IMPASSE is often conceived of as a situation in which a treatment comes to a halt, where there is a clash that cannot be resolved and a rupture. Nevertheless, we must recognize that many treatments that continue also constitute forms of impasse. We are all too aware of analyses of all analytic schools that have gone on for years and years with no sense of impasse while in progress, only to end with no substantial analytic result. The same patients come for second and third analyses in states of cynicism and despair about having invested so much time and money to no significant avail.

What I argue here is that in many of these cases, the basis for the impasse is that crucial interactive issues have never been engaged. The question is how to begin to open analytically the interactive issues that form the core of such impasses. My view is that if we can successfully work with these

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1 Earlier versions were presented at a panel "Negotiating Impasses: Different Perspectives," at the meetings of the Division of Psychoanalysis (Division 39) of the American Psychological Association, April 16, 1993, New York City; at the International Forum of Psychoanalysis, Florence, Italy, May 14, 1994; at the Association for the Advancement of Psychoanalysis, New York, May 26, 1994; at the Derner Institute, Adelphi University, Garden City, New York, December 10, 1994; at the Northwest Center for Psychoanalysis, Portland, Oregon, April 12, 1995; at the Psychoanalytic Institute of Northern California, San Francisco, April 24, 1995; at the Minnesota Society for Contemporary Psychoanalytic Studies, Minneapolis, October 21, 1995; and at the Twenty-fourth Annual Scientific Conference on “The Difficult Patient,” Washington Square Institute, New York City, February 6, 2000.

2 Winnicott (1969) describes “analyses” that can serve as holding operations and become interminable, without any real growth occurring. I view these as forms of the kind of impasse I am describing.
issues, potential impasse actually becomes analytic opportunity. As I have emphasized (Ehrenberg, 1974, 1992), I think this applies no matter what our theoretical perspective. Unfortunately, our theory has not adequately provided for addressing the complex forms of unconscious communication and enactment, of projective and introjective identification, and of collusion, coercion, manipulation, seduction, that go on between patient and analyst and so often tend to be the basis for impasses in analytic treatment. This is particularly noteworthy, given that as early as 1915, Freud wrote “It is a very remarkable thing that the Ucs. of one human being can react upon that of another, without passing through the Cs” (p. 194).

How do we zero in on forms of unconscious interaction between patient and analyst? If patients are submitting or complying, how do we determine the extent to which this may be a response to something we may be communicating to them -consciously or unconsciously- versus the extent to which it may be independent of whatever we may be communicating? Even where a patient’s behavior does seem responsive to something communicated by the analyst, we are well advised to consider that the analyst’s communication may have been, at least in part, a response to something conveyed by the patient, consciously or unconsciously. Certainly, whatever occurs is never unidirectional. Deconstructing the interactive subtleties opens a dimension of analytic exploration that often is not engaged. It allows for exploring the ways in which patient and analyst are each reactive and vulnerable to the other, or function independently of each other, and how this can vary from moment to moment. It also allows for exploring what accounts for these shifts, not only in response, but in responsivity.

Consider the very nature of transference from this perspective. Whether we get a transference of accessibility and vulnerability, of risk and hope, and a working alliance, or we get a transference of defensiveness, despair, resistance, and a situation of impasse, may be as much a function of the analyst’s participation as it is reflective of the patient’s issues. Unfortunately, this is often not recognized.

To the degree that transference is not responsive to the analyst, other questions must be addressed. For example, if the patient blindly trusts the analyst, we might wonder what this reflects. Is the patient so out of touch as to be oblivious to the reality of who the other is and the need to give some thought to whether or not it makes sense to trust this specific other? Many patients have trusted
analysts only to be gravely disappointed over time. Is this a question of bad judgment? Does it reflect not being able to listen to and trust their own appropriate misgivings, or is it a matter of denial or compliance? If a patient’s wish is to be able to blindly trust the analyst, and if this is encouraged rather than analytically engaged, this becomes an exploitation of the “transference” tendency. Where both the patient’s and analyst’s wishes to see the analyst as benevolent, omniscient authority converge, and where the patient’s wish is to be able to blindly trust, and the analyst’s wish is to be blindly trusted, a form of collusion can evolve that can be particularly difficult to recognize.

