The Role of the Analyst’s Facial Expressions in Psychoanalysis and Psychoanalytic Therapy

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This paper, while acknowledging implicitly the importance of transference-distortions in the patient’s perceptions of the analyst’s countenance, focuses primarily upon the real changes in the latter’s facial expressions. The analyst’s face has a central role in the phase of therapeutic symbiosis, as well as in subsequent individuation. It is in the realm of the analyst’s facial expressions that the borderline patient, for example, can best find a bridge out of autism and into therapeutically symbiotic relatedness with the analyst. During this latter phase, then, each participant’s facial expressions “belong” as much to the other as to oneself; that is, the expressions of each person are in the realm of transitional phenomena for both of them. The analyst’s facial expressions are a highly, and often centrally, significant dimension of both psychoanalysis and psychoanalytic therapy. Illustrative clinical vignettes are presented from work with both patients who use the couch and those who do not.

She looked closely at my face and said, with conviction, “You are angry at me, aren’t you?” She was standing just inside the doorway to my office and made no move toward her chair. She had arrived quite late, as so often before in the several months I had worked with her, and I felt, even more than usual, tense and uncomfortable with her.

In response to her question I protested, essentially, that I was not angry at her, and tried to persuade her to come in and sit down. But all this took only a few moments, and she turned around and walked out, never to return. Ever since then, her good judgment in so doing has been evident to me. I was in no condition at that time, now 35 years ago,

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to work effectively with this borderline young woman, who required one to have far better access to one's own feelings than I, either not yet into my personal analysis or barely into it (I don't recall that detail), had yet achieved. At that time it was not that I was consciously angry at this difficult and challenging patient, but unable to use my anger effectively in our work. Quite beyond that, my superego made such a feeling toward a patient unacceptable to my conscious sense of my identity. She saw on my face, I am sure, anger of which I was genuinely unaware; I felt only more tense, uncomfortable, and unconfident than usual in my previous sessions with her.

The main point of this paper is that the analyst's facial expressions are a highly, and often centrally, significant dimension of psychoanalysis and psychoanalytic therapy, a dimension that has been largely neglected, nonetheless, in the literature. This preceding clinical example might seem contrary to this point. One might infer from it that the analyst need only acquire enough of personal analysis to come into reasonably good contact with his own emotionality, and that his countenance will hover thereafter as neutrally and evenly as does, intendedly, his attention to the patient's productions, such that any significant expressions that the patient perceives on his face can be regarded, for all practical purposes, as purely projectional in nature. But please bear with me, for I believe that the cumulative effect of my clinical examples will serve, in due course, to convey my main point.

The second clinical example is from my work, about two years later, with a man who was one of my supervised cases in the Washington Psychoanalytic Institute. He had seen a senior female analyst in consultation, seeking analysis for transvestism, and she referred him to me and provided me with supervision throughout my subsequent years of predominantly successful work with him. The work had a shaky beginning, however. In my first supervisory session—prior, as I recall, to my seeing the patient himself—she said, looking dubiously at me, "I told him that you are experienced." Only in writing this did it occur to me to wonder what expression she saw on my countenance; I am sure, at any rate, that she perceived none that radiated any quiet, self-confident assurance. I had never attempted before to work with any patient who had been involved in transvestism, and had started with only one previous analytic patient of any variety. It was, however, my first session with the patient himself that provides the essence of this second clinical example.

He came in, an older man than I and seeming to me much more intelligent, worldly, and self-possessed than I myself was feeling. He sat down in the designated chair on the opposite side of the small desk behind which I took my seat. The first few minutes of his recounting of his history went well enough; but then he did something for which I was not at all prepared. He took out of his pocket several photographs and shoved them across the desk for me to examine. They clearly had been done by a professional photographer and were all of the patient himself, but wearing a long, blonde wig, lipstick, and scanty, sexy, female clothing, and lounging in various sexy poses.

I looked at these pictures, one after another, attempting to convey a calm, mildly interested manner, trying to assume and maintain the pose of one who was beginning his nth case of psychoanalysis and examining his nth set of such photographs. But I was actually experiencing my nth attack of acute anxiety, with palpitations, sweating, and all the rest. During these few moments, I felt alone with my severe anxiety and these weird pictures, and I felt my situation there to be intolerable. Then I glanced up briefly at the patient himself, and the thought came to me, with a rush of rage, "Why, the son of a bitch is watching me like a hawk!" My rage had dispelled instantly my anxiety, and I was now able to glance through the remaining pictures and proceed through the rest of the interview without any significant difficulty.

This paper is not a tightly organized presentation of theoretical points, illustrative clinical material, and relevant items from the literature. Rather, it touches upon diverse areas of a largely unexplored field, a field whose dimensions I have scarcely more than glimpsed, and about which I am not in a position to make comprehensive or definitive statements.

We analysts probably find it difficult to become free from the tendency among people in general to think that the face is tantamount to superficiality, as is implied in many phrases in everyday usage, such as "of merely face value" or "putting a good face on things." Moreover, if nearly all our patients use the couch and see, therefore, little indeed of our face, we may tend to assume that our actual facial expressions (and I am much more interested in the real input from the analyst than in the patient's transference-distorted perceptions of the analyst's countenance) are of essentially no significance in the work. In addition, it is at least possible that one who chooses to spend, say, 95 percent of his adult working life in sitting behind the couch, his face being observed by no other person, has somewhat more than his share of unconscious conflicts, never thoroughly explored in his training analysis, concerning his face and the play of expressions, or relative lack thereof, upon it.

My interest in what I have termed therapeutic symbiosis has deeply impressed me with the significance of the analyst's facial expressions. Many years ago (Searles 1959), I reported my experience that "symbiotic
relatedness ... constitutes a necessary phase in psycho-analysis or psychotherapy with either neurotic or psychotic patients" (p. 308).

Later (Searles 1963), I reported that "a naturally occurring, and to a significant degree mutual, phase of symbiotic relatedness in the transference, holding sway not merely for moments but for months, is the core phase in the psychotherapy of schizophrenia, ", and emphasized that "The therapist's face has a central role in this symbiotic interaction" (p. 645). I went on to discuss this particular topic for several pages, with references from the related literature, including Spitz's (1945) reporting that "The child . . . learns to distinguish animate objects from inanimate ones by the spectacle provided by his mother's face in situations fraught with emotional satisfaction" (p. 645). Spitz (1957) stated, "The inception of the functioning of the reality principle is evident at the three-months level, when the hungry infant becomes able to suspend the urge for the immediate gratification of his oral need. He does so for the time necessary to perceive the mother's face and to react to it. This is the developmental step in which the 'I' is differentiated from the 'non-I', in which the infant becomes aware of the 'otherness' of the surround" (p. 645).

