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Faces in Relation

A Case Study

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The co-construction of the intersubjective field is of interest to psychoanalysis, yet detailed clinical material illustrating the nonverbal dimension of this process remains rare. This case presentation of Dolores illustrates two themes of the 10-year, thrice-weekly treatment conducted sitting up: (1) the integration of the "faces" of Dolores herself, her multiple early attachment figures, and my own; and (2) traumatic loss and mourning. Dolores was preoccupied with the faces of her childhood, and she wanted to be able to find her own face in mine. But she could not look at me, her own face was dampened, and she was often silent. Extremely fearful, withdrawn, and dissociated, she nevertheless longed for attachment. The paper describes both the process of co-constructing our attachment, as well as her difficulty in using our attachment, in large part because of her difficulty in mourning the traumatic loss of her first mother. Although Dolores was a brilliant and accomplished professional woman, and capable at times of highly articulate self-reflection, much of the progress of creating the attachment occurred through the implicit "action-dialogue" of face, voice, and orientation. I made an unusual intervention, derived from my background with videotape microanalysis of mother–infant interactions. I took a series of videotapes of Dolores and me together, and of my face only while I interacted with her. Because she did not look at me at this time, seeing

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my face seeing her while she watched the videotape and hearing my sounds responding to her, heightened her experience of my response and her own visceral experience: she came to recognize herself in my face recognizing her. Dolores urgently wished not "to go dead," and Dolores had remarkable abilities to reflect on our process, to put her experiences into words, to convey how important I was to her, and eventually to analyze her difficulties with mourning. Our respective contributions illustrate the co-construction of the therapeutic action of the treatment.

ALTHOUGH THE CO-CONSTRUCTION OF THE INTERSUBJECTIVE FIELD IS currently of great interest to psychoanalysts, detailed clinical material illustrating the nonverbal and implicit dimension of this process remains rare. As Lyons-Ruth (1999) notes, much remains to be learned about how implicit modes of intimate relating are transformed and about the analyst's specific, collaborative participation in this process as a "new kind of relational partner" (p. 612). This paper details aspects of verbal as well as nonverbal and implicit processes[1] in the 10-year treatment of Dolores, and particularly my collaborative participation.

Dolores suffered early maternal loss and trauma. Many aspects of her traumatic experiences were communicated to me in nonverbal and implicit modes. She was preoccupied with faces, and she clung to the memory of her first mother's lost face as a beacon of her identity. Two themes of the 10-year treatment conducted on a three times a week basis, sitting up, merit particular attention: (1) the integration of the "faces" of Dolores herself, her multiple early attachment figures, and my own, particularly as we struggled to regain "face-to-face" relating in the process of developing a deep mutual attachment; and (2) traumatic loss and mourning. (Many other aspects of the treatment were important but will not be addressed here.) Although Dolores wanted to be able to find her own face in mine, she could not look at me, she shut her own face down, and she was often silent or dissociated. My response to Dolores was shaped by my backgrounds as a psychoanalyst and as an infant researcher, particularly my own work on facial mirroring and vocal rhythm coordination in the mother–infant face-to-face exchange (see Jaffe et al., 2001; Beebe and Lachmann, 2002). In this way, we were matched: we both had a

[1] See Paper I (*PD* 13/6) for definitions of implicit and nonverbal processes and their complex interrelation.

preoccupation with facial dialogue. Dolores reminds us how powerfully, and how early, we are affected by the "face dialogue."

The Face in Psychoanalysis

Facial communication operates at a nonsymbolic, implicit/procedural level, largely out of awareness. Research using brain imaging suggests that faces enjoy a special status in the brain, because neural activity in the temporal lobes (fusiform gyrus) surges twice as much when adults watch faces versus other objects (Bower, 2001).

The role of the face in psychoanalysis is directly linked to seeing and being seen. Unless the treatment is organized in a sitting position, the face obviously plays a far diminished role, but it is still important in the interchanges around greeting and separation. Seeing and being seen carry many connotations, from Freud's (1913) view that the therapist's being seen dilutes the transference, to Sartre's (1992) view that seeing and being seen can objectify the self and other (see Eigen, 1993), to the view that being seen and responded to by the other is constitutive of the self (see Winnicott, 1965; Bion, 1977; Kohut, 1977).

Winnicott's understanding of mother–infant communication and its analogies in adult treatment has been very influential. One of his most famous descriptions is of facial communication. Winnicott (1974) asks what the infant sees, when he sees his mother's face; and Winnicott's answer is that the infant sees himself. Here we are alerted to the tremendous power of the mother's facial response and its role in shaping the sense of self. However, this famous concept emphasizes the mother's impact on the infant, matching or reflecting back the infant's affective state, but it omits Winnicott's equal appreciation for the role of the infant. The infant's facial/visual responsiveness has a reciprocal power to affect the mother's feeling of being recognized and loved by her baby (see Tronick, 1989).

Eigen (1993) notes that "the centrality of the human face as symbolic of personality permeates the fabric of human experience" (p. 49). He suggests that the human face is the most prominent "organizing principle in the field of meaning" (p. 56). He argues that psychoanalysis must concern itself with the face, particularly with respect to the early disorders of the self, because of the central importance of the face of the other in the formation of self-feeling (see also Weil, 1958; Winnicott, 1965, 1974; Kohut, 1977). Patients

with these early disorders are often unable to create an enduring image of the therapist's face, which is a critical aspect of the treatment. Eigen (1993) argues that the therapist's facial behavior plays an essential role in evoking and broadening the patient's capacity to experience. He describes the work of Levinas (1974), who argues that the birth of the human personality is associated with a positive experience of a face.

A substantial body of experimental adult literature demonstrates that facial action is simultaneously communicative and self-regulatory, modulating physiological arousal and subjective experience. Tomkins (1962, 1963) considered the face central, expressing emotion both to others and to the self, through feedback from the tongue and facial muscles, the sound of one's own voice, and changes in blood flow and temperature of the face. Changes in facial action are associated with subjective changes, either intensifying or inhibiting the experience of the emotion (Tomkins, 1962). Facial action can influence subjective experience of emotion without awareness (Izard, 1971; Ekman, Friesen, and Ancoli, 1980; Ekman, Levenson, and Friesen, 1983; Adelmann and Zajonc, 1989; Levenson, Ekman, and Friesen, 1990).

Because a particular facial expression is associated with a particular pattern of physiological arousal (Ekman, 1983), matching the expression of the partner produces a similar physiological state in the onlooker. Thus matching of expressions is an important way in which the emotional state of the individual can be transmitted to the partner (see Izard, 1971; Laird, 1984; Winton, 1986; Adelmann and Zajonc, 1989). Other research shows that, even without matching of facial expression, *the mere perception of emotion in the partner creates a resonant emotional state in the perceiver,* for infants as well as adults (Davidson and Fox, 1982). Positive as well as negative emotional "matching" reactions can be evoked out of awareness, so that important aspects of face-to-face communication occur on a nonconscious level (Dimberg, Thunberg, and Elmehed, 2000). The Heller and Haynal (1997) study ("A Doctor's Face: Mirror of His Patient's Suicidal Projects") described in Paper I dramatically illustrates this nonconscious facial communication.

Introduction to Dolores

Dolores is a brilliant and accomplished professional woman, capable at times of highly articulate self-reflection. She is very gifted at

language. Preoccupied with very early, nonverbal experiences, she nevertheless possesses a remarkable ability to put her experiences into words. Her descriptions are often poetic. She is very interested in mothers and infants and has read widely. Because of her own remarkable abilities and resources, aided by three previous treatments, Dolores has been able to maintain a high level of professional functioning while simultaneously participating in an intense, difficult, and at times terrifying and destabilizing treatment with me. Aspects of the treatment described are disquieting.

Despite Dolores's language gifts, because of her long periods of profound dissociation and because of her very early maternal loss, much of the early progress of the treatment occurred through the "action-dialogue" of our nonverbal communication. I used all modalities to try to reach her: the rhythm and intonation of our voices, our breathing rhythms, our head and bodily orientation, as well as my steady gaze, the dampening of my bodily activity, and my facial response. Although I was aware of some of my own nonverbal behavior, most of it was out of my awareness. Only after reviewing in detail the videotaped interactions I describe later, in preparation for writing this paper, did I become aware of the full range of my nonverbal behavior with Dolores.

