Psychoanalytic Theory and Clinical Relevance by Louis S. Berger

Hillsdale, NJ: The Analytic Press 1985, 213 pp.

Reviewed by: Arnold D. Richards, M.D.

Louis Berger's *Psychoanalytic Theory and Clinical Relevance: What Makes a Theory Consequential for Practice?* is a timely and important work, though perhaps more so for the questions it raises than for the answers it provides. Berger's central concern is the problem of the clinical consequentiality of psychoanalytic theory. His point of departure is his view that fifty years after Freud's death that theory still has not proven "clinically relevant." Presumed advances in clinical practice over this time, he argues, are not deducible from the evolving body of theory. Berger couches his critique in terms of "logical curtailment": "Were psychoanalytic theory in fact clinically consequential, then advances in practice ought to be deductively derivable from that theory. It should lead one, by deductive steps, to more effective clinical practice; one might say that such advances would be 'logically entailed' within a relevant theory" (p. 3). The testimony of a broad cross-section of ranking theorists and clinicians, as well as his own review of the literature, is then marshaled to buttress his assertion that synchronous progress in theory and technique has never typified psychoanalysis nor is it now the norm. Implicit in all this is the belief that psychoanalytic theory and psychoanalytic therapy *should* be so evolving.

Berger devotes the body of his book to showing why it is that psychoanalytic practice has not been "logically entailed" by psychoanalytic theory. He maintains that the latter is circumscribed by a reliance on "state process formalisms" (i.e., the logical-formal and empirical requirements of theorizing including the language in which it is done) and a preoccupation with "focal issues" derived from a "pure knowledge medical paradigm" (p.5). Berger's arguments against the logical positivist mentality enshrined in these formalisms are persuasive. Drawing on the work of an impressive array of philosophers (e.g., Barrett, Heidegger, Kuhn, Merleau-Ponty, Quine, Rorty, Toulmin, Wittgenstein), he makes the point that "the disarmingly simple, apparently transparent notions of 'objective' ('presuppositionless') observation or description separable or distinct from 'theoretical' explanation have turned out to be untenable and fallacious and an epistemologist's nightmare to boot" (p. 68).

Berger concludes his book by considering the implications of his critique and tries to do better than those who have preceded him, e.g., to "delineate general formal and focal guidelines for clinically relevant theorizing" (p. 178). His final chapter offers "a more specific outline of how a clinically relevant theory might look." It is to Berger's credit that he does not rest content with the role of critic; he tries to outline the form a "better" theory might take, stressing that his own thinking on such matters is still very much in flux.

In the first part of the two sections to follow I present three criticisms of Berger's basic assumptions; in the second section I consider his proposals for a more clinically relevant theory.

I

The Definitional Problem

Berger's critique suffers from his failure to define basic concepts. In particular, a clear definition of psychoanalytic theory is never given. He does say, however, that "psychoanalytic theory is a single, unitary entity" (p. 31), whereas I have argued elsewhere (Richards, 1982) that it is better understood as a set of discrete but interrelated theories—e.g., a theory of development, a theory of pathogenesis and symptom formation, a theory of the therapeutic process and cure, and the theory of how the mind works. Berger seems somewhat aware of this issue when he questions the value of the hierarchical ordering of psychoanalytic theory that is associated with Waelder: "Some may object to my treatment on the ground that it lumps together all analytic theorizing, rather than dealing with each hierarchical level of theory as a separate case" (p. 13). His argument, with which I am in sympathy, is that certain circumstances particular to analysis cast doubt on the notion that its theory can be hierarchically ordered. But the claim that different analytic theories cannot be ordered in terms of levels of abstraction does not touch the fact that different analytic theories with different content indeed exist.

A definitional problem is apparent also when Berger speaks of his failure to find "at least a few clear and explicit instances of significant technical recommendations for practice that had been logically deduced or derived from theoretical considerations" (p. 20). Berger does not make clear here exactly what he means by "technical recommendations." Analytic practice is clearly not reducible to a set of cut-and-dried rules. Berger's point may obtain if one narrows the questions so that one is looking *only* for specific relations between psychoanalytic theory and narrow technical procedures. But I would question just how

essential such connections are to the broader issue of clinical relevance. Consider, by way of analogy, the artist's knowledge of pigment and perspective; such knowledge undoubtedly affects the way he or she paints a picture, but it hardly encompasses the development of an artistic sensibility or the processes at work in the creations of a good painter.

