The Power of Specificity in Psychotherapy

When Therapy Works—And When It Doesn't

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1. 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."

2. 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).

3. 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.

Clinical Consequences of the Shift from the Universality of Structure to the Specificity of Process

The primary consequence of a process view of mind versus a structure view of mind constitutes a radical shift in epistemology. This is a formal way of saying that a process view of mind changes the how, and what we, as psychoanalysts, know, in working with a patient. Specificity theory thus constitutes a new way of understanding psychoanalytic, or psychodynamic, psychotherapy as process. While its perspectives are consistent with many aspects of other process theories, such as intersubjective systems theory, nonlinear dynamic systems theory, and complexity theory, as well as with other relationally-oriented intersubjective theories, as we described in chapter 1, it has a different focus: the co-creative discovery of what may, or may not, be therapeutically effective for the particular patient, given the specific capacities and limitations of the particular participants that emerge at that time, and over time.

When specificity becomes central in our consideration of process, the epistemological shift pre-eminently illuminates how the who of the participants in the particularity of their process will determine therapeutic effect. In other words, these shifts in epistemology have significant clinical consequences.

Specificity theory alters the very nature of therapeutic practice in three basic ways: (1) the role that formal psychoanalytic theory assumes in the therapeutic process; (2) the nature of the therapeutic response and the process through which the particular response is derived; and (3) the nature of the relationship between the patient and the therapist.
ALTERATION OF THE ROLE THAT FORMAL PSYCHOANALYTIC THEORY ASSUMES IN THE THERAPEUTIC PROCESS

In contrast to a theory of process, a structure theory serves a more explicit explanatory and guiding function within the treatment. Much of what the therapist knows about the patient and therapy is derived explicitly from the theory itself, even when the therapist assiduously attempts to apply its understanding individually. Structure theories, such as ego-psychology, object relations, Klein, Lacan, and self psychology offer the psychoanalytic therapist systematically formulated postulates to guide the understanding of the patient and the response to the patient. The theory itself offers the therapist knowledge of the patient’s primary motivations, development, and the prescribed manner in which to helpfully intervene.

Within any given structure theory, psychoanalytic technique is premised upon and determined by the generalities which the theory conceptualizes. These generalities are based upon universal assumptions about man, his development and illness, and they give rise to established prescriptions by which to cure the patient of defined ills. For example, if man is believed to be motivated by unconscious drives and made ill by failure to renounce the gratification of infantile striving—e.g., the Weltanschauung of traditional psychoanalytic theory—then it would be critical to refrain from gratifying any relational desires that the patient has of the therapist as this would interfere with the ways in which psychoanalytic technique is applied to make the unconscious determinants of those desires conscious. If man is believed to be motivated by a need to assure, or to restore, self cohesion, and to realize his ambitions and meet his ideals—the outlook of self psychology—the therapist must respond in prescribed ways that are consonant with these purposes. Specificity theory, on the other hand, recognizes that the constituents of formal theories comprise only some of the many ideas that we utilize to organize, understand and respond to our patients.2

While we contrast specificity theory as a theory that embraces uniqueness and emergent order with structure theory as referring to a variety of theoretical systems that are relatively highly structured, specificity theory by no means dispenses with useful hypotheses, insights, and responses that emanate from structure theories. We recognize that such theory is critical to our work; we cannot think without it. But its role within the application of specificity theory is recast as providing possibilities, models to play with and argue against, not as a source of knowledge of any single patient. We therefore view psychoanalytic structure theories as hypotheses that must be consciously considered as such. The assumptions that underlie a structure theory must be identified and considered as to whether they are applicable to a particular patient at a particular moment in the therapy.

When the specificity of process is at the center of our consideration, the generalities intrinsic to the formalized concepts of structure theories can emerge as illustrative of a particular patient or of a therapist’s specific relationship with a particular patient. Specificity theory can thus assist the therapist to think about and utilize more thoughtfulness and intelligently the panoply of these theories that now abound to guide psychotherapy as generalities, in order to illuminate and think about any particular clinical moment. Structure theories of psychotherapy become simply another attribute among many that may influence a particular therapist about how to understand and be with his patient.

