The Power of Specificity in Psychotherapy

When Therapy Works—And When It Doesn’t

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How Specificity Theory Changes Clinical Practice

Specificity theory, in accord with other process theories, recognizes that we cannot know a priori how any particular response or dyadic interaction will affect either the patient, the analyst, or their relationship, but what we do know is that what constitutes therapeutic action, too, is specific; that is, what may be therapeutic, and what can be therapeutic, for any particular patient is determined by the specific capacities of that particular dyad (or other therapeutic constellation) and the specificity of their unfolding process. With specificity theory the clinician's focus is directed less to specific techniques and more to the specificity of the person and the process itself.

Specificity theory significantly influences how we use psychoanalytic theories that do posit universal motives, stages of development, and curative interventions. Specificity theory as a process theory shifts our focus from a designated response as the sine qua non of psychoanalytic cure to a process that seeks to discover within each dyad that which might be healing. However, not only is it advisable that we not "know" in advance who the patient is, as Bion recommends (see Bion, 1967), we do not know how we may optimally be with him therapeutically from moment to moment, until we discover this through the unfolding specificity of our process.

Formal, and informal, structure theories are variously necessary and all may emerge within process. No psychoanalytic theory that purports ubiquitous application can apply to psychoanalysis when viewed as process. Freud analyzed the free associations of the analysand to discover the repressed in the unconscious, on the basis of his theory of "mind." Analysts since Freud have attended to a variety of data—perhaps mainly to their empathic perceptions—which they "analyze," and respond to in various ways on the basis of various structured theories, in order to offer their patients optimal
therapeutic experience. Specificity theory not only recognizes the variegated ways in which patients may experience their therapists as responding optimally, it also avers that any organized understanding (structure theory, culture, technique, gender) optimally emerges in process as it may apply to apprehending and responding to the particular patient. Evelyne Schwaber’s way of empathic listening to both her patient and herself implies this recognition of the therapeutic importance of specificity in emerging dyadic process (Schwaber, 1981, 2010).

Both Lewis Aron and Jessica Benjamin convey their recognition of specificity as central to both theory and practice. Benjamin quotes Mitchell (1997) “[who contends that] transformation occurs when the analyst stops trying to live up to a generic, uncontaminated solution, and finds instead the custom-fitted solution for a particular patient” (Benjamin, 2004, p. 41). Benjamin concludes her article with the observation that “[a]ll patients, in individual ways, place their hopes for the therapeutic process in us, and for each one, we must use our own subjectivity in a different way to struggle through to a specific solution” (p. 18). Aron concludes his colloquium contribution on November 14, 2006, by commenting, “What is wonderful about contemporary psychoanalysis . . . is that we do not all have to work the same way or expect that we will each negotiate each therapeutic moment the same way—following one book or rather narrow technical prescriptions. This is neither eclectic nor a matter of throwing away the book—it is about having a new kind of book that allows for individualized, negotiated, more personal, and also less predictable responsiveness.”

Specificity theory in effect conceptualizes Benjamin’s and Aron’s views about how therapy happens, at a higher order of abstraction than theories of structure. Specificity theory understands psychoanalytic treatment as optimally constituting a process of co-creative discovery in every instance as to what “theory” may emerge as relevant and useful. This contrasts sharply with the traditional utilization of structure theories that, in effect, inform us, a priori, how we should be therapeutically with our patients. While structure theories guide our interventions, specificity theory allows us to creatively co-discover, through the particularity of each unfolding relationship, how we may, or may not, be therapeutic with a particular patient at any moment in time. At the same time, we also discover, through our process, consciously or unconsciously, what concepts, models, or perspectives may usefully inform how each of us may be therapeutic with a particular patient at any moment in time. So that rather than reaching for the tenets of any formal theory or model in order to understand or respond to a particular patient, we position ourselves receptively so that we may allow for their application as they may—or may not—emerge as potentially relevant in understanding and responding therapeutically to that patient. In focusing on therapeutic effect at the level of the specificity of process, we develop a

theory of therapeutic specificity, which enables a very different, yet potentially more enlightened and effective utilization of both formally established concepts, and a host of other “informal” theory that every analyst as well as every analyst brings to the therapeutic endeavor.

