CHAPTER 6

The Foundational Perspectives Of Specificity Theory

from

*The Power of Specificity in Psychotherapy:*

*When Therapy Works – And When It Doesn’t*

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Therapeutic action informed by specificity theory derives from three foundational perspectives:

I Specificity Theory Focuses on Therapeutic Possibility

II Therapeutic Possibility is Inextricably Linked with Optimal Responsiveness

III Optimal Responsiveness Draws New Attention to both the Specificity and Variability of Therapeutic Possibility and their Dependence on the Fit of Each Particular Dyad

I Specificity Theory Focuses on Therapeutic Possibility

• For therapeutic effect, it is not only legitimate, but essential, that the therapist attempt to tailor the treatment to each patient.

• The therapeutic engagement must necessarily and continually be monitored and adjusted, as far as possible, to fit the specific and ever-changing needs, capacities, and limitations of both participants, regardless of what constitutes the therapist’s structured psychoanalytic model.
• Therapist and patient must find out how they need to be, and what they need to do, together, to be therapeutic. Each encounter is most usefully approached as one where a potentially therapeutic couple has never been before. The overarching focus is the discovery or co-creation of reciprocal responsiveness that will optimally meet the particular patient’s therapeutic needs.

• This specificity, as Carlton has described (see chapters 1 and 2), is based upon a consideration of psychoanalytic treatment at the level of process, which constitutes a new order of theory. Specificity theory thus conceptualizes at a different level of abstraction than more traditional psychoanalytic theories that conceptualize at the level of structure.

This way of conceptualizing psychoanalytic treatment and its application requires that the analyst continuously understand herself as she is affected, uniquely, through engagement with the particular patient, and to monitor the precipitates of her own history as they converge with those of her patient to determine their therapeutic potential as well as their limitations. As demanding as this might be, commitment to doing the best we can with our patients requires that we ask no less of ourselves.

Spontaneous engagement, or “play” (see especially Parsons, 1999, Weinshel, 1998, Winnicott, 1971a, Winnicott, 1971b, Foehl, 2010, Ringstrom, 2001, 2010) can at times constitute the essence of effective psychotherapy, as it may emerge significantly within the specificity of process of the participants in a particular dyad. The early view of the Boston Group’s Process of Change Study Group (Stern et al, 1998), which regarded the “something more than interpretation” to comprise therapeutic effect has since been
modified (Stern et al, 1998; see chapter 9) to encompass a systems perspective in which no particular way to “be with” a patient is privileged. Foehl (2010) has recently presented a process perspective on play that is very much in accord with specificity theory. Foehl encourages us “to rethink anew our process without the encrustations of theory…[and to adopt] a critical “humorous” acceptance of multiple perspectives from the open ground of an epistemológico! pluralism”. We think Foehl might like our “rabbi” story in chapter 2.

The following vignette visibly entails “play” as important; it also illustrates how patient and therapist found playfulness as a way of being together in a new, significantly specific way, in their process.

Stephen and I were working on a familiar theme - how depressively and desperately he is caught up with authority, with the one who “knows” what he should do. We understand that he appears compelled both to defy and comply (e.g., by delaying to do something that feels expected or working endlessly to get it just right) with the result that it takes him an inordinately long time to complete anything – or sometimes even to discover what makes sense for him to do.

Understanding afforded by Classical structure theory, as well as by concepts of self psychology and pathological accommodation (Kohut, 1977; and Brandchaft, 2004, 2007) have emerged as relevant in reflectively “working through” this problem over time. Stephen fights against internally organized burdensome demands for perfection while simultaneously seeking to meet them - both of which constitute reactions to precipitates of his relationship with his father.
I have felt that, in some ways, Stephen and I have struggled similarly in our relationship, and we have talked about this. Earlier in the analysis, I had on occasion, felt expectant tension about whether I would come through with just what Stephen needed from me; at times, he used to insist that I should give him “the answer” which, he implied, I undoubtedly knew, but withheld. We had understood this as both the expression of a desperate fantasy that if he could access his father’s (my) omniscience he would then be “truly” smart. At times, we could also apprehend it as the expression within an “idealizing transference” of a developmental need to experience a different kind of father responding with useful fatherly advice. At other times, I experienced as slightly jarring Stephen’s need seemingly to demonstrate his superior intellectual knowledge. Toward the end of this session, I felt there was more a sense of working together – or rather, a quality of playing with some of these, now familiar, themes.

