SPECIFICITY THEORY AND OPTIMAL RESPONSIVENESS

An Outline

Howard A. Bacal, MD  Bruce Herzog, MD
Los Angeles, California  Toronto, Ontario, Canada

Specificity theory legitimates the analyst's attempts to tailor the treatment process to improve its efficacy. It recognizes that the analyst's responsiveness effectively draws upon a rich palette of both verbal and nonverbal interventions for therapeutic relating. Dispensing with the notion of analytic neutrality, specificity theory recognizes that each therapist offers something therapeutically unique to a particular patient, which includes but also transcends both theory and technique, encompassing who the therapist is as an individual in innumerable respects. It requires that the therapeutic engagement be continually monitored and adjusted to fit the changing capacities and limitations of the particular therapeutic dyad. The principles of specificity theory are suitable to be used by therapists of different theoretical backgrounds—and further, can be applied as an overarching principle functioning to integrate diverse theoretical approaches.

Howard Bacal introduced the term optimal responsiveness in 1985, when it was becoming imperative that analysts make significant adjustments to the psychoanalytic theory of the therapeutic process. The widespread attempts to work with patients who were inaccessible to standard analytic treatment required a theory that incorporated the therapeutic aspects of a more modified analytic technique. In answer to the emphasis of some clinicians on neutrality, insight, and frustration of the patient, Bacal developed an idea that was inclusive of many interventions that were not being formally discussed among professionals. Since then, he has revised and refined the concept of optimal responsiveness and has identified specificity theory as the theoretical perspective that underlies it.

In the present climate of increased tolerance and integration of diverse theoretical ideas by the analytic community, the use of optimal responsiveness as an overall clinical posture is especially germane. This is because the principle of optimal responsiveness can be used by therapists who may already be working in similar ways despite coming from

Howard A. Bacal, MD, independent practice, Los Angeles, California; Bruce Herzog, MD, independent practice, Toronto, Ontario, Canada.

Correspondence concerning this article should be addressed to Howard A. Bacal, MD, 1221 North Norman Place, Los Angeles, California 90049-1540. E-mail: h.bacal@verizon.net
different theoretical persuasions. Further, the use of specificity theory satisfies the eclectic therapist's need for "a higher level of abstraction to guide and synthesize" (Frank, 1999, p. 203) the use of multiple theoretical perspectives.

The intent of this article is to present an overview of specificity theory and optimal responsiveness. Beginning with the suggestion that we dispense with the notion of analytic neutrality in modern psychoanalytic practice, we explore the origin of psychoanalysis from the perspective of optimal responsiveness. We then examine its underlying concept, specificity theory, from the viewpoint of psychoanalytic self psychology, with special emphasis on the selfobject relationship and its reciprocal nature. We describe the mutative effect of the corrective selfobject experience within such a relationship and indicate how an understanding of the phantasy selfobject and the phantasy selfobject relationship can aid the therapist in being optimally responsive. We then explore various clinical advantages to using this perspective. Although our theoretical vantage point is that of relational self psychology, we believe that specificity theory is operational within any psychoanalytic approach—when the analyst prioritizes the specific capacities and limitations for optimal therapeutic interaction that emerge within the dyad in which he is participating.

Specificity theory is particularly advantageous to the patient-centered therapist, as it is a theory that works to improve the fit of the therapeutic couple, maximizing the effective use of patients' healthy strivings as expressed in their hopes and expectations of the treatment process. It strongly advocates against the idea that there can ever be a single correct intervention for a patient, applicable by all therapists. If we take seriously the fact that every patient as well as every therapist is a distinct human being, then any therapeutic interaction should be unique to the particular dyad. Therefore, for the optimal therapeutic benefit to occur, there can really be no one correct methodology and no steadfast adherence to a standard technique.

Toward a More Inclusive Technique Through Reconsidering the Concept of Analytic Neutrality

The use of so-called parameters, suggested by Eissler (1953), has traditionally been regarded as necessary in the treatment of more disturbed patients, but by definition, these interventions were excluded from being recognized as an integral part of the therapeutic process. It seemed that many psychoanalysts maintained the belief that therapeutic efficacy was maximized by practitioners who followed a standard technique, which hardly anyone could consistently maintain—although to be a bona fide analyst, you felt you had to say that it was important to do so. Parameters were described as extra-analytic procedures—required to allow analysis to continue with disturbed patients who were intolerant of the traditional approach—a necessary evil that was to be abandoned and replaced by standard technique as soon as possible. However, as therapists attempted more frequently to treat severe personality disorders, many of them began to discover that much of what they were doing outside of conventional analytic practice had therapeutic potential. This has led some practitioners over the past few decades to consider reworking their position, to allow new interventions to be included as a part of the analytic process.

