interview with Anne Castot (then in charge of scientific information for the Agence française de Securité Sanitaire (AFSSAPS)) conducted by Guy Hugnet in July 2004. The English had just banned the use of Deroxat for under-18s, "whereas the Americans are/were happy with a warning regarding its use, without banning it. In France, this drug [used to be] counter-indicated for the under-15s, but

authorised for adolescents and adults".[18] The AFSSAPS observed the fact and replied: "In France, Deroxat has always been counter-indicated for the under-15s. Beyond that, after 16 years of age, it is based on the results for adults. At the European level, there is disharmony. That is why the Brussels Commission should quickly bring the legislation in European countries into line with each other. […] The recommendation will be to avoid its use for the under eighteens, but without an absolute ban. The choice should be left to the person prescribing. According to the evaluation of the risk/benefit for a given patient, the doctor will be able to prescribe it as a last resort if there is no other solution." [19]

The debate about safety in the use of anti-depressants concerns adults too.[20] One study from the University of Ottawa maintains that the risk of suicide is almost double in those taking antidepressants. Two other English studies conclude, on the other hand, that there is no significant increase in risk. In the light of these contradictory results, who and what can we trust? The *British Medical Journal*, which published these three studies,[21] appeals to the clinical judgment of practitioners and the utilitarian good sense of patients. It is, at least, a partial restoration of the medical act and of the subject's choice in the face of uncertainty. Doctor Freedman, an expert in clinical trials at the University of California in Berkeley, concludes in the *New York Times* as follows, using a beautiful theoretical formula: "We have machines that can extract diamonds from the earth, but we do not have machines that can extract the truth from these studies." It could not have been put better!

Measuring homogeneity and neo-utilitarian childishness

Here we touch on one of the aspects of the impasse of randomised clinical trials and their methodology – which have been presented by some as a panacea. The reasons are not contingent but necessary. There is no point waiting for the next study if you think that the contradictions can be resolved and that we can do without clinical judgment, through the application of a standard procedure.

More profoundly still, we can note that transposing these methods (either to compare psychotherapies with each other or to compare these psychotherapies with drug therapy) comes up against three obstacles. The first is the impossibility of obtaining strictly homogenous groups in the

population. The second is the way in which people are arbitrarily and randomly assigned different types of psychotherapy, without regard for the patient's expectations or prior transference. The third, finally, is the impossibility of obtaining a strict standardisation of psychotherapeutic treatment once it is reduced to the application of a manual.

In order, supposedly, to remove these obstacles, scientists are ready to do anything.

First, in order to obtain homogenous populations, they are ready to segment and break up the clinic to get cases where only pure disorders remain. Inserm's expert evaluation report has pushed this method a very long way. They distinguished fifteen isolated disorders without taking into consideration the overall personality, in order to add a sixteenth category, "personality disorders". As if by chance, psychodynamic therapies emerge as more efficacious when personality is taken into account. This artificial cut between isolated disorder and overall personality, which is a pure product of the mechanism, allowed them to vaunt the success of CBT in fifteen out of sixteen cases! This product can be described as a "mereological mistake", insofar as it consists in isolating a part from the whole and making a strict equivalence out of it. They measure fifteen small parts then a supplementary part is made out of the whole.

The second obstacle to transposing this method is the setting-up of a control group, or placebo group. Some have underlined the abuse of professional ethics that would be constituted by randomly dividing a set of patients, coming for a consultation for mental problems, into either an experimental group, a control group, where they would be put on a waiting list, or a placebo group. As the Belgian report emphasises, "we can only be left aghast by this type of technique".[22] Furthermore, what is a placebo group in a field like ours, where the placebo effect is crucial? It is established that 15% of patients feel better following the first telephone call to fix the first meeting, before any encounter. For that, evidently, it is necessary to consent to occupy the place of the subject supposed to know, rather than to want to destroy it, by way of the authoritarian randomisation.

Thus, the third obstacle concerns the effect of exclusion produced by the standardisation of randomized clinical trials on the group of people who have come for a consultation. This effect is especially denounced in a

long article[23] published in 2004 by American authors, who arrived at the following conclusion: "Rather than focus on standardised treatments constructed in the laboratory, then imported into clinical practice, all the while supposing that any RCT can respond to any clinical question […], we would do better to redefine our aims." Two other American authors, J. Stuart Ablon and Enrico E. Jones, summarise their criticisms as follows: "Randomized clinical trials test a somewhat artificial treatment in an artificially controlled setting with atypical patients, so they have little generalizability to the real world of mental health care delivery." [24]

The limits of the RCT method have already been revealed by the results of "The NIMH Treatment of Depression Collaborative Research Program" [25] which was aiming to evaluate the comparative effectiveness of cognitive-behavioural therapy and "interpersonal" therapy. This study, the results of which were published in the 1980s, produced some surprises. First, a comparable efficacy between the two psychotherapies emerged in the treatment of major depression, while drug treatment was just a little more effective in the severest of cases. That was not the surprise, however. The surprise resided in the variance of the results between the different study centres, despite the maximum standardisation of patients, therapists and manuals, which they were all supposed to apply. How can such variances be justified? The study was then completed by way of other sophisticated ways of measuring and by individual interviews, which revealed that "interpersonal psychotherapy was in even more conformity with the prototype of cognitive-behavioural therapy than cognitive-behavioural therapy. In other words, "interpersonal" therapists did more CBT than its own therapy does, and obtained better results than cognitive-behavioural therapists did doing CBT!"[26] Adherents of CBT were interested in the identificatory processes, while those adherents of interpersonal therapy were not sparing with their prescriptive advice. The variances could therefore not be explained either by the therapies or by the therapists. It depended on the subjects themselves, according to whether they were more or less "narcissistic". It was this variable that took most account of the transferential effects and therefore of the therapeutics actually obtained. When all is said and done, the NIMH programme articulated one of the greatest regularities producing the "dodo bird effect". In a framework as formatted as this is, on account of the

anticipation of evaluation, and despite the so-called abstract manuals, an effect of conformity is assured. That is what, for the most part, the "dodo bird effect" measures.