Unformulated Theory, Blinking, and the Dark Matter of Our Minds

In addition to formal psychoanalytic theory, with specificity theory we also attend to a plethora of other “theories,” or “models,” both conscious and unconscious, that may centrally influence the therapist’s responsiveness to his patient. It is not so easy to discern the vast body of unformulated concepts that every analyst also ineluctably draws upon in understanding and responding to her patient. Specificity theory explicitly draws the therapist’s attention to this type of theory and notes that it warrants our serious attention. Such theory derives from the diverse experience of the particular personal and professional life of the analyst, both past and present, and consciously and unconsciously, as well as from the Weltanschauung to which these give rise. Conceptually, this extends well beyond the narrow confines of countertransference, whether the latter is defined classically as impediment, or as consisting of all the analyst’s feelings or organizing principles. Unformulated theory, like formal psychoanalytic theories, constitutes an aspect of who the analyst is, at any moment. It will inescapably play a part in determining the responses of the therapist toward her patient, and its therapeutic influence can be pivotal and profound. It may be implicitly and/or explicitly operative. However, its effects can be discovered only if we are aware that it exists.

In his book, Blink, New Yorker Science writer, Malcolm Gladwell (1995) has analyzed a vast number of psychological studies that demonstrate that the human mind develops many theories about its world through experiences and observations, many of which are never consciously held nor verbally articulated (25). The human mind continually unconsciously seeks out patterns in situations and behavior. These associations influence our thoughts, judgments, decisions and actions in a very rapid fashion (Gladwell, 50). Gladwell calls this "thin-slicing," the ability of our unconscious to find patterns in situations and behavior based on very narrow slices of experience (23). Not only do we premise many judgments on these unconscious theories, we are not aware that we are not aware (71).
According to Gladwell, "Thin-slicing is not an exotic gift. It is a central part of what it means to be human... We thin-slice because we have to, and we come to rely on that ability because there are lots of hidden situations where careful attention to the details of a very thin slice, even for no more than a second or two, can tell us an awful lot" (43-44). Yet, this knowledge is based on a lifetime accumulation of unconscious theories about our world. Specificity theory explicitly notices the operation of thin-slicing, as one type among other types of informal theories to encourage the therapist to explore and examine continually the underpinnings of his judgments, bearing in mind Gladwell's admonition that most of us feel ignorant of the operation of these unconscious theories upon our reasoning even when provided with scientific evidence that they are influencing us (71).

The ubiquity and abundance of informal theory, conscious and unconscious, that influences who we are and how we behave may be analogous to the "dark matter" of the cosmos that lies between the stars which may constitute much more of space/time than the stars themselves. Like the dark matter of space/time, unformulated "theory" does not easily lend itself to identification or description, yet to ignore it may be to disregard much of what is also central within psychoanalytic treatment.

THE ALTERED NATURE OF THE THERAPEUTIC RESPONSE AND THE PROCESS THROUGH WHICH THE PARTICULAR RESPONSE IS DERIVED IS ALTERED

Theories that are premised upon a structured concept of mind offer definite therapeutic methods and techniques. Structure theories provide a type of blueprint for the desired outcome of therapy, which then gives rise to designated responses in order to obtain the desired outcome. The product delimits the process. Aristotle expressed this as the distinction between what he called techne and phronesis, or episteme (Aristotle, Nicomachean Ethics), each of which connotes a different relationship between the means and the ends. The technique required to produce an object is defined by the endproduct. The method required to understand and respond to a person is itself a part of the creative process. The more experienced a therapist becomes with technique, the more expert he/she becomes—in certain contexts. For example, a cognitive behavioral therapist has an established protocol of treatment comprised of designated exercises to be worked through in a predetermined sequence in a determinate number of sessions, and instruments that continually monitor the patient's progress relative to symptoms reported at the onset of treatment. A classical analyst's structure understanding of mind gives rise to abstinence, anonymity, and neutrality together with verbal interpretation as prescribed curative response.

What we all "know," but variously find it difficult to quite acknowledge, is that, in many contexts, we cannot know what will work therapeutically for our patient and ourselves at any particular time. What then becomes of technique when there is no known or agreed upon end point, when it is the very act of creation in and of itself that is the focus of the work? Specificity theory does not recognize any universal goal of the therapeutic encounter, but endorses Bion's admonition that "desires for results, 'cure' or even understanding must not be allowed to proliferate" (Bion, 1967, p. 273). "The only point of importance in any session is the unknown... in any session, evolution takes place. Out of the darkness and formlessness something evolves" (272). For Bion, therapeutic effect "[derives] from the emotional experience with a unique individual and not from generalized theories imperfectly 'remembered'" (273). He has wryly noted that if the analyst feels he has seen the patient before, he is treating the wrong patient (273).

