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Difficulties in Bridging the Gap Between Therapy and Artificial Intelligence

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Abstract

The use of artificial intelligence in psychotherapy shows promise for expanding treatment access and effectiveness, assisting therapist training, and personalizing interventions for anxiety and depression. However, ethical concerns, privacy, trust, and the preservation of the human element remain central. Researchers warn against overreliance on artificial intelligence, advocating for a collaborative model in which technology supports but does not replace the therapist. Barriers to acceptance include low technical affinity, fears of professional obsolescence, and artificial intelligence's lack of emotional empathy, ethical judgment, and contextual understanding. Strong regulation and clear communication of limitations are essential. The text also addresses physician arrogance, which undermines care and the doctor-patient relationship, contrasting it with the value of humility and patient-centered communication. It highlights the need to move beyond medical paternalism toward patient autonomy and shared decision-making. In psychoanalysis and psychotherapy, therapist variables influence outcomes, with a tendency to overestimate success and avoid acknowledging failures. The therapist narcissism - especially in group settings - can lead to distance, excessive idealization, and analytical stagnation. Transference relationships marked by envy, omnipotence, or seduction hinder therapeutic progress. The therapist must balance empathy with autonomy, acknowledge doubts in the "here and now," and metabolize unconscious aggression, avoiding narcissistic practices that harm patients. Failure to confront one's own narcissism, Brenman warns, risks damaging treatment effectiveness.

Keywords: Individual Psychotherapy, Group Psychotherapy, Psychanalysis, Countertransference, Transference, Therapy.

Abbreviation

AI: Artificial Intelligence

Introduction

The potential impact of artificial intelligence (AI) on psychotherapy. AI applications, such as chatbots and internet-based cognitive-behavioral therapy, show promise in enhancing treatment accessibility and outcomes for anxiety and depression [1]. AI could also facilitate psychotherapy training and increase treatment efficacy [2]. However, concerns persist regarding privacy, trust, and the human-AI relationship in mental health care. Some researchers caution against over-relying on AI, emphasizing the importance of maintaining psychotherapy's human-centric nature [3]. AI's potential to streamline therapy session analysis for training, quality evaluation, and research purposes is being explored by researchers and startups [4]. While AI offers innovative solutions to improve psychotherapy accessibility and effectiveness, experts advocate for a cautious approach that balances technological advancements with ethical considerations and preserves the essential human aspect of therapy.

Current AI is not yet capable of delivering fully-fledged psycho-

therapy on its own, due to challenges in understanding human psychotherapy and building therapeutic relationships [5]. AI can be used to enhance psychotherapy by characterizing affective areas, constructing genograms, determining degree of differentiation of self, investigating cognitive interaction patterns, and achieving self-awareness and redefinition [6]. The introduction of generative AI as an "artificial third" in psychotherapy can have a dramatic influence on perceptions of human relationships and the therapeutic process, requiring ethical consideration [7]. AI psychotherapists have potential benefits but also significant risks that require oversight and regulation [8-10].

It is important to highlight psychotherapists' uneasiness with AI in mental health care. While AI shows potential in diagnostics and treatment personalization, many therapists express concerns about its integration [11]. Factors influencing AI acceptance include perceived usefulness, technical affinity, and fears of professional obsolescence [12]. Psychotherapists emphasize the irreplaceable human qualities in therapy, cautioning against over-reliance on AI that could oversimplify human complexity. Key concerns include AI chatbots' lack of emotional empathy, ethical judgment, and contextual understanding [13]. To address these issues, clear communication of AI limitations, strong regulatory oversight, and alignment with user safety are essential. A collaborative model where AI assists but does not replace human therapists is proposed as the most ethical approach to integrating AI in psychotherapy.

Jesudason et al. discuss the potential risks and challenges of using AI in psychotherapy, highlighting the need for caution and regulatory mechanisms [14]. Brailas explores the implications of an AI therapist with access to all client data and superior intelligence, raising concerns about the uneasiness of psychotherapists in using such AI [15]. Tahan discusses the potential of using AI in psychotherapy, but does not address the uneasiness of psychotherapists in using AI [16]. AI offers innovative solutions for psychotherapy, but ethical concerns about its integration in mental health care remain.

