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Impasses in Psychoanalytic Therapy—A Royal Road

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OUR THESIS IN THIS PAPER IS THAT impasses in psychoanalytic therapy, when investigated from the standpoint of the principles unconsciously organizing the experiences of patient and therapist, provide a unique pathway—a "royal road"—to the attainment of psychoanalytic understanding. Before developing and illustrating this thesis, we first present an overview of the theoretical framework that has guided our investigations of the therapeutic process.

We refer to our framework as an intersubjective approach to psychoanalysis. Previously (Atwood and Stolorow, 1984), we1 defined its essentials, which can be applied to any psychoanalytically-oriented therapy, as follows:

In its most general form, our thesis … is that psychoanalysis seeks to illuminate phenomena that emerge within a specific psychological field constituted by the intersection of two subjectivities—that of the patient and that of the analyst. … Psychoanalysis is pictured here as a science of the intersubjective, focused on the interplay between the differently organized subjective worlds of the observer and the observed. The observational stance is always one within, rather than outside, the intersubjective field … being observed, a fact that guarantees the centrality of introspection and empathy as the methods of observation. … Psychoanalysis is unique among the sciences in that the observer is also the observed … [pp. 41–42]. Clinical phenomena … cannot be understood apart from the intersubjective contexts in which they take form. Patient and analyst together form an indissoluble psychological system, and it is this system that constitutes the empirical domain of psychoanalytic inquiry [p. 64].

We applied the intersubjectivity principle to the developmental system as well:

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1 Throughout this paper we will use the words "we" and "our" in referring to works authored or coauthored by any of us.

Both psychological development and pathogenesis are best conceptualized in terms of the specific intersubjective contexts that shape the developmental process and that facilitate or obstruct the child's negotiation of critical developmental tasks and successful passage through developmental phases. The observational focus is the evolving psychological field constituted by the interplay between the differently organized subjectivities of child and caretakers … [p. 65].

The intersubjectivity concept is in part a response to the unfortunate tendency of classical analysis to view clinical phenomena in terms of processes and mechanisms located solely within the patient. Such an isolating focus fails to do justice to each individual's irreducible engagement with other human beings and blinds the clinician to the profound ways in which he is himself implicated in the phenomena he observes and seeks to treat. From an intersubjective perspective, phenomena that have been the traditional focus of psychoanalytic investigation are seen not as products of isolated intrapsychic mechanisms, but as forming at the interface between interacting subjectivities. In our previous work (Atwood and Stolorow, 1984) ; (Stolorow, Brandchaft, and Atwood, 1987), we have shown that an intersubjective viewpoint can illuminate a wide array of clinical issues, including transference and countertransference, resistance, conflict formation, and borderline and psychotic states.

From the continual interplay between the patient's and therapist's psychological worlds two basic situations repeatedly arise: intersubjective conjunction and intersubjective disjunction. The first of these is illustrated by instances in which the principles structuring the patient's experiences give rise to expressions that are assimilated into closely similar central configurations in the psychological life of the therapist. Disjunction, by contrast, occurs when the therapist assimilates the material expressed by the patient into configurations that significantly alter its meaning for the patient. Repetitive occurrences of intersubjective conjunction and disjunction are inevitable accompaniments of the therapeutic process and reflect the interaction of differently organized subjective worlds.

Whether these intersubjective situations facilitate or obstruct the progress of therapy depends in large part on the extent of the therapist's capacity to become reflectively aware of the organizing principles of his own subjective world. When such reflective self-awareness on the part of the therapist is reliably present, then the correspondence or disparity between the subjective worlds of patient

and therapist can be used to promote empathic understanding and insight. In the case of an intersubjective conjunction that has been recognized, for example, the therapist may become able to find in his own life analogues of the experiences presented to him, his self-knowledge thus serving as an invaluable adjunct source of information regarding the probable background meanings of the patient's expressions. Disjunctions, once they are recognized, may also assist the therapist's ongoing efforts to understand the patient, for then his own emotional reactions can serve as potential intersubjective indices of the configurations actually structuring the patient's experiences.