We are also well aware that when a patient seems to get better, we must be alert to whether this reflects true analytic movement or a form of “flight into health,” a form of compliance, manipulation, adaptation for expedience, a way to evade the analyst. Certainly, it is usually easier to realize “something is up” when there is a negative transference or hostile interaction than when things seem to be going well. Nevertheless, when patient and analyst both go along with a cozy feeling that all is going well, it may be a way for both to avoid dealing with pain, anger, anxiety, or any other negative feelings. When there may be collusion to protect a “working alliance,” patient and analyst may go through the motions of engaging the crucial issues without really doing so, and without even realizing what is being avoided. Things may feel “good” even though they are not.

Conversely, sometimes things can seem “bad” when they are not. For example, too often the concept of “negative therapeutic reaction” is used to explain seemingly negative developments that actually may involve perfectly reasonable reactions to a bad situation. Labeling the patient’s reactions as “negative therapeutic reaction” in such instances can become a way of blaming the patient that can be counteranalytic and undermining. It can preclude the analyst’s recognizing his or her own role in creating a toxic situation. This might occur when an intervention, such as an interpretation—however astute or on the mark—may be experienced as a form of harassment, attack, violation, even as a form of psychological rape. Or it may be a response to the analyst’s need to assert his or her superiority or authority, or a need to be “one up” on the patient, among infinite other possibilities. Silence too can be toxic. It can be experienced as sadistic, withholding, cruel, or simply uncaring. Here too, the possibilities are infinite. The analytic challenge is to explicate the interactive issues. This is true whether the patient may read in meanings or intentions on the part of the analyst that are unwarranted, or whether the patient is accurately tuning in to some aspect of the analyst’s participation of which the analyst may or may not be consciously aware. The complexities
here are enormous, because, as noted earlier, we can never be sure who is responding to what in whom unconsciously. Consider those situations in which the analyst may seem to be exploiting or abusing the patient. To the extent the analyst is, in fact, set up in some way by the patient to do so, this may be precisely what the patient usually manages to structure. Unpacking the complexities involved requires great respect for the bi-directionality of how interactions get coconstructed.

What comes to mind here is my experience with one patient who had been tutored all through childhood. Despite the fact that this was meant to help him, he came to feel it had robbed him of the chance to learn to rely on himself and to learn to trust his own abilities and perceptions. In prior analyses, whenever the analyst was helpful the patient felt diminished or undermined, patronized, infantalized, humiliated. Unfortunately, none of this was ever explicitly recognized or engaged. To the extent the analyst’s interpretations actually deprived the patient of a chance to come to important insights on his own, and to realize that he was capable of doing so, they may actually have constituted a form of emotional theft. My attention to this kind of interactive nuance in our work, and to the pulls to enactment and collusion as they played out between us, allowed for engaging how he pulled for this unconsciously, even as he consciously resented it. It also allowed for clarifying the ways I would get caught in this web unawares. This collaborative engagement constituted a new kind of experience for him, one he had not imagined possible. This also had impact. The focus on the interactive issues, and the process of engaging in this effort in the mutual way we did, helped to facilitate an internal process and internal movement. Our interaction thus became not only the way of clarifying the issues, but also the medium of working them through.

If a patient is associating or lying on the couch as an act of compliance, submission, or surrender, this must be clarified. What are the unconscious fantasies involved? There are always repercussions to whether or not this is analytically pursued. An example that comes to mind involves a situation in which a patient paid his bill on time. Generally we are more likely to question why a patient pays late than why a bill is paid on time. In this instance, my exploring with him the meaning of his paying his bill on time led to our learning that it signified to him something tantamount to offering to become my sexual slave. All of this easily could never have been revealed. One could ask what, if any, was my role in evoking this? Should we have pursued the exploration further in this direction? Sometimes what matters most is that the analyst is willing to entertain this kind of question, and that
we recognize we can never be sure when we have or have not gone far enough. Sometimes, even if this kind of question cannot be answered at the time, it will get answered much later in the treatment.

With patients for whom others are objects to be controlled, used up, abused, possessed and then discarded, letting ourselves be used, even if “analytically,” may be a form of collusion. It may even be a form of masochistic submission on our part. When patients feel they own us because they pay for our time, dutifully listening to associations, dreams, and so forth may become a fulfillment of the fantasy, conscious or unconscious, about such “ownership” and the wish for control. The same applies when a patient might be telling us sexual fantasies for his or her own sexual titillation, to try to arouse us sexually, or to frighten us. In one instance, I learned from a patient that his fantasy was that he was raping me psychically, simply by putting his thoughts into my mind. By simply listening, I was gratifying his fantasy. The reverse, as I noted earlier, where anything we express is felt as an intrusion or a rape, or as persecutory, is equally problematic. If we focus only on the content, which may be rich and seductive, we may miss what is being enacted, including the ways in which we may be involved in collusion.

