The Power of Specificity in Psychotherapy
When Therapy Works—And When It Doesn’t

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The Need for a New Theory of Therapy

"Another theory of psychotherapy?!" you might inquire, with perhaps a tone of impatience, or even exasperation. Do we really need to add more postulates to an already bewildering array of more or less established doctrine? And if so, why this one? Specificity theory—the response to these challenges—is not another traditional structured theory that proclaims the truth about human affliction and its cure. It is a process theory that promotes powerful new ways of understanding and engaging the practice of psychotherapy, and of apprehending why treatment is not proceeding optimally. Specificity theory also offers new perspectives on the training of psychoanalytic psychotherapists.

While traditional psychoanalytic theories have yielded manifold benefits, we need a theory of therapy that accounts not only for the organized, stable, predictable, and universal patterns of mental life, and for its unpredictable, nonlinear patterning; we need a theory that gives substance to the unique and specific development and functioning of the mind in process with other minds. We also need a theory that is consonant with current neurobiological understanding of mind which recognizes its uniqueness as a biological system—in particular, that the human mind is continuously formed and transformed through ongoing selective, specific interactions with itself and its environment. Closely related to this is the need for a theory of therapy that promotes the efforts of our brain to forestall closure prematurely. Edelman (2004) has demonstrated that when the brain is confronted with novel stimuli, the neuronal connections are actively at work to organize and make sense of the stimuli until a familiar pattern is forged or attained. The brain is not trying to form a scientifically accurate picture of the world, per se, but one that is familiar and meaningful to the perceiver.
With this innate biological pull toward closure, curiosity and attention to the novel and unique is blunted. Specificity theory helps us counter this inherent tendency—which can be reinforced by the application of structured theories—and to reengage our curiosity to search out other elements that may transcend the relevance of these theories for the patient.

**SPECIFICITY THEORY—A FIRST DEFINITION**

Specificity theory is a systems theory of psychotherapy. Its central tenet is that effective treatment is a function of the unique and specific unfolding process between its participants. Therapeutic possibility is ultimately determined by the specificity of the co-created process of any particular dyad. It is determined by the capacities and limitations of each therapist and patient to understand and respond to each other. Specificity theory does not provide the practitioner with do's and don'ts. Rather, through its in-depth focus on process, it illuminates how a therapist may practice as best she can with each particular patient. When a therapist fully comprehends the reach and power of specificity of human relatedness at every level and at every moment in time, the application of both explicitly formulated theory, and implicit “theory,” within the clinical situation becomes more apparent, and is enhanced.

**THE CONCEPT OF “PROCESS”**

We use the term, “process,” in a way that differs from its every day understanding; for example, to describe the entire therapeutic enterprise, as in “the psychoanalytic process is complex”; or to describe a particular facet of treatment, as in “the process of joining the patient” or the “process of making the unconscious conscious.” In the instance of theory comparison, we use the term “process” to denote a fundamental defining quality of a particular kind of theoretical construct. “Process” theory refers to the defining essence of therapy and of mental life of the person as comprised of sustained, ongoing phenomena emerging from and alterable by the interactions between the therapist and patient. In contrast, “structure” theories view the mind, development, cure, and technique as definite, objectively knowable universal and predictable entities. We address this distinction more fully in chapter 2 where we consider the use of theory in psychotherapeutic practice. Our use of the word, “process,” also refers to a theory of mind, which we describe in chapter 4, that regards development, illness, therapeutic action and cure as sustained phenomena without a predetermined universal end state. From these perspectives, stable organizations are achieved over time, but are always subject to change, unpredictably, as a result of ongoing relations.

**HOW WE STUDY THERAPEUTIC EFFECT**

Therapeutic effect or whether change has occurred can be considered in two major domains: therapeutic outcome, and therapeutic process, which may or may not be related. Assessment of therapeutic outcome, by whatever criteria and whatever methodology, is the province of formal psychotherapy research. Consideration of therapeutic process—which is about how therapy happens, or does not—requires that we study it from a different point of view, in effect, through the lens of the specificity of process.