**CLINICAL ILLUSTRATIONS**

Here are two clinical examples, offered by Lucyan Carlton, which illustrate how specificity theory changes our practice. The examples comprise vignettes from two different analyses, one in which the author was the analyst and one in which she was the analyst. The first analysis was guided by classical psychoanalytic theory and the second by specificity theory. The vignettes draw attention to the essential theoretic difference between the two types of theory—structure theory, associated with “known” response, and process theory, which determines a position of not-knowing. They also illustrate the clinical difference as we note the shift from responding on the basis of established tenets to awareness of the potential for the therapy when the analyst considers the significance of how she can be within the specific context of treatment with the particular patient.

**Practice That Privileges a Traditional Structure Theory**

When I first met with my analyst, we sat face to face as she assessed my analyzability. I told her of my current difficulties, family history, and personal development. She shared with me that she had her doubts about me. I seemed to be someone who liked to be the “captain of her own ship.” “This does not bode well for analysis,” my analyst opined. However, she suggested a trial few months. She set forth the rules of engagement. “Each time you come in, you will lie down on the couch. You will begin talking, saying anything that comes to your mind. I will be quiet. I will listen, and only say something when I have something to say.” And so our odyssey began.

I did not understand how the assumption of control over my own life would render me unfit for treatment. How did anyone navigate life’s turbulence if he/she was not at the helm? But my analyst’s tone was an indicating one. So, as I lay down to free associate, I was especially attuned to compliance. To be deemed analyzable was my desire.

As I lay down on the couch, my analyst was outside of my view. In front of me on the otherwise blank wall hung a black and white photograph. Three winsome, pensive, latency-age little girls looked out at me with a perpetual curiosity, tinged with sadness. If I turned my head to the right and gazed downward, I could see my analyst’s foot. There was much in the dressing and movement of that foot within which to fill the otherwise blank screen. For several months I spoke to
the girls and my analyst’s foot to the accompaniment of my analyst’s supportive vocal utterances that said, “I’m listening, continue.”

After a few months of my compliant talking, I was declared analyzable. I had begun to acquire some ease with this way of being together when my analyst interrupted her supportive “yes’s” and “Mhmh’s” to offer me an interpretation. I felt judged and a little shocked that her receptive listening would be used to shape a knowing pronouncement about me. Her interpretation settled over me like a web. I timidly began to protest to wrest myself from the gossamer-like envelopment of her words. She interrupted my verbal protest to offer yet another interpretation. Gently, but firmly she said, “You are experiencing me as critical and attacking. I am not that person. I don’t know you yet who in your past treated you that way. It is your past with significant others that leads you to see me as critical and attacking.”

Thump. I understood in that moment my analyst was (1) an authority on what was actually going on with me; (2) knew what was wrong with me; (3) knew that it was all within me; and (4) knew that it was determined by my past. I was relieved to know that someone knew and that the disturbance was within me. If it was in me, I could change. There was hope.

Her responses to me were determined by a set of rules that defined psychoanalysis. Neutrality, abstinence, anonymity, and verbal interpretations, among other ways of being, determined my analyst’s response. Her manner in delivering her interpretations was infused with warmth and concern for me. However, any touching, extra-analytic contact, or my analyst’s sharing of her experiences or feelings was clearly beyond the bounds of the analysis. These possible responses were beyond the bounds, not because my analyst chose to be a distant or withholding person, but because a critical component of cure within this theory required the analyst’s abstinence. Freud stated it this way, “Treatment must be carried out in abstinence... The patient’s need and longings should be allowed to persist in her, in order that they may serve as forces impelling her to do work and to make changes” (Freud, 1915, p. 164).

I understood the rules. I attended all of my sessions, arrived and paid on time, and spoke what came to mind. I asked nothing from my analyst outside of the hour. I gained increasing ease with speaking without conversational expectations, following more an intrapsychic train of thought. As my analyst observed and interpreted, she implicitly imparted permission to me to feel within the relationship and to give verbal expression to those feelings. My feelings and associated memories broadened and deepened. This process began to erode my capacity to remain emotionally removed in other relationships.