The effort to help, or to protect the patient, or to fulfill some function we think the patient is unable to fulfill himself or herself also must be examined. For example, some patients are frightened to be in touch with their feelings. Some suffer from what Bion (1967) has called “attacks on linking.” This may involve inability to think or to “contain” one’s own experience. In such instances, helping to focus the issue, rather than helping to get past it, can be crucial. I stress this because at certain moments, when a patient is struggling, it may be easy for us to help out. Nevertheless, doing so may work to abort the chance for the patient to explore why this is such a struggle, and to have the chance to develop his or her own capacities in this regard. It also precludes an opportunity to see the extent of the problem and to come up against what might happen if the patient begins to grapple with it, or has to confront the difficulty or resistance to doing so in an ongoing way. The analyst’s efforts to “help” in such instances may constitute a form of collusion that involves gratification of the patient’s wish for us to be helpful. It may also be responsive to some understanding that not to assume a “helping” role might risk the relationship. Nevertheless, working analytically here requires addressing the interactive issues and risking whatever anxieties this might stir for both patient and analyst. Whatever is then stirred up, of course, becomes important analytic data that allows for taking the work to yet another level.
Because even a classical analysis is an interaction, attending to the specific interactive subtleties, including how the structure of the relationship may dovetail with some unconscious fantasy on the part of either or both participants is essential. Nevertheless, the issues that play out interactively in the process of such an exploration are no less complex than the interaction that is being so explored. As is true of interpretation or any other way of intervening, focusing on the interaction can become a way of prevailing over the patient, asserting oneself, keeping the patient at bay, an assault, a way of not letting the patient penetrate us in any emotional way. The very interaction that evolves as we focus on the interaction thus needs to be monitored as well. This kind of attending to the process of attending, and to its impact, is integral to what I have described as the process of working at the “intimate edge” (Ehrenberg, 1974, 1982a, 1982b, 1992).

These concerns relate to what distinguishes therapeutic and analytic work. In the former, the analyst may help the patient to feel better by fulfilling some function the patient cannot. In the latter, the pulls for the analyst to play the helping role, and the patient’s feelings of being unable to help himself, or of being inadequate, terrified, or whatever else, are addressed and worked through. It is the difference between providing fish or teaching a person how to fish.

If there is a tendency for a patient to give it over to the other and then to feel co-opted, protecting the patient from doing so does not help the patient. The analytic challenge is to help the patient become less vulnerable to engaging in this way and to help to free the patient from the need to depend on another to fulfill this protective function. This requires that the way in which this plays out, and the issues involved, be explicitly clarified and explored analytically.

An example from an earlier article (Ehrenberg, 1982a) seems pertinent here. A patient who suffered from paranoid rages was shocked to realize how she actually relinquished her own perceptions to ingratiate herself with others as we spelled out how she did this in her interaction with me. By tracking our interactive process in a moment-by-moment way we were able to see that her fears of being compromised in our relationship related to the fact that she so wanted my approval that she would choose to defer to me, rather than assert her own feelings. Furthermore, she later felt angry and compromised, with no recognition that it had been her own choice. Sometime she would go into uncontrollable rages. Finally, seeing her own role in this self-negation led to many associations to
“daddy.” In this context, she began to be able to grasp that the “dangers” she had perceived as interpersonal were, in fact, personal and internally generated. In particular, recognizing that the issue was her own wish to control my response to her was pivotal. It made clear that compromising herself as she did was a choice she made. This allowed for engaging the question of why she felt so desperate that she would sacrifice anything to get the response she wanted from me (or from whomever else). The fact we could talk about all of this, and the chance to realize it was possible to achieve and sustain a connection with me without compromising herself, was a revelation that had great impact. Here the analytic work (and the analytic opportunity) lay precisely in clarifying the ways in which she tended to feel co-opted. The very process of looking at the interactive issues as they played out allowed us to clarify the issues and work them through. It became the medium of therapeutic action.

Some analysts may assume the “helping” role consciously, out of conviction that this is what is “analytically” required. Some think it necessary to process projective identifications and return them in some “metabolized form,” or to try to serve as “container.” In my view, these ways of engaging constitute complex interactive enactments. We can wonder whether there is some desire to control the other from the inside or to be controlled from inside. Is there a sexual fantasy at the heart of this way of relating? The ways in which boundaries are negated (or violated) and desire and agency are projected, and how these may shift back and forth, become most interesting. Is there a wish for fusion and a denial of separateness on the part of either patient, analyst, or both?