In the second year of treatment, I made an unusual intervention derived from my research background with videotape microanalysis of mother–infant interactions. I took a series of videotapes of Dolores and me together, and of my face only while I interacted with her. I was familiar with using videotape viewing to facilitate understanding of nonverbal communication patterns in the treatment of mother–infant pairs (see Downing, 2001; Cohen and Beebe, 2002; Beebe, 2003). I became interested in videotaping as a possible aid to reaching Dolores because, despite her gifts, in very central ways she was deeply shut down and difficult to engage. This paper describes some of these videotaped interactions and their impact on the treatment. By analyzing the videotapes I came to understand a great deal more about the nonverbal and implicit aspects of my own collaborative participation. I hope in this paper to find a language to describe our experiences together as we struggled with the sequelae of Dolores's early trauma and to stay as close as possible to the actual words and actions of the two partners. Although most of this 10-year treatment was conducted as an ordinary psychoanalytic exchange, sitting up, in this paper I focus on the unusual videotaping rather than the background of usual therapeutic exchange.

The paper is organized with two intersecting goals. The first is a description of clinical material, from various points across the 10-year treatment, selected particularly as it is relevant to Dolores's concerns about the face and her traumatic loss and mourning. Some of the material is based on notes taken during sessions, and some from videotapes taken of my face only, as I was interacting with Dolores. The videotaped sessions occur a year and a half into the treatment. Whereas the material taken from notes describes the verbal interaction, the material taken from videotapes depicts the nonverbal and implicit process as well.

The second goal of the paper is an ongoing commentary on this clinical material to illustrate the concepts from Paper III, "An Expanded View of Forms of Intersubjectivity in Infancy and Their Application to Psychoanalysis." Through this clinical material we revisit the central concepts of Meltzoff, Trevarthen, and Stern: the dialogic origin of mind, the role of correspondences, and the idea that symbolic forms of intersubjectivity are built on presymbolic forms. In addition, we revisit from Paper III various concepts offered to broaden a definition of the presymbolic origins of intersubjectivity: interactive regulation, the role of self-regulation, the role of difference, distress regulation, and the "balance model" of self- and interactive regulation.

Dolores is a 40-year-old biology professor, very attractive, and sociable with students. An early marriage ended very unhappily. Since then she has had some long friendships with men, including a long relationship with a boyfriend that did not work out, but she never remarried. Despite a few close and devoted friends, overall she is isolated and spends a great deal of time alone. Her primary mode of adaptation is to withdraw. Although she has been successful in her teaching career, she has difficulty thinking and writing alone. This is her fourth attempt at treatment.

For the first year of the treatment, Dolores and I lived in the same city. However, when she obtained a teaching job three hours away in a neighboring state, where there were no adequate mental health facilities, Dolores and I decided to continue the treatment. Every other week she came into the city for two double sessions in person, on two successive days; otherwise the treatment took place on the telephone.

For the first two years of her life, Dolores had a foster mother with whom she had a close and affectionate relationship. Then her biological mother reclaimed her, and she never saw the "good" foster mother again. During the period with her biological mother, when she was approximately two to four years old, Dolores was emotionally,

physically, and sexually abused. At four years old, she became mute, which precipitated a year-long hospitalization. A photograph taken at this time shows a child with a swollen, bruised face and a sullen stare. After the year in the hospital, Dolores was adopted by a loving family. She thus had multiple abrupt, total changes of her attachment systems, including the early disruption of the bond to the original biological mother.

In treatment, Dolores was preoccupied with faces and particularly the face of her first, good foster mother. She used the metaphors of the "good face" and the "bad face" for her foster mother and her abusive, biological mother, respectively. She longed for an attachment to me, and yet she could not look at me and often could not talk. Her facial and bodily expressiveness was inhibited, shut down. For the first portion of every session, she wore her sunglasses, which she took off only after considerable prodding. She appeared shy, hesitant, wary, low key. At times she was severely dissociated. The treatment was a struggle to regain face-to-face relating and to create a secure attachment. Now, a decade later, she does look at me with a reasonably normal gaze pattern, most of the time. The attachment is progressively more secure, but much remains to be done.

At the beginning of the treatment Dolores and I sat face-to-face at the usual psychotherapy distance. The following process is based on notes taken during the first six sessions at the very beginning of the treatment. She glanced intermittently during these sessions but made no sustained eye contact. Dolores had discussed some good memories of the good foster mother.

The "Good Face" of the First Mother: A Fragment from the First Session

Dolores: [speaking slowly, in a childlike voice] I do have the good face. It made me survive. I know that face, looking at me. I make that face happy; I know how her face goes. When I get so isolated, I'm missing someone I can give this to.
BB: Yes.

Her comment that she can make the face happy, and that when she is isolated she is missing someone she can "give this to," illustrates the bidirectional model of influence that is central in infant research on face-to-face interaction. She describes the experience of the child who makes the mother's face come alive. This is the other side of the

usual description of the mother's echoing the child's own facial affect. It is interesting that Dolores speaks of "the" face, not "her" face.

> **Dolores:** The good face doesn't want my badness though, and then—I'm all alone. Then I can't find the good face anymore. I know it's there, but I can't find it. I just can't find the good feelings in me . . .

Here she illustrates the dyadic organization of experience: her own good feelings are organized in relation to the good face. If her relationship with the good face is disrupted in her own mind, then her own goodness is lost.

> **Dolores:** I remember a time playing with my [adoptive] mother. I looked at her face, but I remembered *another* face. I remembered it so vividly that I felt I actually saw it. When I saw this face, I felt *alive* and good. I *was* good. I felt it in my molecules, the face, and how it tells me I am. I know from the face what I can be, and what it wants from me: when to be happy, and when to be scared; when I'm good, and when I'm not. I know everything about me from the face. It tells me what's next. I know when it will love me, and when it won't.

Her description captures the concept of "expectancies" in infant research: the idea that the infant comes to expect the moment-by-moment sequence of how the faces go and what will be next. Here, however, she frames the description more in terms of the impact of the adult's face on the child's face. Her description also evokes the visual cliff experiment (Klinnert et al., 1983) in which a toddler is placed on a glass table, next to mother. Under the glass table, there is a "visual cliff." At the far side of the table are some very interesting toys. As the child begins to cross the table toward the toys, eventually he or she notices that there seems to be a cliff. The child looks back to mother. When the mother is instructed to show a smile face, the child proceeds without hesitation to the toys at the far end. When the mother is instructed to show a fear face, the child does not cross the "cliff." The child thus knows what to feel and what to do, whether to be scared and not cross, or to be unafraid and cross, from the face of the mother.

Dolores's use of the word *molecules* links her words to the visceral, bodily level of experience, reminiscent of Loewald's (1980) concept

of "linking" of words to preverbal experience (see Mitchell, 2000). Bucci (1997) also emphasizes the link between visceral, bodily experience and emotion in language, with her concept of depth of referential imagery. Dolores's own capacity to make these links was a rich resource in the treatment.

Dolores: I don't want to be so angry at the good face; I want her to help me.
BB: You're angry at the good mother because she left you, and you're worried about being angry?
Dolores: Yes. But I'm so ashamed of what happened. I don't want the good face to know about it. The good face didn't come back to get me because she knew I was bad.

Her fear of shame and of exposure of her "badness" may have contributed to her fear of looking, of being seen as well as seeing. Perhaps the good mother would see something bad in her face.

BB: I can understand how you came to think this way, even though somewhere you know that no baby is bad. That is a two-year-old's theory. I think you are telling me that it is so important for you to remember the love that was there for you from the good mother, even though you were later abused.

Here I have affirmed her love of the foster mother. I sensed the pivotal importance of this love. I also learned here how her shame over whatever happened in this period, and her anguish over being left, disturbed her contact with her memory of her good foster mother. Much later we were to delve into the storm of her rage at the foster mother for letting her go. Eventually I learned that the biological, abusive mother had told her that the foster mother had left her because she was a bad little girl; that the foster mother had found another, good little girl to take her place; and that is why the foster mother never came back.

