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Teresa María Méndez
"No End or Return":
Thematics of Impasse,
a Relational and
Infancy-based Inquiry

ABSTRACT

This theoretical study explores therapeutic impasse through the dual lens of relational theory and infant research. Particular attention is paid to the role that enactment, rupture and repair, and non-verbal communication play in impasse dynamics. Defined broadly--as any time a therapist and patient feel stuck--impasse is conceptualized as an expectable, even inevitable, component of the treatment relationship. This paper further posits that small moments of impasse hold potential for growth. Finally, the implications for navigating impasse are considered through a clinical vignette.

"NO END OR RETURN":
THEMATICS OF IMPASSE, A RELATIONAL AND INFANCY-BASED INQUIRY

A project based upon an independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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CHAPTER I
INTRODUCTION

From the complications of loving you
I think there is no end or return.
No answer, no coming out of it.

Which is the only way to love, isn't it?
This isn't a playground, this is
earth, our heaven, for a while.

Therefore I have given precedence
to all my sudden, sullen, dark moods
that hold you in the center of my world.

And I say to my body: grow thinner still.
And I say to my fingers, type me a pretty song.
And I say to my heart: rave on.

--A Pretty Song, Mary Oliver

The dictionary defines impasse as a road or passage having no exit; a situation that is so difficult that no progress can be made; a deadlock (American Heritage Dictionary, 2000). For the most part, psychoanalytic theory has hewed closely to this definition, equating impasse with failed treatment. Historically, discussions of impasse were either shied away from altogether in the literature, or shrouded in words such as avoidance (Balint, 1952), last resort (Buxbaum, 1954), risk (Loewenstein, 1954), stubbornness (Giovacchini, 1961), hopelessness (Ulanov, 1973), depletion, despair (Gorney, 1979), and paralysis (Maldonado, 1984).

This study is concerned with broadening the definition and understanding of therapeutic impasse. But it also endeavors to circumscribe the belief that impasse is inherently damaging to a treatment. By opening up the definition of clinical impasse to include

any time a patient and therapist feel stuck, impasse comes to be conceptualized as expectable, inevitable even. The essential question is no longer how do we avoid impasse, but rather, how do we find ourselves in such spots? What do they mean for treatment? And, perhaps most importantly, how do we find our way through?

Impasse is a phenomenon encountered by all clinicians at all levels of experience. Yet the literature most frequently addresses protracted and wayward stalemates, a variety of impasse few beginning clinicians will face. To that end, in addition to charting a brief history of the literature on impasse in Chapter II, this theoretical study attends to more subtle impasse experiences as well. In doing so it attempts to address a significant gap in the literature, of particular relevance to beginning clinicians.

Toward developing an understanding of impasse, I first turn to relational theory. Chapter III attempts to illuminate impasse through enactment, a phenomenon that some relational analysts consider synonymous with impasse. Chapter IV presents an understanding of impasse derived from infancy research, pulling particularly from models of rupture-repair and nonverbal communication. Just as a relational approach views enactment as inevitable and necessary, such is the case with rupture and repair through an infancy lens. Finally, the two frameworks are synthesized in Chapter V, through the Case of Bee, a vignette drawn from my own first-year clinical placement.

I suggest that when viewed together, these two theoretical sensibilities open a therapist's awareness to all of what may be happening between clinician and patient during moments of impasse--from the interpersonal and intrapsychic to the relational and behavioral, explicit and implicit, spoken and non-verbal. In conjunction, relational theory and infancy research offer a frame from which to work

with impasse. Through these two theories, clinicians are able to glimpse the transformation and growth that are the counterpoint to even small moments of impasse.

CHAPTER II

ON THE PHENOMENON OF IMPASSE

Loss, mourning, the longing for memory, the desire to enter into the world around you and having no idea how to do it, the fear of observing too coldly or too distractedly or too raggedly, the rage of cowardice, the insight that is always arriving late, as defiant hindsight...
[These] are the stopping places along the way.

--Ruth Behar, *The Vulnerable Observer*

The patient is wondering why the analyst doesn't get it when the patient has tried to show her a hundred times. The analyst feels defeated by the patient's refusal of her understanding, and the patient is convinced the analyst doesn't understand or can't help.

--Jessica Benjamin, *Recognition and Destruction: An Outline of Intersubjectivity*

Early in her collection of essays, *The Vulnerable Observer*, anthropologist Ruth Behar (1996) relays the story of a photographer, a reporter who stood by helplessly snapping pictures as a young Colombian woman drowned in mud. Then suddenly, he reaches out to her.

Behar (1996) identifies this tension, between observing and intervening, containing and enacting, as "the central dilemma of all efforts at witnessing" (p. 2). In essence what Behar describes in that moment when the photographer stands frozen, unsure of how to proceed, is a snapshot of impasse. It is an experience routinely encountered by those professional witnesses who are therapists as well.

The work that goes on in the consulting room and the impassable moments that take shape there may seem far removed from the life and death drama of a Colombian mudslide. Yet the literature often portrays impasse as a juncture where the fate of a therapy stands in the balance. One writer on the subject portentously suggests, "At moments of impasse, both the therapist and the patient are subjected to the

ultimate test. What is each of them willing to do to save the therapy?" (Darwin, 1999, p. 468). Another clinician, in the aftermath of impasse, describes a patient recalling that it "felt like another life and death situation in which one of us would have to 'die' so that the other would live" (Ringstrom, 1998, p. 312). And from the analyst's perspective, a third offers: "I often find myself feeling that I am engaged in some kind of life and death battle for my sanity and mental integrity" (Davies, 2004, p. 719). The ultimate test, indeed.

Yet impasse occurs on a continuum. Certainly there are ruptures so deep there seems little hope of recovery (Elkind, 1992; Pizer, 2004) as well as intractable deadlocks. Perhaps more common, though, and less carefully documented, are the subtle, everyday moments--marked by boredom, confusion, stagnation, and missattunement. They are the experiences that suggest, rather than feeling as though impasse intrudes on therapy, we might be better served in thinking of impasse as simply another part of therapy.

I first became interested in impasse while trying to make sense of an experience with a patient during my first-year clinical placement. A group that I was co-leading with another intern slogged along over weeks as we endeavored to negotiate and re-negotiate one patient's feelings of safety in relation to another. But the more effort we made to accommodate Bee, whose case will be discussed in Chapter V, the more deeply mired we seemed to become. It was not one of the enduring or "dramatically wrong" (Pizer, 2004, p. 2929) bouts that populate the impasse literature. Nonetheless, to a nascent clinician trying to navigate her way through, it felt significant.

The way in which I came to understand this case drew largely on the concepts of enactment, rupture and repair, and nonverbal communication--the former drawn from relational theory, the latter

concepts as described by infancy studies. Together, they are the primary phenomena and theories that will be developed in this thesis, toward a conceptualization of impasse.

Toward a New Definition

Faltering and missteps have come to be recognized as unavoidable parts of the therapeutic process. In defining impasse broadly--as any time a therapist and patient feel stuck--I hope to suggest the experience of impasse can also be viewed through this lens. It need not be dramatized nor shied away from. As with any other aspect of the clinical encounter, where "self-correction is our way of life" (Benjamin, 2009, p. 443), perhaps we will come to see impasse as just one more component of the treatment process, just another part of our way of life.

Though a therapy may seem to have lost momentum (Harris, 2009) or come to a stand still, the very act of surviving and *working through* (Freud, 1914) a therapeutic impasse may ultimately be what moves treatment forward. Even small moments of impasse hold the potential for growth. Woven together, routine impasse experiences give texture to our relationships, both within and outside the consulting room. They are deserving of deeper exploration.

In what follows, I attempt a brief review of the psychoanalytic literature on the historical development of impasse. From there I will offer an introduction to the more contemporary relational and infancy-based understandings that anchor subsequent chapters. This section highlights the shift in psychoanalytic theory from thinking of impasse as a state of resistance located within the patient to a shared experience, one co-constructed and co-negotiated by patient and therapist alike. It parallels the field's broader shift from a "one-

person psychology" to a relational perspective that accounts for the subjectivities of both patient and analyst. This orientation is furthered by the dyadic view of mother-infant interactions that has come to be the hallmark of contemporary infancy studies.

A History of Impasse

Freud's Case: Impasse as Transference

The earliest clinical example of impasse dates back to Freud (1905) and his turn-of-the-century analysis of Ida Bauer, a young woman he called Dora. Ultimately Dora, suffering from what Freud (1905) termed "petite hystérie" (p.23), resolved their stalemate. She leaves treatment and a somewhat befuddled Freud after three months--instead of the yearlong analysis that he had prescribed. Their case is a study in what Elkind (1992) might call unresolved impasse leading to a ruptured termination.

Well before the end of treatment, Freud (1905) conveys a feeling associated with the more garden variety of impasse: boredom. He writes that alongside her lingering, nervous cough, Dora "kept on repeating her complaints against her father with a wearisome monotony" (Freud, 1905, p.46). Freud uses his feeling of tedium as a way into Dora's latent sense that her impotent father, who had referred her to treatment, was engaging in oral sex with his mistress. Yet one can't help but wonder whether perhaps Dora's complaints were in fact a way of expressing dissatisfaction with Freud and her treatment?

At the time, Freud (1905) was just beginning to uncover the concept and utility of transference, speculating that early in their work he might have been for Dora a desirable father figure. In "Fragment of an Analysis of a Case of Hysteria," Freud (1905) further recognizes that he played a role in the two dreams that Dora brought to

analysis. He suggests that his failure to identify this transference early enough may have caused their rupture, postulating that had he taken more seriously Dora's clear hint of not returning to treatment--just as she ran away from her aspiring older suitor--their work together might have continued. Freud nonetheless seems naively unaware of his own more subjective role and feelings in the development of Dora's analysis and their impasse--specifically the depth of his countertransference. Later, Freud comes to understand impasse as a transference phenomenon, a resistance on the part of the patient to unconscious desires and affects (Darwin, 1999).