In the absence of reflective self-awareness on the part of the therapist, such conjunctions and disjunctions can seriously impede the progress of therapy. For example, an intersubjective conjunction may interfere with the course of treatment when the patient's experiences so closely correspond to those of the therapist that they are not recognized as containing psychologically significant material to be investigated and understood. Descriptions of the patient's life that are in agreement with the therapist's personal vision of the world will accordingly tend to be regarded as reflections of objective reality rather than as manifestations of the patient's personality. Commonly, the specific region of intersubjective correspondence that escapes analytic inquiry reflects a defensive solution shared by both patient and therapist. The conjunction results in a mutual strengthening of resistance and counter-resistance and, hence, in a prolongation of the treatment.

The Case of Peter

Peter (whose treatment was discussed in Atwood and Stolorow, 1984), repeatedly complained about the mechanization and depersonalization of American life and expressed longings for a Utopian community within which his existence could have significance and meaning. His therapist, who shared this negative image of our society, never responded analytically to these expressions, for they seemed to him nothing more than indicants of good reality-testing regarding the modern condition of life. Both of them were prone to attributing the difficulties in their relationships to impersonal forces and institutions, and moreover to longing for a world modeled on the idealized images of vanished past eras in their respective lives. The preoccupations with these images also served to

prevent a painful confrontation with certain conflictual issues concerning intimacy and attachment. The conjunction between patient and therapist here extended not only to the content of the expressed imagery, but also to aspects of its defensive purpose. The

opportunity to illuminate the meanings and sources of the material, which also contained implications for the transference, was thus replaced by an unwitting, silent collusion to limit the patient's (and therapist's) attainment of self-knowledge.

Negative Therapeutic Reactions

Especially damaging are the interferences with treatment that arise in consequence of protracted, unrecognized intersubjective disjunctions. In such instances, the disparity between patient and therapist can contribute to the formation of vicious countertherapeutic spirals that produce for each an ever more dramatic confrontation with dreaded scenes having salience in their respective subjective lives. Such persistent disjunctions, whereby empathy is chronically replaced by misunderstanding, invariably intensify and exacerbate the patient's suffering and manifest psychopathology. It is here that we find the source of what analysts have euphemistically termed "negative therapeutic reactions."

The concept of a "negative therapeutic reaction" was created by analysts to explain those disquieting situations in which interpretations that were presumed to be correct actually made patients worse rather than better. Typically, such untoward reactions to the analyst's well-intended interpretive efforts are attributed exclusively to intrapsychic mechanisms located entirely within the patient, such as an unconscious sense of guilt and a need for punishment, primal masochism (Freud, 1923), (1937), narcissistic character resistances (Abraham, 1919), a need to ward off the depressive position through omnipotent control (Riviere, 1936), or unconscious envy and a resulting compulsion to spoil the analytic work (Kernberg, 1975) ; (Klein, 1957). We are contending, by contrast, that such therapeutic impasses and disasters cannot be understood apart from the intersubjective contexts in which they arise.

In our experience, exacerbations and entrenchments of patients' psychopathology severe enough to be termed "negative therapeutic reactions" are most often produced by prolonged, unrecognized intersubjective disjunctions wherein the patient's emotional needs are consistently misunderstood and thereby relentlessly rejected

by the therapist. Such misunderstandings typically take the form of erroneously interpreting the revival of an unmet developmental longing as if it were an expression of malignant, pathological resistance. When the patient revives such a longing within the therapeutic relationship, and the therapist repeatedly interprets this developmental necessity as if it were merely a pathological resistance, the patient will experience such misinterpretations as gross failures of attunement. Consequently, traumatic psychological

injuries are repeatedly inflicted, with impact similar to the pathogenic events of the patient's early life (Kohut, 1971) ; (Stolorow and Lachmann, 1980).

The Case of Robyn

An example of such a destructive turn of events was provided by the treatment of Robyn (discussed in Atwood and Stolorow, 1984), a woman whose difficulties traced back to her early family's consistent failure to provide the confirming and validating responsiveness necessary for the formation of a stable and coherent sense of self. The only exception to this pattern of unresponsiveness that she could recall was her father's sexual interest in her which, according to her memories, began when she was nine years old. This had led to the development of a seductive and coquettish style and ultimately to a pattern of compulsive promiscuity with father-surrogates, in a desperate effort to be recognized and counteract terrible feelings of depletion and nonbeing.