One Friday afternoon, in my fourth year of analysis, I met my mother for lunch. I greeted her, immediately sharing my exciting news. After being a full-time, stay-at-home mom for 8 years, I had decided to return to school. “Mom, I have been accepted into the Masters Program that I really wanted.” “Congratulations,” she responded immediately. “I am so proud of you.” As I warmed to her celebratory praise, she continued talking. Sadness settled around her eyes and a slight tone of regret crept into her voice. She sighed, “Seems you always get what you want. You were like that when you were little too. Always had to be the best.” She drifted into her own reverie, not exactly talking to me, and her regret had turned to resentment. “It was so hard on your little brothers.” She paused, and then her gaze returned to me. “Can you even imagine what it has been like for your brothers, having to grow up with a sister like you? They never felt like they could do anything because you always had to be the best.”

My usual ability to neither hear nor feel the sting of my mother’s words was confusingly absent. As I sat in stunned silence, her vituperative rant gained in intensity, “I don’t understand why you didn’t ever help your brothers. You always were helping others. Volunteering your time. A real do-gooder, but wouldn’t help your own brothers. Others first, family second, that was always you.”

My mother’s familiar way of relating to me began to have an unfamiliar impact on me. A lifetime of these comments, comments that I had not really heard, now all pressed to be heard at once. The ensuing cacophony was dizzying and suffocating.

Later that night, 7:30 pm, my mother’s shrill voice still echoed in my mind. Her words from earlier in the day continued to intrude and accuse, each one a sharp dart that pierced and shattered my sense of myself. “Selfish, hurtful, always.” I tried to blow down my breathing. I tried to challenge the rationality of my mother’s accusations. I tried eating. Finally, I paged my analyst. I had to talk to her. I needed her to listen and help me silence these annihilating words. My analyst returned my call and listened quietly as years of guilt, shame, and anguish dissolved into my tears. “Had I irreparably injured my brothers? How had being me hurt them, hurt her? Was I really a selfish, self-aggrandizing bitch?”

My analyst heard my mounting panic and urgency. He needed her presence. Her listening had begun to have its calming effect when I felt a shift in her compassionate silence. I felt a tension now in her listening. She wanted to end the call. I was too overwhelmed at that moment to comply with the demand that was implicit in her tense silence.

I had become in that moment a difficult patient. Uncharacteristically, I pressed on. My words continued to tumble at a rapid, unregulated pace. Thoughts were lost to me. I felt the strain of breathing and of my pounding heart.

I could feel her caring in her withdrawal, but she held her theory with strong conviction. To respond to my needs in the moment was to gratify my unconscious drives and thereby compromise my cure, she believed. My analyst finally interrupted. She spoke at a calm, measured pace, but with an authoritative tone that allowed no protest, “I will see you at our regular time on Monday. We will make a difference with these feelings for you.”

Our regular time? 63 hours from now! I was enraged. My analyst’s leaving me alone at that moment was more frightening and more disorganizing than my mother’s earlier castigation of me. Then, all feeling drained away: life-saving
non-life ensued. I found the calm of numbness, the numbness needed to avoid
crash. I understood in that moment as my analyst ended our telephone call that
I would be expected, again, as when I was little, to endure unbearable feelings, all
alone. I could not, would not, tolerate a process that would necessitate experi-
cencing abandonment by the one from whom I expected care. I also feared that I
had become a difficult patient, as my analyst had predicted I might.

From my analyst’s theoretical perspective, she felt she needed to bear the
tension of rejecting my demand for her presence. I, her difficult patient, was
demanding a response that she knew would compromise the outcome of the treat-
ment. On the other hand, her theory did allow for making certain provisions,
breaking the analytic frame, if the patient were struggling. I imagine that such
was her reasoning when she called later that evening to ask how I was doing.