As with Freud and Dora, clinicians writing on impasse have historically focused on the patient, relegating the therapist to the background. If described at all, the therapist's function was treated as a signal or vessel for impasse that actually resided within the patient's internal world (Harris, 2009). This emphasis on the transference--the notion that the difficulty of impasse lay in the patient--remained the model from Freud's early 20th-century drive theory through ego psychology and into the self psychology of the 1980s.

Whereas drive theory conceived of impasse in terms of the patient's resistance, ego psychology viewed impasse as the result of conflicts between the patient's id, ego, and superego. Early self psychology attributed impasse to the patient's fragmentation in the face of the therapist's empathic failure. While this final analysis shifted the thinking closer to a contemporary relational understanding, it remained stubbornly fixed on the patient's fragmented response, rather than the clinician's part in generating that response (Darwin, 1999).

Summarizing the prevailing understanding of impasse from Freud through Kohut, Darwin (1999) writes,

The patient brings the therapeutic process to a halt because (1) he can't own his own wishes, (2) his ego is not strong enough to regulate his id and/or his superego, (3) he has unacceptable thoughts and feelings which must be disavowed, or (4) his self is not sufficiently cohesive to withstand empathic failure (p. 460).

In all these formulations, writes Darwin (1999), "Blame for impasses is thus laid at the feet of the patient" (p. 460). Impasse was indeed understood as primarily a transference phenomenon. The analyst was rarely implicated.

Rowley's Case: Transference Continued

In another example of the prominence of transference, Rowley, a British psychoanalyst in the Independent Group writing in the 1950s, describes his work with young and unmarried Emily Standish. She enters treatment two years after becoming frightened at a dance. Emily subsequently finds herself plagued by a general self-consciousness and discomfort around people.

Rowley (1951) understands their work in terms of "revealing and naming of the unknown" (p. 195). Their treatment impasse is marked by Emily's extreme inhibition, which manifests itself as a difficulty speaking freely and revealing her dream life to her analyst. Writing largely in libidinal and aggressive drive terms, Rowley views Emily's relational pattern with men as one in which she first stimulates and then frustrates. In her life outside the consulting room, Emily does not let her partner engage in intercourse. In the consulting room, she will not give her analyst the material he needs to do his work. The parallel process of impasse, both in the therapeutic dyad and in Emily's romantic relationship, is worth noting, if only to remind us of the encompassing nature of relational impasse.

Despite what Rowley (1951) perceives as Emily's "defiant attempt to keep control by rendering the analyst powerless, impotent and castrated" (p. 190), he reports that they are eventually able to work through her efforts at frustrating both analyst and his analysis. In this closely recounted case, however, Rowley makes hardly any mention of his role in either their therapeutic relationship or the resulting impasse. He simply describes the many ways in which Emily has acted upon him--whether it is what she has done to him or the reactions she has incited in him.

Once Emily can speak more freely, Rowley (1951) finds himself less stimulated. It is anti-climactic. He apologizes to the reader for not instilling the case study with more excitement. Though to his mind this can't be helped--it is, after all, the fault of the patient. Again he consigns the phenomenon to Emily:

In considering it, the analyst could then appreciate to the full the patient's pattern of behaviour--that she had indeed been attempting to stimulate him, only to disappoint him later; no climax, as such, having been permitted by the patient to occur (Rowley, 1951, p. 192).

Rowley's (1951) understanding of the case and his write-up are redolent of Freud and Dora. Like Freud (1905), operating from within a paradigm that didn't leave room for his subjectivity, Rowley is woefully unaware of his own presence in the analysis or of his countertransferential feelings toward his young patient. As a result, he seems equally oblivious to how he may be a co-participant in their impasse.

Weiner's Case: Impasse as Structural Conflict

When the clinician's contributing role in shaping impasse did first become an area of inquiry, it was initially only insofar as the therapist failed to effectively manage the patient. The literature warns that impasse may ensue if the therapist errs by failing to be a

blank slate and gratifying the patient's transference wishes or mismanaging the patient's projections.

In his book, *The Psychotherapeutic Impasse*, Weiner (1982), writing from the vantage of ego psychology, illustrates a section on transference-related impasse with a case involving a woman seeking treatment at the behest of her husband. Mrs. L's husband is discouraged by her strained relationship with his mother, and further wishes Mrs. L to adopt his faith. The treatment never gets traction, though. Despite the therapist's efforts at free association, increasing the number of sessions, and disclosing his countertransference attraction to the patient, they are never able to move out of a stalled therapy.

After initially agreeing to end treatment, the patient becomes angered. She doesn't want termination and sues her therapist. Weiner (1982) frames this scenario as a sort of negative therapeutic reaction, whereby an intervention serves only to make the patient worse (Atwood, Stolorow, & Trop, 1989). According to Weiner (1982), it is a case in which, "the therapist colluded with Mrs. L's transference wish to act out her unconscious sadistic urges toward her parents in the form of passive obstructionism with him" (p. 70). Weiner sees the same "obstructionism" in her interactions with her mother-in-law and her husband's minister. He further understands that "her id had been satisfied with the discharge of her sadistic impulses. Her superego and ego were satisfied because her id impulses were adequately disguised by their passive means of expression" (Weiner, 1982, p 70).

Weiner (1982) attributes the therapist's failure to see clearly this complex dynamic to his guilt over his attraction to her. This interpretation could be construed as an effort to incorporate the therapist's countertransference into the case. But therapist and patient continue to be held apart. Weiner does not appear curious about

the ways in which therapist and patient, together, contribute to an impasse dynamic. Furthermore, in his overall assessment of impasse, Weiner characterizes it as a mistake. Thus not only is the impasse itself problematic, but the therapist who finds himself in the midst of one must contend with the ways in which he has erred to have landed himself there in the first place.

Early Solutions

Prior to the 1990s, much of the literature on impasse was prescriptive and generalizable. It seemed to suggest that only nominal differences existed among impasse experiences. All that was needed to find one's way through was a straightforward diagnosis matched with its corresponding prescription. Weiner (1982) provides a list of 10 "tools" a therapist can utilize in diagnosing impasse. He follows with steps for treating impasse, including interpretation, clarification, confrontation, consultation, or transfer to another clinician. Reading these remedies feels akin to discovering a metaphorical doctor's bag brimming with simple impasse cures.

In a classical rendering, the primary solution to impasse was interpretation that made manifest the patient's resistance (Darwin, 1999; Freud, 1914). Yet even Freud (1914) recognized that interpretation may not be enough and could actually lead, at least initially, to impasse. In "Remembering, Repeating and Working-Through," Freud (1914) describes the disappointment of the beginning analyst who points out a resistance to her analysand, only to find the resistance intensified. Freud seems to suggest that interpretation is necessary, but insufficient, for working through resistance and impasse.

Toward a Contemporary Understanding of Impasse

By the early 1990s, the psychoanalytic depiction of impasse began to change. The literature charts a gradual move from the view of impasse as either a form of resistance in the patient or a sign of the therapist's failure to interpret this resistance, to one in which impasse is intersubjective and expectable, though usually still dramatic. A belief that impasse lay exclusively within the patient began to give way to a shared focus on impasse as co-created by patient and therapist (Benjamin, 2009; Harris, 2009).

The relational school has been especially active in broadening this scope of inquiry. In keeping with a relational or intersubjective stance, relational thinkers have attempted to account for the subjectivities of both patient and analyst. By the late-90's, Darwin (1999) notes, "[Impasse] now capture[s] a moment when the transference and the countertransference collude and/or collide" (p. 460). Infancy studies have further widened this perspective. Empirical infant research highlights the mutual regulation and rupture-repair cycles between infants and their caregivers, which in turn have been extended to an understanding of the exchanges between patients and analysts.

In his insightful paper, "Impasse Recollected," Pizer (2004), a relational analyst, summarizes a literature on the range of contemporary ways in which impasse has been formulated. Similar to Darwin's (1999) description, there can be impasse as the collision of a patient's transference and a therapist's vulnerabilities, as well as impasse as the result of a dyad in which patient and therapist are either too closely aligned or too divergent. Other formulations include impasse as a failure of therapist and patient to recognize one another's subjectivities and communicate effectively intersubjectively; impasse as a deadening nonrelating in the dyad; impasse as a dangerous

reenactment or unexamined repetition; and impasse as a form of dissociation on the part of either patient or therapist.

Each of these scenarios considers the analyst's role in impasse worthy of extended examination. As Benjamin (2009), a feminist psychoanalyst, notes, contemporary theorists and clinicians are increasingly open to accepting "the analyst's role in contributing to breakdown, rather than simply being the one responsible for repairing it" (p. 442). No longer can we avoid the therapist's contributions to impasse. Nor should we desire to.

Interestingly, Darwin (1999) elucidates how, even in the late-'90s, impasse continued to be equated with failure. In highlighting the risks--and risk taking--required of a therapist working through impasse relationally, Darwin (1999) writes,

This way of working has created a new position for the therapist who, for the sake of the treatment, leaps outside the normal strictures of the frame and emerges either as the hero who saves the day or the bad therapist who fails her patient (p. 460).

The stakes are high and the blame has shifted, so that it was the therapist's failure alone:

The added inducement for therapists to heroically leap is the change in perception... Impasse used to be viewed tacitly as a failing in the patient. It is now viewed, implicitly and explicitly, as a failing on the therapist's part (Darwin, 1999, p. 469).

Even as the general understanding of impasse became less punitive and critical, the definition of impasse-as-deficiency tenaciously found another foothold in the therapist.

Pizer's Case: Dissociation

Pizer (2004), presenting a current case of impasse, conveys how fraught the subject remains. He sets about unraveling what he calls a more "subtle" (p. 291) impasse experience, organized around "weak

dissociations" (p. 304). For the most part this treatment had been successful and rewarding. Nonetheless, Pizer (2004) sets himself, the therapist, the nearly impossible task of teasing out a sliver of interaction that may seem mundane but is in fact pivotal, the very crux of treatment:

It is just this sort of moment, often seemingly innocuous, everyday, trivial--indeed, barely noticeable--that our next choice negotiates a step that will move the treatment into or out of impasse or perpetuate a subtle leitmotif of impasse that maintains its familiar (that is, undetected) grip in the relational field (p. 298).