But introducing clinical innovation has always been at risk of being met with suspicion by one's colleagues. Many analysts may have kept their more controversial interventions out of serious consideration, fearing that they would be considered unscientific and lacking in the type of analytic neutrality that was admired at the time. This unfortunately seems to have relegated the discussion of some clinical innovations to the periphery of
analytic discourse. As a result, much that was helpful to the patient, or even that which may have been most therapeutic in a particular treatment, remained shrouded in obscurity—only to be spoken about sotto voce between colleagues, who might talk informally about what they believed had really worked in a particular case but tacitly agree that such views were definitely not to be expressed openly. Over the years there have been analysts (e.g., Greenberg, 1986; Kohut, 1977, pp. 250–252) who have warned of the dangers of misusing the notion of neutrality, but even today the issue can still function as an unfortunate constraint to many analysts.

We feel that this problem can be most usefully addressed if we recognize that all of our interventions in the analytic setting may be experienced by our patients as potentially mutative or traumatic. We also suggest that no event occurring within the therapeutic milieu is experienced by the patient as entirely neutral, nor is it ever uninfluenced by the therapist’s subjectivity. By way of these assumptions, we can functionally dispense with the need for a concept of analytic neutrality, a position that Lindon (1994) has also articulated in his rejection of the usefulness of abstinence (see also Ricci & Broucek, 1998; Wolf, 1976). This is of considerable service to us, as it frees us to use ourselves in the best way we know how for our patients. It also helps us to legitimize a patient’s experience of trauma in the analytic setting as not necessarily being an expression of transference in a neutral environment. Such disruptions could be considered in the light of whether a therapist’s response, or lack of it, was not optimal and was possibly experienced by the patient as a traumatic reenactment.

Some Historical Precedents to Optimal Responsiveness

Psychoanalysis had its beginnings in Breuer’s work with Anna O. (Breuer & Freud, 1893–1895/1955; Jones, 1953). She had insisted on receiving what she needed from Breuer, which would involve her talking to him at length on a regular basis. In response, he engaged in something that must have been quite novel in the culture of his time—he did exactly what a patient told him to do: He sat and listened for extended periods to what she needed to tell him. Anna O. called this the “talking cure,” which is still an apt description of what psychoanalysts do. What Breuer did in the context of the zeitgeist of his time was equivalent to a serious enactment of today; that is, he was outside of acceptable treatment guidelines when he allowed himself and Anna O. to develop such an intense and reciprocal therapeutic relationship. By doing this, both Anna O. and Breuer had given psychoanalytic treatment its start, with Freud having the wisdom and foresight to recognize and cultivate its potential. Freud discarded his experiments with hypnosis and the laying on of hands in favor of the talking cure, which was not only more effective but, up to this point, was arguably the first method of psychiatric care ever initiated entirely by a patient’s directives to her therapist.

Whether Breuer knew it or not, when he listened in answer to Anna O.’s need to talk, he was being optimally responsive. According to specificity theory, it was the particular way in which he; at that time, could be uniquely therapeutic for this patient. Specificity theory also accounts for his inability to do so beyond a certain point—determined largely by the limitations he encountered in himself in relation to this particular patient.

Just as the discovery of the talking cure occurred because someone listened to what a

1In fact, Aron (1991) and Hoffman (1983) have both suggested that the analysis of the patient’s experience of the therapist’s subjectivity can be an integral part of the treatment process.
patient said was important, so it behooves us to continue in the same vein, discovering new methods of treatment tailored to fit the patient's needs, because they are based on what our patients report to us is most therapeutic. Further, the previously untreatable patient might potentially be able to advance our methods of treatment just as Anna O. did. Such a patient may now be viewed as someone who has been either unable to comply with presently available methods or unable to make therapeutic use of the available responsiveness of that particular therapist.