Specificity theory entails sustaining and tolerating uncertainty. The psychotherapist must attend to the context, the emergent, the disorganized and the unknown. Specificity demands that structured theories be used intelligently. The therapist must be aware of the assumptions inherent in the particular theory, the context from which the theory emerged and the aspects of a relationship that are attended to or privileged and those that are relatively discarded.

With specificity theory, technique and know-how are supplanted by an increased capacity to tolerate the anxiety of not knowing the response (and whatever theoretical substrates may underlie it) that could emerge as therapeutically useful for the particular patient, and possible for the therapist who is treating him. Practice informed by specificity theory engages with the patient without prescriptive or prospective responses and without guidelines. Such a process requires a unique use of the therapist's self in the psychoanalytic encounter. When we really grasp the uniqueness and specificity of each therapeutic encounter, and when we deeply appreciate that the mind is created through and by the relationship, we are continually engaged in the moment to determine each time the responsiveness that will optimally meet the particular patient's therapeutic needs. This does not envision an analyst who necessarily becomes more expert in psychoanalytic technique, but rather one who increasingly gains comfort with not knowing and with sensing the use of himself or herself, both consciously and unconsciously, in engaging his or her patient's therapeutic needs.

Yet, as we emphasized in setting out the foundational perspectives of specificity theory in the last chapter, it is essential that the therapist allow herself to fit her responsiveness to each patient (Bacal & Herzog, 2003). Apprehending the nature of process and its specificity give substance to the legitimacy of this variability. Such variability expresses the uniqueness that is intrinsic to the treatment engaged by a particular dyad and which
may transpire between “mother and infant, therapist and patient, teacher and student, supervisor and candidate” (Lachmann, 2008, pp. 64-65). Lachmann appears to be drawing attention to the unique yet in some ways “predictable” sequences that obtain for a particular dyad who come to “know” each other’s moves or play, similar to what Tronick understands as “thickness” (see chapter 9). Lachmann adds, however, that while the two boxers need only predict each other’s behavioral sequence, the co-creation of empathic responsiveness “requires this and more” (p. 65). (See also Lachmann, 2010.)

From the perspective of specificity theory, therapeutic effect constitutes a function of the capability for requisite reciprocal responsiveness that emerges within the particular process of the specific participants interacting within their system (e.g., the dyadic system of psychoanalytic therapy, or the multi-person system of a group, or family).

Once again, we emphasize that this constitutes a process, whose therapeutic value does not rest on an objective standard. Its assessment will never be knowable in any “objective” sense, unless one undertakes the sort of evaluation that “outcome research” offers (see chapter 1). Yet, we can find opportunities, within the system comprising the specificity of process itself, for optimal therapeutic responsiveness (Bacal & Herzog, 2003, 642). Much depends upon “therapeutic fit.”

The Importance—and Indeterminacy—of Therapeutic Fit and the Range of Therapeutic Possibility

However much we might want to believe we have a valid sense of “knowing” whether there would be a therapeutic fit between us and our patient, and what sort of theory or technique would work best for her or him, specificity theory teaches us that we must forgo these prognosticating exercises. Important as it is, “therapeutic fit,” in whatever shape or form it may emerge, is never reliably predictable. That therapist and that patient must discover the most therapeutic ways of being together. This requires that the therapist consider, from moment to moment, not only what may be “effective” therapeutic responsiveness with that patient, but also whether he is capable of providing it.

In other words, apart from the likelihood that we will not infrequently find out what is optimally responsive for our patient at any particular time through our discovery that we are not providing it, we cannot know in advance whether that person’s therapeutic needs will be met by our capacity to respond to them. Or, indeed, whether a treatment will even get off the ground. Bion’s dry response to my inquiring during our first supervision session what he thought of my undertaking the analysis of a particular patient who had applied to the London Clinic of Psycho-Analysis was, “A
patient may take one look at you and never want to see you again” (Bion, personal communication, 1965). During my next 45 years of analytic practice, I have had occasion to recall Bion’s wry caveat. Sometimes, though, this takes more than one look; and at times, a patient may never leave us, and may benefit greatly from therapy over a long period of time. While we may come to feel that a certain range of therapeutic possibility obtains with a particular patient, we may also be surprised to discover in the moment or/ and over time how our ability to interact therapeutically with that patient may transcend this.