At the start of the following session, Stephen brought out a deck of cards, and asked me to pick one – in my mind. He then took the cards away, and produced cards again. “Is your card there?” “No”, I acknowledged, openly impressed. “It is not there”. Then, with friendly, generous flair, Stephen showed me how the trick was done. The cards were all face cards, but they were all different, in both lots, so of course, “my card” would not be there.

I had been so focused on the possibility of his “knowing” in this magical way what was in my mind that, for a time, I was entertaining the possibility that he could actually do this. I slowly began to realize that we were, now, in our process, experiencing quite specifically a creatively transformed version of how
Stephen and his father had related in a pathological way, even a “crazy” way (Stephen’s description). We now found ourselves playing (literally and figuratively), with my allowing – and enjoying - him as really knowing, but with neither one of us having actually to be omniscient, or depreciated, i.e., made to feel stupid, or inadequate. Indeed, I felt immensely entertained by Stephen, and I believe he felt this in my responsiveness. And he was looking forward to hearing how the trick would go over when I showed it to my family members later.

During the session, and then later on when I shared with Stephen what I had written, we did some “analysis” of what had happened between us. I acknowledged that I was in some ways a bit like him. For a moment, I had been unable to think about how he might have done this (other than by reading my mind), because I was inclined to attribute omniscience to an admired other who seemed to offer this as a condition of relationship. As a child, my relationship with my mother was in certain respects similar to the one he experienced with his father. Like Stephen with his father, I had experienced myself with my mother as quite smart. While not being “perfect” for her was not an option, it was also clear that she was indisputably “the” smart one.

I also told Stephen that in another respect, too, I had felt in his presence a little like how he must have felt with his father. I spoke of my irritation at times when he would demonstrate his cleverness but that I had never addressed it because it was always subtle, fleeting, and lighthearted. Stephen told me that this was how his father actually behaved. “If only he had spoken in an openly depreciating way, it might have been easier”. I then realized something that I had
not understood until now. I had been taught to experience my mother’s brilliance specifically in the way that Stephen had learned to accept his father’s – through her sweet, subtle, yet unquestionably superior attitude. Now, though, Stephen’s “offering” his “omniscience” by implying that he would “know” the card I was thinking of, i.e., could read my mind, was also an offer of something that felt new, and therapeutic: engaging the specificity of a shared problem - the unquestioning idealization of a ‘superior’ mind – in a different way – a way that enabled us both to look only “magically” omniscient, but really clever.

As Stephen was leaving the session, he offered a grammatical critique of one of the words in my write-up of the vignette. I thanked him – I was truly grateful for this – and I did not feel a trace of annoyance.

II Therapeutic Possibility is Inextricably Linked with Optimal Responsiveness

- In addition to the analyst’s sustained empathic attentiveness to her patient’s and her own subjective states, therapeutic possibility depends upon whether the analyst can respond optimally to these needs. Within specificity theory, the field of analytic observation is expanded to include discernment of the response that the analysand expects from his analyst, because when the expression of a psychological need occurs in the patient, whatever follows may be experienced by the patient as a response to that need.
- That is, therapeutic effect is dependent upon both the continuous operation of the analyst’s sustained empathic attentiveness to her patient’s and her own subjective
states, and the analyst’s response to a patient’s expectation that his particular therapeutic needs are going to be met.

- Optimal Responsiveness and therefore therapeutic effect may usefully emerge from the influence of a variety of structured psychoanalytic theories that may contribute to the possible understandings of the interactions within a particular analytic dyad at any given point in time.