It is therefore enough that the measurement of rapid therapeutic effectiveness is on the horizon for homogenisation to occur. During a conversation on a radio programme, we could hear one psychoanalyst agree that, in many cases, he did not hold back from a therapeutic accompaniment that was close to the aversion aspect of behavioural therapies. It is, without doubt, due to this standardising effect that in Switzerland, at the time of the debates surrounding the *Livre noire de la psychanalyse*, there was a return to the "dodo bird verdict", and that the professor of psychiatry and psychoanalysis, Jean-Nicolas Despland, a specialist in the evaluation of psychotherapies, was able to declare on that occasion that: "The results for psychoanalysis are difficult to evaluate, and it is only fairly recently that psychoanalysis has gone along with it. All the studies that are viable from a methodological point of view show, however, that in terms of effectiveness, all schools are equal. The type of therapy is, in the end, a parameter of little importance for the cure. What is decisive is, on the one hand, letting the patient choose, and on the other, the quality of the therapist, whichever school he may belong to."[27]

The effect of conformity and homogenisation may also occur the moment there is an emulation of RCT methods, which are said to be quantitative, that leads to the elaboration of qualitative methods that would make it possible to take the complexities of clinical reality better into account. These qualitative methods have been given diverse names. The authors of the Belgian report recommend that we do not trust solely in the results of the RCT, but take account of other evaluation approaches instead — and they isolate four of them.[28] For example, the German psychoanalytic association (DPV) of the IPA launched a study, described as "qualitative",[29] in order to evaluate patients' retrospective assessments of their psychoanalysis or their psychoanalytic therapy; and also the effects, several years after they came to an end. The results, published by the *International Journal of Psychoanalysis*, show the efficacy of psychoanalytic treatment both from the point of view of patients (over 70% of them reporting positive changes in different registers) [30] and from the point of view of the evaluation scale of symptomatology, since they

indicate that the majority of former patients are no longer disturbed to the extent of still being diagnosed as clinically ill." [31] The individual beneficial effects don't go without a study of the utilitarian repercussions for the good of everyone, in terms that are close to those of the WHO report: "With regard to health sector expenditure, this study has shown that long term therapies have helped to reduce costs in other medical disciplines in a permanent way. This fact has been brought to the fore by the decreasing numbers of days out of work, or days of hospitalisation. Besides, costs have also indirectly decreased – whether this is due to creativity and enhanced professional efficacy, or because patients who were previously without work have found new jobs, or even because their capacity to react empathetically towards their own children had increased significantly, or because they overcame social isolation by involving themselves in the stakes of the social and the public." [32] As we can see, everything human is taken into account in this unbounded utilitarianism. Nothing in this study is said about the disclosure of private lives implied by the compilation of such lists after the event. No questions were formulated about the suspension of confidentiality that it implies. There was not the slightest questioning regarding the eagerness demonstrated by these former patients to respond. Here we are dealing with the establishment of a real panoptic, founded on this sort of foolish and naïve "pass," which consists of speaking about one's analysis to investigators who are inspired by psycho-sociological methods.

The neo-utilitarian childishness of research results obtained in this way can be compared to the homogenising effect of the way they are measured. Everyone does the same thing and does not aim higher. We then get what Jacques-Alain Miller called a "Third-rate […] panoptic".[33]

The effects of the will to destroy the subject supposed to know

Some of these evaluation methods described as qualitative are more interesting than others. For example, those which put the accent more on subjective preferences than on measuring the effects of conformity. The American Psychological Association (APA) seems to have become aware of this. From 1995, it had supported studies with randomised clinical trials and it has now oriented itself towards other means of evaluation. Witness a "political report on practice, based on the evidence in psychology, as elaborated by the presidential working group 2005 of the APA".[34] The

APA wishes to support an approach which allows the preferences of patients regarding their treatment to be taken into account, as opposed to random and authoritarian allocations. Having given in to the sirens of *evidence-based medicine [English in original]*, it now insists on the limitations of the false, scientistic universal. Adapting to the particular situation of each subject supposes a consideration of the expectations each person has towards his psychotherapy. We need to pass from an *evidence-based* evaluation to a *value-based* [English in original] evaluation. The random and authoritarian allocation of treatment introduces a supplementary bias, in having no regard for each subject's values. There are those who wish to speak about or know something of their symptom, and those who wish to be rid of a disorder, like a foreign body, without wanting to know anything about it. The recommendations decreed on the matter of treatment ought to be able to take account of this. As the authors of the Belgian report say, the decision-making of a subject with regard to his or her treatment, "always implies a complex process of evaluation, which, albeit "*science informed*", is equally guided by [his or her] individual situation, values and wishes". These choices are thus "always *value-based*, that is to say, [based] on the "value" that each client grants to personal and ethically acceptable preoccupations; for example, less symptoms, more understanding of his or her psychic functioning."[35] Beneath this mask of value, which the subject does not want to give up, hides the supposition of knowledge that the subject attributes, or not, to the Other whom he has gone to see.

Besides mental health, other domains in the social field already acquainted with the perverse effects of the techniques and rhetoric of evaluation also perceive the consequences of the will to destroy the subject supposed to know, masked by the look of the necessity for transparency. The wish to expose and detail every procedure, every way of doing things, leads to the suppression of democratic debate and the tyranny of the One. "In a social world where people are conscious of their diverse interests, such an appeal to a benevolent or moral visibility is all too easily shown to have a tyrannous side – there is nothing innocent in making the invisible visible.""[36] In England, universities and research bodies have particularly suffered from the loss linked to the alleged "gain in evaluative information". This plus of information gets paid for by a lack of confidence and an attack on the social bond. "This can be especially applied to the

'expert systems', such as those that characterise scientific research or teaching. Such practices can never be rendered fully transparent, for there is not a single substitute for implicit knowledge, which is what constitutes the prestige of a teaching or of an experienced and recognised researcher. This implicit knowledge is the basis for the confidence and respect inspired by the practitioner. The 'information society', on the contrary, which promises us that we can attain 'an ideal of transparency' […] undermines the confidence necessary for an expert system to function effectively." [37]

All you have to do is substitute the properly psychoanalytic term transference for the sociological usage of the term confidence in order to understand this. When it is a matter of knowledge and transmission, sociologists themselves discern the importance of implicit knowledge, the subject supposed to know, which is crucial for installing transference as the basis of the experience.