Robyn's therapist began her treatment in accord with his understanding of the precepts of classical psychoanalysis, which included an overly literal interpretation of the rule of abstinence. This meant that he responded to her urgent requests for affirming, mirroring responses with silence or at most a brief interpretation. She began to experience his seeming aloofness and "neutrality" as a repetition of the traumatically depriving circumstances of her childhood, and alternated in treatment between sexualization of the transference and attempted seductions on the one hand, and expressions of deep rage on the other.

A central configuration in the therapist's subjective world concerned issues of power and control. The salience of these issues had largely arisen from a problematic childhood relationship with his mother, in which he had violently resisted submitting to what he felt was her tyrannizing and oppressive will. The dilemma

around which major aspects of his subjective life were organized was the danger of relinquishing control and autonomy, which seemed to him equivalent to becoming the slave-like extension of others. The patient's desperate demands for mirroring responsiveness were unconsciously assimilated into his emotionally charged themes of power and control, evoking a reaction of stubborn resistance and entrenching his already withholding and unresponsive style. Unaware of the countertransference reaction that had been precipitated, he envisioned his patient's intensifying demands as expressive of a malignant need for dominance. A vicious spiral was thereby created, in which the disjunctive perceptions, needs, and reactions of patient and therapist strengthened one another in a reciprocally destructive way. The treatment continued in this situation for 18 months until it was finally broken off when the patient attempted to commit suicide.

Impasses: A Royal Road

Having reviewed and illustrated the kinds of intersubjective situations that, when not recognized, can lead to serious obstructions of the therapeutic process, we turn now to the central focus of this paper—the new understandings and enhancements of the therapeutic process that can be achieved when the principles unconsciously organizing the experiences of patient and therapist in an impasse are successfully investigated and illuminated.

The Case of Alice

Alice was a 34-year-old teacher of Oriental descent who had entered therapy two years prior to the impasse to be described because she felt depressed about a relationship she was having with an older man whom she had been seeing for one year. She felt that this man had become more interested in his own activities than in her and was not attending to her needs. In particular, she felt he had been ignoring her when she wanted attention and physical affection. She appeared as an attractive and well dressed woman whose quiet manner often betrayed her agitated state of mind.

She had been married in her early twenties for about a year, but the marriage ended when her husband began to withdraw from her and she became increasingly rageful with him. She had no children, which continued to be a disappointment to her, and she experienced a chronic sense of loss, along with a persistent feeling

that she was not feminine and that she was a failure as a woman. She was able to put these feelings aside only when she was working, and she described how happy she was teaching her students about reading and history. She often imagined that they were her children and thereby achieved an illusory sense of completeness.

Alice described a longstanding inner experience of deficiency and lack of confidence in her attractiveness. She was an only child, born when her parents were quite old. Consistent with his cultural background, her father had desperately wanted a male child. Throughout her childhood her mother and other relatives had told her repeatedly about his disappointment when she was born. Apparently he had become convinced that, because his wife was having a child late in their marriage, the child was destined to be the boy he had always wanted. He was devastated when she was born, and he precipitously left the family for several months. When he returned, and continuing throughout her childhood, he virtually ignored her and had little to do with her, leaving her care entirely to her mother. The patient emphasized to the therapist that her father had never been overtly cruel to her, but that it felt to her as if she did not really exist in his eyes. He

seemed completely absorbed in his professional work, and she believed he regarded her as an obstacle to his ambitions. He remained distant and uninvolved with her until his sudden death when she was 16 years old.

Her mother was a very critical and perfectionistic woman who often seemed overwhelmed by her household tasks. Her mother had told her several times about her father's reactions to her birth without showing much emotion, but the patient had a persistent impression that her mother, too, had felt ashamed because Alice was not a boy. Her mother did encourage the patient's love of books, and the patient became more and more withdrawn growing up, retreating into the world of literature and fantasy. She was very shy and isolated during her childhood, but distinguished herself academically and decided to go into teaching.