Stretching, Limitations, and a Word about the “Third”

I have found that in situations when I feel that I am reaching the limits of my ability to work effectively with a particular patient, my capacity to offer needed responsiveness emerges as a function of my willingness, or felt ability, to stretch myself to meet my patient’s therapeutic needs, along with my awareness that doing so will not necessarily strain my ability to respond therapeutically. My patient may also need to discover her capacity, and her limits, too, for stretching, in order to work with me.

Whatever capacities we may discover for such stretching may be variously affected, as we noted earlier (p. 65) by the impact of adjacent systems. We have wondered whether what some psychoanalysts refer to as the “third” constitutes one of these systems. Would the analyst’s capacity to “stretch” herself be facilitated by its utilization?

Much has been written and discussed about the idea of the third; a 2006 IARPP colloquium was recently its theme, based on a paper by Lewis Aron (online colloquium, October 30—November 19, 2006; see also Aron, 2006). Of the many aspects, or varieties, of “third” that have been put forth (and there are now a plethora of them), the one that makes most sense to me, and that feels useful, is its characterization as a shared experience co-created by analyst and analysand that can be helpful in negotiating impasses in treatment (as emphasized by Pizer [1998], echoed by Aron [IARPP online colloquium November 14, 2006], and elaborated by Benjamin [2004]). Both Aron and Benjamin liken the third to the “potential space” of Winnicott (1971, pp. 107–110) where mother and baby somehow find a place and way to connect. According to Benjamin (2004), who vividly illustrates its function in cases where analyst and analysand are stuck in an often hurtful “doer and done-to” mode, the sense of third, if achievable, may constitute a space for cooperative endeavor.

I have wondered whether this theory of the third might have made sense of my effort (which I described in chapter 5) to transform a disruptive experience in my analysis with Balint into a therapeutic one. I had suggested to Balint—when he was hurling hurtful (and unusable) confrontations at me during the early days of the analysis, that he consider a metaphor for a different way of working—that we might be like two children sitting on the floor side by side, leaning against the couch looking at something together and discussing what each of us saw in it. Did this constitute a plea to him that we try to find a way, such as Benjamin describes, of “creating a dyadic system that contains by virtue of mutual reflection... [and thereby transforms our] conflict around responsibility into a shared third, an object of joint reflection” (Benjamin, 2004, p. 15)? This description of the “third” appears at first glance to offer a possible conceptualization of that situation. We would, in this way, have created a different therapeutic situation, characterized by a specific experience of sharing (see Herzog, 1998), rather than my being the object of judgmental confrontation. Yet, conceptualizing this as a shared “third” does not accord with my experience. I was desperately trying to elicit from my analyst a particular kind of responsiveness that would feel specifically therapeutic for me—that we share something interesting to both of us in a way that excluded oppressive inequality and judgment. I also sensed that he would have to stretch himself a whole lot in order to do this.

The notion of third may skirt the recognition of the incapacity of that analyst and analysand to transcend for therapeutic purpose the limits of their particular dyadic capacity. It is important to recognize when this may be the case. In such situations, the invocation of the theory of the third could constitute an attempt of the dyad to do an end run around their limitations. In contrast, when impasses are courageously engaged by both parties, as Jessica Benjamin illustrates with her case example (see Benjamin, 2004), the resulting struggle may embrace a remarkably therapeutic—though, at times, quite painful—experience through overt sharing of their specific limitations in context. The experience on the part of both analyst and analysand in situations such as these centrally relates to the question as to whether that analyst and that analysand can stretch themselves adequately in specifically important ways. We have described two instances that illustrate this: in chapter 6, the situation in which the analyst shared with his patient that his analytic credo precluded his asking her by her given name, which for her, precluded the intimacy with her analyst that she yearned for. This was also vividly depicted in the analysis of Beth with Lucynn Carlton (in chapter 3) where the patient desperately felt she needed the analyst actually to hold her, which Lucynn felt she could not do.