After having taken note of the destructive effects of the culture of evaluation on universities and research institutes, and while certain voices recommend a "qualitative" counter-culture of evaluation, we can ask ourselves whether a "good evaluation" is really possible. Far from sharing the bio-psycho-social conception of the symptom, taught by the rival English-speaking university McGill (a large producer of evaluative rhetoric), the co-authors of a book coordinated by a social science researcher from the University of Montreal insist that it is necessary to shift perspective. In order to do this, they gave themselves "the task of rethinking the notion and the mechanisms of evaluation of the quality of services in Quebec, from the point of view of its users".[38] They emphasise the perverse effects of the standardisation of structures of care kept within strict protocols governed by quantitative indicators. This becomes especially important inasmuch as the mechanisms for the distribution of care are concentrated. They also underline that the "complexity" of problems encountered in the mental health field necessitates a "variety of perspectives and practices",[39] all the more so in that the protagonists are faced with "a work on oneself [which] largely exceeds the control of symptoms". Pursuing this path of research regarding qualitative criteria, the authors of this Quebecois work are then led to put forward some indicators of quality.[40] However, can we not fear that the effect produced

by these indicators will not, in the end, result in different but equally present effects of conformity?

Positioned on the political chessboard in a place symmetrical to that of Marilyn Strathern, the liberal commentator David Brooks is able to draw analogous lessons from the traps of evaluation that have been applied to education. In this way, he criticised the American education system for its weighty evaluation, justifying the *No child left behind* [English in original] programme of the Bush administration. "What can be measured by tests […] is merely the most superficial component of human capital. Students are being treated like robots acquiring knowledge in an economic machine […]. These programmes are not conceived for people as they really are. The only thing that works is local immersion, from one person to another, which transforms students to the core of their being. What works are extraordinary schools that create an intense culture of success." [41] What D. Brooks calls here a "local immersion, from one person to another", is a formulation, in the neo-managerial language of those he is addressing, of the uneliminable character of the subject supposed to know.

To summarise our criticisms of the results of evaluation, we could say that this form of measurement, such as it is applied to psychotherapy, only takes into account the most superficial aspects of the process at stake and tends to make everything conform and be homogenous. It teaches nothing about what really happens. We must resolutely turn our backs on this approach, which tends to produce standardised therapies for formatted disorders. It is a question of training psychoanalysts who are capable of applying psychoanalysis in the best way to the patient who has come to see them, by taking account of the complexity of the context of the demand. It is a question of always discerning the extraordinary character of a situation, instead of reducing it to the standardised protocol of Procrustes's bed.

Evaluation of ODD and of psychopathies under the scientist's gaze

The acts of violence that shook the French suburbs in November 2005 pushed the government's wish to promote the study of violent behaviour to the fore, in order to determine how to prevent it. Experts in the bio-political management of populations were summoned to allay anxiety. During this period, two documents were published, each exemplary in their genre.

Let us first consider the collective examination report of Inserm, *Behavioural disorders in children and adolescents*. Here, the "disorder" corresponds to a sociopathic definition and integrates very heterogeneous elements. It includes a wide "palette of very different behaviours, which range from fits of anger and repetitious disobedience on the part of the difficult child, to serious acts of aggression like rape, inflicting blows and injuries, and theft by the delinquent".[42] Treating these behavioural disorders, a "risk factor" in delinquency, would enable the prevention of delinquency. In this expert evaluation report, Inserm focuses once again on the defect in "biological equipment", which it is deemed to be urgent to measure right from the child's birth. A refusal of social norms is imputed to cognitive defects, measurable according to two – only two – distinct functions. This would refer, in the subject, to a *theory of mind* [English in original] defect, bringing about, on the one hand, a deficiency in the identification with the other, and a deficiency in inhibition of action on the other hand. This way of taking these deficiencies into account is detrimental to any possibility of a clinical historicisation of the symptom intersected by any singular signifying articulation. The subject's history is thus reduced to the influential role of environmental factors on the expression of genes.

Of course, behavioural disorders do not occur on their own – that is to say without the famous "associated disorders". For our experts, they should not be linked too quickly to personality disorders, however. Indeed, in its clinical diversity, they are related firstly to attention-deficit/hyperactivity disorder (ADHD) and to oppositional defiant disorder (ODD). From the point of view of a genetic defect, one has to then measure its co-morbidity with other disorders, such as anxiety disorders, depressive disorders and learning disorders, each considered as distinct and compartmentalised entities. There once again, this co-morbidity is estimated to be present since birth. No other therapy is envisaged by this expert evaluation other than educational training and the prescription of the whole arsenal of drugs used by psychiatrists: anti-psychotics, thymoregulators and psychostimulants. The worrying prospect of recording items such as "has been fighting/punching/biting/kicking/ refusing to obey/showing no remorse" in children's health reports has considerably affected the public, beyond the milieu of specialists. Columns in the daily papers have been opened up to the indignant reactions of very

diverse professional and educational milieus. The widely circulated weekly women's magazine *Elle* has also expressed worries about this potential, precocious filing of records on children.

In this respect, the public hearing *Taking charge of psychopathy*, organised by the Haute Autorité de santé (HAS) and open to a fairly wide public of 300 people on the 15th and 16th December 2006, can be considered as a marketing exercise on the same subject, but in a different sense to the Inserm report. Already, the way in which the title is formulated reveals it for what it is. Instead of starting from a loosely defined "disorder", the hearing is concerned with "taking charge of psychopathy". The term psychopathy is a term from the clinical tradition, even if it has had a tendency to disappear from it. Instead of asserting a will to replace the clinic with a knowledge stemming from statistical surveys, it's about professional practitioners considering communications which focus not only on biological studies, but on clinical studies as well. The bibliography provided does not confine itself to Anglo-Saxon statistical studies and includes French work from the psychoanalytic movement. A "bibliographical synthesis" presents a systematic commentary on it compiled by Mme Sarfati from Marseilles, a psychiatrist who had participated in the "Psy Forums" organised in the wake of the Accoyer amendment. All the same, we have to note the limits of this opening: not a single Lacanian psychoanalyst figures among the authors heard. The intention of this collection of communications is stated in the conclusion. It is a matter of taking due note of a profession that is profoundly divided "between a biologising current, inherited from the *DSM*, which diagnoses disorders with no link to the subject's history and privileges behavioural therapies (relying on theories of learning and conditioning); and a psychodynamic current, which recognises the contributions made by psychoanalysis and uses them to approach treatments as well as the forms of its practice, and which envisages each subject in his or her history and singularity." [43] This division occurs under the eyes of a master who, in fact, is not divided. For the HAS, the objective is clear: to perfect a useful instrument for the judges, in order to know how to keep watch over and punish those who commit violence. "It is likely that the expert psychiatric evaluations requested by the judiciary differ fundamentally depending on the training and orientation of the psychiatrist." [44] In this sense, the

different contributions are conceived as a *vade-mecum* for judges and the utilitarian intention in it is clear.