- Specificity theory itself is not a theory that posits defined stages of development, universal mental structures or innate motives (such as drives, or even relatedness), or defined disorders or prescribed ways of being with patients. Structured theories, such as classical psychoanalysis, ego psychology, object relations theory, Kleinian theory, and more ‘traditional’ self psychology, conceptualize the mind as a self-contained entity that can be objectively observed, relatively independent of the influence of the observer, and understood through universally applicable principles and changed through prescribed techniques. Structured theories offer us rich and complex descriptions of possible states of organization between analyst and analysand. Specificity theory holds that such theories must be used intelligently, as they are only one possible organization of process and then perhaps applicable only for a point in time.

- Therapeutic effect as inextricably linked With Optimal Responsiveness therefore privileges the influence of experiential awareness that emerges unpredictably via the specific interaction between analyst and analysand. This awareness may or may not reflect the elements of any recognized structured theory. It may also entail the application of other “theories” or models that the two participants bring
from a myriad of other sources whether or not consciously held or formally articulated.

- In contrast to the traditional psychoanalytic view that verbal interpretation of certain kinds is both the only mutative response as well as the only correct mode of intervention, the analyst's responsiveness properly and effectively draws upon a rich palette of both the verbal and the nonverbal in order to promote optimal therapeutic effect. All of this implicitly contradicts the notion that there can ever be one universally applicable analytic approach.

III Optimal Responsiveness Draws New Attention both to the Specificity and Variability of Therapeutic Possibility and its Dependence on the Fit of Each Particular Dyad

Therapeutic effect is centrally associated with the therapeutic fit between the two participants - between that analysand’s therapeutic needs and that analyst’s capacity to respond to them. Despite apparently striking differences, there may be remarkably harmonious fits in which there is safety and affection. And, despite apparently striking similarity, it is sometimes very hard to find a good fit. But, the spectrum of fit or misfit is not a static event, and may alter unpredictably and sometimes quite surprisingly over time. Therapeutic effect is specific to each analytic pair, in effect, to the potential and the limitations of the particular analytic dyad within which each participant responds to each other in the moment and over time. The nature of the fit, or linkage, is specific and variegated: of origin, culture, outlook, humor, values, development, therapeutic quest, motivation, trauma, or disruption, etc. that may emerge as significant within their process.
Limitations may comprise constraints of all sorts - professional and personal. And a dyadic system may be impacted by an adjacent or distant system, which can constrain the capacity of the dyad for optimal mutual responsiveness. Here are a few very brief illustrative situations, whose specificity variously derives from the analyst’s professional training; who the analyst “is”, and her limits, within different contexts; and from the pressure of an adjacent system.

In her analysis, the analysand, herself an analyst, pleaded with her analyst over months to please refer to her by her first name, not her professional name, Dr. X. He continued to use her professional name, Dr. X. As her frustration, disappointment, and anger mounted in the face of his refusal to meet her felt need for more warmth and personal recognition that use of her first name represented to her, the analyst finally said to her, “I cannot do it. My professional training proscribes such familiarity. I would violate my own standards of acceptable analytic behavior”.

In a second example, an analytic student seeking additional clinical training in one of my study groups conveyed that, while she was aware of the value of staying with the validity of her patient’s subjectivity, she was also becoming aware that something within herself – in effect, the sense of conviction attending her own subjectivity - at times tended to interfere with her doing so. She gave as an example the distress of one of her patients when the phone rang in session, even though she would not pick up the call. This, he told her, really upset him, and he didn’t know why the analyst would allow this to go on. He was quite
adamant that it took her attention away from him, and that it significantly disrupted the work they were doing. She, however, not only did not share these views, she also found it really difficult to take his distress seriously. After all, she told me, it was only the telephone ringing! She was struck how differently she felt in a situation where she had no difficulty “staying with” a patient’s painful experience that whenever his wife was on the phone, it was evidence that she was betraying him sexually with other men. She could respond to his experience by conveying that she could appreciate how this must torment him.