Pizer (2004) goes on to recount his longtime work with one of his first patients. Rebecca begins treatment in her early 20s and their work together eventually spans nearly two decades. In the early stages, within the context of a withholding and deteriorating family, Rebecca is a volatile addict, highly dependent on Pizer who comes to suspect her alcoholic father of sexual abuse. She is demanding, manipulative, reckless, and frequently suicidal. Pizer finds himself accommodating Rebecca's dependency: he takes frequent phone calls between sessions, accepts a low fee, and engages in occasional physical contact. This phase of their work ends with Rebecca markedly stabilized, yet abruptly ending treatment. Pizer comes to see that their early therapy was not about narrative exploration. Instead, he acted as a sustaining and holding environment for Rebecca. He concludes that he largely "survived" (Pizer, 2004, p. 294) this stage of their treatment--the import of which should not to be underestimated in navigating impasse.

Thirteen years later, Rebecca seeks out Pizer (2004) again, apologizing for her behavior years earlier. She reveals that she recovered memories of having been extensively sexually abused by her father, which she reentered another therapy to work through. Rebecca thanks Pizer, telling him that she had been unable to address the

abuse--which Pizer (2004) describes as having been "nonnegotiable, or impassable" (p. 295) between the two of them. "You did everything right" Rebecca tells Pizer (2004). "You stood by me. I felt loved and sheltered. You made it possible for me to stay alive long enough, until I was ready to face the work I had to do" (p. 294).

About a year later, Rebecca asks to reenter therapy. Toward the end of this five-year analysis, Pizer (2004) identifies the pivotal exchange. Their encounter is wonderfully complex, holding all the intricacy, muddle, and promise of impasse. Rebecca arrives to her final session of the week breathless and late. She asks whether Pizer has extra time at the end. He is torn. Knowing that he does have the time, wanting to hold the frame, yet loathe to deny Rebecca so small a request, Pizer (2004) replies, "Probably." Rebecca then announces that they will stop at their usual time, adding, "Good. Now I know. It's excellent that I asked the question" (p. 297).

Pizer (2004) offers us a glimpse into the myriad thoughts running through his mind in this moment: Does he comment on the exchange, which seems so ripe, nudging their relationship into the fore? Or does he allow Rebecca to go on with whatever she so pressingly needs to discuss that day? His process brings me back to Behar's photographer at the Colombian mudslide, wavering between action and inaction.

Eventually Pizer (2004) does ask. He and Rebecca share with one another what each had been grappling with internally during their brief, four-sentence exchange. And with Rebecca's reply, the entire course of therapy shifts, moving them toward the start of termination:

Rebecca proceeded to elaborate, for herself and for me, her own reflective formulation of the meaning of her therapeutic and analytic experience with me over time. She said, "I think I said we'd end at 10 partly to take care of you--to spare you the tension and the struggle. But it's more than that--more than just taking care of you. It's also about my being a peer of yours and sharing the

responsibility here for our relationship, and our boundaries.... And of course there are moments when I want to stay really little and have you be big and take care of me. But we're also peers. I've thought of you as older, even though you're not that much older. But I've needed to see you as the one who's older ... and takes care of me. But now it's more like you're about five minutes older than me. And I can take some responsibility between us. I mean--yes, I need to be filled inside and surrounded on the outside by peace and comfort--it's like twinning with people. But it's a repetition--there's no growth in it. It's like turkey and stuffing and gravy--it's the same every year for 48 years. It's a comforting Thanksgiving ritual, but it never changes. Three minutes of more time would be a repetition of the same. And holding to the boundary means I can long for more but choose otherwise. And I can help you choose--not just leave it up to you" (Pizer, 2004, pp. 299-300).

Rebecca's commentary offers a window onto the artfully co-created, intersubjective work that relational clinicians strive for.

Pizer (2004) uses her reflections to illustrate how easily we are pulled into doing things as we have always done them, how impasse can develop around simple inertia. By choosing one path--questioning whether Rebecca might have been asking about more than just the time at which their session would end--he creates the space for forward movement and a deliberately articulated growth.

Yet Pizer's (2004) central concern seems to be what might have happened had he not asked? What course would their treatment have taken if he had let himself be pulled into and carried through a familiar enactment? By way of an answer, Pizer (2004) confesses,

I still can shudder when I think of how that threshold moment with Rebecca might so easily have played out differently. Embedded as I was in the weak dissociations of our special and familiar kinship, I could so easily have failed to inquire into the small detail of three minutes. But impasse is often in the details (p. 304).

Certainly impasse does lie in the details as much as in the drama. But I wonder, had Pizer not commented at this moment would there not have been another? Must even the possibility of entertaining a "leitmotif of impasse" (Pizer, 2004, p. 192) still induce one to shudder?

Enactment

The notion of enactment evolved along lines similar to that of impasse. In the broadest characterization, enactment is any relational entanglement played out between patient and therapist (Ginot, 2009; Renik, 2006). Yet like impasse, the term can encompass a range of experiences. Aron (2003b) offers a definition that captures this breadth: Enactment refers to "both the continual interactive dimension of all psychoanalytic process and to special and unique incidences in which unconscious variables are played out in either subtle or more dramatic form between patient and analyst" (p. 627).

Instances of discrete, dramatic enactments include the startling story of a patient who collapsed to the floor where he was joined by his therapist, on whose shoulder he eventually ended up sobbing (Davies, 2000), as well as the time another boldly let himself into his therapist's office, while it was still locked (M. Black, personal communication, February 27, 2010). The idea of enactment as more continuous describes a general and gradual pattern of interaction flavored by a patient's past relationships that unfolds over time. Pizer (2004) understands Rebecca's request for a longer session and his response as an enactment. While her request represents a discrete enactment, the interchange that unfolds is of the more gradual variety. It both reenacts Rebecca's earlier relational patterns as well as the rhythms of relating that had developed between Pizer and Rebecca over time.

Many relational therapists consider enactment inevitable, even necessary, before truly meaningful work can begin (Darwin, 1999; Davies, 1994). Some clinicians use the concepts of enactment and impasse interchangeably (Ginot, 2009). Burnstein and Cheifetz (1999) introduce the term "impasse enactments" (p. 74) to describe this

relationship, while Stern (2003) defines impasse as a dramatic kind of enactment. For the purposes of this paper, I will continue to consider impasse and enactment as separate but entwined phenomena.

Rupture and Repair

As I now shift from a relational to an infant studies perspective on impasse, it's worth noting that these demarcations are somewhat arbitrary. Relational thinkers have embraced the study of infancy just as many of those conducting infant research do so from a vantage informed by relational theory. Rupture and repair is one mode of thinking that holds saliency for impasse but could as easily appear under the rubric of relational theory as under the heading of infancy studies. However, its utility for managing impasse, which can be conceptualized as a failure to repair rupture, lies in the set of nonverbal and procedural cues that pass back and forth between mother and infant during times of rupture and subsequent repair.

The field of infancy research has extrapolated empirical findings from observing mother-infant dyads to the therapist-patient relationship. Benjamin (1995), a relational analyst steeped in the study of infancy, elaborates the essential role that rupture and repair play in early infant-caregiver interactions. "One of the main principles of the early dyad," Benjamin (1995) explains, "is that relatedness is characterized not by continuous harmony but by continuous disruption and repair" (p. 47). This non-harmonious but ever reparative way of relating continues throughout the lifecycle.

An example of rupture and repair between a mother and child might unfold as follows: A mother matches her baby's squeals of delight with hand clapping and an enthusiastic gaze. This moment of gleeful attunement is ruptured when the infant becomes over-stimulated. Arching

her back, she turns away from her mother, who continues to lean forward and clap excitedly. The repair begins as the mother, recognizing her baby's discomfort, stops clapping and helps the infant re-regulate by matching her less-engaged state. Soothed, the infant is able to resume eye contact and the dyad moves forward, in sync once more (Walker, 2008). Infancy theorists postulate that much of this mutual recognition and regulation goes on outside the conscious awareness of either partner. Yet the ability to tune into unspoken modes of communicating offers recourse in times of impasse.

Benjamin (1995) locates the mutuality of the mother-infant dyad in the analyst and patient, emphasizing that, "The concept of mutual recognition should include the notion of breakdown, of failure to sustain that tension, as well as account for the possibility of repair after failure" (p. 22). Within this framework, rupture becomes an inescapable part of all relationships from infancy on, including the treatment relationship. Thus, the rupture that constitutes impasse can be considered normative. The emphasis lies on the ability of the analyst to facilitate restoration and repair. Breakdown is viewed as part of what allows the infant, or patient, to internalize an ability to tolerate and regulate difficult emotions and learn to "transform disconnection into reconnection" (Walker, 2008, p. 6).

We are able to repair the therapeutic relationship by tolerating and working through the pain of rupture. This restoration holds until the next impassable moment takes shape. Yet with each turn of the cycle, the hope is that patient and therapist become better able to withstand moments of impasse and more adept at reconnection (Benjamin, 2009; Maroda, 1999; Walker, 2008).

Contemporary Solutions

In her paper tracing the changes in perception of impasse over time, Darwin (1999) poses the question: "What is necessary and what is sufficient to resolve impasse?" (p. 469).

Infancy theorists might offer that knowing these moments are survivable is sufficient. Relational theorists might suggest that the experience must be spoken--articulated and scrutinized besides being enacted--in order for clinician and patient to grasp and make thinkable their roles in the impasse dynamic. Hoffman (1999), a relational analyst, calls for conscious verbal interpretation--not dissimilar from a classical technique--to pull us through and make room for reflection:

At the very moment that he interprets, the analyst often extricates himself as much as he extricates the patient... The interpretation is "mutative" (Strachy, 1934) partly because it has a certain reflexive impact on the analyst himself which the patient senses. Because it is implicitly self-interpretive it modifies something in the analyst's own experience of the patient (p. 65).