In the future, the evaluation scale will supplant the clinic in the psychiatrist's practice. The path towards objectification and the exit from this question of the clinic is recounted by Francois Caroli[45] in the introduction to this hearing: "The difficulty in approaching psychopathy resides in the fact that it combines in its very description "social semiology" and "clinical semiology, which are both linked to one another. Psychopathy has thus "crossed time and culture, creating a multitude of nosographical concepts". Then we have, "in face of the difficulty to describe this polymorphism, a whole system of dismemberment [has been] progressively [put] in place in favour of a sort of objectivity, nay objectification, through the [suppression] of the term psychopath" in the classification of mental illnesses by the *American psychiatric association*.[46] As F.Caroli notes, the "most curious thing (and here only the notion of hysteria has undergone the same fate) resides in the fact that having totally disappeared from the nomenclature, it is nevertheless a fact that it is remains extremely topical for the description of certain clinical realities".

Likewise, even if the clinic of the *DSM* is criticised by psychologists and sociologists (who sing from a different hymn sheet than biology), they underline its omnipresence. Serge Lesourd, a psychology professor in Strasbourg, ironically presents the cultural dimension of oppositional defiant disorder (ODD), after having recalled its definition in the *DSM* (we will limit ourselves to the first diagnostic criterion): "A pattern of negativistic, hostile and defiant behaviour lasting at least six months during which four (or more) of the following are present: often loses temper; often argues with adults; often actively defies or refuses to comply with adults' requests or rules; often deliberately annoys people; often blames others for his or her mistakes or misbehaviour; is often touchy or easily annoyed by others; is often angry and resentful; is often spiteful or vindictive."[47] S. Lesourd goes on to comment on the effect produced by these entries beyond what they actually say: the "reading proposed by *DSM-IV* of ODD includes one questionable aspect, for by making a disorder of an oppositional stance, it erases any possibility of grasping the, occasionally justified, meaning of a revolt. If we take the reading of this same adolescent disorder using a social reading of the same signs, we

would have the definition of a leftist in 1970, and in 2000 the definition of a young person in difficulty. If we do a political reading, in 1970 we would be dealing with a trouble-maker and in 2000 with someone who is a 'little savage'. If we read these signs in the light of psychoanalytic theory, we could speak of a narcissistic or borderline personality. […] Psychopathies are thus to be understood as social symptoms: they are constructed according to the coordinates of a subject's encounter with impasses in a given social moment." [48]

Similarly, child psychiatrists pick out the contradictions in the definition of the anti-social personality in the *CIM-10* and the *DSM*. Indeed, the latter specifies that for this diagnosis, "the patient must be at least 18 years […] and must have had a history of some symptoms of behaviour disorder"[49] before the age of 15. D. Marcelli and D. Cohen note that this "little sentence included almost stealthily poses in fact some extremely complex questions. If we accept the ideology of the *DSM-IV* on the categories of the disorders being described – a point of view that challenges every dimensional, as well as developmental aspect - how can we understand this sudden change of categories according to the patient's age: can an illness befall an individual from the sole fact of turning 18?" [50] On the other hand, noting the confusion that the ODD category provokes for the *CIM-10* itself – indeed, the *CIM-10* specifies that the aforementioned "category has been retained to take account of a current diagnostic practice and [that this] facilitates the classification of disorders suddenly befalling young children" – the authors conclude as follows: "We have, on occasion, the impression that the *CIM-10* looks for excuses for having introduced a disorder with such vague outline!" [51]

Furthermore, the same authors criticise co-morbidity within the medical model. "Co-morbidity is a major problem in the diagnosis of ADHD [Attention-Deficit/Hyperactive Disorder] in children, adolescents or even adults. It is extremely complicated to disassociate the combined effects of ADHD from true co-morbidity." [52] Everything lies in the link between the morbid and the co-morbid. But where is the really essential point?

Finally, far from sharing Inserm's enthusiasm for the cognitive causality of the disorder, D. Marcelli and D. Cohen underline that, "despite their number, neuroradiological, neuropsychological or

neuroendocrinal explorations have not yielded convincing results" and that ADHD refers to an unknown aetiology.[53]

Yet, these critical points of view only underline the invasion of a *biologising* tendency. For instance, M. Pham is passionate about the Hare[54] scale, which would enable us to define an ideal psychopathy by distinguishing it from the group of antisocial personalities. According to him, this distinction, gained by testing, would serve to anticipate not only the type of violent act of a subject (thefts with violence, instead of sexual offences or murders), but also recidivism. Finally, the tautology that states that psychopathic behaviour is badly controlled behaviour, serves to found this clinical category which is difficult to define on the basis of an evident genetic deficiency: "Psychopathy could be the consequence of a neuro-developmental disorder linked to affects".[55] An emotional deficiency (the coldness of the psychopath) is therefore explained by lesions in the frontal cortex or a dysfunction of the amygdale. With that, we find again the *continuum* that was already perceived in the hypotheses of the Inserm expert evaluation of behavioural disorders in children. We see that people with gland deficiency will soon be numerous.[56] From phobics to psychopaths, the dysfunction of the amygdale is going to have to explain a lot.