Freud's (1913) oft-quoted, pioneering reference provides another useful point of departure:

I hold to the plan of getting the patient to lie on a sofa while I sit behind him out of his sight. This arrangement . . . deserves to be maintained for many reasons. The first is a personal motive, but one which others may share with me. I cannot put up with being stared at by other people for eight hours a day (or more). Since, while I am listening to the patient, I, too, give myself over to the current of my unconscious thoughts, I do not wish my expressions of face to give the patient material for interpretations or to influence him in what he tells me. . . . I insist on this procedure. . . . for its purpose and result are to prevent the transference from mingling with the patient's associations imperceptibly, to isolate the transference and to allow it to come forward in due course sharply defined as a resistance (pp. 133–134).

Jones (1955), in his biography of Freud, commented upon this aspect of Freud's technique:

He mentioned the historical source of the custom as dating from the days of hypnotism and also the personal point that he did not like being stared at for many hours of the day at close quarters. These, however, are extrinsic factors. More important is the necessity for the analyst to be in a position to give free rein to his thoughts without the patient detecting them from the play on his features, which would impair the purity of the transference phenomena (p. 236).

A borderline man in his twenties, with whom I worked for three years at a frequency of one or two sessions per week, was similar in a number of regards to several patients, of various degrees of illness, whom I have treated. It never became feasible for me to recommend that he use the couch, for even though he improved very appreciably over this period of time, he gave me reason to feel that his ego integration was sufficiently precarious that it was better for him to remain sitting. This aspect of the work was quite stressful for me because of the extent to which he was attuned to my facial expressions. He seemed close to hallucinating during the first year of the work, seemed often to return to looking at my face as a refuge from myriad semihallucinatory figures off to the sides, and at many moments, while he was looking at me, I distinctly had the sense that what he was seeing was neither my face nor that of any other human being, but something very distorted, indeed (although he never would or could confirm this surmise). I came to realize, in time, that it was useful for me to note at what point there occurred this now progressively infrequent phenomenon in which his looking at my face in a basically realistic, separate-individual, interpersonally related fashion dissolved, once again, into his face's looking, once again, immersed in staring at God-only-knew-what, although appearing still to be looking toward my face.

I felt typically, in nearly all of nearly every session, in considerable conflict, and it was impossible for me, in my work with this man, to mask my facial expressions. My conflicts undoubtedly were introjected to a high degree from him, and he essentially looked to me to tell him what was going on in his own unconscious. Moreover, he was sufficiently verbal about his nearly schizophrenic parental-family life of years ago to give me rich material for interpretations. Also, our time together was so limited, and the moments for possible interpretation were so fleeting, that I felt a precious opportunity would be lost if I held my tongue.

On the other hand, my better judgment told me that, with rare exceptions, any interpretations would be premature. I did make relatively many, nonetheless, and found occasion to share with him, also, a rather large number of relevant vignettes from my own past; but with chronic self-censure for so doing. He would frequently ask me, "What are you thinking?"—invariably at a juncture when some new realization about him had just occurred to me. I eventually came to feel that a major, if
not the major, reason why he predominantly throve in the years of our work together was that I found the courage to share with him as much as I did, despite the chronic intimidation from my superego.

Along the way, I came to realize that the aspect of premature interpretation had to be balanced against the potentially tantalizing and hostile withholding aspect of my (from his view) clearly having just had a significant thought that I now refused to impart to him. The work was inevitably chronically tantalizing for both of us, but he eventually came to convince me that he found great value in my revealing to him, as freely as I did, the fact of my being in various emotional conflicts during the sessions, and the natures of those conflicts as best I could articulate them. I believe that one of the great values of our work, for him, was that he was thus enabled to identify consciously, much more deeply than he had become able to do in his parental family, with one who is able consciously to experience, and to articulate, emotional conflicts.

In my work with him, as in that with a number of other patients of varying degrees of illness, I found evidence of his unconsciously identifying, in his facial expressions, with my own as he perceived (largely unconsciously) mine to be. That is, on occasion he would endeavor to quote or paraphrase something I had said in an earlier session, and his facial expressions (and other aspects of his demeanor), in his effort to do this, gave me to understand that he was unconsciously quoting or paraphrasing, as it were, not merely my words but my facial expressions (and other nonverbal aspects of my demeanor) in my making of those comments. For example, he said one time, “Do you remember what you said in last week’s session? You said—” and then he fell silent for a few moments, looking very detached, and then he paraphrased, for perhaps a minute or two, some of the comments I had made in the previous week’s session, reproducing these reasonably accurately, as I remember them; but the immensely interesting thing was the way in which he said them. After he had been silent for a few moments, near the beginning of this, I asked if that pause were part of what I had said, and he disclaimed that it was. Parenthetically, I have found patients typically highly resistive to seeing the unconscious identificational aspect of such behavior on their part.

He went on, paraphrasing what I had said, and meanwhile floundering, speaking hesitantly, starting a line of thought and not finishing it, looking diffident and, far more than that, showing clear evidence of a marked thought disorder. I found it privately hilarious and enormously revealing of his unconscious perceptions of me, including my facial expressions. He immediately rejected my attempts, twice later in this few minutes of interaction, to suggest that this was the way I had looked and sounded to him while I had been saying the things he was quoting or paraphrasing. It was clear that he was attributing all his floundering for thoughts and words, all his vacant and lost-looking facial expressions, and so forth, simply to his own difficulty in remembering what I had said and in expressing it in a way that would do justice to what I had said. It is, of course, routine for patients to use such grounds to explain their difficulties in quoting something the analyst has said. As in the instances of other patients, his unconscious perception of me as the personification of person(s) from his past who had appreciable difficulties in ego integration, person(s) who were contributory sources of his own sickest introjects, was defended against by a tenacious overidealization of my mental functioning.