I actually encountered a non-linear theory of therapeutic specificity for the first time during my participation in a formal psychotherapy research project. None of us who were involved in the research recognized this to be so at the time. Yet, such theory was, in effect, embedded within the project’s unique methodology to assess outcome, and it basically determined how we evaluated our results. The project, which was conducted under the leadership of D. H. Malan at the Tavistock Clinic in London in the 1960s, entailed the assessment of the psychological status of a series of formally untreated “neurotic” patients who had been seen at intake at the Clinic at least two years previously (see Malan, Bacal, Heath, & Balfour, 1968). The criterion for a person’s inclusion in the study was never having seen a psychologist or a psychiatrist more than twice in his or her life. Our aim was to explore at follow up interview the extent to which improvement had occurred over time in particular ways without formal treatment.

After reading the initial intake for each patient, each of us independently offered his view of what would constitute progress specific for that patient if he were to have undertaken a course of psychotherapy. In other words, we considered the attainment of true change neither on the basis of relief of symptoms nor on the basis of the usual general categories of healthy social and psychological functioning, but rather upon significant amelioration in specific aspects of the patient’s life situation that appeared to reflect change in his or her susceptibility to experiences that stressed particular vulnerabilities.

While we rarely agreed when it came to formulating the patient’s dynamics on the basis of traditional psychoanalytic concepts (even though our theoretical differences were minimal), we had little trouble reaching a consensus on what would constitute improvement for the particular patient. Further outcome research on our study itself (Malan, Heath, Bacal, & Balfour, 1975) also indicated the operation of an unpredictable process of specificity. It turned out that those who were most significantly changed
on psychodynamic criteria had either experienced significant therapeutic effect from particular experience in their initial consultation, or/and were subsequently able to "use" similar, specific "therapeutic" responsiveness from others.

While this psychodynamic research illuminated the specificity of outcome for the particular individual, it also suggested that therapeutic process that led to whatever outcome is less dependent upon application of any particular formal theory and more a function of the specificity of dyadic interaction. In effect, the research findings implied that a different kind of theory would be needed in order to learn more about this—a theory that focuses upon and conceptualizes the very nature of a therapeutic process.

When the therapeutic method is structured in a linear mode, such as psychopharmacological therapies, cognitive behavioral therapy, or other therapies guided by structured theories, process and outcome will be evidently related. We can follow how the intervention leads to the result. Symptom identification and therapeutic intervention are linked in a predictable way with evidence-based outcome studies. They may not be so clearly related, though, if the therapeutic method is less structured. Unless psychotherapy is structured and confined to certain issues, as in brief therapy or cognitive behavior therapy, the problems patients initially present may not only "change" as therapy deepens, but the process whereby change occurs may itself become impacted by unpredictable factors. Here, we enter the world of non-linear systems, where we are challenged to discern what or who has been responsible for therapeutic effect (coburn, 2002; galatzer-levy, 2007).5 Psychoanalytic treatment, in many of its forms, comes under this rubric. In this situation, we require a theory of therapeutic effect that is not only consistent with the domain that it considers—that is, a process theory—but also one that directs our focus to its ineluctable specificity.

SPECIFICITY THEORY AND OTHER PROCESS THEORIES

The perspectives of specificity theory are consistent with aspects of other process theories, such as intersubjective systems theory and complexity theory. These include intersubjective systems theory's view that "psychological phenomena [both developmentally and in the psychoanalytic situation] take form within an intersubjective field constituted by the interacting subjective worlds of child and caregiver or of patient and analyst" (stolorow, in skelton, ed., 2006, p. 250). The perspectives of specificity theory also concur with stolorow's extension of his intersubjective perspective into contextualism as "a broad-based philosophy of psychoanalytic practice" (stolorow, in skelton, ed., 2006, p. 250), a philosophy wherein "standards of knowledge and justification vary with context" (see brower, 2000, p. 174).

Complexity theory has been described by many authors from both without and within the world of psychotherapy, beginning with the classic article of thelen and smith (1994), and thelen, e. (2005). In effect, specificity theory takes up the challenge proffered by coburn (2002) to apply the experience-distant, hypothetical constructs of complexity theory to the clinical situation. This subject has also been addressed by weisel-barth (2006) (see also richetta [2010], for a comparison of the application of complexity theory and specificity theory in a particular clinical case).