The veritable function of these extremist productions from Inserm is not, perhaps, to convince the whole of the profession. Rather, it is more about getting people used to radical formulations, scientistic avant-garde discourses, and biologising ritornellos. Once people have picked up the habit, it only remains for the HAS to present itself as conciliatory in order to get the pill of the so-called modernist discourse to pass into the ranks and to maintain a supposed equilibrium. In the face of the scale of the problem, it is not certain that the manoeuvre will succeed, for example, where there are psychopathic behaviours alternating with frank psychotic manifestations.[57]

Psychopaths.eu

Away from the scales, can a kind psychopath exist? If there were one who could lay claim to this title, it would be Frank Abagnale Junior. The latter turned his life as a psychopath into a book, which Steven Spielberg made into a film in 2002. In it Spielberg draws a portrait of a cold, seductive and

narcissistic conman, an expert in forging cheques and thus false names, and an antihero of family entertainment. Leonardo Di Caprio successively incarnates a young man, then a doctor, a lawyer and above all a pilot in the film. It was the era in which pilots practised the sexiest of professions within the serious-minded virile register. Pilots had *the right stuff* [English in original] and air hostesses were veritable *top models* [English in original]. Frank's father is presented as just as unreliable as John Le Carre's (which is really saying something) and his mother as an irresponsible, distant and narcissistic woman. She is, furthermore, French - an aggravating circumstance from the moral point of view. From this formidable mixture, Spielberg manages to produce an unsettling piece of entertainment, which follows its course towards complete misunderstanding. The *New York Times* critic, Stephen Holden, could not stop himself regarding the film as "the most charming of Mr. Spielberg's mature films".[58]

We could say that Frank Abagnale is not a psychopath but a mythomaniac, who found himself pacified by prison and the neo-paternal obstinacy of his plaintiff; or else we could say that he would have a very bad score on the Hare scale, etc. Undoubtedly, but this does not change the fascination that the cold narcissism of the psychopath exerts through his action, which is placed at the same time outside the comprehensible motivations of neurosis, and outside the reactions of manifest psychosis or homicidal perversions.

What question does he pose for us? For us, the clinic of the symptom as a whole is distributed between, on one hand, the signifying side of its formal envelope, and on the other, the libidinal charge of the object *a*. The two sides are linked like the faces of a Moebius strip. We can also say that these two dimensions are held together by the link of the sinthome. Truth and jouissance are thus caught in a continuous fabric. The sinthome, as approached by the psychoanalytic experience, designates, according to the phrase of J.-A. Miller, "a real for psychoanalysis". This real obeys no law. On the contrary, it designates what provides an obstacle to the regulation of the speaking being. The non-regulation located by the "psychopath" entity is a limit case. It is the subject who obeys nothing. It is a residual figure onto which are knotted jouissance and norms, without transcendence and without appeal to interdiction.

According to Lacan, this real that psychoanalysis deals with testifies to the omnipresence of jouissance in the Other. The fascination with the

way the psychopath acts is founded on the idea of a being who would be "all jouissance". He would have thus broken from the signifier in a different, though just as efficacious way as the autistic person, the limit case in the field of psychosis. In fact, the "ideal" psychopath repeats actions that never result in an act. These actions testify to the missed encounter with the traumatism of language.

The psychopath acts in such a way that he is unaware of the interdiction and the dialectic that links him or her to transgression. He does nevertheless reminds us, in his own way, that the central question for the speaking being is the place of jouissance, which the interdiction only serves to indicate. Lacan does not formulate the interdiction without jouissance. Interdiction protects from jouissance that causes anguish. That is why, in his "Discours aux Catholiques", he approaches *Totem and Taboo* from the starting point of anxiety and phobia: "The reflections in *Totem and Taboo* turn around the function of the phobic object, and it is that function that puts him on the path of the function of the Father. Indeed, the latter function constitutes a turning point between the preservation of desire […] and the correlative principle of interdiction, which keeps this desire at a distance. The two principles increase and decrease together if their effects are different – the omnipotence of desire engendering the fear of defence that ensues in the subject, the interdiction driving away the statement of desire from the subject, in order to make it pass to an Other, to this unconscious, which knows nothing of what supports its own enunciation." [59]

By putting the emphasis on jouissance, Lacan comes to express the knotting differently. Jouissance becomes first. The superego says: "Enjoy!": [*Jouis*!] and the signifiers of the Other find themselves implicated in it because the subject responds: "I hear!" [*J'ouis*!] The parasite of language, the Other as such, traumatises the body, and gives rise to the jouissance of the speaking being and to its encounter in the symptom or sinthome.

The psychopath is the reverse side of the sinthome. Far from being a saint, he or she is, rather, the damned of the symptom, and yet he or she makes a sign in its direction. For us, the co-morbidity of ODD, ADHD, generalised anxiety disorders (GAT) and other BPDs (borderline personality disorders), makes a sign towards RSI, SIR, IRS and towards the Name-of-the-Father as an instrument. These letters name the different modes of knotting the real, symbolic and imaginary, through which we

endeavour to think the symptom in its particularity. The traumatism of the language-parasite on the living produces the sinthome, a stump cell that enables the grafting of the language parasite on to the body, and fabricates the speaking being.

Our world is no longer experienced as dominated by a transcendent interdiction. Transcendence is no longer that of divine interdiction, which is so difficult to maintain now that science has silenced its voice. Yet, these days, the divine and science are articulated in another way. What takes the place of truth is scientific certitude, which is concerned with objectivity of the world. Eternal truths have given way to “objective truths”. God still roams around in it. Willard Van Orman Quine concluded his inspired 1953 article on “The two dogma of empiricism” with the statement of his private and ironic religion. In it he gave an epic turn to the god of philosophers and scholars. “For my part I do, *qua* lay physicist, believe in physical objects and not in Homer's gods; and I consider it a scientific error to believe otherwise. But in point of epistemological footing, the physical objects and the gods differ only in degree and not in kind. Both sorts of entities enter our conceptions only as cultural posits. The myth of physical objects is superior to most in that it has proved more efficacious than other myths as a device for working a manageable structure into the flux of experience.” [60] These objects and these gods designate a real outside of language. The pragmatism of Richard Rorty goes further and is opposed to any metalingustic conception of truth. For W. V. O. Quine, scientific law are those which support an “objective” real. It is the dimension outside of language that makes it possible for science to hold together through its impossibility to resorb the real. For R. Rorty, there is no impossible point outside language any more. That is why his colleague Simon Blackburn reproaches pragmatism for its levelling aspect, which is obtained solely by considering the usefulness of language games. Let us read what R. Rorty says about it: “Blackburn writes that pragmatism is characterised by ‘the denial of differences, the celebration of the seamless web of language, the soothing away of distinctions, whether of primary of primary *versus* secondary, fact *versus* value, description *versus* expression, or of any other significant kind. What is left is a smooth, undifferentiated view of language’. It is Blackburn who adds that this vision can easily lead to