As she described her relationship with her boyfriend during the early sessions of her therapy, Alice continued to feel increasingly that he was self-centered and preoccupied with himself. He only wanted to talk about his work, she said, and was not interested in her activities. She described how she felt neglected and mistreated

and became furious with him. Her relationship with the therapist generally felt supportive to her, but on several occasions when the therapist focused on how she felt about herself when she was ignored, the patient felt he was implying that her experience with her boyfriend was not real and that she was fabricating it. At these times she would become angry with the therapist and insist that he was interested in proving some theory of his own and did not really want to understand her. The therapist would then return to her experience and clarify that she did not feel he was on her side and that she needed him to understand how difficult her boyfriend was for her. She was able at times to understand that her relationship with her boyfriend automatically revived her childhood feeling of not being valued as a female, and that this feeling reinforced and fueled her anger at him. She did decide to stop seeing him about nine months after starting treatment, and this was very difficult for her as she began to ruminate about how she might have been more appealing to him. In particular, she focused on her physical attributes and her overall feeling that she was unattractive. The therapist clarified for her again how she organized the meaning of this experience according to her own feeling of deficiency. It revived for her the recurrent and painful feelings associated with her father's rejecting her because she was a girl.

As she began to feel better about her decision, a pattern began to take form in the transference. Alice began increasingly to focus on the therapist as a source of romantic interest. This occurred gradually but with greater intensity over a period of several months. The patient was embarrassed at first, but indicated that she found the therapist

attractive and wanted to meet a man just like him. She told him she was concerned that he would be uncomfortable with her and that he would pull away. Assimilating the patient's concerns into an organizing principle of his own, the therapist reassured her that he would not withdraw from her. He also communicated his understanding that her feelings represented a longing to consolidate and build a sense of herself as a female, as this had never happened in her family. Soon the patient's romantic interest became tinged with sexual fantasy, and she confided that she had sexual dreams involving the therapist, but said she was too embarrassed to describe the details. She began to ask for a more direct responsiveness from the therapist. She said she could sense that he found her attractive and she felt certain

of this. The therapist acknowledged how important it was that she feel special to him. On a few occasions she would respond angrily and say that she knew he felt she was unique and that she was upset that he would not directly confirm this. The therapist, now in the grip of a conflict within himself, replied equivocally, stating that she was indeed a special person and that she needed to feel this about herself.

After being in therapy for 18 months, the patient was away for an eight-week trip in which she took a group of children on a cultural tour of several foreign countries. When she returned she was happy and excited about what she had done, but acutely felt the absence of a man who might share this with her. She had thought of the therapist often during the trip and had fantasized about the two of them enjoying the beauty together. As she began to tell the therapist about a present she had purchased for him, he reacted uneasily and told her that it was not necessary for her to give him a gift. The patient felt crestfallen and then became angry. She felt that the therapist had completely rejected her and that, whereas he had previously encouraged a special relationship with him, he was now changing his attitude. She felt he had misled her and stated that she would seriously consider finding a new therapist. During the next few sessions the patient expressed an intense need for the therapist to indicate directly that he found her attractive and sexually exciting. Her demands for a concrete affirmation of her sexual self became increasingly strident. The therapist, feeling enormous pressure, finally did acknowledge that she was an attractive woman whom many men would find appealing. The patient became furious at what she felt was a lukewarm response. She continued to demand that he simply acknowledge that he felt sexually excited by her. She reiterated her awareness that they would actually never do anything sexually, but she still wanted him to demonstrate that he was interested and excited. In reaction to her increasing demands, the therapist became more emotionally disengaged and adopted a more intellectual stance, inquiring into why she was feeling so needy at this time. The patient became even more incensed and felt that he was abandoning her and that she should leave him. It was at this point that the

therapist sought consultation in an attempt to understand what had happened between them.