In my supervision, going on four years now, of a colleague’s work with a severely borderline man, the therapist described that “He has said that he knows what he’s feeling by the expression on my face; he’s said that many, many times over the years. He said once that he knew he was angry because I had screamed at him.” In this therapy it has been very striking to me, as well as to the therapist, how frequently the patient has become able to gain access to his own (dissociated and projected) emotions, first, via the expressions that he sees on the therapist’s face.¹

In my experience, it represents deeply significant progress in the development of improved ego integration and differentiation, for the patient to become able to focus his attention upon the analyst’s facial expressions; but this development may be greatly slowed, or may never occur, if the analyst remains largely oblivious of the central importance of this dimension of the work.

I learned something about these matters during my one-and-a-half years of twice-a-week therapy with a thirty-year-old man whose mother had become chronically psychotic during his early childhood. This man showed a borderline ego functioning, with features of psychotic depression. It was clear that he had narrowly avoided frank psychosis in recent years, and the issue remained in doubt for some time after our work began. He was an extremely intense, demanding individual, and the sessions were very stressful for me. At no time did he use the couch, nor did I recommend it. One of the helpful developments, for me, was when I came to realize, after more than six months, that part of the stressfulness of the sessions derived from his focusing upon my facial expressions as he talked (he did by far the greater part of the talking).

¹ I am grateful to Patricia Fox, ACSW, for permission to include this material.
while unvaryingly looking dissatisfied, giving me to feel that, whatever my changing expressions were (and I am sure they included a wide variety of positive as well as negative ones of various sorts), they were not satisfactory—they were not the ones he was needing. He made very important gains during our relatively brief work together and, although I did not realize it at the time, the fact that he had come to focus perceptibly much upon my facial expressions was one of the gains he had made; I simply assumed that I had not recognized, much earlier, the supposed fact of his doing this all along.

Despite his moving safely far from potential psychosis and getting considerably far into the realm of his oedipal conflicts, his predominant dissatisfaction with me, and my negative reactions to him, eventually prevailed, however. Approximately sixteen months along in the work, I came to feel free to look at him with cold dislike, and this felt very liberating to me. This touches upon the matter of the degree to which any analyst in his work with any patient, at whatever stage of the work, may feel it necessary to mask his spontaneous facial expressions; surely it may bespeak much improved ego strength on the patient’s part if the analyst need no longer endeavor at all to wear a neutral or benign mask on his face, so to speak, irrespective of what he is actually feeling.

Surely I had glanced, many times before, at various patients with an undisguised look of cold dislike on my face. But never before had I knowingly allowed such an expression to emerge as expressive of my basic attitude toward a patient with whom I consciously intended, despite the stress, to go on working. It really felt good to me; I felt that perhaps I could afford to be more myself, in my work with patients generally, than I had previously dared to think. Unfortunately (but surely not coincidentally), it was not many weeks later that the patient, saying he had been aware for a long time that I did not like him, told me that he had decided to go to another therapist.

I have learned in recent years that once it has become evident to both patient and analyst that the latter’s facial expressions are of significant interest to the former, it then becomes of further significance to ascertain to what, if any, degree the patient feels able to affect the emotions that he sees on the analyst’s face. The more well he becomes, the more readily he assumes, and knows, that what he says and does is intimately related to the responsive expressions on the analyst’s face.

In the instance of the man I have just described, I did not sense that, in his focusing upon my face throughout session after session, with an intensely dissatisfied look on his own face, he was feeling any connection between what he was saying and doing, on the one hand, and the various facial expressions that he perceived on my face, on the other hand. That is, I did not have any sense that he was feeling any sense of self-dissatisfaction because of any felt failure on his part to bring to my face the expression(s) for which he hungrily looked.

Another patient who showed something like the same degree of relatedness and unrelationalness with my facial expressions was a 42-year-old woman with whom I worked, at a frequency usually of once a week, for a little more than one year. This woman, readily recognizable at the outset as borderline in her ego functioning, used words in a quite machine-gun fashion during the hours. I felt, from the beginning, subjected to a highly aggressive verbal barrage, although the patient herself seemed genuinely to dissociate the realm of her transference aggression toward me. In my brevity here, I do not mean to imply that I did, meanwhile, nothing. But I recall that it was only after several months, at least, that I was struck by how exactly the patient behaved as though she were watching television (as, I am sure, in her reclusive daily life she did literally for many hours per week): she would watch my face, while subjecting me to an unending, rapid-fire stream of borderline-psychotic verbal productions, but the look on her own face indicated that she felt no more the personal cause of the changes in my facial expression than any ordinary television-viewer feels; her look was of one who is passively watching a fascinating spectacle.

After several months I vented upon her the pent-up anger, about this, of which I had been increasingly conscious for some weeks. She was dismayed by my reaction, but far from crushed or crippled by it, and the work went better for the remaining months until, because of circumstances largely external to our work, she was unable to continue with me.

Mrs. Douglas (a pseudonym) is a chronically schizophrenic woman with whom I have worked for many years; I have written elsewhere (Langs & Searles 1980; Searles 1972) of some aspects of her tape-recorded treatment. Here I wish to report that the improvement in her ego integration and differentiation has been considerably accelerated, during the past approximately one year, in a setting of her focusing upon my facial expressions, or lack thereof, during the sessions. It has been fascinating to me, and of enormously constructive value for her, for us to become increasingly aware of the extent to which her verbal expressions of delusional experience were heretofore unconscious attempts to cause various expressions to appear on my face. It had been several years ago, already after many years of her treatment by me, when her own face had become more and more alive with long-dis-
sociated emotions of myriad sorts; but she remained for some years, still, so out of touch with the emotions that one could see on her face that interpretations regarding these were not useful to her.

Only a few samples of the relevant data during one recent month are related here. Parenthetically, it had been very striking, and both exasperating and amusing, to me to see, about two months earlier, how unable she still then was to feel that she herself was in any degree responsible for various negative emotions she saw to come over my face. During one particular session in which I was feeling maddened and deeply conflicted under a noninterpretable assault of predominantly sadistic, delusional outpourings from her, she looked at my face and said, with sympathetic-sounding concern, “What are they doing to you?” The “they” clearly referred to the omnipotent persecutors who, in her experience, victimized not only herself but also me and everyone else. The disavowal of her own sadism toward me could not have been more complete.

Prior to the month in question she had spoken many times, for several months, of feeling the stress of having to think of things to say to make conversation during the sessions, and of dread, often, to come to the session, for this reason. I, for my part, had long been aware that I used compulsive talking as a defense during the sessions with her, and had been endeavoring for months to help both of us to become free from the need to keep conversation going.