It is no coincidence that analysands enjoy exchanging stories about their own analyses in private, and although they may tell others about an unforgettable interpretation, often there is some relish in chatting about things that would be considered extra-analytic—the analyst's offer of a glass of water, or an aspirin for a headache, reading something the patient has written, or the acceptance of a gift. If these events were only incidental to the analytic process, we might wonder why patients frequently experience them as so important. Perhaps doing things outside the scope of normal practice has always been necessary in the treatment setting. In effect, patients have historically found extra-analytic behavior on the part of the therapist to be powerfully meaningful to them, and even in very classical psychoanalytic therapies these behaviors were often a source of fascination. After all, why do some of us still take an interest in Freud's own deviations from standard technique in his clinical work? Freud was supposed to have been a model of neutrality, yet his patients saw his family, knew his dog, smelled his cigars, and on occasion were helped financially by him, were fed by him, and went for walks with him. Freud had felt the need to theorize about a rule of abstinence, perhaps in response to any misinterpretation by others of Ferenczi's (1988) experiments with intensifying the therapeutic experience, but he did not necessarily observe his own rules in his analytic sessions. And others have followed Freud's example—even Kohut, who, while making optimal frustration a cornerstone of his theory of cure (see Kohut, 1984),2 did not apparently work in this way. It is possible, then, that many psychoanalytic theorists—beginning with Freud—may have, through their writing, inadvertently encouraged some therapists to adopt a rigid therapeutic position by writing of an idealized neutrality that went beyond what they themselves practiced. In fact, it is more likely that, since the inception of psychoanalysis, successful therapists have worked in ways that were more responsive to their patients' therapeutic needs than the concept of analytic neutrality might indicate. We have come to appreciate that a distinct tradition of responding with such a Weltanschauung, after Freud, was moved forward through the creative therapeutic work of Sándor Ferenczi, Franz Alexander, Donald Winnicott, and Michael Balint (see Bacal, 1998, chap. 7). Yet, even these analysts did not offer an inclusive theoretical conceptualization of working in this way—where nontraditional activities are considered part of the analyst's legitimate repertoire of effective clinical technique.

Despite the fact that many effective interventions in the past had yet to be validated theoretically, the finest clinicians in psychoanalysis still were prepared to treat their patients' needs with the flexibility that the situation demanded—in effect, being optimally responsive. The story of Kohut's ability to treat the notorious Miss F. by simply echoing her subjectivity when he discovered that anything else precipitated a rage-filled attack is often cited as the "official" beginning of clinical self psychology (Kohut, 1971); it is also

---

2Some self psychologists, notably Basch, felt this was a retrogressive step on the part of Kohut, which he offered as a gesture of conciliation to his alienated classical confreres (M. Basch, personal communication, 1984).
a quintessential example of the application of specificity theory. In this connection, we note that the response that Kohut discovered was optimal for Miss F. was not an interpretation but rather a particular way of being with this patient. Thus, specificity theory is a modern representation of what has not only been fundamental in psychoanalytic treatment from its inception but what has also significantly advanced our field. We now propose to identify it as a central theoretical linchpin of our therapeutic work.

Defining Specificity Theory

Specificity theory is the theoretical foundation whose assumptions are the basis for the use of optimal responsiveness. It contains the hypothesis that the specific characteristics of a particular therapeutic constellation will always centrally determine any therapeutically useful experience. In psychoanalytic practice, this constellation constitutes the capacities and limitations for therapeutic relating of the two people involved in the treatment setting.

Aspects of Specificity Theory

Tailoring of the “Fit” Between Therapist and Patient

The theoretical use of specificity intends to emphasize that the potential for optimal therapeutic interaction occurring within an analytic setting is tied to the specific characteristics of each member of the dyad. Thus, as no two therapists or patients are exactly alike, any discussion of the process of psychoanalytic treatment must necessarily take into account the unique abilities of both therapist and patient—and must acknowledge that no two analyses can ever proceed in exactly the same manner. Consequently, there is no one method by which we conduct an analysis, and to insist on a singular technique will limit an analysis so that it cannot access the specific capabilities of therapist and patient; in effect, this may result in a type of analytic paralysis. To avoid this and do our most effective work, we must cultivate the flexibility of both parties so that the best fit possible is attained in the analytic setting.