As a result of the consultation it was clarified that an intense

stalemate had developed from the interaction between the patient's and therapist's organizing principles. The patient's invariant principle was that no man would ever sustain an interest in her as a female. This was the product of her repeated experience of her father being totally disinterested in her because she was not male. She had mobilized with the therapist an intense developmental longing for mirroring responsiveness to her femaleness—a longing that had become eroticized. The therapist had attempted to be flexible in response to the patient's needs. His efforts to be responsive, however, had been codetermined by an archaic organizing principle of his own. As a child he had felt required to devote himself to maintaining his mother's self-esteem by mirroring her for her physical attributes. In addition, his mother would periodically become enraged at him because of some slight he had inflicted. Although these episodes were infrequent, they were very frightening and powerful for him. It became absolutely imperative for him to anticipate what would make his mother angry and to avoid this at any cost. In the treatment situation, the patient's intense need for mirroring of her sexual attractiveness, together with her propensity to become enraged when injured, had revived these painful themes from the therapist's history. His self-esteem became focused around maintaining the patient's emotional equilibrium, instead of investigating and elucidating her inner experience. The patient's demands had become assimilated into an archaic organizing principle of the therapist that required him literally and concretely to fulfill the patient's longings for affirmation and to prevent her from reexperiencing with him the painful developmental failures of her childhood. However, continuing along the path of direct fulfillment had increasingly put the therapist into conflict with his personal ideals as an analyst. Thus the therapist had been ambiguous in his message to the patient around her developing sense of femininity. While at times he concretely affirmed her in an attempt to be responsive and extend his own boundaries, at other times he became alarmed about the potential consequences of his responsiveness and the patient's escalating demands and then withdrew into cool intellectualization.

In the next several sessions the therapist conveyed to Alice his understanding of their interaction and how it had unfolded. He communicated to her that he had tried to extend his range of interactions with her in an attempt to be responsive to her needs. She

was, however, perceiving and reacting to his oscillation between a responsive mirroring stance and a retreat into more distant intellectual inquiry, which made her feel like a specimen. He further stated that at this point he wanted to establish a firmer definition of his own boundaries so that he could help restore a therapeutic atmosphere between them. He told her that his ideal of himself as an analyst prevented him from responding directly to her questions about whether he found her sexually attractive and exciting. He further acknowledged that because of a conflict within himself—between a feeling that he must be responsive to her and an equally strong feeling that he must live up to his own analytic ideals—he had sometimes withdrawn from her, as when he had rejected her gift. He said that, within the limits of his own view of himself as an analyst, he would like to work with her to reestablish their relationship. The patient responded very favorably. She said that, although she thought his training was somewhat stupid, she understood what had happened and now had an idea of what she could expect.

Clarifying the intersubjective disjunction both reestablished a facilitating atmosphere between therapist and patient and made possible a deepening understanding of the principles organizing the patient's experience in the transference. The patient continued to have romantic feelings toward the therapist, but the demands for a concrete response receded. Concomitantly, the patient became aware of her underlying conviction that the therapist must surely be repulsed by her romantic and erotic feelings. The patient and therapist came to understand that Alice's central and most painful fear in the transference was not that she would be rejected as sexually unattractive, but that her feelings and longings for responsiveness in and of themselves would repel and alienate the therapist. This was accompanied by a belief that he must feel dirtied and disgusted by his association with her, and that he must be relieved when she had left his office. Thus, the successful illumination of the impasse had unveiled the patient's deep conviction that her affective longings were repugnant, a sign of a loathsome defect within herself. This conviction, along with its childhood roots, could then become a primary focus of analytic investigation.

For the therapist, the new understanding of his own vulnerabilities and the firmer delineation to the patient of his analytic ideals created an increased sense of confidence. The patient's feelings of

disappointment and anger could then be seen as an inevitable component of the process of her consolidating her sense of herself as a female, not as harbingers of a disaster that he had to forestall. The clarification of the intersubjective disjunction freed him of the

requirement that he center himself around alleviating her distress and helped create an atmosphere wherein he felt a greater freedom to be naturally responsive from within a stance of sustained empathic inquiry.

The Case of Sarah

Sarah, a 27-year-old unmarried physical therapist entered treatment because of recurring experiences of herself as a small, vulnerable child lost in a threatening world of powerful grownups. This patient was in actuality a successful, well-respected professional, with many supervisees and disabled patients relying on her expertise. Subjectively, however, she was increasingly prey to feelings of extreme intimidation, as if she were a weak and inadequate little girl suddenly thrust into high-powered adult roles and responsibilities.

Sarah had made one earlier attempt at psychotherapy while she was in college, but this had ended disastrously after two years when her therapist had begun to use her for the fulfillment of his own sexual needs. She was devastated when, after finally expressing confusion and doubt concerning their physical intimacy, she was angrily told by him that he had made a mistake in believing she had become capable of "mature love." Never showing any understanding of her reactions, he made her feel completely deserted by him. The final result of this was that she resolved never to rely so deeply on another person again and tried to block the entire episode out of her mind for the next several years.