Dolores: Can you help me let the good face know what happened, and see if she still thinks I'm good?
BB: Maybe you and I together can let the good face know what happened. You so long to feel the good mother's face. Without her, it seems so hard to feel that you are good yourself.

Dolores: Maybe if you know that babies aren't bad, maybe you and I could say that there still could be a good face of the mother and a good face of the baby? I don't want to leave the session. I need you to hold the two faces together.
BB: You are struggling to hold together the face of the good mother and the face of the good baby, even though you were abused.
Dolores: If the good mother knew the bad things, the baby would still be good?
BB: Yes.

Setting the frame of the therapy, I respond strongly that the child is good. By asking if I can help her let the good face know what happened, she goes right to what she needs. In this segment I join her capacity to be in the Winnicottian transitional play-space: "Maybe you and I together can let the good face know what happened." Together we have created a capacity for play, improvisation, and, at times, humor. Her capacity to be in this play-space, and to invite me in, is a rich resource in the treatment.

Her urgent request that the two faces be held together, for she cannot proceed with her development without being able to hold together her own face and that of the good mother, can be related to the "dialogic origin of mind" proposed by Meltzoff, Trevarthen, and Stern (see Paper II). She needs to be able to hold on to that early "face dialogue." As the three infant theorists have eloquently argued, prior to language there is a rich face (as well as vocal and touch) dialogue, nuanced and complex, as Dolores was well aware. My own background in research on face-to-face interaction led me to think of the face dialogue (as well as gaze, orientation, voice) as a complex arena for expressing and responding to emotions rather than a mimicking or manipulation of faces. The following fragment illustrates one of the major themes of the treatment: how Dolores engaged me to help her in her quest to integrate her different mothering experiences, each with a radically different set of expectancies.

Not Being Found by the Adoptive Mother's Face: Fragment from the First Weeks of Treatment

Dolores: I searched my [adoptive] mother's face, and there was no rest for me there, where faces meet and match. This is what I lost, though I know I *did* once have it. Help me wake up. I do not

want to go dead. [pause] I know I did not look right to my [adoptive] mother. I didn't know why, I knew my face wasn't right. I couldn't look at her and find me. [pause] I had it once, though not for long, I know I did. And that is what is here with you.
BB: That is what you came looking for?
Dolores: You can help me find it. I have a resting place here, a coming alive, feeling recognized, someone who doesn't turn away. I won't live if I don't get it. [pause] My [adoptive] mother needed to stop me. She never found herself in me, so I never found myself in her. I shut down. Though once I had it, I know I did.

Dolores has described the terrible impact of a disruption in the mutual facial mirroring process between her and her adoptive mother and the disaster of not being "found" (Winnicott, 1965, 1974). I admired her striving to hold on to "the good face" and to her aliveness. When she speaks of the powerful impact of feeling me respond to her, I am drawn closer. I am very affected by her invitation, but I also hear the panic: she will not live if she does not get it. Her plaint has made me feel worried as well.

"Where the faces meet and match" is reminiscent of the description of matching found in the body of work of Meltzoff, of Trevarthen, of Stern. "Meeting and matching" seemed to be the essence of a certain kind of aliveness for her, and without it she would "go dead." A central dilemma is that she urgently wanted this meeting and aliveness, and yet she could not accomplish it. "Going dead" is reminiscent of the infants who are later classified as disorganized attachment at 12 months (K. Lyons-Ruth, August 18, 1999, personal communication; Jaffe et al., 2001; Beebe, 2003). At four months these infants lose postural tonus and go limp, "playing possum" (see Papousek and Papousek, 1977) or "inhibiting responsivity" (see Beebe and Stern, 1977), presumably in a move toward conservation-withdrawal (Perry, 1996). Eventually a feeling of inner deadness became one of the most pressing issues of Dolores's treatment, reminiscent of deadness as a core clinical concern in Ogden's (1986, 1994) theory of intersubjectivity.

Dolores seemed to "recognize" in me someone who "recognized" her. This bedrock of the treatment was established almost immediately. Her determination to regain the feeling of being alive, to find the place where "faces meet and match," to find herself in the face of the other, continued to be a source of hope in the treatment, a counterpoint to her deadness.

"I Don't Have a Face of My Own": Fragment from the First Weeks of Treatment

Dolores: You know, there is a lot of confusion about my face. When I'm more stressed, bad things happen. Sometimes I feel very young. I have the sensation then of a thin piece of skin over my eyes, and the sensation of my face turning to stone.
BB: It seems you feel your face stopped moving and your eyes stopped seeing, in reaction to not having your good mother's face to respond to you. You must have been so terribly depressed with the abusive mother.

I am tender, warm, worried. Here she returns to a visceral experience of deadness, feeling her face turning to stone. Her face went dead after she lost the good foster mother, and sadly she did not regain the aliveness of her face with her adopted mother. The face going dead seems to be a metaphor for the self going dead after losing the good foster mother. Her state at that time, without an attachment partner, without a face-dialogue, constituted the loss of any possibility of intersubjectivity, however defined.

Dolores: [continues] I feel alienated from my face. My face doesn't *feel* like *me*. *I don't have a face of my own.* I look at *other* people's faces to see what *my* face looks like. My adoptive mother looked at me like a stranger. I didn't feel my face looked right. I couldn't look at her and find me.
BB: It seems that your adoptive mother wasn't able to be *responsive* enough to your face. Each of you couldn't really respond to the other, and then you developed the idea that there was something *wrong* with your face.
Dolores: Maybe *you* could understand [pause] that I might not *have* a face. Maybe something *is* wrong with my face. Maybe I *do* have a bad face. I need to see your face, to feel that I am looking at the good face, and to feel good myself.

Dolores has two traumatic ideas here: that she has a bad face or, worse, that she might not have a face at all; and that her face turns to stone, is dead. These experiences of her face are presumably coordinated with an unresponsive or an abusive partner. She again states one of the core issues of the treatment, that she needs my face

to regain her own inner aliveness and goodness. Yet, she cannot look at me.

> **BB:** A child gets her own face from the face of the mother, and the mother gets her feeling of being a mother from the face of her child. You feel that you had it, and then you lost it. Then evidently all you had was the bad face. That made you feel like your own face is bad. Now you want to see my face, to reflect back to you your own good face. But it's very hard for you to look.
> **Dolores:** I understand. I have to find you, to find your face, to find my own face. I don't like feeling like I don't have a face. You recognize me. Maybe you could understand that I might not have a face.

It is remarkable that Dolores knows that she must find my face to find her own. In some very palpable sense, it is true that Dolores does not have a "face," or facial-visual responsiveness that she can use in co-creating our engagement. She essentially defines for us one of the central goals of the treatment. Her ability to reflect on the process in this way was another essential resource. My comments emphasize that Dolores's experience of her face was developed in relation to a lack of appropriate responsivity in both the abusive, biological mother and later in the adoptive mother. I was very touched by Dolores. I responded to her longing for engagement with me.

I was moved by the horror of her early childhood. My experience of her terror was perhaps most palpable when I approached her warmly in the waiting room to greet her. She would back away from me, with the look of a frightened animal. I learned to approach her very slowly and to keep my distance at first. In the Ainsworth separation–reunion test of attachment at one year, backing away from the mother upon reunion is a behavior characteristic of infants classified as disorganized (Main and Hesse, 1992).

My Difficulty Reaching Dolores

Following a half dozen initial sessions during which she told me her story in a halting manner filled with intense emotion, and quite

coherently, Dolores began to sit with her body oriented away from me, without looking, barely talking. She seemed out of contact, dissociated. At this early point in the treatment I tried many different strategies to make contact with her. I noticed that at various points, without looking, she oriented toward and then away from me. I suggested that, instead of trying to talk, perhaps we could begin by trying together to become aware of when she was able to move her body to be oriented to me and when she oriented away. Over the course of the ensuing months, Dolores began to elaborate on the metaphor. She would say, "I'm in your orient" or "I'm falling out of your orient." Dolores's ability to respond in this rather poetic way was very touching, and it helped us work on maintaining a sense of a bond.

