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Validating psychoanalysis: what methods for what task?

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To clarify the various issues involved in Grünbaum's critical appraisal of psychoanalysis it is imperative to differentiate among three methods used by psychoanalysts:

(a) The psychoanalytic method, a clinical technique for observing a patient by listening to him in a state of evenly suspended attention and influencing him by giving him "answers" to his "questions." This takes place within a dialogue; it has been a self-misunderstanding of psychoanalysts to conceive their interpretative activity, including the so-called preparatory actions such as confrontations, clarifications, and even sometimes questions, to be similar to an independent variable introduced by an experimenter in a laboratory setting. Research on actual tape recordings of sessions has amply shown that psychoanalytic dialogues are but a highly technical and rule-specified variant of discourse. Discourse analysis has only to spell out the specifics of the conversational rule system that underlies the manifold clinical recommendations. The "questions" of the patient are represented by the sections of his personality he does not understand and are initially presented in the form of symptoms, which are then transformed into relational patterns (transference neurosis). These enable the analyst to elucidate for the patient what he is asking for. The "answers" of the analyst consist of metacommunications about what the patient wants (e.g. see Flader, Grodzicki & Schröter 1982).

We agree with Grünbaum's verdict that the causal role of any agent in the etiology of neurosis cannot be definitely established by the clinical knowledge accumulated within the frame of this Socratic enterprise.

(b) The psychoanalytic collective thinking method: The experiences gained by each psychoanalyst in the analytic setting are pooled together in a highly unsystematic way, comparable to ethnologists coming home from their field work and trying to systematize their collected data. This process is heavily influenced by the prevailing conceptions – theoretical and clinical – of the group in which the individual psychoanalyst has been trained and with which he works. This feature accounts for the academic aspects of psychoanalytic groups, which have been an object of criticism from prominent outsiders within the psychoanalytic movement from very early on. However, if science must also be regarded as a social enterprise, this kind of collective thinking can be found in all kinds of scientific endeavors. If the concept of clinical science has any meaning at all, it refers to this process of mutual stabilizing of intervention procedures and interpretations. For psychoanalysis as a method to be more than a mere observational technique, aiming to achieve change in patients, it must share with many other respectable scientific enterprises the epistemic problems of intervention paradigms.

One would wish that philosophers of science like Grünbaum would devote more attention to the epistemological evaluation of such processes of joint collaboration of many people over many decades. To belittle clinical wisdom as Grünbaum does when he quotes Luborsky and Spence (1978) on the present state of quantitatively controlled knowledge versus the vast body of clinical knowledge bypasses the fact that psychoanalytic therapy, although probably built on epistemically weak foundations, has proven to be as effective as other psychological treatment modalities. Why does it work at all, and why has behavior therapy, originally claimed to be rooted in experimental psychology, nowadays been reduced to a synonym for "methodologically controlled psychotherapy," rejecting any simplistic theoretical embedding in learning theory?

(c) The extraclinical method: A small number of psychoanalysts have engaged in systematic research on therapeutic processes based on careful documentation of the transactions of the analytic session. Considering the complex issues involved in building up a research methodology that can claim

to capture the decisive features of the therapeutic process, the results as compiled by Luborsky and Spence (1978) or Masling (1983) are highly encouraging; research begins to influence therapy, as reflected in Luborsky's own reversal of his 1969 opinion that "research cannot influence practice" (Luborsky 1984, p. 22). Grünbaum's repeated plea for experimental studies may be pertinent for selected parts of the clinical theory.

We have been able to show in a recently completed experimental study on the relation between trait anxiety measured by Spielberger's test and free association measured with Bordin's scales that there is an inverse linear relationship which overrides the impact of analyst/patient physical positions (face to face versus lying on a couch). The results will have therapeutic relevance to the extent that the analogue character of such experiments can be demonstrated by parallel investigations of transference-resistance features (Kächele, Hölzer, Heckmann & Robben 1985).

We agree with Grünbaum that the final validation of the causal hypothesis concerning neurogenesis would require large-scale epidemiological studies like Schepanck (1984), twin-studies (Schepanck 1974) and developmental studies such as Emde's work on the psychobiology of emotions in infancy (1980). There is a vast amount of work before us, and it may turn out that psychoanalysis as founded by Freud will undergo major changes or even dissolve into a new frame of reference. This possibility is echoed in Grünbaum's repeated observation that "It may perhaps still turn out that Freud's brilliant intellectual imagination was quite serendipitous for psychopathology and other facets of human conduct." In this statement he comes very close to an intuitive understanding of why psychoanalysts are not so disturbed with the epistemic weakness of their enterprise as so brilliantly exposed by Grünbaum.