In the first session of the month, she was speaking from the delusional conviction, which she had had for several months, that we were on the moon, and that she needed and longed to be driven to her (highly idealized, delusional) home down on earth. An imaginary friend, Ed, was to do the driving; but he was drunk in a motel near the halfway house where she actually lives, and “he has our station wagon, too. We can’t do anything until he sobered up.” Then she paused for several seconds (which was not unusual); during this time she gave me a very direct look of the sort that meant, as I had learned long ago, that what she had just said applied, directly, to me—either that I was to rectify the situation she had just outlined or (often) that I was to reassure her that I personally would not do to her various terrible things that (oftentimes) she had just described as having been done, over and over, to her by the malevolent and omnipotent “them.”

I commented, here, “You’re giving me, again, that direct look. What am I to do—sober him up?—I’m supposed to—” She interrupted me, explaining, “That’s—uh—Sibyl,” which I knew, for months now, to be an introject who, as she put it, is in her right eye and often does most of the talking during the session.

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I commented, to confirm, “Who looks at me like that.” She replied, “Yeah. She looks at you like that, waiting for you to make the conversation.” I commented, thoughtfully, “Oh.” She went on, “I asked her [that is, Sibyl] if she was ready this morning. She said, ‘Yes; but I want him [referring to me] to do the work.’” I asked, “Well, is Sibyl giving me the kind of look that I usually give you? Huh?” And she agreed emphatically, “Yeah.” I commented, “I give you these direct looks?” Again, she confirmed this, “Uh huh.”

I found this very illuminating—although, of course, dismaying also. In my several months of attempting to help her (as well as me) to become more free from a need of conversation, I had been quite unaware that I was still giving her (or, for that matter, had ever given her) the enormously pressuring, direct, putting-on-the-spot kind of looks to which, she convincingly showed me with her own look, I was still subjecting her.

This as an example of a patient’s facial expression being an identification with that of the therapist as the patient has been perceiving the therapist’s face to look. Further, I do not doubt that in this instance (typically for such examples) such an expression was in reality there on my face; but I had been unconscious of it heretofore.

In a session four days later, at one point I privately gained some deeper understanding of a long-held delusion that she was elaborating in a somewhat new way, and she said, glancing at my face, “You act as though you’d completed some great job.” I replied, “Just now?” She said, “Yeah.” I commented, “You haven’t seen me look that way, before?” She confirmed this, saying, “No. That’s the look you wanta have?” I replied, “Well, you can believe it is the look I wanta have—right?” She replied, “Yes.”

I went on, “That would bring in the possibility that I am in control of my looks—huh?” She replied, “Well, it’s hard to be in control of your looks; but, I mean, it might be what you’re trying to develop.” I commented, “You find it hard to be in control of your looks, for example?” She replied, “Yes. I used to be able to do it; but I can’t do it any more; it’s terrible.” I commented, sympathetically, “Huh.” And she went on, “I haven’t gotten my head yet. [For many years she had been experiencing her head, and other body parts, as not being her own.] I’m supposed to get it on Monday, then we’re supposed to go down to earth—home.” I commented, in my usual semi-inquiring tone, “Well, having your own head would presumably include being able to have the kind of look you wanted to have on your face?” She said, “Yeah.”

A few minutes later in the session, when she was vocalizing a long-familiar delusion, but doing so in a fashion that enabled me to see a
clearer meaning in it, she said, watching my face, “There! Now you’re getting the expression again!” “The expression” clearly meant, in light of our earlier dialogue, my expression as though I had completed some great job. Significantly, she said this in a tone of her own having accomplished, to her satisfaction, a difficult task, and her own facial expression was much like what she described to have reappeared on my face. I laughed loudly and said, ironically, “You’re of course not trying to make me feel self-conscious, are you?” She protested, “No, I’m not; I just wanted you to keep that expression.”

In a session five days later, about 20 minutes along in the session, at a point when I was feeling and showing exasperation (as often happens), she asked, looking at my face, “Why do they make Dr. Searles [note the plural of my name; throughout our work she had perceived me, and other persons significant to her, as having many “doubles”] get so mad all the time? Is that—?” I interrupted, “This one [i.e., this Dr. Searles] seems to be starting to get mad, too?” She agreed, saying, “Just starting today, yeah. Some of them make mad all the time. The poor things have the most terrible time, controlling themselves.” I replied, “Yeah.”

She went on, “I guess that’s what they do it for.” I replied, “They apparently do it so that the Dr. Searles’ will have a terrible time—well, ya think they’re trying to teach them to be able to control themselves?” She immediately confirmed this: “Yeah.” I replied, “Oh,” indicating that I now understood how she meant this, and I went on, “Kind of an exercise in self-control?” She agreed, “Yeah.” I went on, “And you are left to simply watch the spectacle, right?” She replied, “Yes, and they just get agonized, and they turn all sorts of colors.” I inquired, “There is a kind of interesting aspect to seeing it: is there not?” She conceded, “Well, it’s sort of fascinating.”

I responded, “Hm. You’ve obviously never had even a momentary sense of contributing in any small way to their exasperation, right?” She confirmed this by saying, “No,” and added, while I was now chuckling in amusement, “Except that when we don’t talk, they seem to get mad.” I commented, “That’s one of the big reasons, I guess, why you have—uh—worried about what to—have to say to them, huh?” She replied, “Yeah.” I pressed her further here, “Is that it? They get mad if ya don’t—have things to talk about?” She agreed, but added, “Well, they don’t seem to have many ideas, themselves. Well, they spend all their time controlling themselves—and changing color.” I commented, “So that they don’t have much—energy to—devote to thinking, or—” She agreed, emphatically: “To thinking, no. Use up all their time.”

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After a momentary pause, she commented in a different tone, confronting and teasing, “Well, you control your self very well, though; you got it all—subdued.” I commented, “But two or three minutes ago, though, you were starting to wonder?” She replied, “Yeah; it looked as though they started on you.” She said this with a facial expression of grimly sadistic satisfaction (not rare among her expressions), and I inquired, casually, “D’ya ever find yourself—uh—kind of—hoping they will, or—?” She immediately replied, “No.” I pressed her, “Huh?” And she said, “Uh uh” [meaning, “No”]. I said, “No? You wouldn’t wish that on me, I guess?” And she agreed that she would not.

This interchange was, for me, a striking example of how unable she was, still, to accept any responsibility for causing my facial expressions to be so exasperated, angry, or agonized—all of which they indeed are. Further, I was sobered by this additional evidence of how greatly pressured she still felt, by me, to have things to say during the sessions. I felt that all these perceptions of me, their transference origins notwithstanding, had much of immediate reality in them.