Though from a truly relational position, what is thought to be "mutative" is less the interpretation and more the space created for a mutual pondering and being. By engaging the patient in shared reflection, the analyst is valuing the patient's ability to interpret, understand, and empathize.

In exploring the "heroic" acts taken by relationally-oriented clinicians to resolve impasse, Darwin (1999) makes an interesting observation. She points to a symmetry in the therapists' responses to their patients: "Hoffman's patient acted a little crazy in the colloquial sense and Hoffman acted a little crazy as well. Davies' patient expressed his desire and she responded with her expression of comparable desire" (p. 464). (Darwin, 1999) goes on,

To be effective, the intervention has to indicate to the patient that resolving the impasse is as important to the therapist as to the patient. Despite the inequity inherent

in the fact that the patient has only one therapist while the therapist has many patients, the therapist must show parity of emotional investment (p. 469).

Perhaps what is therapeutic about impasse, then, is the way in which it brings into relief and makes palpable the therapist's all-in investment in the relationship.

Summary

With the shift away from understanding impasse as a mistake--the hallmark of a failed treatment, good for little more than causing the patient unnecessary discomfort (Weiner, 1982)--has come a significant recognition of the potential impasse holds for therapeutic growth and change. There lie opportunities in the cracks in our relationships.

Relational analysts recommend we embrace impasse as vital and indispensable. Ringstrom (1998) describes a treatment marked by not one, but a series of impasses. He and his patient together bear the feeling of "damned if I do, damned if I don't." In the end, Ringstrom (1998) concludes, what they experienced were "essential impasses, transformative in their resolution" (p. 315). Infancy researchers have also shown how dyadic repair and survival can be curative, the manifestation of a mutually constructed treatment tended to by both therapist and patient.

The language used to depict the transformative potential of impasse frequently involves a spatial metaphor. Whether described as thirdness (Benjamin, 2009; Ogden, 1986), the liberating wingspread of freedom and change (Pizer, 2004), standing in the spaces (Bromberg, 1996), mutually reflective space (Ginot, 2009), or additional space for the therapist's subjectivity (Beebe, Knoblauch, Rustin, & Sorter, 2005), this language articulates a powerful and promising new expanse.

In the murky encounters with strong affect, difficult enactments, and painful rupture as well as the muddling through less eventful, more habitual aspects of the therapeutic encounter, lies hope. The work of therapy is a constant negotiation and renegotiation, sticking and un-sticking. At times we must stand still, or even step backward, before we can move through. Because really, it is all impasse.

CHAPTER III

TOWARD A RELATIONAL THEORY OF IMPASSE

Relationality is what defines us.

--Stephen A. Mitchell, *Relationality: From Attachment to Intersubjectivity*

At heart, relational theory is discursive, a meta-theory pulling from and building upon the psychoanalytic traditions that came before it. Beneath the relational umbrella, schools whose perspectives had been treated as irreconcilable--notably ego psychology, Kleinian theory, and British object relations--were integrated and brought into conversation. Among others, the relational model has drawn heavily from object relations and interpersonal theory, both dating back to the 1950s (Mitchell & Black, 1995), as well as contemporary self psychology and intersubjective theory (Benjamin, 1995).

The beginning of the relational movement was marked by the 1983 publication of Jay Greenberg and Stephen Mitchell's *Object Relations in Psychoanalytic Theory*. Greenberg and Mitchell coined the term "relational" (Mitchell & Aron, 1999, p. xvii) to describe a group of theorists who had replaced the traditional emphasis on libidinal and aggressive drives with a focus on relational needs. While Greenberg and Mitchell viewed their psychoanalytic approach as an "alternative" (Mitchell & Aron, 1999, p. xiii) to the classical drive model, some critics have argued that this distinction actually creates a false dichotomy between the two theories (Mills, 2005).

Benjamin (1995), a relational analyst, perhaps captures the relational movement best with her pithy and discursive play on Freud's (1933), "Where id was, ego must be" (p. 79). In suggesting, "Where objects are, subjects must be" (p. 29), Benjamin (1995) modifies Freud's explication of the role psychoanalysis plays in mediating the different structures of mind. Instead, she proposes, analysis can mediate our way of relating to one another.

The American relational tradition coalesced in the mid-1990s around a group of psychoanalytic clinicians and scholars trained in feminism, sociology, philosophy, and anthropology. Postmodernism was in ascendancy, and constructivism advanced the questioning of longstanding psychoanalytic tenets, such as the analyst's objectivity and abstinence, the rigidity of the frame, and the feasibility of extending a single theory of mind to a wide range of people (Mills, 2005). As a result, within a relational framework, the analyst is no longer considered the expert, context is of vital importance, universals are believed to be rare, and meaning is thought to be shaped by the interpersonal realm in which it comes into being (D. Stern, personal communication, December 5, 2009).

In his tribute to Stephen Mitchell, the psychoanalyst regarded as the principle founder of the relational school, Aron (2003a) notes Mitchell's skill for finding a third way--"an alternative reconciling the tension between the first two" (p. 273)--whether among seemingly disparate theoretical orientations, or in conflicting approaches to a clinical impasse. The same dialectical approach has been said to characterize the larger relational movement, and its attempts to support the tension between internal and external, intrapsychic and interpersonal, past and present, fantasy and reality.

As an analytic theory of mind, the roots of the relational model lie in a Freudian understanding of the primacy of the unconscious, the patient's resistance to uncomfortable desires, the significance of fantasy, transference toward the analyst, and the persistent residue of the patient's past. While classical analytic technique calls for a withholding analyst to frustrate the patient, leaving the analyst's own subjectivity outside the consulting room, a relational approach shifts the locus of work. Rather than a primarily intrapsychic focus on the patient, it creates space for the interpersonal, though the two remain entwined. As Mitchell (2000) describes it,

Interpersonal relational processes generate intrapsychic relational processes which reshape interpersonal processes reshaping intrapsychic processes, on and on in an endless Möbius strip in which internal and external are perpetually regenerating and transforming themselves and each other (p. 57).

Both participants in the analysis and the way in which they interact become relevant to a treatment that pivots on the dynamic and reciprocal, though asymmetrical, relationship between patient and practitioner. According to Mitchell (2000), "In the broad sea change in the ways in which the analytic process is now understood and envisioned, the analytic relationship, the personal relationship between the two participants, is now granted a fundamental, transformative role" (p. 64). A relational approach places considerably greater emphasis on the present than does classical analysis. Particular attention is given to the way relational patterns learned in the past become lived and enacted in the therapeutic relationship. This acknowledgement and exploration of the conscious, present moment interaction of patient and analyst as a device for and site of change stands among the most significant breaks from classical technique.

Relational Theory and Impasse

Perhaps not surprisingly, then, relational thinkers are among those most interested in the phenomenon of impasse. Clinicians working relationally have been at the forefront of shifting the spotlight of impasse from patient to a shared illumination of the patient-therapist dyad and, more recently, clinician alone. This can be seen reflected in the literature. Over a hundred papers in which analysts relay some experience with clinical impasse have been published in the relational journal *Psychoanalytic Dialogues* since its launch in 1991.

Throughout the remainder of this chapter, as I consider what a relational framework offers an understanding of impasse, transference-countertransference dynamics particularly as seen through the phenomenon of enactment figure prominently.

Countertransference and Enactment

While Freud (1905) eventually came to view transference as something that "cannot be evaded" (p. 116), he continued to hold that countertransference--in his estimation a sign of the analyst's unresolved conflicts--should be (Chodorow, 1999). Enactment, first described as such in the mid-1980s, received similar treatment (Renik, 2006). At the time, clinicians were trained to avoid enactments. If enactment did slip into treatment, the analyst was to control for damage and make the experience as therapeutically useful as possible. Renik (2006) and others (Suchet, 2004) have critiqued this view for converting enactment into a euphemism for what was previously and pejoratively called *acting out*.

Contemporary formulations of countertransference and enactment are considerably more expansive--both in terms of what is viewed as part of these phenomena as well as how they may be of therapeutic use.

Beyond the analyst's thoughts and feelings about the patient or therapy, countertransference can include the therapist's dissociation, missatunement, or defensiveness (Benjamin, 2009). To a relational way of thinking, the essential question may not be so much what makes up countertransference, but rather: What is not countertransference?

Renik (2006) argues for taking a similar stance with enactment--defined in the previous chapter as an entanglement played out, or enacted, between patient and therapist. He believes that enactment should no longer describe "*particular* events that *sometimes* occur in treatment, but a *constant* dimension of *all* treatment events" (Renik, 2006, p. 91). Though I examine more discrete moments of enactment, Renik's thinking is in keeping with a relational approach. It also underscores one of the major premises of this project: That countertransference, enactment, and impasse cannot "be minimized, let alone eliminated, from analytic treatment" (Renik, 2006, p. 91). They should not be considered obstacles, but rather equally a part of "unproductive" as well as "productive interactions between patient and analyst"(Renik, 2006, p. 91).

Like impasse, moments of enactment can leave a patient and therapist feeling precariously entangled, or else vastly apart (Ginot, 2009). What enactment does, however, is allow us in. As clinicians we enter the experience of the patient, able to get a little further inside the patient's internal object world (Benjamin, 2009; Bridges, 2005; Darwin, 1999). And often what relational clinicians discover is that there are experiences and feelings impossible to verbalize or express in any other way (Ginot, 2009). Because of this, a number of contemporary theorists argue that enactment--which for some is interchangeable with impasse--is a necessary part of the treatment process. Clinicians embracing this thinking believe enactment

unconsciously alerts the therapist to the necessity of engaging with a previously unknown aspect of the patient (Bromberg, 2003). Davies (1994) explains,

We assume--indeed, we rely upon--the hope that analyst and patient together will become enmeshed in complicated reenactments of early, unformulated experiences with significant others that can shed light upon the patient's current interpersonal and intrapsychic difficulties by reopening in the analytic relationship prematurely foreclosed areas of experience (p. 156).