The Equation of "Change" with "Advance"

Berger assumes throughout that change in theory is equivalent to advance in theory, from which technical gains should be derived. This assumption is unfounded. Certain theoretical innovations may not represent genuine advances and may even be retrogressive with regard to therapy. I have argued elsewhere, for example, that the self psychological emphasis on contentless mental states impedes the analyst's ability to help patients understand important conflicts and unconscious motivations (Richards, 1981). The question that must be asked, then, is which of the many theoretical proposals in psychoanalysis *do* represent genuine progress. Here honest men and women may disagree. Berger, ignoring the distinction between genuine and spurious advances, turns repeatedly to the work of Gedo, Kohut, Schafer, Kernberg, and G. Klein to make his case. This perspective, skewed as it is toward work that promotes itself as innovative, overlooks theoretical developments that may connect less equivocally to clinical work. The development of ego psychology following Freud's second theory of anxiety resulted in a significant shift from id analysis to defense analysis. A more recent example is Charles Brenner's view of depressive illness as not specifically related to oral conflicts of a preoedipal cast. His contention that calamities may arise from other developmental phases as well is clinically relevant in the sense that it leads to a therapeutic orientation toward the depressed patient different from that derivable from "classical" theory, with its focus on oral conflicts.

Berger's skewed perspective is evident in his consideration of borderline pathology. Using the work of Gedo, Kohut, and Kernberg, he demonstrates that in regard to this nosological category the claim for a "theoretical grounding of recommended therapeutic techniques and principles" is spurious (p. 18). His point is that alternative clinical approaches are compatible with the formulations of these theorists. True enough. The problem he ignores, however, is that the formulations themselves are problematic, quite apart from their technical applications. For example, the three differ among themselves on the fundamental issue of the role of conflict and deficit in borderline psychopathology, a difference that shows itself in their technical recommendations. The work of Gedo, Kohut, and Kernberg cannot be lumped together as a unitary version of "psychoanalytic theory" and it is not self-evident which if any of their respective claims are indisputable "advances" in the understanding of borderline psychopathology.

The Medical Paradigm and Psychoanalytic Theorizing

Berger's critique includes the proposition that psychoanalytic theorizing occurs within what he terms the "pure knowledge medical paradigm (p. 5). This paradigm includes (1) an emphasis on the centrality of pure knowledge; (2) an adoption of beliefs and practices borrowed from medical theory and research; and (3) the ambition to make psychoanalysis a general psychology. For Berger the medical paradigm has distinctly negative connotations; theorists who operate within it aim, somewhat paradoxically, at an understanding of disease at the expense of the practical knowledge relevant to therapy. Here, Berger has put up a straw man. The dichotomy between pure knowledge and knowledge with useful application is overdrawn, Freud's own commitment to knowledge for the sake of knowledge, which Berger underscores, notwithstanding. Any knowing—this according to Berger himself— may be said to have "application," as it necessarily alters the knower and to that extent results in change. It oversimplifies matters greatly to characterize the contemporary medical model as concentrating on pathology at the expense of treatment. As for psychoanalysis, the analyst tries to let his understanding—his theory—of pathology inform and mobilize his attention to process issues and therapeutic action to the benefit of the patient. Berger does not succeed in proving unwarranted the belief that progress in treating illness generally follows progress in understanding it. Further, his indictment of the medical model makes no allowance for the fact that an established relation between new knowledge and clinical practice need not issue in therapy that is invariably effective. It is true, for example, that advances in cardiac physiology have enhanced the ability to treat heart disease. If despite this, certain conditions remain unresponsive to treatment—patients continue to have fatal coronaries—this fact does not call into question the accuracy of medical knowledge. Finally, regarding the question of psychoanalysis as a general psychology, it is of course true that certain analysts, notably Heinz Hartmann, have aspired to this program. Most contemporary analysts disavow this goal, however, recognizing that psychoanalysis does not speak to every aspect of human behavior.

