The Rationale of the Clinical Process[*]

Pier Francesco Galli[**]

Abstract. Several issues regarding the rationale that is behind the clinical process are critically examined. Some of these issues are the following: the transmission of psychoanalytic technique and its misunderstandings, the problem of truth in psychoanalytic interpretation, measurement and verification in psychotherapy, the gap between theory and technique in psychotherapy, the role of the therapist's personality factors, the problem of "classical" psychoanalytic technique and its "as if" relation with theory, "classical" psychoanalytic technique as a mark of credibility of a social group, the shift in psychoanalysis from the criterion of "truth of interpretation" (a strong concept) to that of "truth of the therapeutic frame" (a weak concept), the role of insight and the concept of the "function" of insight, the role of empathy and of unconscious communication, the conception of *Praecoxgefühl* (a feeling or experience of the schizophrenic patient on the part of the therapist) formulated by H.C. Rümke in the 1940s as a threat to classical nosography within traditional European psychopathology (i.e., the use of a criterion associated with experience and affects has been employed even in the realm of descriptive objectivity), and so on.

Key Words: Psychoanalytic theory, Theory of psychoanalytic technique, The "truth" of psychoanalytic interpretation, H.C. Rümke's conception of *Praecoxgefühl*, Relation between theory and technique in psychoanalysis.

My address has basically three objectives which intersect in different ways. From a clinical perspective and according to the psychology statute, it is first necessary to give the right of citizenship to the clinical process within the field of scientific psychology and eliminate sterile comparisons from the debate. I will endeavour today to demonstrate, through the identification of specific areas subject to verification, how, within the history of psychological thought, the clinical process plays a central role within the theoretical discussion on the method in general. My second goal is to provide a tentative contribution which particularly stimulated reflection on the facts, revelations, and observations that derive from the clinical process. My third aim is to underscore that much too often (and it has happened as well at this meeting[1]), when psychoanalysis is alluded to, it seems as if we know what is being referred to. Herein lies the basic error: psychoanalysis has passed through a series of vicissitudes that have undermined the establishment itself of a theoretical discourse within the discipline, in particular after the identification of the limitations of the criterion of "the truth of interpretation". The specific moments of the evolution of psychoanalytic thought are presented in a series, often without an in-depth grasp of their implications, therefore possibly causing the impression of solidity in the body of doctrine. This fact, coupled with the omission in Italian history that still lingers in the absence of a specific critical culture, fosters the misunderstanding of an apparent synchronicity, both in terms of concept and methodology, and ultimately plays a deeply misleading role.

I will now attempt to point out some problems internal to the clinical issue in order to give it as lucid a character as possible, by pointing out, with a minimum of conceptual specificity, those

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[**] Via Garibaldi 3, 40124 Bologna, Italy, E-Mail <pierfrancescogalli@libero.it>.

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questions and doubts that could still be raised to this day. I would like to start with an old definition that I used in 1964 (Galli, 1964; see also Galli, 1962, 2006) when once again the clinical discourse had been inserted in every respect into the realm of *Science* after the crisis of the radical neo-positivistic approaches. The criterion of *a priori* verification of each and every fact that was inputted into the creation of hypotheses had resulted in methodological sterility and redundancy. The so-called position of *empirical realism*, defining the historical function of scientific discoveries, had applied the concept of individual human ability to *carry out operations of prediction with a minimum of information.* From this perspective, the specific and unique role of the human individual constitutes the centrality of the issue of clinical process. I saw this position as linked to the learning of this *ability* and therefore to the mechanism of making it possible for some to maximize this ability: in this way I classified the issue of training in psychotherapy and the establishment of psychotherapeutic practice in all their implications with regard to the problem of measurement, in terms of an *a posteriori* verification, and therefore with regard to a crucial theme in psychology.

I will now present a second aspect of this problem into which I would also like to insert the element of psychoanalytic activity. If we accept the centrality of the operation carried out by an individual human, this centrality must be subject to a deconstruction, which allows for a recognition of its components. From a research perspective, we can define the field along a bipolar axis. One pole is represented by the close tie between therapeutic behaviour and theoretical indications; the other pole is represented by the degree of maximum freedom with respect to theory. Along the axis we place the various levels of transformation that the therapist achieves in practical terms, with respect to the operations that he/she should achieve in theoretical terms. These transformation levels are: a) an indicator of the gaps within the theory of technique, something that is verifiable for any theory including the most rigorously behaviouristic; b) an indicator of the personality factors of a given clinician in general and in a given particular situation.