Davies (1994) goes on to say, "The analytic space provides the backdrop against which previously foreclosed experiences can be reopened, mastered, and more effectively integrated within an internal system that no longer views such moments as overwhelming and dangerous" (p. 157). This might be described as a repetition compulsion model of enactment, whereby the patient uses therapy to belatedly master a past relational difficulty (M. Stark, personal communication, March 28, 2009).

Within enactment tinged by repetition, the patient may become, for example, a traumatizing parent and the therapist a traumatized child, or vice versa. M. Stark (personal communication, March 28, 2009), a psychoanalyst informed by relational theory, understands that it can be too painful for the patient to have a relational encounter unfold in any way other than how it had in the past. To do so would mean the patient's earlier relationships could have been different as well. The impasse, then, provides an opportunity for the patient to achieve mastery, a transformative reworking.

Davies' Case: Enactment in Therapeutic Action

Perhaps the most iconic representation--and one of the more controversial--of a contemporary, relational understanding of impasse, in which enactment plays a prominent role, is Davies (1994) paper "Love

in the Afternoon." Davies comes to understand the impasse that develops between herself and her young male patient as the result of an enactment recalling his erotic relationship with his mother. His mother was overtly seductive toward Mr. M, yet became punitive and rejecting if ever he responded to her advances (Darwin, 1999).

In treatment, Mr. M has repeated a pattern of fantasizing erotic relationships with the women he encounters, but imagining himself too unattractive and weak to ever have his feelings reciprocated. He has shared with Davies (1994) a highly erotic transference, relaying sexual fantasies involving Davies that she describes as "almost poetic" (p. 163). But in the next breath he invariably becomes self-loathing, declaring it impossible that his feelings could ever be shared.

Davies (1994) eventually chooses to disclose to Mr. M her own erotic feelings toward him. She believes it is the only way for him to know that he alone has not created the sexual undercurrent in the room --in the same way that his childhood feelings were not his alone. Just as Mr. M finds himself attracted to Davies, she, too, feels attraction for and fantasizes about him.

Initially, Mr. M is horrified and furious at the countertransference revelation. He threatens to sue, insisting that Davies (1994) has overstepped a boundary. But later he comes to understand--in a way interpretation had not been able to convey--that his mother may have struggled with her own erotic feelings for him. He can begin to entertain the possibility that it was her own shame, not anything wrong or repulsive in him, which his mother was responding to. Davies revelation allows the impasse, in this case the repetition, to shift.

Managing Impasse Relationally

So how do we manage? The relational literature suggests leaning into impasse. The clinician cannot conduct a perfect treatment, but can acknowledge disruptions and continually engage in the process of discussing and rectifying these rifts.

Benjamin (2009) insists that therapists take responsibility for their failures, whether the result of dissociation, lapses, or personal vulnerabilities. Clinicians must give up the fantasy of being a "complete container" (Benjamin, 2009, p. 442) and instead submit to knowing that at times we will cause pain, hurt, even harm. In place of this fantasy, we avail ourselves of the dyad's ability to withstand: "The idea that both participants in the analytic dyad survive--or perhaps more properly said *come back to life subsequent to--*the other's failure is the principle to which an analyst needs recourse during impasse and lesser breakdowns" (Benjamin, 2009, p. 442). Recognizing and enduring impasse can be excruciatingly difficult and near impossible in the moment. At times, the best we can do is wait for the next session or the right time in order to open what has transpired to conversation (Benjamin, 2009).

Mitchell's Cases

Aron (2003a) locates Mitchell's genius for "navigating clinical stalemates" (p. 273) in his creativity, transparency, and patience:

When dealing with therapeutic impasses, Mitchell learned to tolerate, sustain, and identify the entrapped states in which he found himself until he could free his imagination and gradually discover some third avenue along which to proceed (p. 273).

Often this involved Mitchell bringing his patient into his process, letting her know how trapped he felt by the only apparent options.

Mitchell (2000) describes one such impasse with Helen, a corporate executive who brings her explosive anger to treatment. They alternate between periods of working together successfully and times when Helen becomes so furious she storms out of treatment. Mitchell, in turn, vacillates between warm and loving feelings and strong frustration and anger. Finally, after one of her rageful outbursts, Helen taunts: "I know you are hating me. Why don't you just come out and say it. Look, if we were out on the street, if this weren't an analytic relationship, what would you say to me right now?" Mitchell (2000), feeling trapped, responds, "If this were *not* an analytic relationship, if this were out on the street and you were talking to me this way and I weren't your analyst, I probably would say 'FUCK YOU!' But I *am* your analyst" (p. 142). They both end up laughing.

What finally moves Mitchell and Helen out of their interactive pattern--their impasse--is their ability to straddle two spaces at once. Mitchell (2000) understands their interaction on multiple levels:

She had somehow managed to risk confronting me fully with her hatred while, at the same time, suggesting a kind of transitional space, in the imagined confrontation in the street, in which we might play it out. I had somehow managed to find a way to express my rage and, at the same time, to signal to her that I was not unmindful of my responsibility to take care of her and the process, of which I was the guardian (p. 142).

Mitchell (2000) is able to hold two roles, and let Helen into his feelings about each. He responds authentically as himself, but remains aware of his position as the analyst. He is both in the experience and able to reflect on it.

In recounting another case--his work with Becky, a 30-year-old history graduate student in her fifth year of treatment--Mitchell (2000) describes an impasse that results from a reenactment of her interactions with her parents:

She had expressed considerable anger at me. I had been missing how much trouble she was having, she claimed. Perhaps I was misled by her apparent success at school, not noticing how depressed and anxious she often felt about how blocked she was in the papers she was supposed to be writing.... I thought there was some truth to Becky's charge.... We explored some of the ways in which she and I had recently been *drifting*...along into a joint created sense of complacence regarding her external successes (p. 71).

Theirs is an experience not unlike the lulling, dissociated repetitions described by Pizer (2004). Mitchell and Becky find a way out not through interpretation, but rather the shared, lived experience of dialogic exchange. They begin talking about her writing projects, something she was not able to do with her parents. As a result, Mitchell (2000) writes, "I felt we had managed to cocreate the kind of experience she had never had with her parents, whose narcissistic concerns and investments made an enjoyment of Becky's own creativity either irrelevant or too threatening" (p. 72). Mitchell does not dwell on their impasse, but rather heeds what Becky says she needs from him.

Summary

Among relational clinician writing on impasse, one consensus seems to be that often--though not always--these moments can be resolved through verbal communication (Davies, 1994; Ginot, 2009; Maroda, 1999; Mitchell, 2000; Renik, 2006; M. Stark, personal communication, March 28, 2009). This frequently requires some form of self-disclosure. Maroda (1999) outlines how,

Often the road to reconciliation and reconnection following inevitable ruptures or mutual negations involves the use of self-disclosure. Each person admits his or her feelings, differences are aired, and attempts are made at understanding and forgiving. Once again the relationship is repaired even though each person knows that eventually it will be ruptured anew. And they cycle continues. Without the use of self-disclosure we have no method of adequately exploring this deep and complicated relational pattern (p. 488).

Disclosure is admittedly a complex undertaking, whether it takes the shape of revealing shared feelings, as Davies (1994) did; acknowledging and surviving the therapist's failures, like Benjamin (2009) recommends; or Mitchell's (2000) revelation of feeling trapped. Benjamin (2009) explains the power of such transparency: "Such action is meant to show that the analyst *can* change, can model the transformational process, and that revealing her struggle to do so also transforms the analytic process into one of mutual listening to multiple voices" (p. 450). By choosing self-disclosure, the therapist conveys to the patient a willingness and ability to survive, acknowledge, and explore her participation in impasse (Ginot, 2009).

M. Stark (personal communication, March 28, 2009) suggests that one way of opening up impasse for conversation is by acknowledging the necessity of enactment, particularly in light of the therapist's inability to initially recognize some piece of the patient's experience. Like Renik (2006), Stark believes in respectfully framing the patient's activities not as acting out, but rather as a necessary communication.

Does this mean that had the therapist been listening harder or hearing more clearly, the patient would not have had to resort to enactment or impasse in order to be understood? Relational analysts surmise there may actually be no other way for a patient to make certain experiences, including trauma, understood (Schoore, 2002). If not drawn into participating with the patient, the therapist may be missing an opportunity for knowing a part of the patient.

In the previous chapter, Darwin (1999) conveyed the importance of the therapist's investment in the relationship. We must first allow ourselves to be pulled into the messiness, into an enactment, in order to be able to get back out. The therapist's willingness and

availability to impasse communicates empathy, while the effort to reflect on and work through impasse in conversation with the patient signals a commitment to the therapy (Ginot, 2009). If this can be done effectively, "Together therapist and patient rework the patient's narrative and rewrite the patient's story"(Ganzer, 2007, p. 118). Relational theorists have suggested that meaning is not only discovered but also created (Leary, 1995; Mills, 2005), a notion that holds especially true of the meaning that emerges from impasse.

CHAPTER IV

TOWARD AN INFANCY RESEARCH THEORY OF IMPASSE

Psychoanalysis is not "the talking cure," but more precisely "the communicating cure."

--Allan Schore, *Affect Regulation and the Repair of the Self*

In the previous chapter I considered a relational approach to impasse, one that often calls for verbal communication between analyst and patient. But what happens when talking is not enough? Or spoken narrative is not possible? In this chapter, I turn to nonverbal communication, another avenue for navigating impasse as elucidated by infancy studies, an offshoot of attachment theory.

Though they developed in parallel, mainstream mid-20th century psychoanalysis initially rejected attachment theory. As a result of his behavioral approach and concern with adaptation to the real world, British psychoanalyst John Bowlby's ideas were considered too material and mechanistic, better suited to research than analysis (Mitchell, 1999). Mitchell suggests that the intrapsychic model of Freudian and Kleinian drive theory left little room for concern with lived relationships. Bowlby, on the other hand, centered his work on the real relationship between mother and child. In 1980, Bowlby wrote:

Intimate attachments to other human beings are the hub around which a person's life revolves, not only when he is an infant or a toddler or a school child but throughout his adolescence and his years of maturity as well, and on into old age (Mitchell, 1999, pp. 90-91).