I am currently supervising a colleague’s once-a-week psychotherapy with a borderline young woman who, during the first several months, talked in a nonstop and rapid-fire fashion, seeming aware only very rarely of him and his feelings, although looking often at his face in a covert way as she spoke. Meanwhile, he said very little, and she seemed not to want more from him the greater part of the time.

In a session some six months along, she said, “I don’t feel close to myself at all—I don’t like looking at myself in mirrors—I look at my body, but not my face—it’s kinda creepy . . .” Later in the same session, after describing another of her myriad borderline experiences of herself and the world, she said of that particular (recurrent) experience, “I think it scares the shit out of me. . . . Don’t you think it’s kinda weird?” He remained silent, as usually seemed to work best in that era. I suggested to him my impression, based upon his work with a similar patient, that her question signalled her puzzlement at not seeing on his face an expression that indicated that he shared her sense that the experience she had just described had been, indeed, weird.

I did not mean to imply that his face should have worn such an expression, but rather that the role of his face, and her interest in it, had come to be of greater significance in the therapy than she had been able consciously to give him to realize. I surmise, in fact, that it is in the

2. I am grateful to Lawrence Tarnauer, Ph.D., for permission to include this material.
realm of the therapist's facial expressions that such a patient can best find a bridge to an interpersonal relatedness with him, increasingly, as the work goes on—a bridge out of her autism, one might say. This patient manifested, in the first several months of the work, much of the self-absorbed dynamics of narcissism, as well as more typically borderline features. There is every indication, currently, that the psychotherapy is proceeding well, and I assume that her estrangement from her own face will become resolved through her coming to terms with her projection-laden perceptions of the therapist's face. This brings up the question as to whom—therapist or patient—do the therapist's facial expressions "belong" in the work with such a patient.

In an earlier paper (Searles 1976), in which I was writing of psychoanalysis and psychoanalytic therapy with patients generally (rather than with any one variety of patient), I ended the paper with this paragraph:

I suggest that the patient's symptoms become, with the development of the early phase of therapeutic symbiosis, transitional objects for both patient and analyst simultaneously. As with the patient's symptoms, so with his transference images of the analyst: I believe that in order for any effective transference analysis to occur with any patient, whether neurotic, borderline, or psychotic, the analyst must have come to accept at least a transitional-object degree—if not more deeply symbiotic degree—of relatedness with the particular transference image, or percept, which is holding sway presently in the analysis.

Here I wish to suggest that, as it is with the patient's symptoms and his transference images of the therapist as described in that quote, so it is with the therapist's and the patient's facial expressions. That is, in the therapeutically symbiotic, core phase of the work with any one patient, each of the two participant's facial expressions "belong," in a sense, as much to the other as to oneself. In the work with a very ill patient, the therapist may find himself grimacing and having agonized (or other) facial expressions of a kind and degree that feel considerably foreign to him, and that are largely a response to dissociated feelings on the patient's part. It has been my impression, time and again, that only insofar as both participants can accept partial responsibility for such phenomena—to regard the therapist's and the patient's facial expressions as being, to apply Winnicott's (1953) concept here, transitional phenomena semi-"belonging" to each of the two participants—can the patient's previously largely dissociated emotionality become more truly his own, and the therapist's face come to feel, once again, more fully his

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(the therapist's) own, after its having served so deeply, for so long, as a plastic screen for the patient's projected emotions.

Rethinking, in this light, my experience with the man who quit treatment not long after I had become free (so I felt) to look at him with cold dislike, it may be that my "own" dislike of him was predominantly not my own, but was based largely upon my identification with contents that he was projecting into me. It is possible—although I do not find this easy to believe—that if I had treated the expression of dislike that I found on my face more as sharable analytic data, exploring for, in particular, warded-off feelings of dislike on his own part, from his childhood and other areas of his life, he might still be in treatment. It was as though I had prematurely reclaimed my face as being my own.

My earlier paper (Searles 1977) is relevant here; patients, whether borderline or not, are described as going through a phase in the evolution of the transference whereby the analyst becomes a symbiotic identity partner for the patient. Kohut's (1971) paper concerning what he calls mirror transference is also relevant. So far as I know, Kohut never read any of my writings, including those published twelve years earlier concerning therapeutic symbiosis (Searles 1959), a topic closely related to some of his own views. Kohut writes,

In this narrower sense of the term the mirror transference is the therapeutic reinstatement of that normal phase of the development of the grandiose self in which the gleam in the mother's eye, which mirrors the child's exhibitionistic display, and other forms of maternal participation in and response to the child's narcissistic-exhibitionistic enjoyment confirm the child's self-esteem and, by a gradually increasing selectivity of these responses, begin to channel it into realistic directions. As was the mother during that stage of development, so is now the analyst an object which is important only in so far as it is invited to participate in the child's narcissistic pleasure and thus to confirm it (p. 116).

[He favors using, in a larger sense the term mirror transference for the whole group of transference phenomena that are the expression of the therapeutic mobilization of the grandiose self (p. 123).

For prolonged periods while the analysand begins to mobilize old narcissistic needs and, often struggling against strong inner resistances, begins to deploy his exhibitionism and grandiosity in the treatment situation, the patient assigns to the analyst the role of being the echo and mirror of his reluctantly disclosed infantile narcissism. Apart from his tacit acceptance of the patient's exhibitionistic grandiosity, the analyst's contributions
to the establishment and unfolding of the mirror transference are restricted to two cautiously employed sets of activities: he interprets the patient's resistances against the revelation of his grandiosity; and he demonstrates to the patient not only that his grandiosity and exhibitionism once played a phase-appropriate role but that they must now be allowed access to consciousness. For a long period of the analysis, however, it is almost always deleterious for the analyst to emphasize the irrationality of the patient's grandiose fantasies or to stress that it is realistically necessary that he curb his exhibitionistic demands (p. 271–272).

Kohut's comments are of much value, although I do not believe he was aware of the startling degree to which very ill patients had been called upon, remarkably early in their lives, to function as just such a mirroring mother to their own mothers (Searles 1966–7, 1975). I wish merely to emphasize, however, that whereas Kohut does quite full justice to the patient's need for responses in the realm of empathic tact, gentleness and, in essence, kindly acceptance on the part of the analyst, he dwells in his books (Kohut 1971, 1977) scarcely at all upon the patient's equally great need for well-timed responses of a very aggressive sort, indeed, from the analyst.