Alternatively, even though projective and introjective identification seem to cross boundaries, each taking the other in or being taken in more or less “whole” can become a way of remaining unchanged, even untouched, by the other. It can become a way of protecting against the danger of being actually transformed, as might occur if one were to risk “mixing it up” with another. This may be as much an issue for the analyst as it is for the patient.

In addressing interactive issues, it is crucial to explicate the impulses to collusion, manipulation, seduction, among infinite other possibilities, from both sides of the analytic dyad, whether or not they are actually enacted. I stress this because simply avoiding the enactment does not advance the analysis. The impulses must be addressed, whether or not they are acted out. By working this way we establish that whatever patient and analyst feel in relation to each other is vital analytic data. The
challenge is be able to engage this kind of exploration in a constructive way and to be able to recognize and deal with the limits of what might actually be reasonably engaged. Certainly there are feelings we might not consider safe to share, even as we recognize them as vital to the work. Being able to address the nature of the limit here has bearing on creating a sense of safety. What must be conveyed is our belief that there is no area of mutual experience that cannot be safely acknowledged, even as there is no requirement to go any further than both parties feel it is safe to go at any given moment. This expands the analytic field to include what otherwise might be left outside in a kind of “taboo” zone that is somehow designated too dangerous to even acknowledge.

Where there is a risk of paranoid projections that might escalate out of hand and of toxic entanglement, attention to interactive nuance is especially critical in establishing and maintaining a context of analytic safety. Attentiveness to interactive nuance and careful tracking of how patient and analyst affect and are affected by each other in an ongoing way become a way to keep the toxicity from escalating to unmanageable proportions. In many instances, this becomes the key to the patient’s analyzability. Nevertheless, the issue is never just one of “attending to the interaction.” The nature of how the interaction we attend to is structured and developed is equally crucial.

In this regard, though I have frequently been told that I work with such “disturbed” patients, I have consistently observed that this applies as well for the same patients who, in working with other analysts, never quite revealed the same level of pathology they later revealed with me. In these instances, the issue was not that they were less disturbed before, but that, for whatever reasons, they did not feel safe enough to get into the more frightening aspects of their own experience in the prior relationships. Focusing on the interaction made it possible to begin to work through issues they had not been willing to risk engaging elsewhere.

Paradoxically, it is precisely by deconstructing what goes on at the interface of the patient-analyst interaction - what I have described as the “intimate edge” of the relationship - that we make it safe for the patient to begin to access the most profound intrapsychic issues. I emphasize this because too often the assumption is made that addressing the interaction precludes attending to the intrapsychic issues. My experience is that the reverse is true (Ehrenberg, 1974, 1982a, 1982b, 1992). A focus on the interaction allows for zeroing in on intrapsychic issues that may not be accessible any
other way. Furthermore, the actual interactive process of attending to subtleties of the interaction then becomes the locus of working through and of therapeutic and analytic “action.”

The kind of attention to the interaction I have in mind requires a reversal of figure and ground in terms of traditional thinking. The idea is that transference and countertransference are influenced by the interactive experience in an ongoing way. We must attend to the process of how the transference-countertransference develops interactively, not simply to the results of this dialectical process. If we insist on making this an integral part of our technique, I believe we set a standard of analytic rigor that goes beyond what ordinarily is achieved.

We can never assume that any way of responding or not responding, on the part of patient or analyst, is out of the loop of interactive enactments. Failure to recognize this leaves critical forms of collusion analytically inaccessible. In this regard, the assumption that we ourselves can ever be beyond unconscious influence is a blinding form of countertransference denial that can itself become a basis for varying forms of impasse. Elkind (1992) gives examples of how the analyst’s failure to recognize or take responsibility for his or her own participation in destructive kinds of enactment can lead to chilling situations where treatment itself becomes another traumatic experience.