While Bowlby's placement of human relationships at the center of his work posed a challenge to the psychoanalysis of his day, today it has moved him into the pantheon of the precursors to the relational movement (Mitchell, 1999). In fact, relational psychoanalysts have

deemed empirical infant studies--with roots in the attachment work of Bowlby and American psychologist Mary Ainsworth (Shilkret & Shilkret, 2008)--the contemporary body of work currently having the greatest impact on psychoanalytic ideas (Harris, 1997).

The Study of Infancy

Analysts initially looked to infant research as a means of helping deepen their understanding of their patients' early childhoods. Now a more explicit connection is being drawn between the interaction of infant-caregiver and patient-analyst. Beebe, Knoblauch, Rustin, and Sorter (2003) hypothesize that the preverbal communication of infants corresponds with nonverbal and implicit communication in adults, most of which occurs outside conscious awareness. The basic process of this nonverbal communication remains consistent, though not identical, across the lifespan (Beebe & Lachmann, 2002). As a result, the empirical work of infancy studies can be extrapolated to patient and analyst interactions in treatment. Clinicians working off an infancy framework are able to call on a variety of methods beyond the spoken word for engaging their patients. These include implicit behavioral and procedural modes of interaction.

A shift in the study of infancy occurred in the 1970s. As in the relational field, where the dyad became the primary area of inquiry, infant researchers began to focus not only on the caregiver's impact on the infant, but on the bidirectional, mutual flow of influence between the two. Lachmann (2001), a psychoanalyst, describes this as the "era of the constructionist infant, the infant coconstructing its world in interaction with its environment" (p. 168). Beebe (Beebe & Lachmann, 2002), a psychoanalyst and infant researcher, movingly captures both the infant's responsiveness and influence as she describes the

encounter that cemented her decision to study mother-infant reciprocity:

I remember one particular day when I played with a baby whose face was full of joy. As I watched her face responding to mine, going up and up and up, tears came to my eyes. I was so moved by how closely she tracked my face and by her bursting into a sunbeam (p.3)

While the baby's sunbeam is a joyful response to Beebe, it is clear that the baby also exerts a powerful effect on Beebe.

Infant researchers suggest that even newborns have the innate ability to be in sympathetic communication with their caretakers, with "each aware of the other's feelings and purposes without words and language, by matching communicative expressions through time, form, and intensity" (Beebe, Rustin, Sorter, & Knoblauch, 2003, p. 812). Empirical research has elucidated the subtle, nonconscious dance of mutual engagement, disengagement, and reengagement that occurs in the early dyad. A similar sequence can be observed in the consulting room, where both patient and therapist hold sway over the steps and turns that are taken in the course of treatment (Beebe & Lachmann, 1998).

Nonverbal Communication: Correspondence and Elaboration

Among the forms of preverbal interaction identified in infancy studies are matching, or corresponding, with the other. The notion of correspondence is consistent with the way therapists relate to their patients. By matching a patient's expressions and nonverbal states, the therapist can "communicat[e] to the other a feeling of 'being with'... a fundamental ingredient of intimacy" (Beebe, Rustin, et al., 2003, p. 809). Yet infancy researchers note that a mother rarely exactly replicates her baby's affect or behavior, but rather elaborates upon them. Similarly, by elaborating on what a patient has expressed, the therapist is able to widen the range of affect and experience available

to the dyad, as well as help the patient regulate distress. On occasion, a therapist may try a true matching, more closely aligning herself with the patient, being with the patient in whatever she is feeling--what Stern calls "sharing without altering" (Beebe et al., 2005, p. 135).

By way of example of the escalation that can occur during a faithful and unmindful correspondence, Beebe (Beebe, Rustin, et al., 2003) describes the problematic mutual escalation of infant and caretaker. As the infant becomes more distressed, her caretaker does as well: "Each partner then proceeds to match the other's increasing arousal and distress, each topping the other, going up and up and up, until the infant disorganizes, perhaps by vomiting (at four months) or screaming (at 12 months)" (Beebe, Rustin, et al., 2003, pp. 819-820).

Using Shakespeare's Othello and Desdemona, Beebe illustrates a similarly distressed and dysregulated adult exchange. Both characters are so preoccupied with the content of their discussion that neither is able to grasp what is happening on a procedural level or attend to self- or mutual-regulation. They are at cross-purposes: Othello anguished over a possible affair between Desdemona and Casio, and Desdemona guilelessly pressing her case for Casio's return to Othello's army. The conversation escalates until neither lover can reassure the other, and Othello storms off stage. Their impasse ends unresolved, to say the least, with both lovers dead by the end of the play.

Done deliberately and with care, however, Beebe (Beebe, Rustin, et al., 2003) shows how matching negative states can be used as a form of distress regulation. She soothes 17-month-old Dan by remaining attuned and sympathetic to his responses, joining his dampened state:

Dan suddenly became completely still, collapsing tonus with his head down. The stranger became similarly still and waited. After half a minute, Dan looked up from under his

brows, with his head still partially down. The stranger very softly said, "Hello, it's okay." Dan then looked down again, and became motionless. Dan and the stranger cycled through this pattern many times over, for about two and a half minutes. Then, as suddenly as it came, it went, and Dan emerged partially smiling and gradually resumed play with the stranger (Beebe, Rustin, et al., p. 820).

Beebe, Rustin, et al. (2003) describes a similar, nonconscious matching of a distressed state in the psychoanalytic treatment of an adult patient. The therapist connects to her by reproducing the rhythms of the patient's whimpers and cries:

The patient was increasingly distressed, speaking tensely, gesturing rapidly with her hands, her torso leaning forward tautly, her face screwed into a precry. The analyst was silently listening, his face very attentive. As the patient's agitation began, the analyst slightly shifted the orientation of his chair toward the patient. Both maintained continuous eye contact. As the agitation mounted, the analyst's foot made intermittent brief, rapid jiggles, matching the rhythm of the patient's body. He then moved slightly forward in his chair. At this point the heads of both analyst and patient went up in a synchronous movement. At each escalation of the patient's agitation, the analyst participated, crossing and uncrossing his legs and nodding his head up and down in rhythm with the patient's movements and each time saying "Yes," softly. Gradually the patient began to calm down; the analyst's head movements became slower. There were several long moments of silence. Then slowly they began to speak to each other... (Beebe, Rustin, et al., 2003, p. 832).

The researchers clarify that what the therapist matches is not the intensity of the patient's arousal, but the shifts in her arousal. By matching in this way, the therapist is able to convey that he is attuned and with his patient. I wonder, too, whether once the therapist was able to connect on an implicit level, if he began to slow and calm his movements as a way to help soothe the patient.

Beebe, Rustin, et al. (2003) suggest that correspondence in pleasure is one area of the infancy domain that has not been adequately picked up by adult psychoanalysis, where the emphasis remains on differentiation and conflict. Matching positive states can be critical

for sharing in the successes of treatment, facilitating the therapeutic alliance and a secure attachment (Beebe et al., 2005), as well as moving out of an impasse.

Rupture and Repair

In addition to forms of corresponding, we see in both infant/caregiver and patient/therapist dyads the ongoing dialectics of rupture, or disruption, and repair; attunement and missattunement; engagement and disengagement. If we take as a given that these experiences are normative, we can then turn our attention to repair, re-attunement, and reengagement. The *good enough* caregiver whose infant becomes distressed in the face of her missattunement is able refocus and re-attune, thus helping regulate the infant (Schorer, 2002). In adult treatment, "The goal is the restoration of recognition after its breakdown, which includes re-establishing the tension between differences and sameness, negation and recognition. Such restoration increases the patient's sense of agency and ability to contain pain and loss" (Beebe, Knoblauch, et al., 2003, pp. 761-762).

Benjamin's Case: A Bridge Between Relational Theory and Infancy Studies

In a recent paper, Benjamin (2009), whose work draws heavily on infancy studies, relays an impasse that occurred toward the end of a long analysis. Employing a contemporary relational approach, Benjamin (2009) turns the spotlight onto her own role in a therapy that becomes "lock[ed]-in" (p. 442). She shifts from viewing the analyst as solely responsible for repairing rupture to examining how she helped create the rift in the first place. Benjamin discovers that through her insistence on reassuring her patient, Hannah, whenever she berated

herself, that she was neglecting to truly acknowledge and accept Hannah's "bad" self.

Benjamin (2009) readily admits to having failed to completely contain Hannah's "shame and persecution" (p. 448). Yet she does not view this disruption--or the impasse that ensues--as a true failure. She and Hannah are able to strengthen and restore their relationship through dialogic repair. The therapist's failure to contain, manage, and metabolize does not necessitate collapse: "What usually solidifies and makes intractable re-traumatization in the analytic dyad is not the enactment itself but the analyst's failure to acknowledge, which the patient correctly grasps as the *avoidable* failure" (Benjamin, 2009, p. 444). The harm a patient experiences is not owing to impasse, but the failure to acknowledge and work through it.

Benjamin (2009) and others (M. Stark, personal communication, March 28, 2009) note that breakdowns in the treatment relationship can be especially common when the work moves to an examination of trauma, where there may be "unlinked self-parts" (Benjamin, 2009, p. 443). Benjamin (2009) further "emphasize[s] that our 'failure' to link is inevitable...and not the failure it feels like" (p. 443). So impasse does not necessarily take shape as failure, after all.

Relevance to Impasse

If impasse is conceptualized as a communication breakdown (Maroda, 1999), then one way to reopen communication is on the procedural, nonverbal level: "When language fails, the psychoanalytic dyad can still have access to prelinguistic and implicit forms of communicative competence and intersubjectivity" (Beebe, Rustin, et al., 2003, p. 813). Schore (2009) further emphasizes that the primary process, right-brain to right-brain, nonverbal communication of the

infant and caregiver is the predominant form of communication when patient and therapist are caught in stressful clinical situations.