Therefore we have two possible types of measurement: one which concerns the gaps in theory, the other which concerns personality factors. Both of them refer to specific characteristics of the clinical process. These aspects can be studied in the psychoanalytic realm, inasmuch as we can prove that the clinical operations achieved in practice have a rather minimal link to theory. In fact when examining the history of how much it has been considered as a prescription of the so-called *classical technique*, it becomes clear that therapeutic behaviours were actually generated in an "as if" type of relationship with theory. This "as if" type of relationship has been transmitted in dogmatic terms and creates the fantasy of the existence of a *classic psychoanalytic technique.* In fact the system of consensus of a particular social group has been passed down as a derivation of theory. Hence the term *classical technique* only demonstrates the mark of credibility that a given social group has been able to attain as a result of factors that have little to do with the validity of the theoretical system. Moreover, as soon as some concepts considered fundamental were subjected to critical investigation, they were abandoned in favour of others without changing the acritical and dogmatic relationship with the theoretical proposition. In this respect, we have an indicative example in the shift from the criterion of the *truth of interpretation* to that of the *truth of the therapeutic setting* (i.e., the ground rules of therapy, the concrete arrangements between analyst and patient such as the couch, the weekly frequency, etc.). A relationship of this kind with theory certainly serves to maintain the identity of the psychoanalyst and therefore of the *specialist-practitioner* social group. This factor however must not be mistaken as an indicator of theoretical coherence. When in the 1950s David Rapaport, a theoretician who was trained in psychology, began to explicitly explain the theoretical implications of psychoanalytic formulations, he was accused of neo-rationalism, of neo-Aristotelianism, for presenting abstract theoretical proposals in relation to the so-called clinical "reality". He had not elaborated an overarching theory with respect to the existing one, but he simply drew attention to the rational criteria of the psychoanalytic system of connections. Consequently, the rejection of metapsychology, seen as a leftover of the nineteenth-century culture of Freud, came into being. And beyond this: when philosophers such as Ricoeur (1965) subjected a certain kind of theorization of the concept of

interpretations to critical attention, and the vagueness of the conceptual apparatus of this psychoanalytic criterion of truth became evident, the loss of specificity in this area defined a relativization, the implications of which, for the stability of the theoretical system in its entirety, were not evaluated in full. Thus began the dismantling of the concept, later presented in terms of the relativity of a history, the construction of a history, the construction of a history that has its own internal character of plausibility. The concept of interpretation, that had been the indicator of the specificity of the method against the tendency to emphasize the importance of the emotional relationship, was however a strong concept with respect to theory. It was substituted by a weak concept, currently in revival mode, with which to define the method—namely the concept of *therapeutic frame* or *setting.* This concept is particularly weak whether in its relationship to theory or its implications. It is however a kind of "watchword" that has substituted the foundation of the concept of interpretation.

With respect to the verification criteria of the psychoanalytic process, it can be said that a keyword has practically disappeared from the literature—the term *insight*—a relevant concept, for instance, for issues in cognitive psychology. But we should not forget that, precisely in reference to the problems of *insight*, a line of demarcation had been drawn between *real and genuine psychoanalysis* and *child psychotherapy* or the *psychotherapy of psychosis.* The latter types could not be called psychoanalysis, in that it is believed that structures capable of receiving *insight* may not exist in either the child or the psychotic. This theoretical difficulty has been tackled by means of the concept of the *function* of insight. The clinical observation that an insight could be forgotten, therefore once again repressed, while the function that it had had, from the perspective of the formation of intrapsychic structures, could persist, has brought about the need to change the point of view of theory, moving from an approach in topical terms to the repositioning of the concept of *insight* from a structural perspective. The theoretical relevance of this problem for psychology in general is demonstrated by the connection, identified by the writers that dealt with it, to Piaget's ideas on the formation of structures.