'minimalism, deflationism, quietism'. This is precisely the way in which I understand language".[61]

Let us replace pragmatic utilitarianism with the satisfaction of jouissance and we will obtain a quietism of jouissance. For us, in the dimension of the other real, the real without law, the psychopath through his untreatable, repetitive, unregulated, mad action, outside meaning, reminds us of the presence of the primordial world from before any interdiction. The continuous fabric of language and jouissance does not authorise quietism. The psychopath attempts to produce a rent in the fabric, through the short-circuit of his action. The enigma of his way of doing things hangs over the circle of those damned by violence. This enigma has not yet finished questioning us. We can well imagine the consequence of the HAS hearing: the creation of a website. We will propose that it is filed under the name of the future domain: .eu. "Come on, gee up!" One more effort to deliver the studies of psychopathy from the shackles of the scale!

Translated by Michelle Julien

1. *HMO: Health Maintenance Organization*, health agency which supplies outpatient and hospital care in return for a premium paid for by members.
2. Krugman P., "Pride, prejudice, insurance", *The New York Times*, 7 November 2005; cf also McKibbin R., "The destruction of the public sphere", *London Review of Books*, vol. 28, no. 1, 05/01/06.
3. Conseil Supérieur d'Hygiène (working group under the direction of Pelc I.), *Psychothérapies: definitions, pratiques, conditions d'agrément,* advice n°7855 of the Conseil Supérieur d'Hygiène (Brussels) p.6 (available on the internet site of the Service Public federal (SPF) Santé publique, Sécurité de la Chaîne alimentaire et Environment); the authors refer here to the mental health reports that the WHO published in 2001, 2002, 2003 and 2005.
4. WHO, *Mental Health: New Understanding, New Hope* (Geneva, WHO, 2001). This report is available at: http://www.who.int/whr/2001), cited in the Conseil Supérieur d'Hygiène, *op. cit.*, p.6.
5. ECR: Randomised Clinical Trials.

6. Conseil Supérieur d'Hygiène, *op. cit.*, p.15-16. Cf. the references that this passage relates to: Luborsky L. Rosenthal, R., Diguer L. & co., "The Dodo Bird Verdict is Alive and Well – mostly", *Clinical Psychology: Science and Practice* vol 15 nº 1, 2002, p.2-12 (article available at: http://www.csun.edu/~gk45683/Lester_Luborsky.pdf);ed. Lambert M. J. *Bergin and Garfield's Handbook of psychotherapy and behaviour change* (New York: J. Wiley & Sons 2003) 5th Ed.; Lambert M. J., Ogles B. M., "The efficacy and effectiveness of psychotherapy", Lambert M. J., ed. *op. cit.*; Norcross H. C. ed, *Psychotherapy Relationships that Work* (New York, OUP, 2002); Wampold B. E., *The Great Psychotherapy Debate: Models, Methods and Findings* (Mahwah (NJ): Lawrence Erlbaum Associates, 2001).
7. Cf. L. Carroll., *Alice in Wonderland* (London: Penguin Classics, 1998) p.24-30
8. 'Caucus' is also a term from American political life. It refers to the coming together of declared supporters of a party voting for the investiture of a candidate.
9. L Carroll, *op. cit*.
10. Conseil Supérieur d'Hygiène, *op. cit*., p.18-19 & 45. Cf. also the works cited in this report: Messer S. B. "Empirically Supported Treatments. Cautionary notes" *Medscape General Medicine* 4 (4), 2002 (available on the website: www.medscape.com); Smith M. I., Glass G. V. "Meta-analysis of Psychotherapy Outcome Studies" *American Psychologist* Sept. 1977, vol 32 p.752-760; Shapiro D., "Meta-analysis of Comparative Therapy Outcome Studies: a Replication and Refinement" *Psychological Bulletin* Nov. 1982, vol. 92 nº 3, p.581-604; Shapiro D. A., Shapiro D., "Comparative Therapy Outcome Research: Methodological Implication of Meta-analysis", *Journal of Consulting Psychology*, 1983, vol. 51, p.42-53; Wampold B. E., Mondin G. W., Moody M. & Co., "A Meta-analysis of Outcome Studies comparing *bona fide* Psychotherapies: Empirically "All must have prizes", *Psychological Bulletin* 1997, vol. 122 nº 3 p. 203-215 (available on the internet); Grissom R. J., "The Magical Number .7 ± .2: meta-meta-analysis of the probability of superior outcome in comparisons involving therapy, placebo, and control", *Journal of consulting and Clinical Psychology*, Oct. 1996, vol. 64 nº 5, p. 973-982; Luborsky L.,

Rosenthal R., Diguer L., & Co *op. cit.*; Wampold B. E., *The Great Psychotherapy Debate*, *op. cit.*