With the tranquility that accompanies determination to leave a traumatizing
relationship, I responded to her, “I am fine.” She asked, hesitantly, “So you are
doing better? I will see you on Monday?” “Yes,” I replied tersely. I hesitated, and
added, “but I will not be there on Monday. Since our earlier call, I have realized
a few things. There will be a letter for you in your office on Monday.” I moved
to hang up. “That sounds ominous,” she replied quickly. I felt the protective
certainty of my decision to terminate challenged. I paused, “I do not mean it to
be threatening, I just will not be back. I will place the envelope under your door.”
She then asked, “Would you meet with me at my office tomorrow morning
instead of sending me this writing?”

I uttered a meek assent, but my feelings did not match my tone. Her response
dissipated my lifeless state, but intense, too intense, feelings rushed in. Surprise
and pleasure conjoined with fear. I felt relief as the 61 hours now would only be
12, and she had responded. I felt confused and anxious as the serenity of the
certainty of my decision to leave analysis was threatened.

As I drove to my analyst’s office on that Saturday morning, I mentally re-
hearsed my words of termination to steel myself against any persuasive protests
that I imagined she might offer. As I entered her office, she asked that we talk
face to face. She explained to me that I was experiencing a confusion that was
interfering with my treatment. I had confused her with my mother. She patiently
explained that as we work in analysis I might experience her as if she were my
mother, but that it was critical that I hold on to reality. She said, “I am not your
mother. I am your analyst. We should meet face to face for the next several
sessions to resolve the psychoanalytic transference.”

Thump. Again. I thought that I was angry with her. It was she who refused
to be there for me, as I needed her. Instead, I am psychotic? I was stunned
and more than a little mystified. I had forgotten what I had learned from her at the
beginning of the analysis. It is all me, and in me, and she knew what was in me.
After a few sessions where we sat face to face to dilute the intensity of my
transference, I calmed down. I lay down again to understand more, and resumed
my “as if” experiencing with my analyst. Her difficult patient again became a
compliant patient.

At that moment, on a Friday night so many years ago, I became a difficult
patient. It was difficult not so much because it was Friday night, after hours,
after a long week, and I was difficult not so much because I demanded an
emotional, personal response, but I was difficult primarily because the partic-
ular response that I needed was one that my analyst’s theory deemed an
impediment to the curative process.

Though today I would say that I actually was angry with her for not re-
playing to me in a moment of crisis, I would add that her seeing me on
that Saturday provided me with the requisite, healing response, despite,
to me, the inaccuracy of the verbal content of her interpretation and her
explanatory theory.

However, several years later, I moved from the analytic couch to the
analyst’s chair. As analyst, I began to question the objectivity and scientific
truth of my former analyst’s theory and her technique shaped thereby.

In my second analytic tale, specificity theory informed my therapeutic
relationship with my patient.

Practice That Privileges Specificity of Process

The course of this analysis had been marked by rapid, extreme, and
seemingly discontinuous shifts from positive to negative transference. In
the positive transference, my patient, Beth, experienced me as all good
and powerful. She called me her “Jesus with skin.” At other times, Beth
perceived me as a sadistic seductress creating intimate, loving moments in
order to enhance my power to injure her. And at still other times I was ex-
perienced as a neglectful therapist, turning away just at the critical moment
when she needed comfort or protection. Beth’s perception of me could alter
rapidly, shifting from feeling safe with me to feeling either abandoned or
even abused by me. And I need to add that these shifts would occur with
little awareness on my part of any actual precipitant. To me, I might have
felt only a slight alteration in my actual physical posture or expression, or
warmth in tone or content of my speech.

This analytic tale begins toward the end of the third year of the analysis:
There had been a tension between Beth and me perhaps since the earliest
days of our work together. This tension had played at the edges of our rela-
tionship. We would feel it and flee from it, yet never fully acknowledged it,
or name it. However, in this session, Beth was obviously upset as she
entered my office.

Beth lay on the couch in silence. Her frustration and anger were palpable, as
was my increasing tension and confusion. In the silence, I mentally reviewed our
last session, and I could not recall anything that would now account for her feel-
ings, something that might help me make sense of Beth’s accusatory anger. She
finally spoke, demanding, “Will you or will you not . . . hold me?” For me, the
relational tension of this moment was crystallized, not by Beth’s stark demand to be held, but in the vulnerability of her anguished plea, “I have to get the holding and soothing touch from you. This is too much for me to sit in your presence, the presence of caring. I just actually need the physical touch. I need to be held.”