In addition to contextuality, points of contact between specificity theory and complexity theory comprise non-linearity—the quality of a function that expresses a relationship that is not one of predictable relations, that is, small perturbations may yield large effects and vice-versa; and complexity itself, that is, that any behavior, whether mental or physical, results from many heterogeneous constituent parts that interact to produce a coherent pattern (thelen, 2005), a pattern that is organized and coherent, but nevertheless continually altered through ongoing relations among the constituents. As coburn (2002) states, experience takes shape and continues to transform dynamically out of multiple, interpenetrating systems. While systems may seem at times to recede into the background within the context of an analytic situation, they "never die, and...we continue to be 'of all of them'" (p. 666). Further, both complexity theory and specificity theory regard mental life in systems terms, that is, both theories understand minds to be continuously and dynamically formed, self-organizing, and continuous in time. In other words, such systems organize patterns from multiple constituent parts continuously in time, and dynamically, which, "in the language of complexity theory means that the state of the system at any time depends on its previous states and is the starting point for future states" (thelen, p. 261). They also exhibit dynamic stability, that is, systems that organize into patterns may have different degrees of stability and flexibility (ibid., p. 261).

While specificity theory shares these field properties with other systems theories, its focus differs. Specificity theory is centrally concerned with therapeutic possibility. On the one hand, structure theories assert, a priori, that certain kinds of interventions based upon them will determine therapeutic effect. A radical systems sensibility would maintain that what accounts for therapeutic effect within ongoing process is indeterminable. Specificity theory moves the therapist to explore, within the uniquely unfolding process of the therapeutic dyad, how her responsiveness may make a therapeutic difference.

Specificity theory also offers a valuable new dimension to the education of the psychoanalytic psychotherapist, a topic we consider in depth in our
final chapter. Focusing on the specificity of process within supervisory situations—both individually and in groups—educates the student not only about how to become the clinician he or she can be with that particular patient, but also how she or he may become a better therapist for all of them.

NOTES

1. Unless otherwise indicated, the terms “psychotherapy” and “psychoanalytic therapy” are used in this book synonymously to designate a relatively non-linear psychotherapeutic process.

2. While our focus is the dyad, this applies to any therapeutic constellation, such as a therapy group or a family in family therapy.


4. Our intent was to establish a baseline in order to challenge H. J. Eysenck’s (1952) hypothesis that, in psychotherapy, one-third of patients will improve, one-third will get worse, and one-third will remain the same. On the basis of our study of “untreated” patients, Eysenck turned out to be right, on symptomatic criteria, but not on psychodynamic criteria (see Malan, Bacal, Heath, & Balfour, 1968).

5. In this book, “system” and “process” may seem to be used interchangeably, but their meanings are not identical. A system refers to a group of constituent parts that stand in relationship to one to the other, i.e., a change in one affects a change in the other. Process, within this work, refers to a focus on the relationship that pertains in a system. In other words, in a process theory, the attention is more on the relatedness and movement among the constituent parts of the system, than on the constituent parts themselves. A process theory recognizes the continual changeability of the parts, parts that may appear to be self-contained structures, but in fact are not.

6. See also Galatzer-Levy (2002), where he introduces mathematical understanding of “emergence” to posit that each analytic dyad is unique with unique and unpredictable exchanges and outcomes.

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The Use of Theory in Psychoanalytic Practice

THE LIMITATIONS OF STRUCTURE THEORY

Our use of theory of one sort or another in psychoanalytic practice is indispensable and inevitable, yet its usage poses discernible problems that are not infrequently shoved under the couch. Theory can be a helpful partner in our work; but it can also lead us astray, or get in our way. Although we do not openly acknowledge it, we tend to look to our preferred theories, consciously or unconsciously, to inform our understanding and to advise our responses to our patients. These theories are the ones that we have come to feel comfortable working with, the ones that we come to regard as truth. And if we have been trained as psychoanalysts, they will tend to reflect the beliefs of the analytic institutes where we have been trained, or the analytic societies or groups with which we are affiliated.

When Freud first led us from the chaos of psychological ignorance into the order of psychoanalytic theory, he understood emotional suffering, and even certain physical impairments as arising from mental determinants. Over his lifetime Freud developed a nomothetic theory of human development, and of psychological illness, health, and cure. That is, Freud’s theories involved the formulation of general or universal laws that were premised upon an ordered and structured view of mental life, upon which definitive techniques of psychoanalytic treatment were based. Many analysts have continued to follow Freud’s dicta. Freud’s critics—a number of them ultimately hailed as psychoanalytic pioneers—have since elaborated many other theories and different ways of applying them. While these theories differ in their conceptualizations and modes of practice, each is premised on assumptions of order, continuity, and universality in human development. It is an open