But it continued to be difficult to make contact with her with a more usual verbal narrative, and she continued to be dissociated for long periods without speaking. Eventually I experimented with moving my chair into a more "biological" face-to-face distance, the two chairs at right angles, with a small table in between. This distance is approximately that of usual adult face-to-face interaction distance, closer than usual face-to-face psychotherapy, but not as close as that between mother and infant. This arrangement facilitated my making contact with Dolores: she seemed more aware of my presence, and the long dissociated periods became less frequent and prolonged. We have maintained this arrangement.

How was I affected by not being able to "get" Dolores's gaze or face? I experienced her muted face and voice as fear, rather than as withholding. I felt patient, as when I was interacting with the infants of my research. I tried to have no agenda but to stay with her, to try to sense what she felt and follow what she said. Dolores frequently told me how important I was to her. I am certain that, if she had not been as forthcoming in this regard, I would have had a much more difficult time, and the treatment would have taken a very different course. Her own generous and loving approach to me was a critical catalyst in the treatment.

Because after the first year of treatment Dolores's teaching position required that she live at a considerable distance from my office, much of the treatment was conducted on the telephone. The sessions in person every other week were usually long double sessions. Whereas we were usually successful in generating a genuine engagement in the sessions conducted in person, over the telephone the sessions were very difficult. Dolores was often completely quiet for long periods.

And she was in agony over the long periods without seeing me in person. She explained that she could not remember me in-between sessions. She had tried and tried to remember the good foster mother. Every day she had thought that today maybe she would come back. And day after day after day, the mother did not come back. Until, eventually, one day, Dolores described that her "mind snapped: it was a physical feeling of breaking." After that, something changed, something had been broken.

Introduction of Videotaping

About a year and a half into the treatment, when Dolores was having a great deal of trouble adjusting to seeing me less frequently in person, she brought up the idea of videotaping some sessions. She knew that my research involved videotaping mothers and infants. We discussed it and were both interested in the idea. I thought that, because Dolores could not look at me, the videotape might help her to sense more of my feeling for her. I believed that her ability to engage with my face was essential in reclaiming her relatedness and aliveness. Initially Dolores asked a friend to videotape us briefly, for 10 or 15 minutes at the end of a long double session. Some of the footage was of Dolores and me together, but some of it was of my face only, as I interacted with her. Later we videotaped without the friend.

At this point, Dolores was barely looking at me, except for rare fleeting glances. In her peripheral vision, however, she could certainly detect my body movement and facial changes, although not the exact facial expression. Obviously she could monitor my vocal rhythms, contours, and cadences. For my discussion here, I have selected portions of the videotape that I have permission to show to professional audiences; only my face is visible. My face reflects what I see in her, what I see her feeling, as well as my own response. Her face is omitted according to her wishes. In this portion of the videotape, her speech was nearly inaudible, requiring close attention to understand it. Her voice was muffled and childlike.

The following are based on close videotape analysis. I distinguish vocal rhythm (see Jaffe et al., 2001), vocal contour (Fernald, 1987), and pitch. I also comment on my degree of bodily activation, self-

comforting self-touch, hand gestures, and face (see Beebe, 2003). Although Dolores's words often are barely audible from the videotape, the rhythm of her words is usually detectable. I generally repeat what I hear her say, because I am straining to understand her words. Although I may have been aware of some of my nonverbal behavior, most of it was out of awareness. For example, I know that I was being "quiet" with my body in the first section I describe, but only after I examined the tape did I realize how completely quiet I had become, so that I could adjust to her level of fearfulness. I am aware that I also slow down and reduce my level of activity when I interact with infants. But for Dolores I did so in an even more dramatic fashion.

Moments When Dolores and I Reach Each Other: Videotape Illustration I, One-and-a-Half Years into the Treatment (Two minutes)

As this moment opens, my face is in side-view. My body is completely still. I am careful not to make sudden movements. In contrast to my usual high-energy style, I have lowered my arousal to the very bottom of my range. I am leaning forward, with an intent, direct, sustained focus. I am paying very careful, tender attention to Dolores. I listen to every word and am clearly working hard to understand what she says. It is as if nothing else in the world exists for me except for her. Dolores does not look at me.

> **Dolores:** In the, in the [pause] good way [pause] that [pause] that I [pause] that I feel [pause] complicated about . . .

Dolores's speech is hesitant, dampened, stop–start, stuttering, fragmented, with a staccato rhythm. She seems to be in considerable distress and is struggling to express a complicated feeling.

> **BB:** In that good way? In the good way that you feel complicated about?

My tone is very soft. I repeat her phrase but bring it into a more flowing and coherent rhythm. I don't hesitate. The contour rises by the end of the sentence, with a feeling of "questioning" and "opening." The rising intonation at the end is slightly enlivening. It is as if I am sensing

her longing to connect to me, despite her terror, and I am elongating the moment, as if to say, "Stay here in this moment with me." As I work hard to understand her words, my rhythm and tone render her fragmented communication more coherent, as I convey "I am getting it." As I say, "In that good way," my chin is tilted upward and my left hand holds my chin. But as I continue with, "In the good way that you feel complicated about," my hand moves upward and I hold the side of my face and forehead. My own self-soothing acknowledges her level of distress. This interaction illustrates not a "matching" but a "difference" response. My rhythm is clearly different from hers, but it facilitates the relatedness. I provide more opening, enlivening, and coherence, which she then partially joins when she reaches "good but sad" in the ensuing dialogue. This interaction illustrates one form of distress regulation: I enter the rhythm and cadence of her distress, but I also slightly transform the expression of it. This would qualify as a "difference" response, rather than a "matching."

Dolores: Uh-huh.
BB: The good way of being connected to me that's so complicated?

Here I repeat her phrase but elaborate it, adding the phrase "of being connected to me," a symbolic elaboration. My rhythm is flowing. I emphasize her longing to connect.

Dolores: [long pause] Good but sad.

"Good but sad" is an important integration that Dolores achieves here. Her rhythm here is flowing, more organized. Perhaps my increased coherence through the rhythm of my speech, and my symbolic elaboration, enabled her to describe this poignant dilemma.

BB: You feel good but *sad*? [pause] Good but *sad*? [long pause]

Here I match the rhythm of her phase but again slightly elaborate on it as well. I use a rising intonation and elongate the word *sad* with a question intonation, conveying an opening quality. By repeating her phrase twice, I tarry in the feeling of it, giving us both a moment to absorb it. My intent face conveys the intensity of my listening. Dolores's

ability to endorse the positive and the negative feelings alike is extremely important, and my repetition underscores it. This interaction again illustrates a form of distress regulation, in which the matching aspect of my response constitutes entering her distress, but my elaboration on her rhythm is a form of slightly reorganizing it.

BB: Is the complicated part about having to leave? [pause] Are you thinking about that right now? And whether you'll turn to concrete?

I connect her feeling to the imminent end of the session. "Turning to concrete" is a phrase she used earlier in the session to describe her feeling about leaving. With each sentence, I slightly change the pattern of the way my hand is self-soothing my face, registering my own efforts to regulate my intense feelings with Dolores. Dolores's feet are visible in the videotape at this moment, and her toes wiggle, then rub up against each other, self-soothing.

Dolores: [inaudible]
BB: [repeating what I think I hear] But you're planting a flower before you leave?

My chin moves upward, in a greater focus of attention, and my body is completely still. This may convey to Dolores how intent I am on what she is saying and feeling.

Dolores: [inaudible]
BB: You're planting a flower that you're coming back?
Dolores: [inaudible]
BB: Before you turn to concrete?

My eyebrows go up in a concerned expression. The more hope she has, the more she dreads that she may lose me. Leaving is excruciating. On the other hand, in this vignette she integrates the opposites of her experience: good but sad, alive flower and inanimate concrete.

The next time Dolores came to a session in person, together we watched this videotape that we had made. She watched the video without taking her eyes off it. She was riveted, and tearful. This was the first prolonged period that she had been able to see my face, and she was utterly moved to see me. We talked about how she still could

not look at me while we actually interacted, but how important it was to her to be able to see me on the video.

Reaching Each Other through an Expanded Range: Videotape Illustration II Three Months Later (One minute)

In this session my body moves around slightly, with greater range, suggesting that I sense that at this moment Dolores is not as vulnerable as she was in the earlier session, when my body (although not my hands) stayed completely still. Now my body uses the three dimensions of space and shapes the space in a more open, embracing way than in the previous vignette. My chest has a concave shape, similar to that of a mother snuggling her baby into her chest. My gestures have a soft, circular, undulating quality. My head tilts and bobs at times, and overall the movements of my body are more playful.