A pattern of being emotionally neglected and exploited actually was characteristic of her whole life history. During her early years there was massive neglect by her depressed and alcoholic parents, who for the most part relied on her to take care of them. Being nurturant to the parents provided the only consistent means of experiencing a connection with them, and major aspects of her developing self became organized around the caregiving role. This role specifically excluded the showing of any direct need for care from her mother or father; expressing such a need seemed invariable to make the parents resentful, and they reacted either by

pressuring her to be grown-up or by angrily rejecting her for being a burden to them. Illustrative of this pattern were the patient's earliest memories, which were of times when she cried uncontrollably in her crib and her mother responded by screaming at her to be quiet and violently throwing a bottle into her bedding.

Among the long-range consequences of Sarah's early situation was an interpersonal style of giving to others but asking nothing directly for herself. This affected not only her career choice in the field of disability, but also her intimate relationships. Her history was

one of a series of romances in which she played a nurturant role with men who gave little or nothing in return. She always reacted to the depriving quality of these relationships with upset and depression, but regarded such feelings as signs of something wrong with her rather than reflections of how she was being mistreated.

The first months of Sarah's new therapy seemed to unfold very smoothly. She told the long story of her life in all its sad detail, including the story of her relationship to her first therapist. Her new therapist listened sympathetically as she spoke, and although he noted the rapidity with which she seemed to be opening up the various areas of her experience, he did not anticipate the transference storms that were soon to arise. There was an early dream, symbolizing the process that was occurring, in which the patient traveled back to the town where she had grown up and approached a large house and went in. She passed through room after room, and finally came to a small closet in which there was an infant covered with dirt, cuts and bruises cowering against the wall. In discussing the dream, she and her therapist understood the imagery as a picturing of their developing discovery of the sequestered, deeply hurt child within her.

The impasse to be described crystallized around the therapist's telling Sarah of a six-week interruption in their work that was to occur during the following summer. Recognizing that such a long separation might be exceptionally difficult for her, he explained that he would be only a phone call away. She showed no special reaction to the announcement for a few days, but then reported a dream of an old mangy animal left lying on its back in the wilderness. When her therapist suggested that perhaps the dream was related to his plans for the summer, she grew visibly frightened, haltingly saying that maybe she was experiencing an impending

abandonment. At this point the therapist repeated his reassurances that he could remain in touch with her by phone and reminded her they still had a number of months to decide how they would handle the separation. To his surprise, Sarah reacted to the intended reassurance by becoming still more upset and turning physically away from him. When asked what she had felt, she said that she could not bear being in the room for a moment longer and wanted to go home. Her therapist asked her not to leave, but rather to stay and tell him more of what she was feeling. Again she responded fearfully and was now unable to talk. The session continued essentially in a tense silence until the hour was finally over, at which point Sarah rushed out the door.

The patient now began coming late to their meetings, reported great difficulty restraining herself from running away once she had arrived, and otherwise had little to say. The therapist redoubled his efforts to understand the meaning of the impending separation and continued to seek ways to ameliorate its inexplicably growing disruptive impact. He told

the patient he was sure they could find their way through this period by planning for it, having occasional contacts by telephone, and he even offered to see her once during the middle of the six-week interruption when he had to return briefly. With each of these efforts to explore and soften the effect of his departure, Sarah became still more frightened and unable to communicate her feelings to him. She then told of repeating nightmares in which she arrived at his building for a session, but somehow his office had vanished and she was unable to find him. As the situation worsened, the therapist began to feel more and more helpless, at times becoming consumed with anxiety on her behalf. Sarah noted her therapist's growing distress, and this added to her difficulties, for now she felt she had become a painful burden to him.

During the vacation itself, the patient refused to have ongoing contacts of any kind, rejecting her therapist's calls with what he experienced as icy hostility. Finally she sent a letter telling him that he had treated her with brutal insensitivity. She added that she felt completely betrayed by him and she was therefore terminating treatment. Still not understanding what had transpired, he replied in writing that he regretted the ending of their relationship and hoped she would feel welcome to come back if she ever changed her mind. Sarah did finally return after several more weeks had

passed, and their sessions continued. The impasse, however, persisted through a series of subsequent episodes and was only very slowly clarified over the next 18 months. These episodes had in common a crisis around a physical separation interrupting their work or some other circumstance dramatizing an aspect of the therapist's unavailability to the patient. In each instance Sarah again reacted to her therapist's attempts to understand and alleviate her pain by withdrawing, and the treatment was maintained during this interval only on the most precarious basis.