In response to my query about how she might explain how differently she felt about these two situations, she told me that what helped her to respond in the way she did to the patient whose wife was on the phone was that, in contrast to the other patient, this one seemed able at times to hold to some small possibility that what he was otherwise convinced of might not always be so; and therefore she could anticipate the possibility of her responsiveness relieving the intensity of his pain over time, if not relieving him of his delusion. A striking example of how the potential for empathic understanding and optimal therapeutic responsiveness can differ with the therapist’s experience about a particular capacity, or not, in the patient, which apparently reflected what she herself struggled with, specifically, in process. In effect, this therapist was different in each situation. Although our understanding could benefit from much more information about the therapist, we might consider that her initial request for help with regard to a problem attending her feeling stuck in the validity of the rightness of her own subjectivity, or perspective, merits particular attention. Whether this work would most usefully be carried
out at the level of therapy – which, we suspect, most analysts would likely assert - or addressed in the context of particular dyadic situations in supervision, is a question that we consider extensively in chapter 10.

Here are two brief examples of how an adjacent system can affect the specificity of optimal therapeutic responsiveness.

A therapist told her supervisor that after she and her patient met after the Christmas Holiday break, she wished she had told her patient that she could contact her during the break if she wished to do so. There had been no crisis – just the therapist reflecting that, in effect, it might have been better for the purpose of maintaining a thin relational link with this somewhat relationally distant patient who seemed to have started to come a little closer recently. The supervisor asked the therapist what made her not say that to her patient. She thought for awhile and then said, “Well, I have two small children…”

An analyst had been working successfully with a woman with a significant traumatic history. She needed frequent contact in the evenings for support with flashbacks that were stimulated through their work together. The analyst understood the patient’s need, felt that such response was therapeutic, and had no difficulty extending it. However, at one point in the treatment, the analyst’s husband sustained a fairly serious neck injury. He could no longer tolerate his wife spending evening time with this patient. He required his wife’s quiet and consistent presence through the recovery process. This limitation from an adjacent
system then limited the analyst’s capacity to respond to her patient’s need for evening call.

Therapeutic possibility available to any particular therapeutic dyad (or to the members of any therapeutic constellation, such as a couple, a group, or a family) develops at the interface between a particular therapist’s and a particular patient’s capacities and constraints to respond to each other from moment to moment and over time in specific emerging context. Therapeutic fit and thereby therapeutic possibility are variously affected by the therapist’s experience of reciprocal responsiveness from the patient in particular ways. This constitutes dimensions of interaction that transcend the narrow perspective of the concepts of transference and countertransference (a topic we address in some detail in Chapter 8).

Therapeutic fit is significantly related to the therapist’s commitment both to stretch herself to meet the patient’s therapeutic needs as well as to recognize the limitations that would strain her capacity to respond effectively. Therapeutic fit available to a particular dyad will become evident in the responses of the participants to one another and only knowable after the fact. The nature of therapeutic fit that determines therapeutic possibility is both much wider than generally acknowledged, and simultaneously more specific - to the particular participants. This is preeminently depicted in the following example.
Karen, Wheeler, and Dr. B

This clinical illustration may strike you as a tad surprising if your appreciation of the remarkable emotional responsiveness of the minds of dogs – at least some dogs – does not quite approach mine. I have always kept my dog with me in my consulting room, unless a patient objects (I inquire about this before the first consultation). When I first began to do this, many years ago, my (in part) classical background helped me rationalize this on the basis that Freud did too. As far as I’m aware, though, Freud’s Chow was never his “associate”.ii Wheeler – whose nick-name is “We-dog” – is mine, and he plays a variably important part in the therapy of my patients. For some, very little. For others, though, his presence is not insignificant. For Karen, it played a crucial - and specific - role. And the ways in which Karen experienced Wheeler’s responsiveness as therapeutic are part of a weave of specificities of all three of us as they emerged in our process. Here is the backdrop to those specificities.

Wheeler is a 10 year old English Shepherd who joined me in my life when he was 16 months old.

There has almost always been a dog in my life. All of them except Wheeler were puppies when they came to live in our home. One of them had been especially important to me as a child when I sought a safe, reliable, and loving intimacy in refuge from my experiences of verbal abuse and emotional abandonment, by my mother.

I was looking for an English Shepherd a few months after our Golden Retriever died at age 13. I found Wheeler in Oregon through the English Shepherd rescue service. Dog person that I am, I flew from my home in Los Angeles to Portland, from where I
drove 60 miles north to the little town of Dallas to meet Wheeler. Wheeler’s owner recognized early on that her absence throughout the day was making Wheeler very lonely, and she transferred him to “foster care”, where he had been living for about a year with two kind ladies. Although Wheeler and I only had a brief meeting, we seemed to connect well, and I made arrangements with his foster parents to adopt him and he was flown to us in Los Angeles a couple of months later.