BB: You told me something important that will help us with why it's so hard. [pause] You told me that if you look at me [my head tilts, I lean forward, and I gesture with my right hand], maybe I'll become the mother you'll never see again. [pause] If you let yourself *have* my face, it will be like the mother whose face you *lost*. That if you *look* at me, you'll never *see* me again. [pause] So no wonder you wouldn't want to look at me [my eyebrows go up]. [long pause]
Dolores: Unh.
BB: If you don't look at me, it won't happen. That's your idea, right? [long pause]
BB: [slight smile, with soft sadness: I see something on her face.] You're worried about leaving aren't you? [long pause]
Dolores: If I don't look at you, it won't happen. [for a split-second Dolores glances at my face]
BB: [big, soft smile]

A few minutes later in the same session:

BB: [picking up on something she has just said] [smiling] If you look at the *videotape,* it will put my face in front of your eyes, but not through *your* looking.

I am referring here to the fact that the first time she really looked at my face for more than a split-second occurred when we both watched the first video of a session together a few months earlier. She was very moved to see my face, and tearful. She could tolerate seeing me in the videotape better than in vivo. My tone is playful, with rising contours. I am gently teasing her about not looking at me, and we are sharing some humor. Earlier in the exchange, my head-tilt, leaning forward, with a hand gesture, emphasize my verbal communication. Head tilting or slight shifts of head orientation, as well as orientational changes and hand gestures, are important markers of the exchange, accentuating the moment.

Dolores: [inaudible]
BB: [repeating what I think I have heard her say] My face jumped into your eyes, for one little second? [pause] Really? [pause] Well, *that's* good.

My eyebrows go up, I have a big smile, and the phrase, "Well, that's good" has a "sinusoidal" contour, known in infant research as a "greeting" contour. I am greeting her playful effort at engagement.

[Big shift: I see something on her face]
BB: You feel sad.
Dolores: [inaudible]
BB: [repeating what I think I have heard her say] "Leaving is the *worst* thing that could happen?"

Her positive feelings rapidly move to sadness. I match the rhythm of her words, including her emphasis on "worst." I add a slightly questioning intonation at the end. My body becomes very quiet. I briefly close my eyes, and I let out a soft sigh. This interaction illustrates a form of distress regulation that is very close to an exact matching. I elaborate in two subtle ways: the questioning intonation, which leaves open the possibility of other feelings, and the sigh, which elaborates on the sense of loss.

Dolores: [inaudible]
BB: All the wrong faces will come back?

I repeat her sentence, but add a question intonation at the end. Again, this slight elaboration of the question intonation holds open the possibility that this might or might not happen.

Dolores: Unh.
BB: And will you get rid of *my* face?

I want to help her to connect to my face in every possible way. I imply that she is active in keeping or losing my face. This is where I hope the treatment is going (see Kohut, 1977; Loewald, 1980), although at this point she seems to have very little ability to hold on to the image of my face. [long pause]

Dolores: [inaudible]
BB: You won't be able to take the subway to come see me.

Here I exactly match the rhythm and contour of her statement. There is no question that she will not be able to take the subway to see me during the next period, when the sessions will be held on the telephone. My face has a "woe-face" expression, giving a palpable form to the feeling in her words.

Dolores: [inaudible]
BB: Or call up down the street.

Dolores is referring to the fact that the next period of sessions will be on the telephone, and she lives so far outside the city that she will not be able just to take a subway to see me, as she could if she lived in the city. On this particular day she had called me from her cell phone down the street as she was coming to the session.

I nod my head. My face is quiet. But my head and my words exactly match the rhythm and contour of her statement without changing anything. Exact matches can constitute a very particular form of empathy; here I have no agenda but to stay exactly in her feeling. I am accepting her very coherent statement of loss, exactly as she expresses it. This interaction also illustrates a form of distress regulation that I term "joining the dampened state" (see Beebe, 2000, 2003; Cohen and Beebe, 2002). The cross-modal matching of my head and her words illustrates Stern's concept of affect attunement.

Dolores: [says something inaudible; I don't repeat it.]
BB: [gentle laugh; body moves]

In this fragment of the session Dolores is experimenting (ever so slightly) with looking at me. After I elaborate on her own interpretation of why she does not look at me (that I might become the mother she will never see again), she glances at my face. Then I gently tease her about looking at me, and she glances at me again. My expanded nonverbal range, with more bodily movement, laughing, without marked self-comforting self-touch, parallels Dolores's own increased engagement and verbal participation. It contrasts with the session three months earlier when my own nonverbal range was more constricted, presumably in an effort not to overarouse or frighten her and to stay closer to her own range of activation. Immediately following the increased engagement and aliveness of the first portion of this vignette, Dolores goes into the sadness of the imminent end of the session, poignantly expressing her feelings. But by the end of the vignette, Dolores again introduces some gentle humor, and I softly laugh. In this approximately one-minute vignette, Dolores shows an expanded range by integrating experimentation with looking, sadness about loss, and humor.

The Struggle to Discuss Dolores's Early History: Second Half of Second Year

These videotapes document aspects of our slow, careful work of bonding. They show how we both contributed to the possibility that Dolores might feel less distressed, more engaged, and at times comforted. A period then followed in the second half of the second year when Dolores made a concerted effort to tell me some more about her early history. It was extremely difficult for Dolores to tell me anything concrete. We might spend an entire session struggling to make it possible for Dolores to communicate one piece of information.

During this period, at the point at which she might begin to discuss any of the details, she would become agitated, her body would tighten, and eventually she would hold her breath, as if in an effort to hold everything in. She would hold her breath for long periods, unable to stop, until she would begin to panic. Eventually I began to try to get

her to synchronize with my breathing. I made soft, rhythmic sounds as I breathed in and out. Dolores called it the "breathing song." Together we began to be able to anticipate when an episode of breath-holding was about to begin, and we would do the breathing song together before she became extremely agitated. Over the course of the next couple of years, the breathing symptom gradually became less frequent.

In another dramatic expression of her difficulty communicating the details of her early history, she would abruptly fall into a deep sleep after revealing something particularly painful. The sleep would last for the rest of the session, and she could not be awakened. I would sit near her head, and while she was sleeping I would softly tell her what had just happened and why I thought she had to fall into a deep sleep. Then I would stay next to her while she slept and every once in a while softly tell her that I was there while she was sleeping. Toward the end of the session, she was able to wake up and would listen while I again told her what I thought had happened. Gradually she would be able to reorganize. I would walk with her around the room until I felt she had regained her full consciousness and could leave. Very often a friend met her at the end of the session.

Going to sleep as a way of escaping these painful memories gradually yielded to a less severe form of retreat, in which Dolores's eyelids would begin to flutter and she would declare that she was "going behind her eyes." This became a way of communicating to me that she was becoming overwhelmed and needed to retreat. Our validating her need to retreat would very often make it possible to proceed.

During this period she touched the same two scarred areas on her body, over and over, in a quasi-trance-like state. She would ask me if she was bleeding. From this behavior we were able to understand that she had been beaten in childhood. She remembered that she would hide in the closet to escape the abusive (biological) mother. She whispered over and over to me, "Shhh. Don't move. Be quiet. Shhh." Her body was tight with fear.

During the periods in which she was struggling to tell me something about the sexual abuse that occurred during the period with her biological mother, she vomited on her way to the sessions. There was a tightening in her face around her mouth, and she did not want anyone to come near her mouth. These symptoms, together with other memories, associations, and drawings she brought me, were eventually linked to oral sexual abuse.

She also had an impulse to smash her glasses on the wall of my office. This smashing of glass was linked by her to memories of jumping out the window, breaking the glass in her effort to escape from the abusive mother and look for the first mother. During this period of the treatment she remembered that she had once gotten on a bus, around the age of 20, and traveled all day and all night, looking for the first, good mother. She had found a file that belonged to her father with information about the adoption. In that file she had also found the photograph of the little girl with the bruised, swollen face.