11. Cf. Inserm, *Psychothérapie. Trois approches évaluées,* expertise collective Inserm. Paris., ed. Inserm 2004, report available on Inserm's website (http://ist.inserm.fr/basisrapports/psycho.html).
12. Conseil Supérieur d'Hygiène, *op. cit.*, p. 45.
13. Inserm, *Psychopathérapie…*, *op. cit.*, p. 44
14. Pignaarre P., *Comment la dépression est devenue une épidémie*, Paris, La découverte, 2001, p.81-82
15. Rose S., in "Will science explain mental illness?", *Prospect,* n° 115, Oct. 2005, p. 28
16. The first results of this study were presented in June 2004, cf. March J., Silva S., Petrycki S. & Co., "Fluoxetine, cognitive-behavioural therapy, and their combination for adolescents with depression. Treatment for Adolescents with Depression Study (TADS) randomized controlled trial", *JAMA*, August, vol 292, n° 7, p.807-820.
17. Carey B., "Pills or talk? If you're confused, no wonder", *The New York times,* 8 June 2004.
18. Hugenet G., *Antidépresseurs. La grande intoxication. Ce que 5 millions de Français ne savent pas,* ed. Le cherche midi, Paris, 2004, p. 201.
19. Castot A., in Hugnet G., *ibid.*
20. Carey B., "Antidepressant safety debate may include adult patients", *The New York Times*, 18 February 2005.
21. Cipriani A., Barbui C., Geddes J. R., "Suicide, depression and antidepressants" *BMJ*, 19 February 2005, vol. 330, n° 7488, p. 373-374. This article and the three studies that they comment on (published in the same issue of the BMJ) are available on the BMJ's website (http://bmj.com).
22. Conseils Supérieur d'Hygiène, *op. cit.* p.45-46. The authors also quote the ideas of Roger Perron & coll. Here: "Comment des gens, s'il s'en trouve, qui s'appliquent ainsi à ne pas soigner peuvent-ils se croire et se dire 'psychothérapeutes?" (Perron R., Brusset B., Baruch C., & co., "Quelques remarques méthodologiques à propos du rapport Inserm *Psychothérapie. Trois approches évaluées*", 2004, available at: http://www.spp.asso.fr/Main/Actualites/Items/24.htm.
23. Westen D., Novotny C. M., Thompson-Brenner H., "the empirical status of empirically supported psychotherapies. Assumptions,

findings, and Reporting in Controlled clinical Trials", *Psychological Bulletin*, 2004, vol. 130, n° 4, p.658 (article available on the internet). We will give some of their conclusions here: "The average RCT for most disorders currently described as empirically supported excludes between one third and two thirds of patients who present for treatment, and the kinds of patients excluded often appear both more representative and more treatment resistant in naturalistic studies. For most disorders, particularly those involving generalized symptoms such as major depression or GAD, brief, largely cognitive-behavioural treatments have demonstrated considerable efficacy in reducing immediate symptomatology. The average patient for most disorders does not, however, recover and stay recovered at clinically meaningful follow-up intervals. […] Despite frequent claims in the literature about treatment of choice, few data are available comparing manualized treatments with treatment as usual... what *is* known is that treatments in the community tend to be substantially longer than treatments in the laboratory, regardless of the therapist's theoretical orientation, and that in naturalistic samples, more extensive treatments tend to achieve better results according to both patient and clinician reports." Note that the studies referred to as "naturalistic" are studies conducted in ordinary care settings and not in the clinics of "research laboratories" on artificial, collaborating groups. This homage to nature is strange; perhaps it serves to deny the cultural dimension of the clinic.

24. Ablon J. S., Jones E. E., "Validity of controlled clinical trials of psychotherapy: findings from the NIMH treatment of depression collaborative research program", *American journal of psychiatry*, May 2002, vol. 159, p. 775 (article available on the AJP's website: http://ajp.psychiatryonline.org).
25. Jean-Michel Thurin describes it thus: "established in the mid 80s [and supported by the] *National Institute of Mental health* [NIMH], [this programme aimed to] test the efficacity of two forms of short-term psychotherapy in the outpatient treatment of depressed patients who are neither bipolar nor psychotic, corresponding to the diagnosis of Major Depressive Disorders. The two therapies which had been partially shown effective in anterior studies were cognitive-behavioural therapy developed by Beck and coll. at the University of

Pennsylvania and the interpersonal therapy described by Klerman, Weissman and coll. at new Heaven and Boston" (Thurin J.-M. "Le programme collaboratif de recherché sur le traitement de la dépression." 2005, available on the site *Technique psychothérapiques*).

26. J.-M Thurin concludes: "what one usually calls 'non specific effects' could well be the coexistence of specific technical factors in different therapies: an equivalent process, equivalent results" (Thurin J.-M., "Le programme collaborative de recherché…" op. cit.)
27. Despland J. N., in "Freud cloué au pilori", dossier realised by Sonia Arnal and Daniel Sibony, *L'Hebdo* (Lausanne), nº 41, 13 Oct. 2005, p. 24.
28. Conseil Supérieur d'Hygiène, *op. cit.*, p. 16: the "open clinical trials in natural contexts – without a control group, but with a greater external validity; the study on the effects of the processes, where the links between certain variables of the process and the (intermediary) effects are studied; the multiple 'case design', in the course of which the evolution of the process can be analysed in depth; in depth study on the specific procedures and the processes of change."
29. The first stage of this study was to get the consent of psychoanalysts, who, we are told, were 89% in favour of this study. The second stage was to determine a representative sample of all patients in long-term psychoanalytic treatment coming to an end in the course of the period determined by the study; this stage did not pose the problem of recruitment (n = 401). The material was multiform: recorded interviews, open or semi-open questionnaires… The interviews (two for each ex-patient, with an additional third interview with the analyst) were recorded and studied with the research worker. (Cf. Leuzinger-Bohleber M., Stuhr U., Rüger B. & co., "How to study the 'quality of psychoanalytic treatments' and their long-term effects on patients' well-being". A Representative, multi-perspective follow-up study", *International Journal of Psychoanalysis*, April 2003, vol. 84, nº 2m, p. 263-290).
30. The Conseil Supérieur d'Hygiène reports: "In their questionnaires, 75% of patients retrospectively qualified their general state as 'bad' before the psychotherapy and 81% qualified their general state as 'good' after psychotherapy; 80% of patients indicated positive changes in the course of long-term treatment in relation to their

psychical condition, their internal growth and in their relationships; between 70% and 80% indicated positive changes in their capacity to confront life's events, in their self-esteem and sense of humour, as well as in their satisfaction in their own life and in their efficacity."