I expect that my body and facial expressions answered her question in the negative before I could even begin to think about her demand. In general, in my personal life, I am not a very touchy-feely person. I readily touch and hold my loved ones in order to comfort, reassure, or convey love. For a time. But I am not comfortable with holding or being held over time.

In deciding how to respond to Beth, I do not want to simply say “No.” Rather than say, “No” or even “I don’t know,” I hope to stay with her feelings and convey my understanding, an understanding that might provide for her an experience of being held by me. “As you feel your love for me and mine for you, the old feelings of the baby not held or caressed come right along with them. Your suffering today from this early deprivation can only be relieved through my physical holding. Does it help when I understand and try to stay connected with the little one, connected through our daily voice mail exchanges?”

Beth turns away from me. From my implicit “no.” I remain quiet. I can feel the intensity of her suffering, a pain that has been intensifying over the last several months, a pain that does not remit at the end of our sessions. I feel, too, her painful confusion that her need of me creates for her. The mature, intelligent and competent adult craves being caressed and rocked as if she were an infant. I strain with the dilemma, a simultaneous desire to respond to and to retreat from Beth’s plea.

Without a formal prescribed response found within most structure theories, I am left to engage in a unique analytic process with this patient. I must examine my own capacities and limitations to respond to my patient’s demand, and explore the therapeutic implications of my response. Should I satisfy my patient’s felt need, which feels uncomfortable for me, or endure my patient’s disappointment, anger, and pain as I feel that I cannot provide the desired response, all within the context of how my requests might or might not be therapeutic for my patient. Without a predetermined theoretical answer or even guideline, I am called upon to analyze and assess my patient’s demand upon me within the unique context and relationship that is always emergent between us.

Finally, Beth responds, “Your responsiveness makes these feelings more intense, but more manageable, too. I can talk about this forever, say the same thing forever. But it doesn’t change the need to be held by you. I want to feel you. My desire to be held needs to be satiated. I am crying and crying to be fed, and you offer me words. Your words don’t touch me.”

This session initiated many more sessions that moved inevitably to her insistent demand to be held and caressed by me. My understanding of her agonized state deepened as I encouraged Beth to share her feelings, and her memories. Beth was born to a mother who had been too overwhelmed and depressed to respond to Beth. Her mother recounts today of Beth as a baby, she had been such a good baby, content for most of the day alone in her playpen. Beth recalls how she wished to be held, even putting her own small arms around herself, pretending that they were her mother’s. She remembered many nights of her childhood where she hugged the plaster wall adjacent to her bed. After awhile the wall absorbed and held her warmth, and she could pretend that she was cuddled up to her mother.

When Beth was 2 years of age, her father’s anxiety disorder had become so disabling that he was placed on leave from his job. With her mother’s return to work, Beth’s care was entrusted to her mentally ill father. Her father would lure her into shared delightful moments of intimacy, to stirle, frighten or actually injure her. One such model scene (Lichtenberg, 2005) is captured in her memory of a cold winter night when she was 4. Her father awakened her from sleep to invite her to “Come. There is magic outside.” He bundled her up in his large parka, enveloping her head to toe. He carried her outside. He whispered to her, “Now for the magic show,” as he lifted the arm of the jacket, like a telescope. From within the dark, warm jacket she lifted her gaze and a sparkly starry sky magically appeared. She recalls the sudden thrill and shared excitement, as her father surreptitiously poured a glass of ice water down the sleeve. She fled, sobbing, wept and cold to the sound of his satisfied laughter. The others in the family chided her for being unable to take a “joke.” Her mother not only was unable to be emotionally responsive to her little daughter, but she also did not protect Beth from her father.

However, my understanding and our deepened understanding of her feelings, through these revealed memories, did not ameliorate the intensity and torment of her desire to rest in my arms. We continued to explore her desire, and elaborate the possible meanings and genesis of this need and desire. We worked in this way for many months, but with each new understanding or memory, she would return to her concrete need to be held. She became desperate. She began to make plans to leave the analysis to find a therapist who would hold her throughout sessions. I felt a continual strain, and was regularly preoccupied with whether and/or how Beth and I would find a way to address her intensely felt need, a need that I could not actually satisfy.