Dolores's Discovery of a Man in My Life: Toward the End of the Second Year

Six months later Dolores discovered that I had a man in my life. This revelation reminded her of the last day she had seen the first, good mother, who had left with a man. To her, "the man" had taken her mother away. She was convinced that "the man" would take me away from her and that she would lose her "place" with me. Much later in the treatment we discovered that this traumatic theme, that the father figure would take the mother away, was repeated in various ways in all three of her family constellations.

The presence of a man in my life evoked in Dolores this core traumatic theme, which, from then on, became a central aspect of the treatment. Our "honeymoon" was over. She began to struggle with the feeling of being "kicked out," as she had felt "kicked out" by the first, good mother. For the first six months after discovering "the man," Dolores barely spoke to me. It was an "ice-rage." The sessions over the telephone were particularly difficult for us. It was quite a loss for me to endure such a profound withdrawal of her love. At first I felt terribly guilty, and the situation evoked a core traumatic theme from my own early childhood, my own "badness."

My reaction sent us into quite a tailspin. It became extremely difficult for me—for us—to tolerate how enraged she was. 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. This acknowledgment meant a lot to her,

and she did not press for details. Slowly she began to talk to me again. Although we have continued to struggle with this theme throughout the entire treatment, we have increasingly been able to think together about what it means.

Dolores's Use of Viewing the Videotapes to Foster an Internalization Process: Making My Faces on Her Face Two and a half Years into the Treatment

These are notes taken during a session on the telephone. While she was alone, Dolores had been looking at the videotapes taken a year and a half into the treatment, described earlier.

Dolores: I was looking at your face looking at me. I saw the way it's different when I'm with you.
BB: You saw it watching the video?
Dolores: Yes.
BB: What did you see?
Dolores: I saw that you were seeing me. I wasn't seeing you when I was with you in person, but later, when I was watching the video and I saw you, I felt much more real.
BB: Wow.
Dolores: Yes. In a way that, when I am with my feelings alone, sometimes I don't. But when I saw my feelings on your face, I felt more, feeling my feelings. I felt kind of familiar. But I don't *feel* them, necessarily, when I'm alone.
BB: That's very interesting. "To feel them" means what, really?
Dolores: When I'm alone with them I feel more confused. When I see them on your face, I can read them better. When I'm having them all by myself, there isn't any sense to them—that's part of what feels so bad, nobody to make any meaning.
BB: Can we make the same meaning when we're talking on the phone, now, without the faces?
Dolores: I need to see, or I need to *feel*. I have the picture of you, looking at me, and I like it; you never take your eyes away from my face. But now, on the phone, your voice floats on the ear, floats away. I want your eyes looking at me.

This session shows how Dolores began to use watching the videotape as an adjunct to the internalization process. Internalization can be reconceptualized as an expectation of an interactive process in which the inner organization is based on reciprocal coordinations, joint bidirectional interactive patterns, that regulate the exchange (Loewald, 1980; Benjamin, 1988; Beebe and Lachmann, 1994). Watching the videotapes provided a format in which she could actually see and take in more information from my face. And, recall, videotaping was her idea. From my research on the facial interchange between infants and mothers, I am convinced that she needed to see my feelings for her in my face, as well as hearing my emotions through my voice. The videotape gave us a powerful way to do that. At this point in the treatment, she still was not looking at me, and we did not yet completely understand the dynamics behind this behavior.

The research of Dimberg et al. (2000) can help us imagine what was happening when Dolores watched my face as I watched her. Out of her own awareness or conscious intention, Dolores's expressions probably matched mine. The work of Ekman (1983; Ekman et al., 1983; Levenson et al., 1990), showing that particular facial expressions are associated with particular patterns of physiological arousal, suggests that Dolores had visceral as well as facial responses as she watched my face. This research is consistent with Gergeley and Watson's (1998) suggestion that, in the parent–infant face-to-face exchange, one function of facial mirroring is to amplify the infant's inner state. Seeing his or her own facial expression reproduced or elaborated on the face of the partner may help the infant sense and register his or her own face and associated proprioceptive feedback.

Something like this seems to have occurred between Dolores and me. She was learning more about her own feelings by watching me experience her. Her inner registration and identification of her feelings had been difficult for her. When she was able to "see" herself in my face, she was able to sense her own inner state more clearly (George Downing, 2001; July 18, 2001, personal communication). She was also better able to register her own response to me in a verbal mode: she *liked* the feeling of my face watching her so closely. The discovery of "mirror neurons," described in Paper II, is also relevant to Dolores's watching the videotapes. Simply by her watching my actions, for example, a moment of tender response on my face, her brain may have been activated in the premotor cortex, as if she herself were performing those actions.

At the end of this portion of the video, she poignantly reminds us how difficult it is for her on the telephone. Her great difficulty remembering me in-between sessions was exacerbated by the unfortunate necessity that we have so many sessions over the telephone.

Further Work on Internalization: "Those Good face-feelings: That Is What I Have Inside Me."

[Continuing over the telephone one week later]

Dolores: I'm thinking about how I used the video to remember you. Because I don't look at you when I'm with you. I don't have the memory of my face *interacting* with your face, because I don't *do* that. But when I was *watching* you, on the video while I was alone, I was interacting with your face. When I wanted to have certain feelings, I called up the feeling of your face. *I was making your faces on my face*.

Here her experience brings to mind the work of Meltzoff described in Paper II. Dolores is describing a "like me" experience. She can get back to her own experience through my face. First she senses that, as I interact with her, my face is like hers: I feel her and my face reflects what I feel. Then, as she matches my face in the video while she is watching it, her face is like mine. In this way she has gotten back to her original feeling.

BB: Like imitating?
Dolores: Yes, but not imitating exactly. More remembering the feeling of your face talking to my face—not the words. I said your "face-talk" *on my face*. I was getting the feeling for what was happening in the faces, and that's how I remembered certain feelings, certain good feelings—how I remembered feeling comforted—during watching the video and after—during the good period when I wasn't saying that your face isn't for me, anymore.

Here Dolores is referring to her reaction after she discovered the presence of a man in my life: she felt that her face was no longer for

me, and my face was no longer for her—the trauma with the good foster mother. But nevertheless she is able here to talk about a profound feeling of facial connection between us.

BB: I'm so sorry that you feel that now. But I still feel that my face *is* for you.
Dolores: You have such good faces. I have those good face-feelings. That is what is *inside me.* I sometimes have bad face-feelings too. Your good faces, the "still-lake-face," the "resting-face"—I like best your "just-watching-all-the-time-face," it makes me safe.
BB: I'm so happy that you can see what my face feels for you. And how did you remember us after you watched the video?
Dolores: I wanted the feeling again. *One strange thing: afterwards I made your face.*
BB: Oh! Which one?
Dolores: A certain face. A picture of my feelings. Deep. Like when you see I'm worried or sad.
BB: Then you made my "worry-sad-face"?
Dolores: Yes. I moved my face. I could just feel you.
BB: You could feel me responding to you?
Dolores: If I don't have a responder, I can't even have that feeling. It's *you*, feeling *me*, and it's *me,* seeing myself on your face. *Then I can feel more real, then I know that it is me.* On the video, when I let myself be with your face, *then I knew that your face was for me*, the second time I watched it. I could see that your face was not bad or scared or mean. The face is the beginning of a person. This faces loves me; I'm okay.
BB: I think you felt this once before, with the face of the first, good mother, and now you feel it again with me.
Dolores: I guess I took it away from you.
BB: Because you think that my face is not supposed to be for you anymore because of "the man"?
Dolores: I don't want there to be three faces. If there are three, only two go together, and my face isn't in it.
BB: You're describing to me a way of using the video to help yourself know that I sense you. But because of this terrible tragedy when you lost your first, good mother, and you think a man took her away, your ability to know that my face is for you has been disrupted. This is very difficult and sad for us.

Dolores: All the other times I looked at the video I saw your face, but I didn't let myself *be* with your face, and I didn't let your face *be with me.* This time I did. It caught me by surprise.
BB: You really let yourself have it this time? You need my face to feel my reach for you, and to feel yourself.
Dolores: Otherwise I'm like a blind baby.