The illumination of the impasse occurred gradually and involved not only a new understanding of the patient, but also a concomitant change in the therapist's self-understanding. For Sarah, the crises pertained must fundamentally to her sense that her therapist showed no concern for the enormously frightened, vulnerable child she repeatedly experienced herself as being. His attempted reassurances that a way could be found to overcome the disruptions of occasional separations she perceived as implicit demands that she feel better and not become scared. This replicated early childhood scenes in which her parents expected her to withstand very trying circumstances, including sometimes long separations from them, and behave like the grown-up girl they needed her to be. Her first therapist as well had told her he expected her to be "mature" and made her feel she had lost all connection to him on account of her failure to do so. A fundamental truth of Sarah's life was that she had never been allowed to be a child, and with her new therapist she was again experiencing the same disastrous situation. His

expectation that she join with him in planning for a separation flew in the face of her feeling that such a long break in their contacts was utterly impossible to bear. What was most disruptive for her was not, it was later understood, the six-week separation itself; the more central problem was that she felt her therapist could neither understand nor accept the paralyzing sadness and despair his departure was triggering. His well-meaning efforts to arrange contacts to help her only dramatized this lack of understanding. She also had been experiencing his efforts as containing the implicit message that she should not be so upset, and thus as a rejection of her child-self. This self had originally been disavowed in consequence of repeated events making her believe that the expression of her needs threatened her ties to the people closest to her. The specific danger associated with the

emergence of her long-suppressed childhood longing for understanding and loving care was that she would be rejected for imposing such a loathsome burden on anyone around her. This danger had seemed to actually materialize when her therapist first informed her of his summer plans.

The therapist throughout the period of the imapsse did not clearly perceive the patient's child-self as a distinct part of her. He was aware of her intense suffering, but did not fully comprehend the nature of this suffering as the boundless despair of a small child. Instead he tended to see the difficulty she was having in terms of the relationship between them and felt responsible for her pain. This feeling of magnified responsibility contributed to his intense distress and formed part of a vicious cycle by reinforcing her picture of herself as an intrinsically burdensome, rotten creature that no one could ever love.

The changes in the therapist's self-understanding that contributed to the resolution of the impasse arose largely out of his personal analysis, which was occurring in parallel to the treatment being described. He was a person in whom there was also a disavowed child-self, but with a different background than the one of his patient. He had grown up in a family which had been profoundly affected by the sudden death of his mother when he was eight years old. She had been the emotional center of family life and her loss had been utterly shattering to all the family members. The therapist had as a child responded to this massive upheaval in part by forming an identification with his mother and assuming aspects of her nurturant, supporting role in relation to his grieving father and siblings. His own sense of inner desolation was hidden in this process, becoming buried, as it were, with his mother. The result was that much of his style of relating to others began to center around the themes of caretaking and rescue, which served to protect him from feelings of devastating powerlessness and solitude. His inability to rescue Sarah as she spiraled into despair had thus challenged a central part of his way of maintaining his own emotional equilibrium.

As a result of intensive analytic work, the therapist began to have the immediate experience of his own child-self, with all its attendant feelings. The gradual integration of this previously disavowed part of himself occurred within the bond to his analyst, which provided the holding, containing context that had been

missing in the shattered family of his youth. A central theme in his analysis was in fact the recognition of how he had been hurt not only by the loss of his mother, but equally by the emotional unavailability into which his father and other family members had lapsed in the aftermath of her death. As this integration slowly took place, his perception of his patient also began to change. He now came to see her child-self as a much more distinct entity than had been apparent to him before. He understood also that within this part of her there was an indescribable depth of despair and loneliness, feelings that again and again had been triggered in the transference. He specifically grasped why all his efforts to ease Sarah's pain during their separations had failed: the separations were simply impossible for the child within her to manage, and she had needed from him a response showing his understanding and acceptance of this fact. His efforts to reassure her contained the expectation that she would do well while he was away, which was very far from how she felt. This expectation had made it seem that he was no longer available for contact with her, and this was symbolized in the dreams of his office having disappeared. The reassurances were in addition felt as rejections of her child-self, which replicated the many traumatic interactions with her parents and first therapist.