Had this analysis been conducted with a structure theory, such as classical theory, I would have had a theoretical guide, even an answer. Freud provides the following answer to my dilemma: “Analytic treatment should be carried through, as far as possible, under privation... in a state of abstinence” (1919, 162). The analyst must ensure that “the patient is left with unfilled wishes in abundance” (1919, 164).

In other words, Freud prescribed abstinence. Abstinence was the assumptive stance, and any deviation therefrom, constituted a “provision.” A provision (such as touching, let alone holding my patient) was anything
other than interpretive explication, and was proscribed. A provision according to this theory would gratify my patient’s unconscious libidinal wishes, depriving her of the opportunity to have them made conscious. Cure in this theory occurs as the unconscious libidinal strivings are made conscious and interpreted. With this new awareness, renunciation of the infantile wishes and replacement with more mature desires and goals becomes possible.

It is not only within classical theory that touching is prohibited. Most traditional psychoanalytic theories proscribe touch, let alone holding, as detrimental to the patient’s healing. However, I work from the perspective of specificity theory, a process theory. Any particular clinician who uses this theory may or may not actually follow the theory’s conclusion (indeed, as Freud himself did not always follow the dictates of his own writings on technique), but regardless of how a particular clinician may use the theory, I am concerned here with the operation of the theory itself. Specificity theory does not interdict touching (or any other response) unless it is illegal or officially proscribed by one’s professional organization, but directs the analyst to engage with the patient to find out whether such a demand would be therapeutic for the patient and possible for the analyst.

My patient demanded, and believed, that her healing required my sustained, loving caress. However, my capacity to offer this response was limited, and fell far short of the holding that my patient craved. For me, holding has no natural or agreed upon stopping point. I imagined that I might begin to feel anxious over time with the physical or emotional containment that holding would require of me, which she would feel and possibly interpret as rejection. If we decided that I would hold her throughout the session, I imagined awkward discussions to determine the when and length of holding. Or would it become a ritual, the expected way that we would be together in session? With extended holding I imagined limbs going numb and itchies left unscratched. How would we talk about not holding for a session, and what present and historical meanings would attach to such a discussion?

Further, and more significantly, given the nature of our relationship over the course of the analysis, the extended holding presented the danger that she would begin to feel that I was exploiting or abusing her. Two people experience and share intense feelings through physical holding that may be difficult to identify or talk about. Their meanings can be implicit, intense and rapidly shifting. Who is holding whom, who needs to be held, do I need her to need me to hold her? Throughout our relationship, Beth experienced me as abusive and exploitive whenever we felt increased intimacy. She was not able to explore these beliefs as her subjective experience, but rather as concrete proof of my malevolent intentions.

I was challenged to discern the response or responses that would provide healing experiences for my patient, and that I felt willing and able to provide. She began to experience my refusal as sadistic, that I had from the inception designed our interactions so as to create this intense need of me in order to enjoy my power to deprive. Or, alternatively, when she was experiencing me as less evil, she felt that my refusal was motivated by my own unconscious desire for her: It was I who desperately needed her, who needed her to be dependent on me. She reasoned that if I held her, she would gain health so that she no longer required therapy. I would then lose her, the one whom I so desperately needed.

As I continued to offer my patient my understanding and to undergo suffering with her, and to endure her resentment and anger, I came upon a blanket. It was a size, heft, and texture that would envelope an adult as a parent would as she held a child. One side was made of a smooth satin that offered a rich, sensual tactile experience, and the reverse was made of a synthetic knit that offered a warmth, depth, and yield to the touch approximating the touch of a human body. I thought that it was possible that the blanket, if it were from me, might provide her with the needed experience of holding.