I want to be clear that I do not see attention to interactive factors as a “parameter” to be used in problematic situations. My point is more radical. I believe that attention to interactive nuance is essential with all patients (Ehrenberg 1974, 1982b, 1992). It becomes a way to protect against dangers of manipulation, suggestion, coercion, collusion, “transference cure,” and so forth. Working this way allows for engaging competitive feelings, issues of control, or any other feelings in both patient and analyst. As the work proceeds it also allows for dealing with issues of gratitude and reparation in both directions. The emphasis is on expanding the analytic field by bringing into the explicit dialogue what is usually left unsaid and what is usually not addressed, and on demystifying aspects of analytic work that often remain elusive. Nevertheless, though I am suggesting that a focus on the interaction is always essential, I want to be clear that attending to the interaction does not require that we actively intervene or even make it the focus at all times. If the patient is working internally, as is usually the case once a problematic interaction has been penetrated and explored, then it is equally crucial to know when it is important not to intrude or interfere.
Clinical Example

During a thunderstorm, when I was startled by a sudden crash of thunder and lightening and glanced out the window, Rachel became irate. She insisted that I was using the storm as an excuse to momentarily distance from her. Certainly, some might see this as an opening for an interpretation, or for an inquiry as to why she was so upset; or it might be occasion for questioning whether, in fact, she might have been on to something with regard to my response. Was I indeed using it as an excuse to distance? If so, from what, and why?

What impressed me most at the time, however, was how taken aback I was by how self-righteous and attacking she was. I was certainly aware it was quite possible I was acting out something unconsciously. Nevertheless, I felt that even if this were so, my behavior did not warrant my being treated so punitively. I was also aware of feeling angry at her insistence that I could not look away for even a moment. It felt like a violation of my own freedom. Did she think she owned me because she paid me? Was this what she demanded in all relationships or what she evoked in all relationships? If so, was my looking away an act of rebellion against her very demandingness? Or, did she need for me to fail her in some way? Was I being set up? Was she? From my perspective, the point here was to try to deconstruct what was going on between us consciously and unconsciously. The problem, of course, is that to the degree something is going on unconsciously, there is no straight line that we can follow in order to be able to consciously grasp what might be involved.

My response at the time was to note that we both seemed to be feeling violated by each other. I also told her how punitive I experienced her response to be, even if it were true that my looking away was more complex in meaning than I might have been able to grasp at that moment. I was thus establishing that there were two issues to consider: the first was what had gone on between us when I looked out the window, the second was what was going on between us now. She insisted that the tack I was taking was defensive on my part. We seemed to be at a point that had the potential to become an impasse or an analytic opportunity, and it was not yet clear which it would be.

In the session following, Rachel again began berating me for having looked out the window during the storm. She insisted it was my issue, not hers, that I should go back into analysis and work out
my problems, and that she didn’t want to waste her session dealing with my issues. She challenged, “Whose analysis is this anyway?” She stated in no uncertain terms that she didn’t want to be paying for me to deal with my issues. In her view, she was the one who had brought up the issue of my looking out the window. How come I had not done it? After all, if she was paying me to do my job, she wasn’t supposed to be doing my work for me. I again told her how aggressive and punitive her response felt to me. She again insisted this was defensive on my part.

The following session she came in steely eyed and angry, telling me she was not sure she wanted to continue. She told me she thought I had problems. She was combative and tried to engage me in an argument. I told her I had been thinking about our interaction and I was not interested in fighting with her. I thought that neither fighting nor submitting was the issue. I then asked whether she was frightened to really get into herself? Was focusing on what she saw as my issues a way to avoid her own issues? (As I write this, however, it is clear that it was a way she had found to communicate her issues very vividly, and that we were both engaged in the struggle now between us.) She argued strenuously. I held my ground. She hesitated, then suddenly softened and conceded that she was terrified to find out what could (or could not) happen if she were to get involved in the process. She also talked with much feeling about her loneliness and her vulnerability.

I noted that in my view the fears she seemed to be experiencing about becoming more involved appeared to be precisely the fears that made her so reluctant to engage in any kind of close relationship. She said she felt attacked by this, and she argued that I was off base. She then stated that she was very vulnerable and easily hurt, and this was why she was so sensitive to my every response. Her view was that I should be sensitive to her vulnerability. Furthermore, in her view, the issue was mine, not hers. I replied that she seemed to feel that the fact she was so vulnerable gave her license to tyrannize others (now me). I also noted that if the other person reacted, she saw it as confirming her worst fears, without appreciating her own role in provoking them. (Clearly, something was being enacted between us.)