With the therapist's increasing acceptance and tolerance of the catastrophically extreme emotions of his own childhood, he became able to tolerate and contain the correspondingly extreme feelings of his patient. No longer assimilating the circumstances of the treatment to the trauma of his early family situation, he no longer felt a compelling need to rescue his patient from her pain and despair. As he moved away from attempts to ameliorate her suffering and focused instead on conveying his understanding of what she felt, Sarah slowly began to relax in his presence. The changing intersubjective field then made it possible for her to tell of a wishful fantasy concerning what she most deeply yearned for from him, a fantasy that previously she would have been far too frightened to disclose. It was that she could be held protectively in her therapist's arms and fall gradually into a peaceful sleep. This imagery concretized a needed bond that was at this point crystallizing between them, a bond of holding and containment within which the patient could experience secure acceptance of her childself

and thus discover the possibility of her own emotional wholeness.

Discussion

We presented two brief clinical examples (the cases of Peter and Robyn) in which, in the absence of reflective self-awareness on the part of the therapist, patterns of intersubjective transaction became established that resulted in unresolved therapeutic stalemates. In contrast, we offered two more extensive clinical reports (the cases of Alice and Sarah) illustrating our thesis that when the principles unconsciously organizing the experiences of patient and therapist in an impasse can be investigated and illuminated, significant new understandings and enhancements of the therapeutic process can be achieved.

The cases of Robyn and Alice were similar in that, for both patients, early unmet developmental needs for mirroring responsiveness took on a sexualized form when these needs were revived but then rebuffed by their therapists. Robyn's therapist remained unaware of the psychological configuration that led him to reject his patient's longings, with the result that the erotization of the transference became hopelessly entrenched. Alice's therapist, in contrast, became reflectively aware of his unconscious organizing activity, in turn making it possible to open up for investigation the more primary emotional constellation underlying his patient's eroticized demands.

The cases of Peter and Sarah were similar in that in both instances an overlap between areas of the patient's and therapist's defensive activity opposed the process of analytic investigation. Unlike Peter's therapist, however, Sarah's therapist worked through the defensive disavowal of painful childhood feelings in his own analysis, enabling him to make empathic contact with the traumatized child-self sequestered within his patient.

In the cases of both Alice and Sarah, their therapists' attainment of reflective self-awareness permitted them to recognize and comprehend the intersubjective disjunctions and conjunctions that had produced the therapeutic impasses. There was, however, an important difference in the manner in which the impasses were resolved in these two instances. Alice's therapist disclosed to his patient aspects of his own psychological world that had contributed

to the impasse. This proved highly facilitative because, by revealing himself to be torn between his wish to be responsive and his wish to uphold his ideals, he distinguished

himself from the dreaded father who recoiled from Alice because she was female. In contrast, Sarah's therapist wisely refrained from revealing to her what he had discovered about the diavowals of his own childhood pain that had interfered with his capacity to comprehend her child-self, for she doubtlessly would have experienced such a disclosure as a replication of her parents' expectation that she disregard her own distress and devote herself to nurturing them. What the therapist may or may not reveal about his own contribution to an impasse should be guided by his understanding of the specific transference meanings such disclosures are likely to acquire for the patient.

In a previous work (Stolorow, Brandchaft, and Atwood, 1987), we argued that the analytic stance is best conceptualized as an attitude of sustained empathic inquiry—an attitude, that is, that consistently seeks to comprehend the meaning of a patient's expressions from a perspective within, rather than outside, the patient's own subjective frame of reference (Kohut, 1959). What we are emphasizing here is that inquiry must include the therapist's continual reflection on the involvement of his own personal subjectivity in the ongoing therapeutic process. Since the patient's experience of the therapeutic relationship is codetermined by the organizing activities of both participants in the therapeutic dialogue, the domain of analytic investigations must encompass the entire intersubjective field created by the interplay between the subjective worlds of patient and therapist. As we have seen, an investigation conducted in this manner can transform a therapeutic stalemate into a royal road to new analytic understandings for both patient and therapist.

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