II

Berger's approach to the pragmatics of clinical practice is an outgrowth of his critique of the hierarchical organization of theories. Citing the philosopher J. C. Graves, for whom different theories operate on qualitatively very different cognitive levels, he argues that clinical theory operates on a cognitive level different from that of other psychoanalytic theories. One of the benefits accruing to the recognition of the cognitive level specific to clinical theorizing is that "a theory that has its own separate cognitive level could provide a convenient independent framework within which specialized needs for a new kind of formalism might be identified and met" (pp. 117-118). For Berger this new formalism is embodied in the notion of the "process narrative." Following the strictures of historian J. H. Hexter,

Continued next page

BERGER from page 9

who poses utility as the primary test for adequacy of discourse, Berger argues that clinically consequential theorizing must be guided by a pragmatic focus that reflects the requirements of clinical practice. Such theorizing does not rush to an a priori determination of what constitutes acceptable theoretical discourse; it does not "simply fall in line with some preconceptions about what supposedly constitutes scientific language" (p. 119).

These assertions are compelling as far as they go, but I think there is more to theory-making and theory-building. What Berger leaves out is the idea that playing is an essential stage in theorizing—playing with ideas and concepts. It is always hard to know just when such "playing" will have pragmatic consequences, and it may be that proscribing the analyst from playing with ideas that are not immediately and demonstrably consequential will hamper the process of discovery. But an even more serious flaw is that Berger's pragmatic strictures give short shrift to the crucial status of the psychoanalytic method as the foundation of psychoanalytic theorizing. Clinical pragmatism may follow more from an open-minded receptiveness to the yield of this method than to the development of a clinically pragmatic theory per se. Psychoanalysis becomes scientific by virtue of a methodology appropriate to its domain, namely the psychoanalytic situation (Brenner, 1968).

Finally, one may take issue with the claim that psychoanalytic theory has indeed been developed to fit a certain "preconception about what supposedly constitutes scientific language." This criticism is applicable only to certain aspects of psychoanalytic theorizing, the economic model, especially, and the tendency of structural theory to lapse into reified notions of id, ego, and superego in clinical explanations. Berger ignores recent attempts to recast psychoanalytic discourse in accord with the requirements of conflict psychology. The efforts of Arlow, Brenner, and A. Kris (and, more recently, of Abend, Porder, and Willick) meet Berger's requirements for clinically useful discourse; they place the person in conflict at the center of the analytic field and describe that person in the ordinary language that Berger commends.

In his belief that language is an integral part of the life world and, as such, is usually transparent, Berger appears to join forces with those analysts who over the past decade have criticized Freudian metapsychology and the mechanistic language in which it is cast. I say "appears" because Berger is in fact quite critical of the post-Rapaport school. Theorists identified with this movement correctly identify the problem, according to Berger, "but unwittingly return us to those very state process formalisms from which they sought to escape" (p. 138). Schafer, he believes, "continues to operate within a formalized framework, although the formalization is masked" (p. 140). Likewise, G. Klein remains trapped within the pure science medical paradigm, his emphasis on a nonmetapsychological clinical theory notwithstanding. Sherwood's narrationist approach is faulted for not providing "clear cognitive distinctions between Cartesian and non-Cartesian conceptions of discourse" (p. 139). Hermenutic critiques fail because founded on the assumption that "the material is opaque and in need of translation" (p. 137). Even those most committed to historical, narrationist, and personalogical approaches to analysis, Berger asserts, have failed to rid themselves of the state process formalisms associated with mechanistic and biological models of explanation.

In his final chapter, "Speculations and Generalizations," Berger continues in this vein, taking as his point of departure Rorty's distinction between theory that is "systematic" (i.e., that continues and systematically adds to an established tradition) and theory that is "edifying" (i.e., that looks at the status quo in a radically new way but without offering alternative "systems" or prescriptions). Placing his own work within the latter category, Berger looks at recent "systematic" works that attempt to provide corrections to the approaches he has criticized. Specifically, he hones in on recent theorizing that invokes a general correlation whereby the psychological status of the child is translated into analogous adult pathology, and childhood environmental phenomena, benign as well as malignant are translated into analogous environmental features of the therapeutic situation. Such translations entail pitfalls, including the genetic fallacy, and are typically undertaken casually, with no explicit rationale.