Specificity theory takes into account the infinite possibilities of interaction in the therapeutic dyad, a dyad that is acknowledged to be a dynamic, actively changing system. It assumes that the patient’s experience will be subject to often unpredictable changes in the patient–therapist relationship, encouraging therapists to continually modify their efforts and to choose what they feel is optimal among the numerous possible variations in relating. To tailor responses to achieve the maximum therapeutic result, the therapist must be continuously aware of any fluctuations in the therapeutic relationship. He must also be thoroughly open to both his own and the patient’s experience in the analytic setting at any given point in time. This allows the analyst to tease out the particular complexity of the patient that is activated—whether it is understood to be a need state, conflict, or defensive organization—and to respond to it in the most effective way that he or she can.

Specificity theory holds that all interventions in the treatment setting are potentially beneficial, 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. In effect, it incorporates what we believe good therapists have always intuitively known to be therapeutic.
The Ongoing Selfobject Relationship

Heinz Kohut, as the originator of self psychology, defined the selfobject as an intrapsychic phenomenon derived from positive experience with caregivers, necessary for a cohesive sense of self (see Kohut & Wolf, 1978; Wolf, 1988, p. 184). Bacal (1990) has suggested that the ability of the therapist to affect positive change in the patient, via the patient’s ongoing awareness of him as a new selfobject, involves what he has called a corrective selfobject experience, a concept derived from a respectful acknowledgement of certain aspects of Franz Alexander’s idea of the corrective emotional experience. Most contemporary self psychologists, including ourselves, also believe that vitalizing selfobject experience continues to be derived from growth-promoting relational events that occur throughout life, within or outside of an analysis. Thus, as soon as an analyst responds in any way that is felt by the patient to be a response to a selfobject need, the analyst is potentially providing a selfobject experience.

When the analyst continues to be available in this way, the patient begins to sense the analyst’s reliability as a source of positive selfobject experience. This leads to the development of an expectation in the patient of reliable selfobject responsiveness from the analyst, and it is this expectation that constitutes the selfobject relationship. Kohut (1977) anticipated the idea of the selfobject relationship when he suggested that the analyst could be used as a “precursory substitute” (p. 32) for the selfobject when a patient’s psychological structure was deficient. He realized that certain aspects of the analyst’s actual personality were not only beneficial but integral to the development of new psychological structure and, therefore, to an effective therapeutic process (Kohut, 1977, pp. 32–33). Specifity theory assumes that intrinsic to a therapeutic process is an ongoing selfobject relationship in which the patient may expect specific, reliable responsiveness from the analyst. The characteristics of any ongoing selfobject relationship are always specific to the particularities of the two people involved in the therapeutic dyad. And this relationship will always be variously reciprocal, which we describe below.

When modern self psychology is practiced from the perspective of specificity theory, the analyst considers that whatever he does or does not do may be experienced as responses to any of the patient’s various selfobject needs that may be activated at that time. This means that every activity or inactivity on the part of the therapist can potentially be organized by the patient into some type of therapeutic experience.

The Role of the Phantasy Selfobject and the Phantasy Selfobject Relationship

The work of the optimally responsive therapist includes monitoring both the patient’s cues to what is hoped for in the therapist’s responses and the patient’s reaction to the perceived response. Those cues, often visible from the time of the first contact, convey to the therapist the kinds of responses the patient is looking for as well as provide information about what selfobject needs had not been met in past relationships with caregivers. Bacal (1981, 1985, 1990, 1994, 2001) has conceptualized a particular aspect of this phenomenon through his concepts of the phantasy selfobject and the phantasy selfobject relationship. These denote the patient’s sense of selfobject responsivity from the therapist when he or

---

3It is of interest to note that Mitchell (1999), in critiquing the traditional analytic usage of neutrality, had stated that the patient will invariably experience a therapist’s refusal to respond as a response.
she has had relatively little prior experience of this in the past. They are more rooted in
the creative imagination of the patient than in past memory. The illusory component of a
patient’s selfobject experience becomes especially active when there has been serious
early psychological deprivation. Although phantasy is undoubtedly a component of all
selfobject experience, the degree to which it participates in the generation of the selfobject
relationship may help to explain unexpected severe disruptions, as the experience of a
selfobject relationship in which phantasy plays the predominant role is far more suscep-
tible to rupture. An awareness that phantasy can be a pivotal component in the patient’s
experience of the analytic relationship may be crucial in determining responses that are
therapeutically useful. The patient’s experience of the analyst’s response to what she
needs him to be may help to transform the illusory aspects of the phantasy selfobject into
lived selfobject experience (see Lenoff, 1998).