For some time after he arrived, Wheeler was skittish and apprehensive. Everything that was unfamiliar to him – and there was much of this - seemed to upset and frighten him. It took him six months before he calmed down, and it would take him more than a year before he would play in any way at all. We do not think he had been physically abused, but it was not unlikely that he had been traumatized by his experience of separation (two, now) from people to whom he had become somewhat attached. Despite his agitation, Wheeler bonded to me almost immediately, and very strongly – and likewise I to him.

Wheeler is friendly and affectionate to others who are comfortable with him and who like him, but he tends to be somewhat uninterested in those who are indifferent to him – probably a bit like his Dad. Wheeler follows me wherever I go, and stays with me, all the time, in his “forever” home, of which he is very protective.

English Shepherds are working dogs, “farm collies”, especially known for their protectiveness and for their attuned attentiveness to the farmer’s wishes. Perhaps this is why Wheeler regards his primary job as being with me and helping me do my particular work; he has, surprisingly, turned out to be a remarkable sort of ‘therapy dog’, working with me in my home office throughout the day.
I have wondered what may be in his mind as he greets someone with me at the door, and whether he wonders what their presence will be like today. There is evidence that he knows my (fairly consistent) daily schedule in the way he differentially anticipates the arrival of particular patients; and I suspect he has quite different feelings as he anticipates the arrival of particular patients, again, a bit like his Dad. Wheeler’s level of arousal is particular to each person, his interest in everyone is different, and his way of relating to each is unique. He spends varying lengths of time with each patient, from a few seconds up to perhaps ten minutes (not necessarily the same duration of time in each instance), and he exhibits a wide spectrum of doggie contact and quality with each – from a brief sniff, to a prolonged cuddle and scratch. He then walks back to his little rug in the far corner of the office behind my desk chair where he lies quietly, usually for the remainder of the session. I have not trained him nor even suggested to him that he do any of this. He has just always done this.

Someone who overtly gives him attention is not necessarily the one to whom he may respond. It seems to me – though this may reflect one of my several attributions to Wheeler - that he is particularly inclined to respond to those who he senses need him to be with them. I am a bit like that, so perhaps Wheeler, my sensitive farm collie, is responding as he thinks I might want him to. On one occasion, he got up from his rug in the middle of a session, and lay down at the feet of a patient who, until that moment, had kept his feelings of aloneness and fear of abandonment deeply hidden - certainly from me and probably from himself - but apparently not from Wheeler. The man started to reach down to touch Wheeler, then hesitated, and pulled his hand back. I asked why he stopped,
and he replied, “I’m afraid that if I touch him, he will go away”. Wheeler stayed with him for the rest of the session.

Without having words, without being able to hold an explicit idea of past and future, and unable to reflect on the meaning of behaviors for himself or the other, Wheeler may yet be making responsive, sustainable, and specific connection with various patients, in ways that for some are healing, or even essential, in order that they might connect with any intimacy to another at all. The latter was especially true for Karen.

Karen is a 45 year old single woman from an upper class country family in southern England. She was abused, quite severely, both physically and emotionally, as a small child. She was frequently abandoned by her parents for weeks at a time, left with household staff or farmed out to neighbors when they were away. Karen was also repeatedly assaulted sexually by both her parents, and molested by almost every male member of the household staff, as well as by an acquaintance of her father, which he arranged. Apart from one of the live-in domestics, who would at times protect her by keeping her in her room at night, her refuge from this recurring trauma, and appalling betrayal, was the companionship of her dogs with whom she developed close bonds and with whom she spent as much time as possible.

Although Karen’s experience of abuse far exceeded mine, she too found succor from her suffering by establishing close mutually caring connections with her dog friends in her adult life as well as in her childhood. While Karen has a number of human friends, and has had some loving relationships with men over
the years, she has always lived alone, except for her dogs, whom she cares for as she would a thoughtful and devoted mother to her children.