We wonder whether the conceptualization of third—unless specifically useful for a particular dyad, such as consultation—may constitute an unwarranted reification. The particular metaphor of the third comes from a mechanistic epistemological system incompatible with thinking when operating within a phenomenal epistemology, such as specificity theory. Within specificity theory, we might ask, what third? Everything brought
into the room with two people is brought in with them and through them; there isn’t any “thing” “outside” them, certainly not some isolated factor or belief to which they resort. Benjamin uses the idea of the third to create or to hold the possibility for the dyad that as the two interact there is a third way of being not envisioned by or within either one alone. Experience conceptualized in this way may actually constitute specifically unfolding therapeutic experience by analytic dyads in a variety of ways, through reflecting, playing, enacting, “self-disclosing” etc., when attempting to work through painful impasses to an equitable solution. The advantage of “third” is in supporting a concept of change. The disadvantage is the mechanistic, thereness-otherwise of it, something out there from someplace else that can enter into the dyad in an unidirectional movement and not influenced by who each person is. This constitutes a lower order of conceptualization, from another realm of thought.

A valuable concretization of the idea of the third may, especially in situations of felt impasse or misfit, comprise consultation, or supervision. It is important, though, to keep in mind that this places the analytic dyad in a triadic system of interfacing specificity, which will have its own particular capacities and limitations (see chapter 10). Another evident and potentially useful concretization of the “third” is the modality of treatment that we call couples therapy.

The ability for mutual “stretching” can affect the “fit” of the dyad, and may significantly depend upon that analyst’s and that analysand’s ability to respond in specific ways to each other. The clinical consequence of this is that effective patient-therapist relationship turns out to be much more reciprocally responsive than psychoanalysts have been willing to acknowledge (see Bacal & Thomson, 1996, 1998).

### The Specificity of Reciprocity

As we now explore therapeutic process more deeply through the lens of specificity theory, we are discovering that therapeutic process is ineluctably reciprocal, specifically. That is, reciprocally specific process may significantly affect the patient’s therapeutic experience. It is not only the patient who brings conscious and unconscious expectations to his therapist. The analyst normally has a variety of conscious and unconscious expectations of the patient, many of which are responded to by the patient during therapy. While some of these expectations on the part of the therapist are ubiquitous—such as the patient arriving for sessions, talking sometimes, and tacitly or explicitly acknowledging the usefulness of what the therapist has to offer, as well as conveying this concretely by paying his bill—many more are specific to particular analyst-patient pairs. Many expectations of either party may remain below the radar of each until they are not met. And the analyst as well as patient may experience disruption in their relationship when their expectations are not met. (Ibid.). The complexity and specificity of such expectations are not adequately apprehended by the terms, “transference” and “countertransference,” a topic we look at more closely in chapter 8.

The analyst’s experience of the patient’s specific responsiveness can be as crucial for a therapeutic process as the patient’s experience of that of the analyst. Recognition of the specificity of reciprocal relatedness and its mutual regulation in any particular dyad can be pivotal to the therapeutic effect of that dyad.

### ALTERATION OF THE NATURE OF RELATIONSHIP BETWEEN THE PATIENT AND THERAPIST

In psychoanalysis, the concept, “relationship,” is linked to many sorts of experiences, which have been variously apprehended as “part object,” “whole object,” “selfobject,” or mutually experienced relationships with distinctly delineated others (see Bacal & Newman, 1990). In focusing on the specificity of therapeutic effect, “relationship” becomes one of its functions, the nature of which may be different in any particular instance. And even a priori identification of the “relational” or of the “intrapsychic” as central to therapeutic effect gives way, from the perspective of specificity theory, to a consideration of what emerges at any time as pre-eminently therapeutic within the particular dyad. Either, or variously, both—or perhaps something else that we do not “know” about (see p. 75)—might be centrally implicated in the therapeutic process of a particular dyad.

A therapist who is guided by a particular structure theory gains knowledge about the patient as if he is entirely separate from the therapist. In addition, he tends to relate from a position of authority: the one who knows about the patient as informed by his particular structure theory. Both these aspects of relatedness change when therapeutic practice is informed by specificity theory. When a therapist fully realizes the unique and creative nature of therapeutic relatedness articulated by specificity theory, a relationship of a fundamentally different nature obtains between therapist and patient. Specificity theory recognizes that the therapist, who he or she is, in process with the particular patient, is integral to a therapeutic relationship.