It is from this standpoint that he criticizes Gedo and Goldberg for positing specific treatment modalities correlated to archaic phases of development "too quickly, too casually, and without theoretical examination" (p. 31). In the same spirit he criticizes Kohut's translation of the environmental needs of the child during early development into analogous therepeutic needs in the adult who exhibits a self disorder. Berger concedes that Gedo and Goldberg's and Kohut's recommendations may find empirical support and be effective therapeutically; but that is not his point. Rather, what Berger calls attention to is a matter of formal theoretical treatment:

> I maintain that given the pragmatically central role that translation plays in the kinds of correlation frameworks I have just outlined, it follows that these translations merit much more focused attention, a much more explicit methodological treatment than they have received to date. Where are the specific, orderly procedures that provide and spell out the rationale for a given clinician's translations? . . . I maintain that clear, explicit explanations are nowhere to be found (pp. 155-156).

Given Berger's attention to the epistemological foundations of the theories he criticizes (or the lack thereof), it is dissappointing that in advancing his own position he falls back facilely on certain traditional categories. He takes as a consensus position, for instance, that pathology, psycho-

analytically understood, can be understood as either oedipal or preoedipal. The fact that patients may at certain junctures present material that is relatively oedipal or relatively preoedipal in content does not necessarily "translate into two distinct classes of pathology correlating with two distinct developmental periods." As Paul Wachtel (1987) has recently pointed out, the fact that "pregenital" (or preoedipal) themes are common in the associations of individuals diagnosed as narcissistic personalities says nothing about the point of origin of narcissistic disorders.

From this unanalyzed assumption of the existence of preoedipal and oedipal pathology Berger proceeds to the conclusion that the former category of disturbance requires "expanded" analytic theory and that "a central ingredient of that therapy comprises analogues to the mother-child setting and interaction" (p. 163). But this position is a consensus among analysts no more than is the dichotomy on which it is based. Over and against Modell, Friedman, and Lichtenberg, whom Berger cites (pp. 163-164), should be placed Arlow and Brenner's reminder that to assume that what goes on in the analytic situation mimics mother-child interactions (and that termination always harkens back to weaning from the breast) is to ignore other issues that may be equally important.

Throughout *Psychoanalytic Theory and Clinical Relevance,* Berger is guided by his belief that state process formalisms typifying a natural science methodology are not suitable for disciplines which, like psychoanalysis, "deal with the domain of the person." Predictably, the outcome of his critique is a thoroughgoing humanism, anchored in a philosophical commitment to pragmatism and ordinary language process narratives. And there's the rub. Berger wants to solve the Cartesian dilemma by opting for one horn of the dilemma over and against the other; despite his criticisms of hermeneutically informed theorizing, his proposals for clinically relevant theorizing come from the side of hermeneutics. But such a position flies in the face of the clinician's awareness of the inherent dualities of human existence. I would argue, contra Berger, that such dualities are intrinsic to the data evoked by the psychoanalytic method: mind and body, biology and history, nature and nurture are always conjointly operative in the yield of psychoanalytic inquiry. Berger's radical narrationist approach addresses the basic ambiguities of human experience no more convincingly than do the biological emphases of psychiatric training. The fact is that analysts have no single discourse that can encompass the domains of meaning and causality that are implicated in human psychological functioning; until such a discourse is developed they must be content to use discourse appropriate to the natural sciences and to hermeneutics alternately, successively, and, perhaps at times, simultaneously.

Berger is to be commended for his effort to parse psychoanalytic theory by showing the limitations of the state process formalisms that are part of the analyst's natural science heritage. But his book is edifying only so long as we take it as a thoughtful eludication of our ongoing dilemma.

References

Brenner, C. (1988) Psychoanalysis and Science. *Journal American Psychoanalytic Association,* 16: 675.

Richards, A.D. (1981). Self Theory, Conflict Theory, and the Problems of Hypochondriasis. *Psychoanalytic Study of the Child,* 36: 319.

Richards, A.D. (1982). The Superordinate Self in Psychoanalytic Theory and the Self Psychologies. *Journal American Psychoanalytic Association,* 30: 939.

Wachtel, P. (1987). *Tikun.*