Karen’s mother died when she was 11, and her father married a woman who had no interest in her. Karen had been in treatment since she was a teenager, which included periods of hospitalization for severe post-traumatic stress and occasional psychotic episodes. Karen’s experience of therapy had largely been good. She especially valued her treatment with a particular psychoanalyst whom she came to trust and to become able to share painful, shame-filled feelings about her horrendously abusive experiences. However, several years into the treatment, he developed a brain tumor, and became intermittently psychotic. Tragically, he began to talk to Karen in sexually explicit ways that recalled and reactivated those early traumatic experiences, now in relation to him. Karen felt horribly betrayed, yet was unable to leave him; and then, within a year, he died. Karen worked with another analyst for a few years prior to seeing me. For some time, she gained valuable insights from that analyst; then she asked him for a referral to someone who could provide more of a “presence”.

I saw Karen for appointments four times weekly, at somewhat different times. Wheeler soon knew what these times were, and eagerly anticipated Karen’s arrival. When Karen would appear at the door of my office, she might greet me - in either a friendly or neutral sort of way - but mostly she would greet Wheeler, with warm and happy tones. Wheeler responds by matching her affectionate greeting with wagging tail and burrowing nose and stays with her, allowing her to caress his fur and scratch his back (not something he readily does with anyone but
me). This might continue for up to several minutes. Karen then sits down and Wheeler quietly walks back to his rug behind my desk. Karen and I then “start” our session – the most important part of which, though, has already happened.

I understood that Wheeler is the me that Karen would have wished to be able to trust and connect with like she can with Wheeler, yet my attempts to interpret her behavior with Wheeler as representing an “enactment” of the more deeply desired but fear-filled connection with me – one of the untrustable humans – has no effect. Karen does not refute these interpretations; she tacitly asserts their therapeutic irrelevance by simply not responding to them. While Karen does seem to value my presence and we do at times talk about problems of trust in our relationship, I have the strong impression that this would not be possible were it not for the presence of my associate therapist.

The therapeutic linkage that developed between Karen and Wheeler could be intelligibly conceptualized by the tenets of a number of formal psychoanalytic theories, such as attachment theory, self psychology, and object relations theory. Yet, it is important also to apprehend it at a higher level of abstraction and to consider the relevance of the specificity of healing in this relationship with Wheeler to psychoanalytic practice in general. Specificity theory gives substance to the value of Wheeler’s responsivity to Karen through its recognition of the specificity of therapeutic responsiveness in the present other than verbal interpretations that link past experience with current behavior. From this perspective, therapists can be made more aware of the possibility of healing through their attuned presence, supporting their courage to “not
know” just what will emerge as therapeutic. Wheeler preeminently sits in a position of not knowing, as the kinds of cognitive capacities that we, as humans, engage to “know” and to “analyze” are not available to him.

Karen started to assert herself with other people in ways that she had never done before in order to get the kind of help, and caring, that she has needed to counterbalance the devastating effects of the traumata she sustained during her childhood. The therapeutic yield from the connection between Wheeler and Karen – indeed, between the three of us - was crucially specific to our own histories and to our own sensibilities and sensitivities as they emerged in our process, where we discovered what our particular capacities were to be therapeutic together.

In the next chapter, we will look more closely at the clinical consequences of the shift from the universality of structure to the specificity of process.

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i We believe Wachtel (1986, p. 60), in part, implied such a view when he stated, “It is essential that the analyst address the unique individuality of the patient”...[and] “We are always observing something that occurs in relation to us, and not just to us as screens or phantoms, but to us as specific flesh and blood human beings sitting in the consulting room”.

ii Yet, there is the story of how one of Freud’s Chows, so sensitive to his moods, responded to his pleasure that his patient, Abram Kardiner, indicated being deeply understood by an interpretation, suddenly leaped onto Kardiner's chest and began licking his cheek (Craig Powell, personal communication, 2009).
Sadly, Wheeler died in August, 2009, a little over a year before this book was
published. But he was very much here when I wrote this vignette, so I am writing it as if
he still is. His presence is still very much with me.