In describing the process of what occurs in the patient-analyst relationship--rather than simply the content of what is discussed--infancy studies can expand the ways in which impasse is understood and managed (Beebe & Lachmann, 2002). Of particular relevance are the assorted nonverbal domains that infancy theorists attend to in their research and clinical practice. After all, "An intersubjective field is more than just an interaction of two minds, but also of two bodies" (Schore, 2009, p. 133). Implicit communication can be conveyed through visual means, such as facial configurations and expressions; through the physical dimensions of touch, posture, gesture, and movement; and through auditory elements, including the prosody of vocalization (Beebe, Knoblauch, et al., 2003; Schore, 2009).

Beebe's Case: Early Trauma

Through her work with Dolores, over the course of a ten-year analysis, Beebe (Beebe, et al., 2005) demonstrates the use of infant research in adult treatment. Dolores is articulate and eloquent, a successful and sociable biology professor. But she shuts down, losing language as the treatment moves deeper into her early trauma and loss. Until age 5, when Dolores was adopted by a third family, she was emotionally, physically, and sexually abused as she shuttled back and forth between an abusive biological mother and a loving foster mother.

A feeling of impasse immediately sets in. From the start, Beebe (Beebe et al., 2005) recalls, "[Dolores] longed for an attachment to me, and yet she could not look at me, and often could not talk" (p. 95). Beebe struggles to connect with her deeply disturbed and dissociated patient. What eventually opens up the treatment is Beebe's

decision to reconfigure their seating. She situates her chair at a right angle to Dolores, with a small table between them, at a distance that approximates "that of usual adult face-to-face interaction...closer than usual face-to-face psychotherapy, but not as close as that between mother and infant" (Beebe et al., 2005, p. 104). In doing so, Beebe attends to the physical, their orientation, making herself more immediately present when Dolores enters a state of dissociation.

Beebe (Beebe et al., 2005) sustains the treatment through additional nonverbal modes of interaction and connection. At various points, Beebe matches Dolores' sounds, rhythm, and breath. She mirrors Dolores' head and body orientation and gaze. Beebe also discovers that without realizing it, her movements and facial expressions have corresponded to Dolores' dampened state. Much of this, Beebe acknowledges, occurs outside of her awareness, made available to her only as she reviews detailed videotapes of the sessions.

A second impasse sets in when Dolores discovers that Beebe (Beebe et al., 2005) is in a relationship with a man. For Dolores, this revelation recalls her lost and beloved foster mother. Her mother was with a man the last time Dolores saw her, and on some level Dolores believes he was responsible for taking her mother away. The enactment ruptures their fragile connection. Dolores describes the same feeling of being "kicked out" (Beebe et al., 2005, p. 115) with Beebe that she experienced with her mother as a small child. She hardly speaks to Beebe through six months of treatment. Part of what helps them move through this period is disclosure. Beebe (Beebe et al., 2005) recalls,

Slowly I came to terms with the idea that this theme had to emerge, that it would have happened sooner or later, and that it would be essential to her recovery. I also acknowledged to her that some of our difficulty was coming from something in me, something from my own childhood, that had been re-evoked (p. 115).

Dolores accepts Beebe's acknowledgement of partial responsibility and they are able to again move forward.

During the fifth year of treatment, Dolores describes the difference between her experience with Beebe (Beebe et al., 2005) and with Sally, her previous therapist, who was presumably less attuned to the nonverbal domain:

You accepted it, what my feelings were, or what my face was or offered--you met it. You felt impacted or changed by it. Not like Sally. With Sally it was about my unconscious exerting a pressure on her to feel a certain something, and what did that say about me. It wasn't about "me and you," the way it is here (p. 122).

It seems Sally relied on verbal interpretation, and a more classical understanding of transference-countertransference and possibly impasse.

In reflecting on what went on between herself and Dolores, Beebe describes much that was unspoken: her self-soothing gestures--sighing, cradling her face, rubbing her feet together--as they met Dolores' own self-soothing--her need to wear sunglasses during the transition into each therapy session and a very still body. Minute, implicit adjustments, which Beebe says she learned from working with infants, shade the interplay between Beebe and Dolores.

In identifying what was reparative for Dolores, Beebe highlights Dolores' slow realization that she could impact Beebe as Beebe could impact her, something she had never truly felt before. Dolores recognizes that her pain impacts Beebe, who seeks to comfort her, which Dolores, in turn, experiences as comforting.

After ten years of therapy, Dolores still struggles. But she is more engaged with Beebe, better able to gaze at Beebe and be gazed at by Beebe. She speaks more and is more audible when she does talk. Beebe notes, too, that her own sense of hypervigilance while with Dolores has diminished, and she has returned to her more normal range of movement,

affect, and vocalization as Dolores' tolerance expanded. Outside the consulting room, Dolores has moved deeper into relationship with her new boyfriend and is more connected at work and with friends.

Summary

Looking back on his work as a young therapist, Pizer (2004), the relational analyst discussed in previous chapters, wistfully laments what may have been lost as he moved into a more mature, experienced, and integrated analytic self. Early on, he feels he intuitively tapped into, "The embodied origins of early psychological life based in biological and physical necessities and grounded in the enactive experience of holding, object presenting, affect attunement, and recognition that provide for procedural patterns of being, self-regulating, and relating" (Pizer, 2004, p. 303). Pizer is, of course, describing just the sort of nonverbal awareness and attunement that are the purview of infancy studies.

Meanwhile, after her lengthy work with Dolores and careful deconstruction of the nonverbal arenas of their interaction, almost as a footnote, Beebe describes how much of the early, non-narrative work set the stage for later, explicit mourning. Dolores must come to accept that her good foster mother was also the abandoning mother. This split is eventually bridged through words and interpretation: "The nonverbal and implicit relatedness created the foundation of the treatment, but it would not have been sufficient for the treatment to flower," writes Beebe (Beebe et al., 2005, p. 141).

As treatment and healing progressed, Beebe relays that the nonverbal elements of their work drifted into the background and became better incorporated with the verbal. What Pizer (2004) and Beebe (Beebe et al., 2005) are each calling attention to is the need for

integration: We must have access to multiple realms--the spoken narrative as well as nonverbal ways of knowing.

CHAPTER V
DISCUSSION

The Case of Bee

As I now turn to my own work, I hope to show, through a clinical vignette, how relational theory and infancy research can be synthesized to reconceptualize impasse.

An Introduction

My early experience with impasse was baffling. Only later, as I sat with it, read about it, and discussed it, was I able to make some sense of what had happened. Even still, there is no clear narrative arc, no tidy conclusion. Any discussion of my work with Bee is further complicated by the fact that we interacted in a group setting, as a dyad within a larger system.

Bee joined the Family Issues group that I co-led at a day treatment program midway through my first-year placement. She had been a patient there previously and left an impression on the staff. A white woman in her 40s, Bee, regardless of the weather, wore a periwinkle velour sweat suit with her customary iced coffee dribbled down the front. She had a blank, almost hollow look, her mouth slightly ajar. Even when Bee was focused on me, I got the sense that she was looking through me without quite seeing me.

Bee seemed to want so badly, desperately even, to be heard. She became intensely frustrated when she could not make herself understood;

yet she was often incomprehensible. She spoke in low tones, swallowing most of her words before they could escape her lips.

Bee joined the program carrying an array of diagnoses, including Dissociative Identity Disorder, chronic Post Traumatic Stress Disorder, and Borderline Personality Disorder. Her past was complicated and difficult to piece together. I only learned snippets from Bee herself, and a bit more from the staff and her file. She was abused in her family, physically and, most likely, sexually. There was also mention of Bee having been part of a cult, where she may have engaged in coercive sexual relationships. She had a known history of alcohol abuse.

Family Issues Group

Family Issues was one of the two groups that I co-led with Dave, another social work intern. We defined family loosely for the purposes of the group, so that it included the patients and the staff at our program. This gave us ample opportunity to talk about relationships within the group and the program, as well as among more traditionally defined family, close friends, and community.

The patients enjoyed challenging Dave and me in our role as intern leaders and would routinely question the parameters of the group. Two young men in particular much preferred talking about pop culture and sports to their family relationships. While this could be frustrating, for the most part their active and enthusiastic participation made for a group that I found deeply engaging. We had settled into a fairly comfortable, though somewhat unpredictable, rhythm when Bee joined us.

Impasse

Bee's presence altered the group dynamic noticeably. Because of past relational trauma, she became upset any time she discussed family. It was so deeply upsetting for her that we wondered among the staff whether she should be in a family group at all.

While we encouraged patients to talk about their feelings, we asked them to stay away from personal details that might be traumatic for other patients and re-traumatizing for themselves. But Bee couldn't seem to stop herself. Any disclosure flowed into spilling, leaving her despondent and suicidal. During her first session in the group, Bee described violent abuse, sharing that when she had opened up to her family in the past she was thrown down the stairs--a detail that was difficult for Bee and the other patients. As a result, much of our work as group leaders focused on helping Bee set limits and better titrate what she chose to share.

Rarely did Bee speak to the group about her experiences of dissociation, or "switching," as she called it. At the end of session, however, as if to underscore how triggered and unsafe she had felt, she would sometimes tell me accusingly how many times she had switched during the group.

Family Issues arrived at an impasse just a few weeks after Bee joined us, in the run-up to the holiday season:

Bee announced to the group: "Someone in the group is doing something on purpose and I'm triggered. That's why I need to go outside and take a pill."

I responded: "If you need a little time out, then go ahead. You'll come back though?"

"Yes," Bee replied, then left the room.

Once she was gone, John, a patient, spoke up: "I don't understand what we did that triggered her."

Al, another patient, said, "I bet it's me."

I suggested, "Maybe we can wait until she comes back and ask her."

Al, looking visibly uncomfortable, got up to go to the bathroom. Following our rule about allowing only one group member to leave the

room at a time, I asked him, "Can you wait a minute, until Bee gets back?"

Dave, the co-therapist, attempted to steer the group back to our earlier conversation: "It seems like some of these holidays we are reminded of people missing from our life. I'm just wondering, what kinds of things do you do to get through the holidays?"

John, volunteered, "I watch TV, sports."

Al replied, "Watch TV. I always watch TV. For a year and a half my TV hasn't been working right."