She is even more articulate in this session than in the last one about how she uses the videotape as an adjunct to an internalization process. Her statement, "those good face-feelings: that is what I have inside of me" is a way of talking about how she can both viscerally and symbolically sense my appreciation of what she feels. She is active in the process of matching my faces on the video, participating, creating, rehearsing. She also uses her memory of looking at the videotapes to call up certain feelings, and she makes subtle differentiations among my faces. This is a big shift in her own capacity and activity. The discovery of a man in my life threatens to disrupt her emerging but still very fragile internalization of our relationship.

Being Sensed. One Year Later, Early in the Fourth Year

[Notes taken during a telephone session]

Dolores: When I get so sure inside that I don't have a face, and then I disappear, when I don't have a sensing—I don't know which is first, my face or the other face—then I don't have my senses, even breathing, because all my senses are in the face.
BB: In the face of the other person, in relation to your face?
Dolores: Yes—in *your* face. I don't have a face if I'm not sensed. If I'm not in your senses, then there's no way to be alive. You don't have any of your own senses or sensings without the other person. Then you can't talk.
BB: Is that maybe why you couldn't talk and went mute?
Dolores: I think so. I did not have any senses. I couldn't sense anyone else's senses, or anyone sensing me—even the touching sense—touching is still in the face.
BB: That must have been so terrible.
Dolores: Yes.

BB: And do you feel that way again now?
Dolores: Yes.

In this vignette Dolores tells me how much she needs my sensing her in order to have a sensing experience of herself. The experience of not being sensed by me, and not sensing herself, typically occurred during a telephone session and almost never face-to-face. She is also very coherent and articulate in this session, particularly in contrast to material from the middle of the second year. Earlier in her life she had had an image of herself as completely alone, a "little creature without a head." My association to this session is that she "took off her head" in response to the traumatic loss of a sensing, loving presence when she lost her first, good mother. She could not sense herself alone, and she felt she had lost her head.

Your Face in Response to My Face: You Let Me Affect You. Early in the Fifth Year

[Notes taken during a session in person]

Dolores: My whole life I have had big feelings about a lost face I was looking for. It reminds me how I felt after I lost the relationship with James [the long relationship that did not work out], and I was in unbelievably deep grief and mourning. I don't have the words for it, but I know a huge part of the loss had to do with how I had affected him, how I saw his face respond to me. That was a metaphor, maybe, for a total way of responding. You know, how as a dance makes music visible, a face makes a whole heart visible.
BB: How did his face respond to you?
Dolores: Part of what was so missing was his face—his face-in-response-to-my-face. I learned about myself when I saw my impact on his face. I created something—to see yourself, to see your impact on the other person. I can make that face do a lot of different things. You know, we seek the pleasure and the desire on someone else's face. [long pause] It was not just that I missed his face, but the conversation, what I could make happen. The

loss was being able to make a difference. [Dolores cries]. When I met you—Sally [Dolores's previous therapist] was quite wonderful, but she kept hiding. She was uneasy about letting me have an impact on her, except she would use her own reactions, but only in terms of what I might have evoked in her. The therapist can say, you know, I find myself feeling angry and can use that to talk about the patient's anger. But do you think a therapist ever says, you know, I found myself feeling loved?

BB: [laughs] I do feel that.

Dolores: That is what is different here. From the very beginning you let me affect you. That is what I've been missing my whole life.

BB: How did I do it?

Dolores: [cries] You accepted it, what my feelings were, or what my face was or offered—you met it. You felt affected 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.

BB: I did feel so moved by you and by your story. I remember so vividly the first day I met you.

Dolores: You shook my hand in that little waiting room, the first day.

BB: And the next time I saw you I ran into you in the street.

Dolores: You recognized me—

BB: And we were both so surprised and delighted in the moment.

Dolores: Because of the power of our first meeting.

BB: Yes. I know I did let myself be affected by you, by your story. I remember I wrote down some of the things you said about your face in those first few meetings.

Dolores: Your response to me made me more hopeful. It helped me identify what it was I needed.

BB: I'm so happy you feel this way. [pause] And will you remember this on Monday?

Dolores: No. I am too upset when I remember it and don't have it. Maybe I remember the loss of it.

BB: Yes. I think so. The loss of our conversation, even temporarily, becomes more salient than what we had. Like Stern's infant research example of one mother who attunes to enthusiasm

when the little girl is having fun and becoming excited, on the way up the arousal curve; and another mother who attunes to "*ex*thusiasm" when her little girl is on the way down, after the blocks fell: Don't worry honey, we'll build it up again. You code "*ex*thusiasm."
Dolores: Psychoanalysis is best at entering the patient's distress, not the patient's joy. But the psychoanalyst as the person may resist entering the full despair.
BB: And sometimes you feel I have trouble entering the full impact of your despair.
Dolores: Yes.

The remarkable range of Dolores's functioning is again evident here as she describes the lost relationship with James. Her ability to value her impact on James, and on me, helps to repair the profound helplessness of her early years. Again, at the end of the vignette I am concerned about her difficulty in holding on to these feelings.

Taking Both of Us into Account. Two Years Later, Seventh Year

[Notes after a session in person]

We uncovered her feeling that her face did not have enough to give me. It was at a moment of her deep despair, when I had been feeling that I did not have enough to give her. Her association was that she must have felt that was why the first good mother had left her, that her own face did not have enough to give, and that perhaps I experienced with her what she had felt about her first mother. Increasingly now Dolores has a remarkable ability to take both of our experiences into account.

Beginning of the Ninth Year: Together We Watch the Videotapes We Made in the Second Year

This vignette is based on a session in person. Dolores and I are watching the videotape sections from the second year, described earlier. She

has given me permission to show these clips of my face to a professional audience, and she wants to review them. The following exchange is based on notes taken during the session. We are looking at the section where I am saying, "Good but *sad*? Good but *sad*?"

Dolores: You have an energy here. You have heard something. It marks the moment. You have a lot of hope in me. For me it seems like I'm waking up, being discovered. Same as now. You bring me alive. I was feeling that leaving would turn me to concrete, like going into a coma. You are transforming things—my hope of being found.

[Now we are looking at the section of the video where I am saying, "If you look at me, you feel I'll become the mother you'll never see again." Dolores says, "If I don't look at you, it won't happen." Then, after a long pause, she looks at me for a split-second and I smile.]

Dolores: You are so happy to see me look at you!

[Now we are looking at the video section where we are teasing.]

Dolores: These are the faces that I wait for. They bring me to life.

BB: These are beautiful things to say to me. [pause] You are so much more able to look at me now. What do you think made the difference in shifting it?

Dolores: Your harassment and bullying. [we both laugh] I can see now that I could come to look at you because you gave me so much with your face. I couldn't stand, after a while, not giving you mine. Which I wouldn't know really if I weren't looking at this with you now. How could someone who is looked at the way you look at me not reciprocate? Because one of the important reasons I feel so dead is not being able to give someone my own face.

BB: That is also a beautiful thing to say to me. I think the other thing that helped us was analyzing the fantasy that, if you looked at me, my face would turn into the monster [one of her abusers], or I would see you as a monster.

Dolores: I looked at your face. I did not see a monster, so that could tell me *I* wasn't a monster either. Your looking at my face didn't make you into a monster. You gave me a good sweet face; it must mean I'm not a monster.

The analysis of Dolores's fantasy that if she looked at me she would see the face of a monster, her abuser, or that she herself would have a

monstrous face, went on over the course of at least half a decade. Only very gradually did this terror diminish until finally, at this point in the treatment, she seems to feel relatively free of it.

Dolores: I know the feeling, being on the other side of it. I wonder how *others* perceive it, how close it was to what I felt. What do *others* see about *us*?
BB: I think the audience was very moved by my being willing to show myself to them.
Dolores: But *really* what they were seeing was your willingness to show yourself to *me*. Therapists are not usually willing to show themselves. The face of Jason [one of her former therapists] was like a stone.
BB: I'm grateful that you felt comfortable enough to let me show the videotape.
Dolores: Now that I see it, I feel I'm totally protected.