I wondered whether I should provide this concrete, demanded response. Should I have concluded that my difficulty with providing sustained holding imposed a debilitating limitation on therapeutic possibility in our work and help her find another therapist that worked in a different way than I? Or should I continue to try to respond, now, in this way? Would the comfort of the blanket sooth the experiences that gave rise to the unrelenting pain no longer be available to the analysis, creating a kind of crippling dependency upon me for continual soothing? Or would it provide a response that would enable her to experience a relational world where loved ones respond to her pain without a desire to injure or exploit her. Or could it be experienced as both a healing response and, for a time, a needed level of dependency? These were the main questions I struggled with as I considered the possible therapeutic effect—or not—of this specific response—which I felt I could offer Beth.

As I presented the blanket to Beth in session, I asked “How would it feel if I were to give this blanket to you from me?” Beth was quiet, did not answer, and did not engage with me. As the session neared the end, she wordlessly picked up the blanket.

I awakened the next morning to a voice mail: “You are an analyst. So you can analyze me, but that is for you. I want you to know that the blanket . . . It is the coolest, smoothest texture. You were with me last night. I held the blanket tight and it brings me comfort. No panic attacks. You thought of the idea and it is working beautifully.”

Beth was able to use the blanket in other ways to regulate our relationship. When she was angry or disappointed with me, she was able to use the blanket to give more full expression to her feelings. The morning after a stormy session, Beth left me this voice mail: “With the blanket, I have improved my soothing mechanisms because I have you. But now I see that it helps because I can also have my way with you. You are not in that blanket so I am freer to have my way with it. It is safer than actually having you. It is full of life, yet lifeless. I don’t
trust. I am willing to try, but I know that I need some deep things, and I don’t trust letting you close.”

And then the blanket had a surprising negative effect. The blanket so perfectly matched her need and desire that it intensified her belief that I knew perfectly her private thoughts, beliefs, and feelings. “It is like you are God and you know me fully.” This belief in my omniscience constrained our relationship. Now, if I acted in ways that were injurious to her, she could only believe that I did so with intention, as she knew that I knew perfectly what she wanted or expected. Further, during our sessions, if I inquired how she might feel about something, she became enraged, as she believed I knew how she felt. There was no reason to inquire, as I was all knowing, other than to delight in my power to injure.

Ultimately, the provision of the blanket did enhance Beth’s trust in our relationship, and did provide her with an experience that seemed to contribute to an expansion of her ability to tolerate feelings and memories, and later to benefit from verbal interpretations.

My experience in this analysis, however, does not support either the offering of a blanket, even this type of special blanket, as a prescribed or even recommended response. Perhaps, I will never use a blanket in this way again. Nor does this analysis support the theory that allowing for parameters (Eissler, 1953) later permitted the more ameliorative verbal interpretation. Perhaps, my understanding as demonstrated through the offering of the blanket was essentially transformative for this patient even absent future interpretations.

In one session, months after the blanket had assumed its complex place in our relationship, Beth shared, “The angry, isolated place that I have been. It has felt like fighting the world, and now I see it is me. It is because of my trauma. My father was an ill man. He was abusive and sexually very twisted, and I was, am, sensitive, sensual, feeling, and I was left in his care full time. Physically, I had no soothing. I could scream. I could cry. Momma was tense and nervous. There was no calm holding. What I know of being comforted, I have learned through you. I now know that a baby has needs. Those needs need to be tended to and there is no shame. It is as simple as a baby needs to be held and comforted.”

These two stories exemplify certain clinical contrasts and differing consequences between the utilization of specificity theory as process in contrast with a structure theory—such as Classical Psychoanalysis—a topic we address in depth in chapter 7. In the first example, the analyst’s theory prescribed certain ways of responding and not responding to her analysand. The constraints of her theory—which, one might argue, had become a central part of who she was, professionally—determined her response and intimately shaped the nature of the relatedness between analysand and analyst. In the second example, with a theory that explicitly expands the range of therapeutic responsiveness non-prescriptively, theory played a different role in the therapeutic process and influenced therapeutic possibility in a fundamentally different way. It brought to the fore an examination of the particular way that this analyst might or might not be able to work optimally with this particular patient. That is, working with this theory required the analyst to examine possible limitations on her capacity to respond therapeutically to this particular patient. She was discovering, in process, how she could be, therapeutically, with this patient. She also creatively discovered a way of connecting with her that she could manage, at a symbolically archaic level, and that worked for her patient. Her own limitations and capabilities vis-à-vis this patient were at the center of her examination rather than the theoretically defined standards, or structurally defined theory, against which to assess the patient’s treatability (see also chapter 8, where we look more closely at the question of “analyzability” from the perspective of specificity theory).