Optimal Responsiveness as a Therapeutic Stance

Responsiveness. If all interactions in the therapeutic dyad are potentially beneficial,
then the application of specificity theory will involve the therapist’s positioning himself
to observe the appropriateness of all interactions to the continuing therapeutic needs of
the patient. This leads the therapist to focus particularly on his function as a significant other
who responds to the patient. The word responsiveness presumes that the patient has an
expectation that his selfobject needs are going to be responded to in some way or another
and that the therapist’s resultant behavior functions to either acknowledge or disappoint
that expectation. Knowing this, the analyst attempts to be aware of when the expression
of a need state occurs in the patient, because whatever follows may be experienced by the
patient as a response to that need state.

This description of the psychoanalytic process differs somewhat from Kohut’s (1966/
1978). Kohut described a two-step process of working psychoanalytically: prolonged
empathic immersion in the analysand’s subjective experience, followed by explanation
(interpretation) of what had been thus apprehended. We, too, hold that the first step
usefully consists of sustained empathic attentiveness, but we regard the second step as
entailing optimal responsiveness. The latter will include any activity or inactivity on the
part of the therapist, whether verbal or nonverbal. A response can be, verbally, an inquiry
that invites exploration, an affirmation, an interpretation, clarification, confrontation, or
simple reassurance—along with the tone of one’s voice with regard to any of these;
nonverbally, one’s facial or bodily expression, the act of writing something down, shifting
in one’s chair, or sitting silently. To these, we add the ineffable quality of “being with”
the patient in the ways that are specific to his or her therapeutic needs, which can permeate
each response we offer.

Even though specificity theory may be in harmony with many current theoretical
formulations, we recognize that it is at variance with much of the standard analytic
 technique that some analysts recommend. Thus, one would expect not only some criti-
cisms that require ongoing discussion but also some worry-laden misunderstandings about
its implementation. Two of the most seriously mistaken views about optimal responsiv-
ness have been that it is synonymous with noninterpretive activity on the part of the

\*In point of fact, analysts generally utilize two major listening stances: the empathic vantage
point, the one favored by self psychologists, and the stance that entails listening to how it feels to
be in relationship with the patient, the listening stance most natural to that of object-relations
therapists, which has recently been elaborated by James Fosshage (1998).
therapist and that it eschews exploration in favor of provision (see Siegel, 1999). These misconceptions are not surprising, as strict adherence to a standard technique was supposed to protect the professional relationship from degenerating into a mutually gratifying friendship where therapeutic goals were lost. Specificity theory is now advising a formal revision of the traditional analytic posture, which has been a beacon to many for decades. We can appreciate that suggesting such a major change will be bound to create some concern, even if it involves what many effective therapists had already been practicing for as long as psychoanalysis has existed.

Such concerns arise from the erroneous premise that the refusal to limit ourselves to only exploration and interpretation means that these forms of responsiveness will no longer be used in our work with patients and that they will be supplanted by what is generally termed enactments. In fact, the therapeutic approach that derives from specificity theory does not privilege or ignore any form of intervention. As we have indicated, it rather reveals and legitimates the diversity of responsivity that therapists actually proffer when they are working effectively.

Optimal. The use of optimal in the term optimal responsiveness is meant to move us to assess our responses to patients in terms of their ultimate therapeutic potential. The ongoing consideration of what is optimal for a particular patient’s therapeutic progress helps the therapist to modify his responses as far as he is able, in order to provide the best therapeutic fit for each individual patient. Perfection is not the goal; rather, we as therapists simply attempt to respond in the way that may be most usable at that moment by that particular patient, in moving his or her analysis forward. At times, we consciously consider in advance what responses might be optimal; at other times, we process our responses at preconscious levels and we feel intuitively informed. Regardless of how our responsivity is generated, we can best discern whether it was optimal when our patients inform us through their subsequent behavior.