I added, "Those are both good distractions. Is there anything else that people do?"

At this point the group became silent.

I asked, "So, I'm wondering how this group is feeling to everyone?"

Without missing a beat, Al said, "It feels different from the way the group usually feels."

I replied, "How so?"

Al responded: "It feels like people are on edge."

I said, "Yeah, I agree."

Bee returned to the room.

I asked her, "Bee, are you doing okay? Can you tell us a little more about what was bothering you? Or do you need more time to sit with it?"

Bee, sitting apart from the rest of the group, hesitated. Then, gesturing in the direction of Dave, the co-leader, and Al, she started to say, "He..."

I interrupted, hoping she was talking about Co-leader Dave: "Are you talking about Dave? Or Al?"

Bee replied: "Al. The way he's moving his leg is triggering. It reminds me of something else. My ex-boyfriend and the cult..."

Al, looking stricken, jumped in: "That's not my intention. I..."

Bee, angrily interrupted him, "What! That's your intention."

Dave, the co-leader, interceded: "No, he said it's not his intention."

Al explained, "I have a bad back. I have a lot of energy. I take medicine for my legs."

Bee, plaintively told the group, "I'm not feeling safe."

I asked her, "Do you want to sit somewhere else? Would that help?"

After moving to a table apart from the group circle, Bee said, "I don't feel safe here. This happened in another group. Now I'm by myself."

From this point on, we as a group, and particularly Dave and myself as group leaders, were continually returning to Bee's safety. Al and his shaking leg became the focus of all of Bee's anxiety and attention. She was alternately threatened and rage-filled toward them both.

In turn, I found myself worrying that I had failed in my most basic responsibility as group leader: to create and hold a safe space

for the patients. Partly because of this, I moved further into addressing and readdressing Bee's fear than I might otherwise have. I always left space for her to bring her anxiety back into the room, which she did, repeatedly.

I also felt compelled to systematically remove whatever Bee identified as an external barrier to her safety. I wanted the rest of the group, Al and myself included, to accommodate her. So when Al offered to try to stop moving his leg, I agreed. I suggested once more that perhaps Bee could situate herself so that she would not see Al's leg, thinking that she might move to the other side of the circle. Just as she had done the first day, Bee would remove herself from the rest of the group and then angrily or plaintively tell us that she felt separated and apart from us. Alone. My co-intern, Dave, felt that Al, who was also his individual patient, should not have to adjust his behavior. In this way, Dave and I found ourselves in a sort of parallel impasse.

Relational Theory: Enactment

I see now that I was pulled into an enactment with Bee (Ginot, 2009). By taking on the impossible task of keeping her safe in a world where so much--including a fellow patient moving his leg--was a potential trigger, I colluded (Darwin, 1999) with Bee's fears. Rather than engendering safety, I confirmed and co-created a world that was inherently dangerous. In wanting to respect, engage, and face her fears, I think I ended up elevating them. In suggesting she switch seats, we activated what I imagine for Bee is a continual and fraught dance between connectedness and autonomy. I now wonder, too, what it meant for Bee to be in a group therapy at all, in light of her possible experiences with a cult. In what ways was the group dynamic a

repetition of that experience? Who was Al for Bee--she said he reminded her of an ex-boyfriend. Who were Dave and I as group leaders?

From a relational standpoint, it's possible that I had to be pulled into an enactment in this way so that I could move a little closer toward understanding what Bee experienced (Bridges, 2005; Darwin, 1999; Davies, 1994). It has been suggested that transference and countertransference may be the only way that "severely traumatized persons can communicate their stories of distress" (Valent as cited in Schore, 2002, p. 470). Nor is impasse uncommon among people who have experienced trauma (Benjamin, 2009).

Sitting with Bee, I often found myself overwhelmed and fearful. I felt threatened by her presence in a way that I imagine the world could feel threatening to her. My feeling of never being sure of what to expect--which part of Bee I would encounter, or whether I would even be able to understand what she said--may all hint at the way in which she experiences the world. It's a world that must feel disorganizing, confusing, and unpredictable to a person moving in and out of dissociative states. My somewhat uncharacteristic solution-oriented response may also have been an empathic mirroring of Bee's need to be in control of her environment.

One of my major challenges in working with Bee was our limited access to a dyadic narrative and dialogue. The context of the treatment was a group therapy, where the conversation was collective. Though we did have some success discussing what the group was experiencing, Dave and I struggled to create the space to reflect on the impasse and our own experiences of it (Hoffman, 1999; Ginot, 2009). But just as Bee sat outside the group circle, she often seemed outside of this group conversation.

Even when Bee sought me out during milieu time, which she frequently did, I struggled mightily to understand her. We carried on parallel conversations. There were times when we were able to connect, and she seemed soothed or contained by my words. She may even have felt understood. But just as often my lack of comprehension frustrated her. And I found myself frustrated by our lack of access to a spoken narrative. As much as I found Bee slightly terrifying, I also found her to be sweetly endearing. To help soothe herself, she often carried a stuffed animal with her. At times I'd look over and see a tiny tiger peeking out of her purse. And it was moving how desperately she wanted to connect. Because of all this, the nonverbal realm of infancy studies seemed like a logical place to turn, in order to try to make sense of what went on between the two of us.

Infancy Studies: Nonverbal Communication

It took me a while to realize that I tended to dissociate when Bee was in the group, particularly following the episode with Al's leg. I had an incredibly difficult time focusing. I was simultaneously aware of her presence and my own general sense of uneasiness as I struggled to really be present in the room. The feeling was somatic, which infancy studies suggest may be a sign of early, preverbal communication. At times I would feel almost nauseous and light headed.

One way of understanding this is that Bee was communicating nonverbally what she could not speak or make understood in any other way. Much of Bee's communication seemed centered on the right brain, or right mind--what infancy researcher Schore (2002) terms "the biological substrate of the human unconscious" (p. 446). Whereas the left hemisphere manages verbal communication, an area in which Bee truly struggled, the right brain is responsible for other communication

(Schore, 2002). Infant researchers have also shown that the right hemisphere is where trauma and dissociative responses to trauma, as well as one's sense of one's body, are inscribed in procedural memory (Schore, 2002).

The right mind is considered the locus of empathy (Schore, 2002). I believe there may have been some way in which Bee and I were communicating right brain to right brain, my own dissociative and physical responses an empathic response to her dissociation. If only for a few moments, I got a sense of how difficult it was to exist in such loose and porous states as Bee did.

In considering Beebe's (Beebe et al., 2005) work with Dolores, I also wonder what Bee might have seen in my face in these moments, what I was reflecting of herself back to her? How might she have experienced my difficulty with self-regulation and soothing? Bee herself had very little capacity for self-regulation. Like with the mother-infant interactions that Beebe and Lachmann (2002) observe, she needed the mutual regulation that a caregiver provides.

Later, I saw how organizing and containing it was for Bee to have her fears put in perspective. My supervisor's approach was to reiterate to Bee that Day Treatment was a safe space and that she was okay and safe within it. During a community-wide meeting, with all Day Treatment patients and staff, Bee angrily interrupted to announce that a toilet in one of the bathroom's had overflowed. She said this had been "triggering" for her. I held my breath and watched as my supervisor responded: Yes, this happens and it would probably happen again, in which case Bee should let one of the staff know so that they could take care of it. I was stunned to see Bee's anger and fear go unaddressed. Yet her anxiety seemed to dissipate. She was markedly more organized when, in a sense, told that she was okay, and implicitly shown that she

was not destroying the group, that the group could be restored following disruption (Benjamin, 2009).

In the end, I don't think it was the impasse dynamic that was problematic for Bee and the rest of Family Issues so much as how we managed it. As new interns, Dave and I struggled to understand and navigate the experience on both an explicit and implicit level. I felt an acute sense of having failed as a container (Benjamin, 2009). Had I had the theoretical scaffolding to conceptualize the impasse as more normative and not a failure on my part (Darwin, 1999), I think we would have better been able to make use of and understand the disruption that Al's leg had caused.

Bee continued to struggle throughout her time in Day Treatment, and ultimately floated out of Family Issues group. She was still a member, but missed it as often as she came. Because of this, even the manifest issue of Al's shaking leg was never fully addressed. By the time I left my placement, Bee was only attending the program intermittently.

Summary

What ultimately helps us navigate impasse? And what is mutative? Is it verbal or nonverbal, articulated or felt, interpreted or lived? How do we accommodate ourselves to Schore's (2002) assertion that, "Psychoanalysis is not 'the talking cure,' but more precisely 'the communicating cure' " (p. 472)? For a person most comfortable with spoken forms of communication, steeped in language and narrative, as I know I am, this space can be uncomfortable. I found my somatic responses in relation to Bee especially unsettling.

Yet Harris (2009) writes, "Enactments may be the place where speech and action meet and mingle" (p. 15). I would extend this to

impasse. In impasse, we are given an opportunity to bridge the divide, loosen the boundaries, and exist on the margins between verbal and nonverbal ways of being.

Harris (2009), who works relationally, further suggests, "Slight shifts in experience can give rise to change and great complexity and difference within very short time frames" (p.6). Whereas neuroscience has shown that we may actually be changing people's brains when we accept disruptions as they occur and willingly repair them. This is all impasse.

When taken in concert, the disclosure and dialogue of a relational approach and the procedural and behavioral modes elaborated by infancy researchers open a therapist's awareness to all of what may be happening during times of impasse--the intrapsychic and interpersonal, relational and behavioral, and manifest and latent.

As for the bigger questions of how we get into impasse, what it means, and how we find our way through, the more important question may be: Where can impasse take us?

Rather than something profound, I have come to think of impasse as more humble, mundane. We move through impasse as we move through life, because, really, it is just another part of life. As the poet Mary Oliver said in "A Pretty Song," the epigraph at the beginning this paper, "From the complications of loving you/ I think there is no end or return. No answer, no coming out of it." With impasse, too, there is no answer, no end, no return. We shouldn't try to come out or get through it. Instead, we lean in and see where impasse can take us.

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