She became very quiet, her look very sober. Again she conceded how lonely she felt, but how frightened she was of analysis. She stated that she was not sure what would or could happen, and that she was afraid to find out. I said that I could not make any promises, but thought that if we collaborated, we might be able to do some important work together. She replied, with surprising
animation and affection, that was why she had picked me. She wanted a collaboration. She then spoke at length, and with much feeling, about her very painful adolescence. Later that day she called me, ostensibly about an insurance matter, and noted with great warmth how much the session had meant to her and that I had “done good.”

The same issues, of course, were replayed many times in the months to come. In one session, Rachel again began harping on the time I had looked out the window during the storm, and went on about how I should go back into analysis and work out my problems. This time I told her that, as I understood it, she was coming to me to help her change, I was not coming to her to change me. She seemed taken aback. Then she commented, “That was very good!”

Several sessions later she began talking about wanting to quit. Again she returned to the incident during the storm when I looked out the window, and to the question of whether I was violating her in so doing. This time, however, when I tried to explore why she was once again bringing this up, and to what end this time, she expressed her anger about the fact I had canceled a session the week preceding. She had felt deeply hurt by the cancellation. The discussion that followed included many questions: Was taking care of my needs by canceling a violation of her? Was challenging my right to cancel a violation of me? Did taking care of oneself always require violating the other? How did this apply to the issue of my looking out the window? How did it apply to what was happening between us now? (We seemed to be addressing the issues more directly now.)

During this period she expressed recurring fears that I would not be able to survive her, that she would literally destroy me in some way. She acknowledged, with surprising awareness, that she knew she had been hitting me with a sledgehammer and that she realized she was a “pain in the ass.” I was touched by her conceding this, and replied by saying I was aware that I was also giving her a hard time, perhaps in a way no one else had. She expressed appreciation that I was willing to acknowledge this. It was a touching moment for both of us. Then she became very emotional, reporting that she suddenly realized she was living as though she were preparing to die. I wondered if she feared that to change in any way would feel to her as though some part of her were dying. Were her impulses to quit a reaction to this? Was the issue whether she could survive me, or, I wondered, was she afraid to find out whether, in fact, we could survive each other and our relationship? She replied that her fear was that I would not be able to survive her.
One question this now raised was whether my looking out the window had been an issue precisely because it suggested I was frightened of the thunder and lightening and therefore vulnerable. Had this evoked her fear that I would also be frightened of and vulnerable to her.

This time I referred back to that moment when I had looked out the window. I noted that I now had a new thought about what had happened. My thought now was in the form of an analogy: If a person were drowning, and she tried to hold you so tightly you would drown with her, the only way to save both of you might be to unhook her, then grab her in your own way, so you could be effective. Perhaps I had needed to “unhook” at the time, without necessarily understanding then that this was so. She seemed relieved and reassured. Later that day she called and told me I had been “very good” and that the session had been really important. Nevertheless, she also added that she thought she needed to call me to find out if I was still alive.

In the session following, Rachel reported realizing that some of her demands were ways of testing my resilience. Though earlier in our work she had emphasized her own vulnerability, as we progressed she was increasingly in touch with a profound fear that she could literally destroy me. There were associations to the fact that one of her former analysts died while she was working with him, and another had retired. She had some lurking fear that she had somehow precipitated both events. She also asked whether I was, or even should be, scared of her power. I asked if she thought I should be. She responded with associations to ways in which she tends to submit to others when they make demands on her, out of a sense of the fragility of the other. What we both came to see was that my not giving in to her demands, but helping focus them, helped her to realize that I was not as fragile as she had feared. It also allowed her to discover that she could survive my refusals to comply with her demands and my refusals to be intimidated or tyrannized by her vulnerability. At the same time, I did not run away from her either. All this proved a great relief to her, as it helped clarify the limits of her potential to destroy or be destroyed and showed that she was not only not as powerful as she feared, but also not as fragile.

In a session following, she reported having had a dream in which she was aware of sexual feelings, something she had not felt for many years. It seemed some kind of awakening was beginning to occur.
What I have tried to illustrate is that in moments of potential impasse, whatever is being played out interactively between patient and analyst becomes vital analytic data, and the effort to unpack the complex interactive subtleties involved can become the heart of the analytic work. From my perspective, attending to what goes on interactively between patient and analyst is the way to turn potential impasse into analytic opportunity. This is true even as we also must recognize that we can never be sure we are not involved in some unconscious enactment and collusion, despite our best efforts to the contrary, and that we are as vulnerable to unconscious forces as the patient is. The very process of struggling with these concerns, by working at what I have called the “intimate edge” of the analytic relationship, can become both the medium of the work and the locus of therapeutic action.

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