Although specificity theory appears on the surface to be quite simple, a sort of injunction to give the patient what is most appropriate, its application requires exquisite knowledge on the analyst’s part of what is going on both in himself and in the patient. The problem implicit in explaining this theory has to do with its focus on the continually fluctuating dynamics that occur within the therapeutic dyad. On the other hand, its advantage as a theory is that it blends very well with the therapist’s intuitive capacity. It functions to formalize—as well as to direct analysts to scrutinize and elucidate—the way in which many of us always seemed to have worked. Optimal responsiveness refers to this way of working; it is the methodology for the application of specificity theory in our psychoanalytic work.

The Bidirectionality of Optimal Responsiveness

To be an effective therapist requires a profound awareness of the pervasively reciprocal nature of the analytic venture. This leads us to emphasize that optimal responsiveness will always be to some extent bidirectional, though not necessarily symmetrical. That is, not only is the specific nature of the analyst’s responsiveness a prerequisite for change in a particular patient, but also certain kinds of responsiveness from a patient may constitute specific preconditions for the analyst to be free to respond optimally to that patient. Bacal and Thomson (1996, 1998) have demonstrated this in their descriptions of how the therapist’s experience of the patient’s selfobject responsiveness can function to facilitate therapeutic relatedness and is an ordinary and ongoing part of the analytic process. We have even found, in our own clinical work and in work that we supervise, that it is not at
all unusual for a patient's responsiveness to provide the analyst with the same selfobject experience that the analyst has been providing the patient.

Applying Specificity Theory in the Therapeutic Milieu

Minimizing Theoretical Bias

Regardless of what theoretical background we use to influence our work, the search for the optimal response primarily requires that we divest ourselves of professional and personal bias and float in a frame of mind that allows us to pick up on the information supplied to us in order to learn about our patient's subjective experience. This perspective has points of contact with Bion's idea of negative capability—in effect, his recommendation that we allow as fresh a perception of the patient as possible to reach us (Bion, 1967)—yet it is useful to keep in mind Stolorow's caveat that "there are no immaculate perceptions" (Stolorow, Atwood, & Orange, 1999, p. 387). Thus, as we focus on our vicariously organized introspection vis-à-vis the patient, we allow ourselves at the same time to become as aware as possible of the evocation of our own affect states, our needs, and our predilections, which resonate with or react to those of the patient. This suggestion is in keeping with Baudry's (1991) recommendation that the therapist "monitor his own contributions" (p. 928) in addition to the patient's. While maintaining a therapeutic attitude that tracks the states of mind of both the patient and the therapist, we are encouraged to minimize any intrusion of the therapist's personal, theoretical, or technical bias.

Avoidance of Retraumatization

Our ability to maintain a position of sustained empathic attentiveness enables us to pick up on cues that patients present to us, which contain appeals and even directives—Mitchell (1986/1999) has referred to them as 'invitations' (p. 170)—on how they hope we will behave, and which also indicate what they fear might inevitably happen. For example, the story of a traumatic incident from the past is often a warning about what sort of interaction the patient fears will be repeated in the treatment setting and thus functions as an instruction for the therapist not to behave in kind.

With this in mind, the therapist is encouraged to use the observed clinical data so as not to repeat traumatic-patterns. Our patients inform us by outlining both the traumas of the past and their attempts to search for better relational experiences in the present. When we are being shown how previous responsivity was either traumatic or helpful, our patients are already telling us about what kind of responses they will be needing from us in order to develop a healthy self from within a healthy therapeutic relationship. Our ability to perceive their directives involves an intuitive capacity that is the hallmark of most good therapists, no matter what our theoretical leanings.

\[^5\]Often these hopes are indications of the active presence of a phantasy selfobject, whose imagined responsiveness is often a reaction to serious past selfobject failures.

\[^6\]Herzog (1998) believes that the maintenance of an optimally responsive position can help prevent potentially traumatic demands for patient compliance that might develop in some analyses, particularly when the therapist is inclined to be a rigid proponent of a single theoretical or technical stance. This is because specificity theory directs our focus to the patient's shifting therapeutic requirements, which are not to be sacrificed to satisfy any theoretically based beliefs of the therapist.
Guidance in Using a Multitheoretical Approach