The following example depicts the clinical consequences of the shift from the universality of structure to the specificity of process, a shift that basically entails the recognition that the patient cannot be known or related to in
any “objective,” or “general” sense. The example illustrates that the ways in which the therapist comes to understand, respond, and relate to, any particular patient is inextricably linked to that therapist’s knowledge of himself and who he is with the particular patient.

Dr. C and Dr. B

Dr. C, an assistant professor of Sociology at the University of Toronto, sought analysis with me in the early 1980s after attending one of my clinical seminars on self psychology in the extension program of the Toronto Institute of Contemporary Psychoanalysis. Dr. C and I had been working well together in analysis for about a year. We both felt we were effectively grappling with one of his main struggles—to feel more a sense of himself, to feel more centered. It seemed to me that Dr. C’s progress could be usefully apprehended from the perspective of self psychology theory, namely, the progressive development of an idealizing selfobject relationship, along with experiences of selfobject mirroring. I liked and respected my analysand, and felt that he reciprocated these feelings. We seemed to be a good “fit” in this respect, as well as in some other ways, which I shall describe shortly, even though our backgrounds were somewhat different. Dr. C’s was British/WASP to Vancouver; mine was Rumanian/Jewish to Montreal.

Dr. C had told me that he felt badly that he could not make his father feel better about himself following his recent retirement. He had been a talented set designer for a well-known Canadian movie company in Vancouver, but retired early because he was feeling unwell. Dr. C thought his father was depressed. During his career, Dr. C’s father had always prioritized a high standard of artistic excellence but this had not translated into commercial benefit. Dr. C’s mother, on the other hand, authoritatively espoused the ideal of financial success, and took every opportunity to point out the material achievements of her son’s older brother as an example of someone who had made a sensible choice of business as a vocation. Dr. C was struggling with feelings of disappointment in his father, even while he admired his principles, and felt resentment toward his mother for not valuing who he was because his chosen profession would not enable him to make a great deal of money. Yet Dr. C was not quite able to dispossess himself of considerable shame in not following a career that his mother would have admired and valued.

Dr. C had been talking about his frustration and sadness that his father never reacted when he would do something “bad” as an adolescent. He described a particular incident in which he experienced especially strong disappointment in his father when he was arrested for dangerous driving. His father seemed not know what to make of it; he was silent, and just appeared sad. There seemed no way to talk about it and they never did—and this was the case in so many instances. Dr. C felt still felt confused about this, and cried as he remembered his father’s silence.

We could analyze a good deal of the complexity of his feelings, much of which, it seemed to me, had to do with his not being able to bump up against a strong, idealizable father, with both of us contributing richly to its working through. In one session, I said that I now could see more clearly why he has felt able to open up so freely to me. In addition to his feeling that I was “trustworthy,” he must value the way we were interacting in analysis; it was so important to him to feel free to talk openly about what troubled him—what he felt he could never do in relation to either of his parents—in particular, sharing his feelings of disappointment, anger, and shame. He left the session with a spontaneous expression of gratitude. I was feeling good about how we were together and what we were doing together. Some of this, however, was soon to change, as the specificities of our process unfolded.

Dr. C was somewhat familiar with psychoanalytic theory, and had alluded from time to time about studying it formally, but he was uneasy about doing this because he felt he might be motivated by an inclination to accommodate to my wish that he do so. I realized that he was picking up some of my subjectivity. I was interested in his interest in this, and we had talked about what it would entail. I thought he would enjoy and benefit from the training, but as far as I was consciously aware, I felt no “need” for him to do this. It seemed to me that he had been moving in that direction himself, and I was responding positively. At one point, Dr. C conveyed his interest in actually applying for psychoanalytic training. He had recently attended two major psychoanalytic conferences held in Canada in 1987—the 35th International Psychoanalytic Association Congress and the Canadian Psychoanalytic Society’s annual meeting. Though he railed against the conservative and rigid theoretical perspectives that he thought were too pervasive at both, he remained interested in, and valued, psychoanalytic thinking. Soon after attending these conferences, he decided that he wanted to undertake the training. He told me that, with this decision, he felt truly like himself for the very first time.