The analyst's attunement to his own aggressive feelings, and skillful utilizing of these in his responses to the patient, play a role hardly less than that of his lovingly maternal responses. Although it may feed the analyst's narcissism to experience himself as being a lovingly empathic mother nearly all the time, the emergence of the patient's adult feeling capacities, including his assertive and aggressive capacities, requires that the analyst have much readier access to his own "Bad Mother" kinds of responses than one would believe from reading Kohut.

For example, the chronically schizophrenic patient with whom I have worked most successfully (such that she has shown no more than a borderline degree of impairment of ego-functioning for years now) was an initially very fragile-appearing little woman who, mute and motionless for years early in my work with her, seemed to hover for many months on the brink of death. I have always felt, in retrospect, that a major (and possibly the major) turning point in our work consisted in our gradually reaching, against great resistances on the parts of both of us, a kind of relatedness in which we were savagely excoriating one another. I particularly remember one face-to-face session in which she was shouting indictments of me, her face suffused with self-righteous venom, and I was simultaneously shouting at her—with, I do not doubt, very much that same expression of venomous self-righteousness on my own face. That kind of mirroring, to my mind so essential for the necessary depth of both therapeutic symbiosis and subsequent individuation, Kohut does not describe. I look for it, too, as between my supervisees and their patients; thus I count it a most welcome development when a supervisee, who for years had taken refuge in the role of the healthy, adult therapist who is endeavoring (inevitably patronizing) to extend help to the sick patient, evidently has come at long last to relate to the patient as being essentially his emotional equal and a fellow adult. I concur with Sager's (1957) simple statement, "It is our belief that in therapy [and, I would add, in analysis] one should work toward a relationship in which the patient accepts his equality as a mature human being with the therapist" (p. 306).

The man who sought analysis for transvestism used the couch consistently after the initial interview, and the just-described woman has done so most of the time for years now. With those exceptions, my clinical vignettes thus far have been from the treatment of patients who have not used the couch. Those patients described in the remainder of this paper used the couch.

Occasionally one sees a patient who frankly tells one at the beginning of the session that one is appearing so preoccupied, or fatigued or whatever, that the patient assumes that this session, which has scarcely begun, cannot possibly prove to be of any use. He is quite able to feel and express his dismay, exasperation, futility (and so forth) about this. When a patient is as readily able as this to let the analyst know that the analyst's facial expression at the beginning of the session is greatly significant to him, there is no problem upon which I need dwell in this particular paper.

However, I have seen patients who are not able, for many months or even some years, to let me know that, all along, they had been appraising my facial expression, during the brief moments available to them as they walked into my office, in order to determine my mood, or my capacity or incapacity for deeply significant collaborative work during that session, or whatever. In most instances, I believe, this appraising on the patient's part was long as unconscious to him as it was unapparent to me. But I surmise that a great many hours with many patients are spent largely in vain because the patient, having glanced at the analyst's face upon walking into the office, has already written off this session as being an inherently futile one. I am aware that it is not easy for the analyst to interpret such nonverbal interaction, for one does not wish to increase the patient's inhibiting self-consciousness; but if the analyst is aware of this phenomenon and its frequency, he can find constructive ways of utilizing his awareness that it is occurring.
The previously described phenomenon of the patient's seeing his unconscious emotions in the analyst's face occurs frequently in one's work with patients who use the couch, during those moments when the patient glances at one's face upon his leaving.

For example, a 41-year-old borderline man devoted a whole session to seeking advice from me as to what to do about his younger brother's angry demands upon their father. He was speaking, throughout the session, in an apparently consciously unangry, undemanding, polite, respectful, considerate manner, expressive of his awareness that the giving of advice regarding his life outside the sessions was not one of my functions. But at the end of the session he said, as he got up from the couch, "You still haven't told me what I should do!" In saying this he sounded, and looked, very angry and dissatisfied—such that, for the nth time, I wasn't sure whether he would continue in the analysis. I doubted that he was well aware of how much anger there was in his saying this. I myself felt jolted, in a very unpleasant way, by the abrupt, blunt anger and dissatisfaction in his statement.

He did return on the following day, however, and about five minutes along in the session, while I remained silent as he spoke, once again, of the same daily-life situation that had been troubling him the previous day, he said, "What I said at the end of the session yesterday, when I got up from the couch, I meant as a joke; except when I said it, my voice didn't sound as joking as I thought it would—and your face didn't look as if you thought it was a joke... and you looked surprised..." I told him, "I remember feeling something in the realm of jolted, and doubtful that you were aware of how angrily that came out." He strongly confirmed both aspects of my statement.

A 40-year-old woman, the mother of one child, showed a typical "as-if" type of borderline personality-functioning (Deutsch 1942) upon entering analysis with me. I worked with her for approximately six years, at a frequency of four hours per week throughout. She began using the couch after the first two interviews, and did so consistently thereafter. But for a number of years, I found that the work went best if I were very sparing with my interpretations; during those years, any interpretation I ventured was all too likely to be utilized by this very glib woman in the service of her resistance. (She used words primarily for unconscious defensive purposes, to keep her affects largely dissociated and to protect herself from any strongly felt emotional bond with me.) Meanwhile, during those years, I found that her attunement to my face proved to be a far more emotionally significant avenue for the development and unfolding of the transference, than did the realm of words on the part of either of us.

During the first two years of the work, and possibly somewhat longer, each time I would indicate that the end of the session had come, she would get up from the couch and then, before walking to the door, would turn and look at me for a moment in a strange fashion that gave me to feel that she was mentally photographing me. I did not experience any interpersonal bond during this procedure (in keeping with the large-scale absence of implicit acknowledgment on her part, during the bulk of the session itself, of my individual self). I felt much as though she were photographing a being from a planet alien to her own. I came to understand this as being part of her struggle to establish an internalized image of me, an image that, by her thus photographing me each time at the end of the session, she could maintain until our next session.

As our work together proceeded and became genuinely work-together, I found much evidence, from a variety of sources, evidence of the kind reported in Searles, (1977), that her transference to me had developed in the form of my representing her symbiotic identity partner. That is, in terms of her unconscious experience, I came to personify herself, and she came to personify myself—or, in each instance, parts of that self. It became evident, in retrospect, that at the beginning of treatment her own self had been as alien to, as distant from, her as she had given me to feel during, for example, her momentary "photographing" of me (as I am calling it here).