Because specificity theory positions us as therapists to be strongly patient centered, it easily makes itself a "pan-theoretical" theory. That is, it is a theory that can be readily assimilated for use by clinicians from a variety of theoretical backgrounds or, further, can function as a theoretical bridge that allows different theoretical frames of reference to be used together. This is important in today's climate of theoretical integration, especially where there are calls for "higher levels of abstraction" (Frank, 1999, p. 203) to reconcile various theoretical ideas. In fact, specificity theory can be argued to be a common-factors approach, a "clinical strategy" such as described by Goldfried (1980), in which the therapeutic elements from across disciplines can be distilled down and united by this central principle: The therapist works to improve the fit of the therapeutic couple by monitoring the efficacy of his responses to the patient's therapeutic requirements. Determining those therapeutic requirements can be informed by any number of theoretical ideas, whether used alone or in concert with one another. In this way, integrative or eclectic therapists can use specificity theory as an overall theoretical perspective because it is in harmony with the use of any particular theory that may be appropriate to a specific circumstance with a specific patient.

Recently there has been some productive writing about the integration of different theoretical perspectives. For example, Garfield (1992) has effectively demonstrated the clinical use of a common-factors type of eclecticism, which emphasizes the functional similarities between different therapeutic approaches as a means to reconcile their disparate theoretical ideas. Lazarus (1992) has suggested a technically eclectic approach that is less likely to be concerned with the search for common therapeutic factors but rather focuses on the use of different techniques whenever the situation calls for it. Wachtel (1997) has worked to reconcile different schools of thought through his attempts to blend certain elements of various approaches into one theory. Despite their apparent differences, it is our belief that all of these integrative approaches can benefit from the use of specificity theory, either as a central overarching theoretical premise or more simply as a way to best inform the timing of certain technical interventions. Regardless of whether we see ourselves as practicing a specific type of psychoanalytic integration or not, whenever we permit ourselves to be flexible in our use of psychoanalytic theory in order to maximize our therapeutic efficacy, we are applying specificity theory. Specificity theory is usable by any psychotherapist who is willing to allow his or her theoretical tenets to be subordinated to the determinants of any potentially therapeutic interaction.

All Interactions Have Therapeutic Potential

From the time of the patient's first telephone call, the optimally responsive therapist is aware of searching for cues from the patient as to which responses will be beneficial and which will not. In this way, possible disruptions may not only be minimized but also better understood if they were to happen. Specificity theory recognizes that all events occurring in therapy have the potential to constitute experience that could be either positively mutative and good or retraumatizing and bad. With this in mind, the therapist continually wonders how he is being experienced by the patient, monitoring the patient's reactions to his responses so as to ascertain the mutative or traumatic potential of their interactions. We stress that it is often the subsequent patient reaction to a particular interaction that informs the therapist most conclusively about whether a therapist's behavior was optimal or not.
Optimal Responsiveness and Spontaneity

Regardless of whether an analytic event was intentional, any interaction can still have therapeutic potential. This supposition allows for the efficacy of surprise, spontaneity, and improvisation in the analytic encounter. Therefore, all spontaneously occurring interactions should be given serious consideration by the therapist as to their mutative potential. In addition to the possible therapeutic impact of the patient's spontaneous activity, which may lead to what the Process of Change Study Group calls a “now moment” (Stern et al., 1998), we concur with Frank's (1999) view that spontaneous activity originating with the therapist has the potential to “allow patients to overcome salient maladaptive expectancies and to participate in and develop new and salutary relational patterns” (p. 61). In contrast to the Process of Change Study Group, we do not consider “now moments” and “moments of meeting” (Stern et al., 1998, pp. 913–915) to be necessarily privileged, or even essential, therapeutic encounters. Rather, because we have broadened the spectrum of possible therapeutic responsivity, we regard any spontaneous engagement as one of the many ways in which optimal therapeutic interaction can occur. However, the views of the Process of Change Study Group and our own are similar insofar as we both regard therapeutic interactions as highly specific to the particular dyad and in that they also entail a reciprocal process in which change occurs through “alterations in ways of being with” (Stern et al., 1998, p. 918).

Specificity theory advocates improvised interventions to the extent that the therapist is positioned unconsciously as well as consciously to respond optimally to the patient’s therapeutic needs. In this way the therapist may suddenly find himself “there” with the patient in ways that neither of them could have expected but that are as therapeutic as anything the therapist could have consciously anticipated (see Bacal, in press).