At this point I would like to touch upon something else which concerns both psychoanalysis and classic psychopathology, and which, to my mind, has interesting ramifications from a philosophical point of view. I am referring to the issue of empathy. Freud adopts the term *Einfühlung* for the first time in 1921. The concept was again picked up by Helen Deutsch in 1926 in relation to unconscious communication, and it should be highlighted that, upon *reflection,* the analyst recognizes his/her affective state as not his/her own but as derivative of the other. We are therefore dealing with a knowledge based on the recognition of lived experiences. From the indications emerging from psychoanalytic study, emphasis is placed on the therapist's experience as a tool for increasing knowledge. This experience also becomes a diagnostic category at the moment in which one recognizes that there exist non-diagnosable pathologies in relation to their formal characteristics, but only through the feelings they provoke within the therapist. Psychoanalytic investigation therefore contributes in this way to the enhancement of the subject of the objectification of experience. It is interesting to note how the current problems of the self and narcissism in psychoanalysis, alongside the interest in the issue of experiences, entail an accentuation on the interest in the individual understood as a global being. Regarding the concept of self in psychoanalysis, we basically have two views on the matter: one, present for instance in Kohut (1971, 1977, 1984), considers the self in terms of maturation, as subject to the relationship, able to be transformed within the relationship, with a specific history in the relationship. The other position leads us to the centrality of a nucleus of survival removed from relational vicissitudes. Winnicott (1960), through a clinical study on serious child psychopathology, provides a dual definition of the self: he speaks of the *true self* and the *false self*, assigning to the *true self* a character of nuclearity subtracted from the principle of reality, one which is non-transformable and which is annihilated if reached. The *false self* is structured on the other hand in the relationship as a modality of protection of the *true self.* In this sense, as Professor Emanuele Severino (1985) has pointed out, a nucleus of persistence continues to draw philosophical attention to the problem of psychosis as the focal point of the exploration into subject formation.

Now I would like to propose placing this topic into a completely different conceptual realm, that of descriptive psychopathology. During the 1950s, traditional European psychopathology was in crisis in the face of the attacks coming from the results of the psychotherapies of psychotics, which had shown how even the most serious forms of pathology could be *reducible* to something else in the relationship. This threatened the foundational pillars of classical nosography, in that it cancelled out the qualitative differences in favour of the quantitative ones. Among others, the psychopathologist Henricus Cornelius Rümke (1957) tried to oppose this tendency, basing his line of defence on the hypothesis of the separate clinical entities around the schizophrenia diagnosis. In order to do this, he identified a factor which he considered crucial, in accordance with the so-called "first-rank" formal symptoms of Kurt Schneider. He identified this factor as a feeling, as an *experience of the schizophrenic patient*, naming it *Praecoxgefühl* and therefore referring to a criterion that harks back to the subject of the objectification of experience. Let us see what the ramifications are. Rümke says that above all we are dealing with a tool that only an expert observer can utilize. Thus this implies that it is subjected to the category of learning and detached from that of intuitive knowledge. This tool makes it possible to assign the character of "schizophrenicity" in the presence of symptoms that alone do not make it possible to differentiate the various schizophrenias from those he called pseudo-schizophrenias. (It is interesting to note how he has inserted into these latter a "Sechehaye-type schizophrenia" in contrast to the hypothesis of the reducibility of the schizophrenia arising from the therapeutic outcome achieved by Marguerite Sechehaye [1947, 1950, 1955, 1956, 1960] in her famous case *Renée* using the technique of "symbolic realization"). This tool, in addition, makes it possible to recognize schizophrenia anywhere, in any geographic location (therefore removing it from socio-cultural influences). As Hemmo Müller-Suhr has pointed out in a paper published in the journal *Nervenarzt* in 1958, given that it is not about indicating its placement on a scale between determinate and indeterminate, this type of recognition has the character of phenomenal indeterminateness and makes it possible to recognize the *schizophrenic*—not schizophrenia, but the *schizophrenic.*

It is also in this way that one arrives at the identification of a foundation nucleus, pertinent to the issue of subject formation, assigning cognitive value to the emotional component. Beyond the heuristic value of these considerations, I have wished to point out, as a conclusion to my participation in this discussion, how, even in the realm of descriptive *objectivity,* a criterion associated with experience and affects has been employed. It has been employed in this context in order to uphold a position that made it possible to redefine in terms of *necessity* the biological study into the schizophrenic as a specific entity in support of a particular system of thought. In view of the fact that the current tendency in the psychoanalytic field is often one of assigning to empathy the character of something free, spontaneous, and detached from the limitations of *rationality,* it is important to recognize that empathy is not something more human, and affects are not, in and of themselves, more *spontaneous.* The signs of affect are only such if *recognized* in their differentiation and cannot be separated from successive reflection. This does not represent a constraint on knowledge, and the emotional life can be subjected to the same categories of stereotyping, rigidity, and repetitiveness of which we accuse the rational mental function.

In conclusion, I hope that I have been able to demonstrate how psychological-clinical exploration is not inevitably only a scattering into the winds of the ineffable.

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