As the symbiotic identity transference flowered in the ensuing years, the full spectrum of her emotional life emerged, bit by bit, from its long dissociation, and became, gradually, richly differentiated. Her "photographing" of me continued in the ritualized manner, but I found that it had come imperceptibly to have, now, a much more highly differentiated and emotionally significant meaning than it had possessed before. I now felt that she was a person "photographing" not merely another person, but "photographing" my particular facial expression (if any) at the end of a session that she had filled with, variously from one session to the next, material of a particularly repellent, or infuriating, or discouraging, or provocative, or nostalgic, or grief-laden (or what-not) variety.

In a detailed way, the nature of the looks we exchanged, as she turned to look at me before she left, could sometimes be seen as having a highly significant role in episodes of acting out, both sexual and aggressive, on her part. For example, following our looking at one another in an unprecedentedly warm and friendly manner at the end of a session—but a manner with relatively little, from my point of view, of any erotic meaning—she went to a bar where she found herself ex-
Changing lustful looks with various of the men there, and had an undisguisedly sexual dream (rare for her) that night.

Still later, now after years of our work together, I felt that when she turned toward me before leaving, she was not doing so in order to appraise my facial expressions, in however much detail; instead, now, I felt she was showing me her own face, filled with anguish, hurt, grief, and various other intense emotions. I no longer felt photographed, nor did I feel that she was presenting her face to be photographed. Meanwhile, during all the development traced briefly here, verbal interpretations had been playing an extremely small role in the analysis, and I had not seen fit to make any verbal interpretations concerning these developments.

A 45-year-old mother of two children, a person with a narcissistic personality disorder with manic-depressive features, began in analysis with me at a frequency of five sessions per week. Nearly three years later, I made the following note after one of my sessions with her:

Although I feel chronically frustrated in my work with this woman, for the reason that she keeps the work in her own hands to such a very high degree and makes me feel chronically useless, nonfunctional, noncontributory, I almost invariably greet her in a friendly, firm way at the beginning of each session. And, for no reason, I can come up with the point here, at the end of the typical session in which I am given to feel that there is a great deal of turbulence going on in her with which I am unable to help her in any verbalized way (especially typical of my work with her is my being silent, session after session, month after month). I nonetheless say, as she looks carefully and searchingly (though briefly) at me before she opens the door to leave, "See you tomorrow," or "See you on Wednesday" [for example], in a firm, friendly, confirming, confident tone—in a tone that I feel conveys basically the confirming assurance that this has been a good session and that I know my work to be going well.

Typically, when she comes in at the beginning of the session, she appears preoccupied, scarcely looks at me—often doesn’t, and when she does, does not seem really to see me—and there is nothing like the degree of solid relatedness I feel in our exchange of looks at the end of each session.

Now, I came to realize last evening, some time after her session, that there is a significant question involved in all this: to what extent is my look to her [and my accompanying comment to her] at the end of the hour (a) contributing to a chronic undoing of the development and emergence of negative transference and counter-transference (as I have believed, all along, that it does, to an appreciable extent) and (b) [a thought new to me in my work with her] to what extent is it contributing to holding environment that is still necessary in the treatment of this woman whose transference reactions to me are seldom identifiable and, when they are, are typically of a preindividualization variety?

Another point about the way the typical session goes: after our significant exchange of glances at the end of the sessions and I have said, "I’ll see you tomorrow" [for example], she says, "Yes." Another bit of description: in our mutual exchange of looks, she begins by looking, not uncommonly, very grim, and I often sense a great deal of underlying rage in her, as well as, very frequently, bleak despair. But my way of looking (and speaking) seems to dispel, partially and momentarily, those negative feelings.

I must explain, regarding the above note, that I had come, long before, to feel that our exchange of looks at the end of the sessions was the most significant thing happening between us. By contrast to her emotionally walled-off behavior throughout each session until that point in her departure, her face was then filled with feelings of a variety of sorts on different occasions, feelings ranging from violent anger to loneliness, to despair, to fond comradeship, to small-child dependency, and so on. My steady consistent response, seemingly largely irrespective of her particular emotional demeanor, was not something predominantly planned or contrived by me, but rather something I found myself doing each time.

Two months later I made this note about something that had occurred a week previously:

The session had been spent, as nearly always, with her narcissistic defenses very much in evidence, and I found the session as dull and uninspiring, and myself as useless and irrelevant, as usual. At the end of the session, we looked at each other as usual—she, as she was starting out into the waiting room, and I, as I was starting into my storeroom [where I go, to have a cup of coffee or to work a bit in my files, after nearly every session with each of my patients]. She looked at me in such a way as to persist momentarily until she had succeeded in bringing what she evidently saw to be a twinkle in my eye. I felt, in fact, that in response to pressure from her—pressure conveyed in the way that she looked at me—I did look at her with a reassuring, fond twinkle in my eye. My feeling, when this happened, was that I was confirming thus, from her point of view, the validity of her highly favorable estimation of herself—or, from my point of view, the validity of her narcissistic character-armor.
In the ensuing moments, I did not feel infuriated that this had happened. Possibly I felt somewhat chagrined, or exasperated, or defeated—but relatively little so, if at all. Mostly, I felt this to be an interesting phenomenon, and I think this is a very helpful analytic attitude for me to have reached toward my own, as well as her, facial expressions.

It is probably no coincidence that, only two or at most three sessions later, she gave me a very important glimpse of the remarkably traumatic aspects of her childhood, as regards serious problems of drug addiction among several siblings both older and younger than herself, and perhaps on the parts of each of her parents as well—a kind of material that gave me to feel a genuine sympathy and respect for her.

My response to the way she was looking at me, with a twinkle in my eye, supplying her with the facial expression which, as I was coming now to accept, she genuinely needed from me, is one bit of the kind of analytical material from my work with various patients that has led me to suggest that, during the phase of therapeutic symbiosis, each participant’s facial expressions “belong” as much to the other as to oneself and are, thus, in the realm of transitional phenomena for both of them.