Optimal Responsiveness and Disruptions

The intensity of the patient’s reaction to the analyst’s failed attempts to be responsive will, of course, vary with the nature and depth of the resulting injury and its meaning to the patient. The patient’s admonition that we have let him or her down can be very useful to us, as sometimes we learn most tellingly about what is therapeutic for our patients through their reactions to our responses that are anything but optimal.

The search for an optimal response following such upsets can lead us in a variety of directions, varying from simply attempting to provide what was needed to fostering the careful analysis of what went wrong. In this connection, it is important to recognize that when relational breaches occur, the attempt by the analyst at that moment to provide the response that the patient was looking for can often be experienced by the patient as the therapist evading acknowledgment of his or her own contribution to the disruption; in effect, the analyst denying his or her own failure. Such an attempt could be experienced as profoundly disruptive, as it may not be in harmony with the patient's affective experience of upset. The most optimal response could involve either acceptance of the patient’s perceived experience—to “wear the attributions of the patient,” as Lichtenberg, Lachmann, and Fosshage (1996, pp. 237–238) put it—or a communication that the therapist has resonated with the patient’s affective experience of upset, a type of therapeutic “affect sharing” (see Herzog, 1998). Following this, the analyst might also work in alliance with the patient to examine what went wrong. In these ways the therapist can convert a potentially retro-

---

7An examination of the therapeutic efficacy of improvisation can be found in Ringstrom (2001), with the accompanying commentaries by Meares (2001) and Knoblauch (2001).
gressive, nonoptimal response into a more optimal search for a genuine understanding of how the patient experienced the disruption.

Specificity Theory and Supervision

Specificity theory requires that we not be too insistent when we recommend to associates or supervisees what we would have done in their clinical circumstance. Aside from the fact that our assumptions about their situation may be replete with our own bias, our ideas for intervention are influenced by what we have learned is best when we ourselves are present in the consultation room. In other words, specificity theory informs us that what each of us feels is good psychoanalytic technique is mostly applicable to ourselves when we work as analysts. Interventions that might work best for ourselves may not necessarily be so useful for the therapists we are trying to advise. Therefore, our responses to our supervisees should be guided mostly by our empathic grasp of their situation both as therapists and trainees.  

The supervisor who is using specificity theory to maximize his effectiveness with his colleague will likely be concerned with the following:

1. Taking an interest in the particular characteristics of the supervisee, that is, his or her abilities and limitations as a therapist, to help determine whether the supervisee is working optimally with the patient.

2. Monitoring the supervisee’s reaction to the supervisor’s ideas to determine whether the supervisor himself is working optimally.

3. Understanding how the particularities of supervisor–supervisee interaction may reciprocally affect the therapeutic relationship between the supervisee and her patient (consonant with Ekién & Wallerstein’s [1958] concept of “parallel process”).

4. Realizing that direct advice about what the supervisor would do with the patient might not necessarily be useful to the supervisee (whose proclivities as a therapist could be very different).

Conclusion

An analyst’s responsiveness must be informed by his awareness that the therapeutic process comprises the operation of a complex and unique reciprocal relational system for each analyst–patient couple. Thus, the analyst’s task is to offer responses that, consonant with his capacity apropos that particular patient, facilitate therapeutic interactions that will be optimal for that patient’s therapeutic progress.

Specificity theory tells us that there are infinite possibilities for therapeutic interaction in the analytic dyad and that not only traditional modes of responsivity must be considered for their potential efficacy. This invites the therapist to expand on the use of his or her empathic knowledge by using it directly to aid in the choice of the numerous verbal and nonverbal responses available. It also requires that the therapist carefully track how he is perceived to be responding to the patient’s psychological needs.

Specificity theory legitimizes the analyst’s attempt to tailor the treatment so that it may be most useful to the patient’s therapeutic needs—functioning to improve the fit between analyst and analysand—while it simultaneously recognizes the limitations inherent in a particular dyad when doing so. In addition, specificity theory opens up new avenues for the formal discussion of crucial therapeutic interventions that previously were considered outside the scope of formal analytic discourse.

8 Kindler (1998) has written about the use of optimal responsiveness to enhance the supervisory experience.
References


Optimal responsiveness: How therapists heal their patients (pp. 175–190). Northvale, NJ: Jason Aronson.