Arrogance among physicians can negatively impact patient care and the doctor-patient relationship. Berger notes that physician arrogance violates medicine's benevolent spirit and can arise from sociological and psychological pressures [17]. Stambolović et al. observed meek patients and arrogant physicians in post-war Serbia, highlighting the need for improved communication [18]. Ruberton et al. found that physician humility positively correlates with effective physician-patient communication and patient health outcomes, suggesting that humble physicians are more effective than paternalistic or arrogant ones [19]. Castledine points out that some nurses attribute key communication problems in healthcare to doctors' superior attitudes and arrogant behavior. These studies collectively emphasize the importance of humility in medical practice and the potential negative consequences of physician arrogance on patient care, communication, and interprofessional relationships [20].

Doctors have a moral responsibility to intervene and help patients overcome constraints that impede their autonomous functioning [21]. The doctor-patient relationship should move from medical paternalism to enhanced patient autonomy through shared decision-making and patient-centered communication [22]. Training resident doctors in communication skills can improve their knowledge and attitude towards the doctor-patient relationship [23]. Structural constraints in the medical profession can lead trainees to arrogate decision-making about life-sustaining treatment, overlooking patient preferences [24].

Therapist variables can significantly impact patient outcomes in psychoanalysis and psychotherapy [25]. Therapists tend to overrate their success compared to patients and independent judges, often overlooking patients' dissatisfaction [26]. Psychoanalytic attitudes may be counterproductive when applied to psychotherapy, potentially explaining outcome differences between psychoanalysis and psychotherapy patients [27]. Despite evidence of progressive improvement in symptom distress and morale, especially in psychoanalysis, improvements in social relations remain weak for both treatment types. Notably, psychoanalysts often struggle to acknowledge and address treatment failures, side effects, and negative outcomes [28]. This reluctance may stem from various factors, including countertransference and other therapist-related issues. The high attrition rate in psychotherapy and psychoanalysis further underscores the importance of addressing these concerns. Therapists tend to overrate their treatment success compared to patients and independent judges, suggesting they may overlook patients' negative feelings.

Berghout and Zevalkink examines whether therapist variables like gender, experience, and attachment style affect patient outcomes in psychoanalysis and psychoanalytic psychotherapy. Sandell et al. does not address the effects of psychologist/psychoanalyst haughtiness on patient treatment outcomes. Kächele, Schachter discusses factors that contribute to negative outcomes in psychoanalytic therapies, including therapist factors like countertransference, but does not specifically address haughtiness effects. The paper of Freedman et al. does not appear to be directly relevant to the query about psychologists' and psychoanalysts' haughtiness affecting patient treatment outcomes. The authors describe the efficacy of psychoanalytic psychotherapy in terms of duration of treatment, frequency of the session, and therapeutic relationship [29]. Blatt does not address the haughtiness of psychologists and psychoanalysts, but rather the differential effects of psychotherapy and psychoanalysis on patients with different psychopathological configurations [30]. Therapists' professional and personal characteristics predict working alliance and treatment outcomes in psychotherapy [31]. The match between patient and analyst may play a significant role in the outcome of psychoanalysis [32].

In group therapy, what desire does the therapist respond to when he accepts to be in the place of therapist? And where does "this desire" have connections with "your desire" and your project as a psychoanalyst?

The therapist's desire is "pure analyzing" and promoting in the analysand the desire to analyze himself. The analyst is a model; if he is also a teacher, it will cause confusion. The shadow of the teacher, projecting itself on the one who has the role and responsibility of analyzing - which means, in an Other, the desire to be an analyst - can prevent him from listening to anything other than that which can consolidate his position as depository of knowledge. The analysand will identify with the faithful student, without perceiving what in this act of fervor is a pure effect

of transferential alienation. The analyst-teacher must be aware of this danger that lurks in him; he must, therefore, transmit to the analysand only the desire for analytical knowledge. Between what he offers and what he asks for, the game of seduction is even easier and more dangerous because it fully satisfies the narcissism of both parties. The teaching ends at the moment when the analyst becomes blind to the desire that placed him in this role. Even more serious: it will confuse, under the label of the student, those who expect from him an openness to knowledge and those who have the right to expect an openness to desire [33].

In group cotherapy, the therapist's narcissism is well observed. Envy is the powerful force, both for change and for growth, if it is used to be thought about, meditated and sedimented. In this condition, envy among co-therapists becomes libido and constructive. Therapist narcissism is best detected in cotherapy. The two therapists, mutually analyzing the countertransferences, help each other greatly and, ipso facto, help the analysands, thus avoiding unnecessary narcissism.