A session that had occurred two months prior to the first of my notes quoted above had helped me to develop a deepening realization of her need for me to function, in Winnicott’s (1941, 1950–55) phrase, as a “good-enough holding environment,” and of the therapeutic validity of the nonverbal interaction between us:

For the previous two sessions she had arrived late—once, by some fifteen minutes—and had been making plain that she was very busy with other matters, and had been behaving in additional ways disregardingly, depreciatorily, toward me and the analysis. When she left a message, then, that she would be late once again, I felt considerable rage develop in me toward her, and I thought that, if she proved to arrive very late and to be behaving in a busily self-important way as often before, I would begin the session by telling her that if it is getting so that she is having great difficulty in fitting the analysis into her busy schedule, it is fine with me if she quits.

She actually arrived only about six minutes late, and her manner was sufficiently far from her so-frequent officiousness that I said nothing upon her arrival, other than my usual greeting.

Another important background item: I have continued, practically since the beginning, to say almost nothing to her during the sessions—only greeting her at the beginning and calling time at the end.

During the above session she went on to express both deeply felt gratitude to me for being here, so reliably, over the course of our work, and equally intensely felt grief concerning a number of losses in her very early childhood, including the loss of a younger sister with whom she had formed a predominantly lovingly symbiotic bond, a bond like that which clearly had developed, beneath her wall of words, in her transference to me. It was becoming evident that her symbiotic bond with her younger sister had been patterned upon their mother’s symbiotic relationship with the patient herself, and that the latter, while still a very young child, had largely lost, already, that relationship with her mother. I felt near to tears—an infrequent experience for me in my work with any of my patients—during a considerable part of the session.

Until such time as the phase of ambivalent symbiosis has given way to the predominantly positive phase of preambivalent symbiosis, the patient’s gazing as a symbiotic identity partner at the analyst’s countenance can be severely stressful for the analyst, which is one of the major reasons why we analysts tend to disregard the significance of this realm of our work. For a forceful example of this point I turn far from the work with patients who use the couch, to my experience many years ago with a chronically schizophrenic woman, of whom I wrote in my monograph on the nonhuman environment (Searles 1960):

This woman, for many months after my beginning psychotherapy with her, often glanced at me with an expression on her face of mingled fear, shock, and awe, as if I were a weird monster at which she scarcely dared to gaze for an instant. My discomfort at being so regarded amounted, at times, to a formidable level of anxiety. This anxiety was heightened by the circumstance that I felt toward her, much of the time during that period of the therapy, an intensity of hatred and loathing which, my superego repeatedly admonished me, no human being should feel toward another person—and which a physician, in particular, should never experience toward his patient. I shall not go into the reasons for my feeling so negatively toward her at that time. My point here is that my conception of myself as a human being was under assault from two directions: the patient was reacting to me
as being a kind of monster, and my superego was condemning me as being monstrous, inhuman, in terms of the way I was feeling toward this woman. The fact that her own appearance and behavior, throughout this time, were extraordinarily freakish, in the opinions of personnel members generally (suggesting that her reacting to me in this fashion, as being a weird monster, involved much projection on her part), was only partially reassuring to me, and her becoming able to confide in me, "I know I look weird sometimes, but I'm all right," was a later development, when this difficult though necessary period, of her projecting upon me these weird self-conceptions, was drawing to a close (pp. 365–366).

REVIEW OF RELEVANT LITERATURE

Greenacre (1966), in a paper concerning problems of overidealization of the analyst and of analysis, notes that, "Under most conditions, the mother is the infant's constant companion and very much the center of his universe. . . . There is a play of emotional responses—observable in her facial expressions . . ." (p. 747). In an earlier paper (Greenacre 1958), she had described that

The body areas which are . . . most significant in comparing and contrasting and establishing individual recognition of the body self, and that of others, are the face and the genitals. . . . It would appear that even at a mature age the individual is in need of at least one other person, similar to himself, to look at and speak to, in order to feel safe in his own identity, i.e., that there is a continual reinforcement of the sense of the self by the "taking in" of a similar person without which an isolated individual feels first an intensification and then a diminution of the sense of self and identity (p. 614).

Lichtenstein (1961) conceives of the "imprinting" of an identity upon the child by the mother in normal early development.

Elkisch (1957) describes three patients who "tried to retrieve, as it were, in their mirrored images what they felt they had lost or might lose: their ego, their self, their boundaries" (p. 236).

Youngerman (1979) describes an adolescent boy who had been mute for over a decade who "was hospitalized and initially treated with a non-verbal therapy within the context of a psychoanalytic developmental theory. . . . His non-verbal expressions and gestures were mirrored and expanded into pantomime and absurd theatre" (p. 286).

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Khan (1982) writes of his work with a borderline young woman: "I waited, with my face in my hands, as is my style, when listening facing a patient. First, I don't like watching a patient with a pretend-blankness of neutrality, nor being stared at myself. Second, I can peep through the chinks of my fingers when I need to look at the patient" (p. 466). Winnicott (1959) reports that

It is amazing how even small children learn to gauge the parents' mood. They do this when each day starts, and sometimes they learn to keep an eye on the mother's or the father's face almost all the time. As an example I give a boy of four years, a very sensitive boy, much like his father in temperament. He was in my consulting-room, playing on the floor with a train, while the mother and I talked about him. He suddenly said, without looking up: "Dr. Winnicott, are you tired?" I asked him what made him think so, and he said, "Your face"; so he had evidently taken a good look at my face when he came into the room. Actually, I was very tired, but I had hoped to have hidden it (p. 75–76 in his 1965b volume).

Winnicott's writings (e.g., 1956, 1960, 1965a, 1965b) concerning the relationship between mother and infant (or young child) were the richest source of relevant material as a background for this paper.

CONCLUSIONS

The analyst's facial expressions are a highly, and often centrally, significant dimension of psychoanalysis and psychoanalytic therapy, but one that has been largely neglected, nonetheless, in the literature. While acknowledging implicitly the obvious importance of transference-distortions in the patient's perceptions of the analyst's countenance, I have focused here upon the real changes in the latter's facial expressions.

The analyst's face has a central role in the phase of therapeutic symbiosis, as well as in later individuation. It is significant to what, if any, degree the patient has come to feel able to affect the emotions that he sees on the analyst's face. It is in the realm of the analyst's facial expressions that the borderline patient can best find a bridge out of autism and into therapeutically symbiotic relatedness with the analyst. During this latter phase, then, each participant's facial expressions "belong" as much to the other as to oneself; that is, the expressions of each person are in the realm of transitional phenomena for both of them.
The analyst’s empathic attunement to his own aggressive feelings and skillful utilizing of these in his responses to the patient play a role hardly less than that of his empathic utilization of his lovingly maternal emotions.

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