Practice informed by specificity theory centrally entails a process of discovery of responses that may be therapeutically effective for a particular patient, without the use of prescriptive or prescriptive guidelines, whether or not the hypotheses of traditional structure theories usefully emerge. When we actually grasp the uniqueness and specificity of each therapeutic encounter, we are continually engaged in the moment to determine each time what is the needed therapeutic response, and what is possible for us to provide.

Specificity theory is a contemporary psychoanalytic process theory that is consonant with Gerald Edelman’s theory of the uniqueness of the human brain and of the human mind as formed and created through ongoing selective interactions with its self, its environment, and others. In the next chapter, we consider in some depth the relevance of Edelman’s view of brain function for specificity theory. At this point, though, we would emphasize that, given this bias of human creation, specificity theory as a theory of therapeutic efficacy exhibits the analyst to hold in mind the consequences of the reality that, at the level of theory, no one psychoanalytic structure theory can explain our patients nor determine our response. And at the level of clinical practice, therapeutic effect becomes determined by the limitations and capacities of each particular analyst and analysand to understand and respond to each other at any moment in time over the course of the analysis. In other words, the efficacy of each therapeutic endeavor is centrally a function of the specificity of fit of the participants in their interaction.

Specificity-fittedness

In our clinical experience, the “fit” is an especially important determinant of whether effective treatment is possible between the particular
participants in the therapeutic venture. We have repeatedly discovered that the specificity of fit of the treatment dyad has not been accorded the significance it deserves; in effect, the degree to which this capacity obtains between the participants within any particular treatment dyad may be fundamentally significant for the outcome of treatment.

Undoubtedly, many psychoanalytic therapists have intuitively practiced on the basis of what we now systematically conceptualize as specificity theory, simply because it makes good clinical sense. In other words, they “use” a process theory of therapeutic specificity as we understand it, perhaps much of the time, without recognizing or/and acknowledging that they are doing so.

In retrospect, and quite remarkably, my first inkling of such a practice—though I was yet to conceptualize it as such—was likely in my first class on the work of Melanie Klein at the British Institute of Psychoanalysis some 48 years ago. Elliott Jacques, the senior Kleinian analyst who was leading the class, told us, “You know, there are as many differences between how members of the Kleinian group at this Institute work with their patients as there are between the members of the Freudian and the Kleinian groups as a whole.” It seemed to me at the time that this was the most unbelievable statement that an analyst at that institute could make. I was not only incredulous, but wondered about his motives for making this assertion, suspecting that this was his—somewhat disingenuous—way of trying to mollify possible partisan tensions within a class that was composed of students whose allegiance belonged to the Freudian and Middle Group as well as to the Kleinian group. This may well have been the case, but I have come to recognize a deeper wisdom in what Jacques told us. He was, in effect, referring to the specificity of dyadic process. He was alluding to that part of process to which the analyst contributes, that is, that we bring so much more of ourselves to the interactions with our patients than our formal psychoanalytic theories, that the impact on the treatment of who the therapist is can supersede the influence of any formal theory.

The absence of a theory of therapeutic specificity has left creative therapists vulnerable to the fear of being accused by their colleagues or by their own internal analytic police of practicing “wild analysis,” of fostering an irresponsible ethos of an “anything goes” way of practicing. A reviewer of a paper on specificity theory submitted for publication in a traditional American psychoanalytic journal protested, “You might as well be giving dance lessons!” Specificity theory does, in effect, hold that all potentially therapeutic responses in the treatment situation are legitimately utilizable—with the proviso that they not interfere with the therapist’s professional functioning or exceed either the therapist’s or the patient’s personal tolerance. Yet, the task of discovering responsiveness that is of optimal therapeutic value for the particular patient requires a high level of self-discipline and self-awareness, as well as famil-