31. *Ibid.* p.19-20
32. *Ibid*. p. 20
33. Miller J.-A., "Lacan, pour de vrai", *Le Monde des Livres*, 20 January 2006.
34. Thurin J.-A. "Une évolution de la conception de la pratique basée sur les preuves à l'Association Américaine de Psychologie (APA) ?", 2005, available on the site of *Techniques psychothérapiques*.
35. Conseil Supérieur d'Hygiène, *op. cit.* p.16. The authors here return to the article of Fulford K. W. M., "Facts/values. Ten principles of values-based medicine", in Radden J. ed. *The Philosophy of Psychiatry. A companion.* New York, OUP, 2004.
36. Strathern M., "The Tyranny of transparency", *British Educational Research Journal*, vol. 26, n° 3, 2000, p. 309.
37. *Ibid*. p. 313
38. Rodriquez Del Barrio L., Bourgeois L., Landry Y. & co, *Repenser la qualité des services en santé mentale dans la communauté*, Sainte-Foy (Québec), Québec University Press, 2005, third edition.
39. "The complexity of these problems run up against a margin of uncertainty and should incite us to maintain an open space of experimentation and evaluation of practices with plural criteria and points of view: those of the biological sciences and those of the human sciences; those of the mental health workers [*les intervenants*]; those of the users and of those close to them; the regional specificity and the way that these problems are understood and confronted by other cultures. Maintaining a plurality of perspectives and practices seems to be essential here for the advancement of knowledge and the hope of a better life for the key protagonists involved. Serious mental health problems generally involve profound, existential questioning for the persons who experience them." (Rodriquez Del Barrio L., Corin E., Poirel M.-L., "Le point de vue des utilisateurs sur l'emploi de la médication en psychiatrie. Une voix ignorée", *Revue Québécoise de Psyhologie*, 2001, vol. 22, n° 2, p.220, available online: hhtp://www.rrasmq.com/Publications.html).

40. The framework - in which the authors situate themselves, "proposes criteria and indicators of quality which will allow the evaluation of results, practices, organisation of service in the collectivity, as well as the institutional mechanisms required to guarantee its application and ensure the provision of a quality service. This particularly concerns the mental health sector, but it introduces considerations and a model of reflection which [could] be [applied to] many other domains of health and social services." (Rodriquez Del Barrio L., Bourgeois L., Landry Y. and co., *op. cit.*)
41. Brooks D., "Psst! "Human Capital", *The New York Times,* 13 November 2005
42. Cf. the "Preface" of the Inserm Report., Synthesis of the Report *Trouble des conduites chez l'enfant et l'adolescent,* expertise collective Inserm, Paris, 2005, p. IX. (available at: hhttp://www.inserm.fr/fr/questionsdesante/mediatheque/ouvrages). Also see the two following articles: Laurent D., "Les redresseurs de gènes et le tort fait au social", *La Cause freudienne,* n° 61, p.23-27 ; Misès R., "À propos de l'expertise Inserm relative au 'Trouble des conduites chez l'enfant et l'adolescent'", *La lettre de psychiatrie française,* n° 149, Nov. 2005, p.13-15 (available at : http://www.spp.asso.fr/Main/Actualites/).
43. Haute Autorité de Santé ed., *Prise en charge de la psychopathie*, public hearing, 15 and 16 December 2005, Paris, p. 169 (electronic document can be downloaded from http://www.anaes.fr).
44. *Ibid*.
45. Caroli F., "Psychopathie: genèse et évolution clinique", *Prise en charge de la psychopathie*, *op. cit.*, p. 14
46. As F. Caroli indicates, this disappearance, "follows directly the work of Cleckley (1941) finding the word psychopath stigmatising in *The Mask of Sanity*" (*ibid*.).
47. American Psychiatric Association, *DSM-IV, Manuel diagnostique et statistique des Troubles mentaux*, 4th edition, trans. J.-D. Guelfi & co, Paris, Masson, 1996, p.111-112 [English version consulted online: http://www.behavenet.com/capsules/disorders/odd.htm Trans.]
48. Lesourd S., "Psychopathie: genèse et évolution clinique. Psychopathies et normes sociales", *op. cit.* p.17.
49. American Psychiatric Association, *DSM-IV, op. cit.,* p.758.

50. Marcelli D., Cohen D., “Outils d’évaluation chez l’enfant et l’adolescent”, *Prise en charge de la psychopathie, op. cit.,* p.25
51. *Ibid.,* p.29.
52. D. Marcelli and D. Cohen thus note that: “the literature identifies with certainty three types of co-morbidity, externalised disorders (ODD and BD) for 40 to 90% of subjects with ADHD; internalised disorders (anxiety, depression) for between 25 and 40% of ADHD; learning disorders for 10 to 92% with ADHD […]. The co-morbidity with internalised disorders would be more common in children presenting an ADHD with predominance of inattention when the co-morbidity with externalised disorders appears more in subjects with ADHD with predominance of hyperactivity/impulsivity or mixed forms of it. *Ibid*., p. 27.
53. *Ibid.*, “Several computerised tests are available to evaluate attention deficit notably in the two dimensions of selective attention and global attention […]Up to now, the aetiology of ADHD remains unknown and the diagnosis depends on all the clinical elements gathered from the parents, from the child and the adults close to the child (teachers), on the careful study of history and on appraisals (neurological, cognitive, neuropsychological, of language…)”.
54. Pham T., “Outils d’évaluation chez l’adulte”, *Prise en charge de la psychopathie, op. cit.,* p.31-32.
55. *Ibid.* p.32
56. The amygdalian model of psychopath conflicts with others. For example, *The Economist* (“The Omega Point”, 19th January 2006, p. 72) echoes research on impact of Omega-3 acids on foetal metabolism regarding the regulation of serotonin: insufficient levels during pregnancy would lead to “pathological social interactions”, an “inability to make friends” and, later, to “aberrant behaviour”. Whether the model is amygdalian or based on serotonin levels, the psychopath has always been thus.
57. On this point see Zagury D., “L’expertise pénale des pscyhopathes”, *Prise en charge de la psychopathie*, *op. cit.,* p. 128-129.
58. Holden S., « Taking to a Gullible World like Mouse to a Swiss Cheese », *The New York Times*, 25 December 2002.
59. Lacan J., *Le Triomphe de la Religion, précédé de Discours aux Catholiques*, Paris, Le Seuil, 2005, p. 35.

60. Quine W. V. O. (1953), "Two Dogmas of Empiricism", in *From a Logical Point of View*, New York Harper, Torchbooks, 1961, p.44
61. Rorty R. in Engel P., Rorty R., *A quoi bon la vérité ?,* Paris, Grasset and Fasquel, coll. "Nouveau Collège de Philosophie" 2005, p.57