Yet, it was also not surprising to me that his actually going forward with this would hinge upon a number of problematic considerations. The one I will highlight here is how Dr. C experienced me and what I had to offer him in continuing as his analyst. In the session after he shared his interest in pursuing training and implied that I might be his “training analyst,” he expressed a reservation that reflected a concern about me that paralleled his concern about himself. He was worried that I might be too accommodating. I interpreted that he was worried that I would be like his father who had seriously disappointed him, as he never presented a stance of disciplined authority. He agreed, and reminded me that he was also concerned about his own tendency to overly accommodate,
which manifested in various areas. If I am like that, he said, then he would be in considerable trouble (in continuing his analysis with me) since, because of his inclination to accommodate, he could never, in effect, truly find himself—his true sense of himself—with me. (Self psychologists may recognize the operation not only of Dr. C’s anticipation of a failed idealizing selfobject relationship, but possibly also the anticipation of a certain kind of needed, but unavailable, twinship relationship with me.)

His evidence for my possibly being a wuss, as he termed it, was that I might be someone who needed gratitude. He referred to a case of mine that I had presented where I discovered that, in a particular context, I felt the need for gratitude from a particular patient who rarely expressed it. He told me about a session he had recently attended at the International Psychoanalytic Association meeting, where a particular analyst and his work were acclaimed. The analyst was in a wheelchair, having suffered a spinal injury some months ago. To Dr. C, his being there despite being confined to a wheelchair, as well as his demeanor, seemed to reflect that he “did not have any needs”—in particular, for recognition or flattery, or for any falling in with his views. As he talked more about this, he conveyed that that his (avowed) idealization of this analyst as someone who “had no needs” centrally ensured that he did not need to accommodate to anyone. He could, Dr. C conveyed, constitute his own authority. Being with such a person would enable him to deal effectively with the bewilderment attending his search for a deep sense of his own self, which determined a pervasive sense of uncertainty. He referred to other aspects of his responsiveness to analyses that he had read about. He valued my theory that supported an approach of keeping an open mind, of interacting with patients in the search for responsiveness that was therapeutically optimal. Yet, he conveyed that it was important to him that I not “provide.” If I did, I was an accommodating wuss, who required gratitude. It was, rather, important to him that I maintain the “frame,” that I “knew” what was right. Otherwise, I would be too much like his father, who had not a solid opinion, who would not confront anyone. If I were like that, perhaps I would not be the kind of mentor he needed, in effect, the kind of teacher he wished to emulate. This might also evoke his inclination to accommodate, thereby depriving him of the possibility of finding himself, and his true values, professionally as well as personally.

His major question at this juncture was, should he apply to the local contemporary institute or to the local traditional institute for analytic training? Dr. C talked with several friends and colleagues about this, and spoke with analysts at both institutes. He told me he was feeling drawn more to the structured curriculum at the traditional institute, where Freudian and historical perspectives were accorded more recognition. But which institute did I think he should apply to? It was important to him that I give him my opinion about which Institute would be best for him. He knew that I was a member of both training institutes, but I believe he sensed that my primary sense of affiliation was with the contemporary institute.

I responded by saying that I, too, leaned toward the more traditional institute as the one that would likely be the better choice for him. My response seemed to feel right to him; and that choice, he said, would ideally be served by my becoming his training analyst. And then, we faced another issue that was to affect whether Dr. C and I could continue with his analysis.

As I was a “training analyst” at both institutes, his choice would present no problem in this regard. However, financial considerations did. Dr. C asked me if I would reduce my fee further when he began the training. When we had begun to work together, I had already reduced it to a level that was well below my usual fee in order to accommodate his family budget. I agreed to reduce it further, but was unwilling to do so beyond a certain point. Our “fit” then began to widen a little. Dr. C had said that he had hoped that I would want to be his mentor. We knew that his theoretical bent, like mine, was toward contemporary ideas, so this was a good fit. Would I have been willing to reduce my fee further, he wondered, if he had chosen to apply to the contemporary institute? I felt Dr. C was, at least, testing whether I “needed” him to accommodate to this preference. I replied, “Possibly, but I’m not sure.” I would have liked to be his mentor, but I was beginning to wonder whether too many specificities of mis-fit were emerging for this to happen.