The therapist must not forget that he embodies the biblical myth of Job. He had houses, women and flocks, was politically powerful, full of friends and praised the name of God. The latter wanted to prove it: he took his goods, left him ragged on a pile of manure, abandoned by the women. Job was condemned without trial, becoming the "scapegoat" himself. He wept, groaned, and grieved, but he continued to praise God. The Other (God), touched by that faith, gives him back his goods and the respect of a citizen.

As in the case of Job, the analyst will inevitably be the target of the unconscious fantasies and envy of the analysands, just like a king or chief of a tribe - he will be venerated and respected by his subjects, but he will also become responsible for the misfortunes of the kingdom or of the elam. The crisis will then arise; rapid, irrational and terrible, foreshadowing the death of the "scapegoat". The analyst must assimilate this fantastic aggression, the result of the Oedipal calamity, and metabolize it, transforming it from thanatic into a libido, thus being able to return the "good" (God within him) through faith in his knowledge and attitudes.

The analyst, if he has narcissism, is felt by the patient as if he were full of "bizarre objects" with the power of cursing. What comes from the analyst will be experienced by the patient as something bad and nothing he says can be penetrated; the analyst becomes only an object of idealization and bearer of envy of the good - therefore inaccessible. It is necessary for the progress of the analysis that there is empathy, and for this to happen it is essential that the patient becomes a "bad son"; at the same time, the patient must remain at a certain distance for proper growth.

A patient's dream of Dr. Brenman's eating vegetables with flowers signals the fact that the analyst is giving too much and causing increasing envy. The analyst has become very distant, idealized, not allowing identification. We think that the higher the analyst is, the lower the patient feels, and hence the latter becomes more and more arrogant, arrogant and ironic. The analyst must show the patient as he is and not as the patient would like him to be - he must accept the "split" parts, the bizarre objects. Brenman cites, as an example, the tragedy of the Bacchae, by Euripides, and elucidates that in narcissism object love is normal. On the other hand, the therapist needs to have faith in the work he performs, because he will face very forceful groups that will test his patience and tolerance in order to confirm him strongly and, thus, be able to introject him [34].

For this to happen, the therapist needs to be careful not to be seduced by the group when it uses melodramatic, elegant and chaste language. If the patient likes to suffer with his mistresses, the same can happen during the analysis: he will cultivate suffering, that is, he will try to transform the analysis into a sadistic, cannibalistic-type sexual relationship, full of aggressive love and hate. He probably fantasized about his parents' relationship, perceived as a "combined figure" (stalker). He would be throwing the fragments of the "bizarre objects" and would be receiving them back as Lacanian "corps morcelés" - hence, in certain patients, the fear of dying during the genital act. It is the patient's fear of being destroyed by the therapist during the analysis and, concomitantly, the fear that the therapist will be destroyed by the analysand, thanks to the negative countertransference factor.

Nihilism (no breathing, no life) would serve to feel his internalized objects as "nothing", because that was how that patient was considering his own analysis. The opposite of "nothing" would be "knowledge", hence he avoids living with another person, because he could "know" his "other" - his alter ego - and this he did not want, out of fear; he preferred to stay with his narcissistic defense (lesser evil); however, being analyzed, there would be the danger of being unmasked and of feeling that his narcissistic parents treated him with a lot of hatred (feeling them as a combined figure - always persecutory - who would seek his destruction), and that he was excluded from the copulation of his parents. That is why he relived this copulation, submitting himself to an extremely sadistic and masochism process.

On the other hand, the therapist can enter the patient's idealized move, being considered as a "good father"; but falling into this game, out of comfort or omnipotence, can stagnate the analytical process, and it is necessary to study the countertransference situation itself to avoid the impasse. It can be very difficult to distinguish where normal pride ends and where omnipotence begins; there needs to be a balance between empathy and "living one's own life".

In this era of AI, the therapist who does not admit doubts - imaginary or real - in his analytical work would be exercising the most narcissistic of practices. It would not be a question of knowing or not knowing: it is a question of knowing "at that moment", in the "here-now-with me". According to Brenman, like the citizens of Thebes, if we ignore our narcissism, we risk detriment to our patients.

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In memoriam: Luiz Miller de Paiva.

Conflict of interest

None.

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