

The Complexity of Dyadic Specificity:
A Discussion of Howard Bacal's "Beyond Transference and Countertransference:
The Dyadic Specificity of Psychoanalytic Process"

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I am honored to have this opportunity to discuss Howard's groundbreaking and clarifying paper on dyadic specificity—especially as it directly impacts and extends our understanding of therapeutic action in psychoanalysis, and also because Howard's work has had an enormous impact on my own clinical sensibility for many years now.

Howard articulately shares with us the history and legacy of two cornerstones of psychoanalysis—those of transference and countertransference. He reminds us of the ways in which these concepts and human phenomena have evolved over the last century and how, in our more contemporary climate, they have become more relationalized: They are no longer understood as byproducts of individual, isolated minds striving to distort objective reality and/or to defend the integrity of one's self structure and organization. Interestingly, as I have noted elsewhere, the century long and still-evolving conceptualizing of countertransference arguably reflects our changing attitudes about human subjectivity in general. As Howard points out, countertransference was once considered a rare, even shameful occurrence—a lapse, if you will, in the analyst's otherwise objective grasp on "reality" and capacity to evaluate and understand definitively the workings of the patient's mental apparatus. Then, with the advent of revolutionary theorists such as Alice and Michael Balint, as Howard points out, along with Winnicott, Little, Heimann, Racker, and many others to come, countertransference was not only considered ubiquitous, and a strong contributor to the transference of the patient, but also a necessary and substantial aspect of the analyst's therapeutic armamentarium. These were the earlier developmental tendrils of what Howard has now arrived at: Indeed, as Howard says, the "forms of the self of analysis is one of describing the nature of the relationships the compose it" (Bacal, 1998, p. xiii). Transference and countertransference, if we wish to retain these terms, are now understood as a confluent, dyadic matrix from which unique, lived emotional experience and related meanings emerge. Psychoanalysis, then, becomes a "psychology of the individual's experience in the context of relatedness" (Bacal, 1998, xiii). I have always thought of the proponents of intersubjective systems theory as radical phenomenologists, and, in my view, Howard is no less radical in this regard.

At the core of Howard's sensibility, and his essential thesis in his current paper, is his specificity theory, in which "therapeutic possibility will essentially depend upon how [the patient and the analyst] can be together therapeutically in the moment and over time." Howard is not only a phenomenologist, but also a radical contextualist. I cannot help but resonate with so much of what he writes, in part because of my own interest in complexity theory as applied to psychoanalysis (what I have referred to as psychoanalytic complexity). Specificity theory and complexity theory have much in common. Though perhaps employing somewhat different language games (Wittgenstein, xxxx), in my view

they share related concepts such as (1) emergence (that something unpredictable [and hopefully useful] emerges from within a system that is unique and not teleologically logical—something more than the apparent sum of its parts), (2) autocatalysm (that the system itself produces its own agent of change, as opposed to one person doing something to another person to effect change), and (3) the indeterminacy of precisely and accurately demarcating past from present. All three concepts (or phenomena) can be found in Howard's work with his patient, Mara. I find this third concept particularly fascinating and evident in his case example.

Howard states about one particular juncture:

"Now, in the session, she is telling me about the difficulty she has long had in trying to connect with her mother as a person who had feelings, as she also put it, with her 'two-dimensionality.' We then could connect her concern about our conversations seeming at times to be 'superficial,' with an anxiety about becoming stuck in a similar situation with me. I expect that, with a friendly 'non-specific' conversation, I must have contributed to this 'repetitive mother transference.'"

As Howard earlier alludes, a traditional perspective would hold that Mara's expectation, and perhaps actual experience of him, was a transference phenomenon in which Mara's past, and her interpretation of it, became superimposed over Howard's warm, attentive, and caring presence, thereby distorting the "truth and reality" of the analyst's benign, inquisitive persona. It might even hold that Howard's occasional lapse into "superficial" conversation provided enough maternal familiarity for Mara such that she regressively slides into the "repetitive mother transference"—a phenomenon, however, essentially belonging to the patient's past organization of experience and really not having much relevance to the present. In other words, it would have been assumed that Mara's experience was predominantly derivative of her past, and not her present or present relational milieu. In fact, I would argue, from a complexity theory standpoint, that Howard was as determinative of Mara's experience as was Mara's past experience of her absent, dissociated mother. One might argue that Howard was, more or less, only a recipient of Mara's organizing principles and of her fears and experiences of loss, but I believe otherwise. Alternatively, I would posit that one's past and one's present (and we can include one's imagined future as well) are each mutually informative and that at no time can we definitively draw a clear line between them. The beauty of Howard's clinical work here—among other aspects—is that he remains poised to give equal weight to those two sources of Mara's experience. And this is not easy to do when we analyst's remain on the hunt for the one "true and real" source of our emotional experience, when we remain ensconced in the "irritable grasping after fact and reason" (Keats, 1817). And we analyst's like not to feel that we are as much implicated in our patient's fears, distress, or trauma as their pasts presumably are. Racker (1968) wrote about this. Jessica Benjamin elsewhere takes up this issue as well vis-a-vis our resistance to experiencing ourselves as the (re)traumatizing other, but painfully it is inevitable.

In addition to the therapeutic "fit" to which Howard refers, and to which I will turn shortly, an aspect of Howard's seasoned clinical acumen can be found in his paying such

close attention, from the very outset, to how each participant is interacting with the other, and, importantly, how the dyad is working with and relating to each other. And he shares his observations and musings with Mara early on. This is the “relational” in a relational self psychology. Moreover, we witness how Howard pays exquisite attention not solely to Mara but equally so to his own feelings, fantasies, experiences, and behavior. He is relentlessly reflective and inquisitive, and both parties would be lost without this. That said, in this clinical instance, Howard argues—and I wholeheartedly agree— that perhaps the strongest, most salutary contributor to the therapeutic action was a combination of (1) his also having suffered previously his own irredeemable and traumatic losses, (2) his capacity to access and embody the pain of those losses (i.e, not disavow them or dissociate from them), and (3) his ability to communicate his own awareness and experience of such losses to his patient. And interestingly, Howard accomplishes this third aspect without the necessity of explicit, verbal disclosures to his patient. She knew he knew. Howard was “there,” and not “not there.” As I think Howard might say, these elements combined to allow for the emergence of therapeutic action from within this particular dyad at this particular moment. With another dyad, or in another context, or in another moment, it would be different.

And in regard to that last point, I can imagine, in a different context, perhaps with a different dyad, the analyst’s incapacity to resonate with the patient’s loss, the analyst’s inability to be fully present and fully grasping of the situation, might equally lead to a therapeutic action. That is, if over time empathic failures can be investigated, acknowledged, owned (and owned up to), and lived with, failures and ongoing shortcomings may prove to be the medium in which therapeutic action may emerge as well (that is a topic deserving of an article in and of itself). In the spirit of specificity theory, that would all depend on that particular dyad at that specific point in time. As Sander points out, we look to “open up new possibilities for what [the patient and the analyst] can do together”—and we simply do not know what that looks like until we get there.