Our analysis of these comprised a discovery in process of our needs and limitations in relation to each other. I was aware that the fee he stood by felt too low with respect to my own budget as well as to my sense of personal value. I also felt he needed me actually to be the kind of mother that he never had, the mother who would not only support his move to delineate from her, but also materially support him in that regard. And, unlike the mother, I should eschew the importance of money (to me, at least). I recognized that I was a little like his mother, though, insofar as I attached a certain importance to his willingness to monetarily value my “mentoring” a little higher by putting his money, as it were, where his declaration was.

With regret on both our parts, we could not find a “fit” and we parted, on amicable terms. It occurred to me later that part of his decision to find another training analyst may also have been due to his regarding my disinclination to lower my fees further as the “authority” of a mother to whom making money was central. I have since wondered, though, whether Dr. C may have experienced some therapeutic benefit from a “father” who could assert the value of what he had to offer.

The concepts of transference and countertransference do not quite do justice to the specificity of fits and misfits attending the process between
Dr. C and myself. Because Dr. C and I were able openly to talk about the specific complexities in our relationship (a capacity which, fortunately, was always one of our "fits"), we came to understand and appreciate each other's perspectives, the meaning to each other of our particular needs, positions taken, and limitations.

The crucial issues for this analysand were his experience of who his analyst is, in relation to him, and how this would affect who he needed to become. These issues emerged in the reciprocal specificity of our process. The patient's experience of the therapist as someone who was open to differing perspectives for understanding—including, of course, his own—was salutary, but it simultaneously left him without the sense of being connected to an idealizable authority. Perhaps, though, both of our capacities to respect differing perspectives came to transcend accommodative reactiveness, and he—and I—profited thereby from some optimally responsive time we spent together.

This case material also addresses the question about whether it is therapeutically optimal to the patient that the analyst "know" or "not know." Specificity theory illuminates how the experience of an analyst who is open to not knowing in one way may not be therapeutic for a particular analysand who does need him to be "knowing" in another way. Dr. C would appear to have needed me, in certain ways, to be both. He did not want someone who knew or could know what he wanted to pursue, rather, he wanted to choose pursuits in a world where something was known. There are levels of knowing. At the level of process, he needed me to "not know" with him, but at the level of response, he needed me to "know" which institute. Another way of putting this is that dynamism of discovery itself can, in a specific sense, be anathema or salutary to a particular patient. For this patient, it was anathema in one way, and in another was just what he needed.

Specificity theory also alters how we now apprehend a number of central concepts and principles in psychoanalysis, and has significant implications for how we utilize them in our work. In the next chapter, we focus on some of these, and illustrate them with more case material.

NOTES

1. We use the designations "psychoanalytic" and "psychodynamic" interchangeably.

2. "To fit life every time to a theory is in itself a mechanistic process ... Theory as theory is all right. But the moment you apply it to life, especially to the subjective life, the theory becomes mechanistic, a substitute for life, a factor in the vicious unconscious" (D.H. Lawrence, 1936, in Phoenix, Vol. 1, 1960, p. 378).

3. We also note that the concept, "transference," either in its classical definition as the bringing forward of childhood experience, or in its contemporary designation as organizing activity, also does not do justice to the comparable determinants of who the patient is.

4. We are reminded, here, of the aphorism from 1 Corinthians 14:1-40, that "All our knowledge is partial ... We know only in part and act constantly on the basis of incomplete information." According to the poet, Robert Frost, the ability to do so constitutes the definition of wisdom (referenced by Maurice Levine, in Psychiatry and Ethics, M. Levine, 1972, Publ. G. Braziller).

5. Attempts are being made to measure dark matter through its effect upon gravity.

6. See also Fiscalini (1994) who offers this as a new perspective for the interpersonal approach.

7. cf. Tronick's concept of "thickness," which we describe in chapter 8.

8. See also Ferenczi's analogous concept of elasticity within the psychoanalytic situation (Ferenczi, 1928).

9. For an interesting discussion on a related theme, see Lucynn Carlton's summary of the panel discussions of the 30th Annual International Conference on the Psychology of the Self: "Making Sense of Self and Systems in Psychoanalysis."

10. At that time, I was practicing in Toronto and was introducing self psychology to the psychoanalytic/psychotherapy community.