In this vignette Dolores is able to revisit our early interaction with delight. She takes pleasure in my energy, my happiness when she can look at me even for an instant. She is very clear that my response to her has helped her come alive. She uses this moment to realize that she needed to reciprocate, to give me her own face. This is something so essential that we have been struggling to accomplish. Her capacity for spontaneous delight, for reflection, for humor in teasing me, for appreciation, all indicate a widening emotional range.

Dolores's Face in the Ninth and Tenth Years

Dolores's face has undergone quite a transformation. It is soft and hesitant, but her emotions are visible. She is slow to make eye contact but can sustain a steady gaze at times. At some point in the session, she can usually open up into a smile. At the beginning of every session in person, there is still a question of how long it will take her to take off her sunglasses. I feel very shut out when she wears them, and it is a sure sign that she is feeling distant when she does not take them off for quite a while. Usually these days she takes them off quickly. But more time will be needed before she will be able to look at me in a more ongoing and sustained way.

More Work on the Theme of Being Kicked Out by "The Man"

In the ninth and tenth years we made more progress on the theme of being "kicked out" by the presence of "the man" and her continuing anger at me that somehow, whatever I do, it is not right, or not enough, or not what she needs. This anger was usually very palpable on the telephone; it hung heavy in the long silences between us. We were able to agree that her silences on the telephone were her way of pouting and protesting without putting into words how neglected she feels. She was able to comment that she knew her feelings did not really quite make sense, even though she still felt them as strongly as ever: she felt "squeezed in, stuck on, a 'post-it'." Eventually she was able to tell me, "If I don't hold myself back, angry and stony, I'll just be begging you not to leave, not to end the session. I'm always on the verge of doing that. If I don't let myself be with you, I won't be in a state of panic when the session ends. I feel powerless: it doesn't matter what I feel or want; I'm not going to get what I need, because of the man. Which I know isn't really true."

Dolores was now developing a new, tentative relationship with a boyfriend. Although the increased security in our relationship had made this new boyfriend possible, she felt that something more needed to shift between us if the new relationship was to be possible. The new boyfriend added a new urgency to our need to solve this problem.

In an important series of sessions, she commented that she was always in a "waiting mode," waiting for the time that she would really have me, but she never did. She felt not alive, spending her life waiting. In a very familiar vein, I commented on how painful it was to be waiting for the mother who never came. But then I suggested that perhaps she had a fantasy that someday she would really "have" me—maybe like a mother or a "primary partner"—so she didn't have to be alive now or really use what we had now. Instead, she stayed half-dead, waiting, until she got her mother back. Dolores could not in this session focus on or hold on to this idea. In the next session [in person], however, Dolores was more forthcoming:

Dolores: In-between our sessions, the waiting is interminable. I'm protesting the waiting. Even though I know that it's not really *you* who made me wait. This is what I feel when we talk on the

phone: angry, you've made me wait, the way I had to wait for my mother, and she never came.

BB: [I refer back to the previous session's idea that she has a fantasy that she will eventually "get" me, so she doesn't have to use me now.]

Dolores: What I have with you is not sufficient, so I'm not going to settle for it. I'm not going to let it count as the real thing.

BB: The "real thing"?

Dolores: Something that can never be. Something that I never had, a better past, a real mother. If I make it okay, what I have with you—though it *is* wonderful—then I would have to accept what has already happened, and what will never happen.

BB: You seem to have the idea that the loss is not irrevocable, you could get her back, you could get me back, it could be "just you and me" the way it was originally just you and your first mother.

Dolores: Probably. I know I can't go back to being a *baby*. "The man" has something I want; he has the advantage; I'm diminished.

BB: You are having difficulty mourning for the terrible, irrevocable loss. You are holding out for something else, something better, getting your mother back, getting us as a primary mother–child unit, that I could somehow be the real mother. And you had these difficulties before "the man" entered the picture.

Dolores: I want to go ahead with this new boyfriend—whatever is happening with him is so different—but I have the idea that if I do go forward, I will give up the opportunity to find something that I already lost. A grown-up relationship runs counter to the fantasy of getting my mother back.

BB: To be able to go forward with this new relationship, and to accept that I am your "real" therapist now, require facing this mourning.

Dolores: [crying] My only hope was to get her back. I knew it was impossible. I always knew this. But I try anyway. It keeps me from having a life. I can't think about it.

[later in the session]

Dolores: The man—pushes me out—is probably connected to the idea that I can't grieve. If I keep him there, kicking me out from being with you, then I'm holding on to the idea that I *could* have you. It's because of the man that I can't have you, rather than the problem with grieving.

BB: That is such an important realization.

Sharing this Paper with Dolores and the Impact on the Treatment: Tenth Year

In the process of obtaining Dolores's permission for me to write up our treatment, I gave her a draft of this paper to read. This event became a catalyst for reviewing the treatment together. This vignette occurred over the telephone.

> **Dolores:** In the videotapes you were sitting so quietly, so respectful, so careful. Did you know that you were honoring the potential overarousal of my longing?
> **BB:** I did feel careful. I felt your fear. I felt your longing, your terror of loss, a huge love and a huge loss.
> **Dolores:** I was longing for engagement but it was intolerable to get it. I shut down interaction in the arena most important to me.
> **BB:** Yes, you shut down facial engagement and looking, but you engaged in other ways: you really did talk to me. Even during the periods that you were so dissociated and didn't remember, you were always trying to explain what had happened and struggling to remember all the traumatic things.
> **Dolores:** I might not have looked at you directly, but I took in enough of your face. I took it in the very first time I met you, the very first minute, in that little waiting room. I *saw* it, and I *had* it. I made it a good face. I had your face instantly. You looked right at me, and I felt totally welcome. You were totally welcoming me. Any time I did look, your face was always right there, always waiting for me. And your voice always had a face. I got glimpses of your expression, and I got enough to make a strong image of a good face in you.

I believe that something very important happened for Dolores as she saw my face for the first time. We did, however, continue to struggle in the early years of the treatment: if she looked at me, my face might look like the "monster," or her face might look like a monster as well. In addition, by avoiding gaze, Dolores was trying to keep out a face that might evoke too much painful longing, or a face that might abandon her. If she looked at me, she might lose me. It took years of testing out to see if my face might be safe to look at.

I Feel on My Face the Feeling on Your Face: Tenth Year

[Notes taken during a telephone session]

Dolores: I was thinking about the "good" between the faces, and how I hold on to that feeling. When I have to leave you, I feel on my face the feeling on your face, saying "good, but sad."
BB: As you see it on my face, you feel it in yours?
Dolores: Yes. I feel *you* on *my* face. I see your eyebrow furrowed, trying to see something. You're listening to me so intently. And I can *feel* it on my face, in my body-face. I use it on my own face, the good-mother face, your face. [pause] When you have the good-face-in-relation-to-the-good-face, you get to be the good face; you get to have the good face.
BB: You remembered this, and it became the foundation for your beautiful capacity to love.

Discussion

Dialogic Origin of Mind

One of the central ideas of the infant theorists of intersubjectivity illustrated by this case is the dialogic origin of mind. In early infancy Dolores lost her biological mother and she was given to a foster mother. At approximately age two years Dolores lost the dialogue—of face, voice, touch, smell, and some words—with her first (foster) mother. This loss was further compounded by the substitution of the abusive (biological) mother and sexually abusive men. The theory of mind based on presymbolic intelligence, briefly described in Paper I, posits that infants code expectancies of "how interactions go." One aspect of the trauma that Dolores suffered was a profound violation of her expectancies of "how the faces go." She expected a warm and loving face, the face of the first mother, whom she could make happy—and instead she was "faced" with the angry, hostile mother who told her she was bad, and she had to deal with sexually abusive men. One reason she did not look at me was that she anticipated that either she or I would have the "monster face" associated with the abusive men. She essentially had learned three different sets of expectancies of

interactions, three different sets of implicit relational knowing: one with the good mother, one with the abusive mother and men, and one with her adopted family. We were always working with all three, trying to integrate them, while validating her very different experiences in them.

But eventually her voice and face went mute, when she was approximately four years old. She described this experience as "going away," "going dead," "defeated," "lost," being "in the quiet place." Perhaps Winnicott's (1958) concept of the loss of going-on-being comes close to describing this trauma. This profound disruption in the *dyadic* organization of her experience threatened the dialogic organization of her mind. It resulted in a loss of *all* forms of "intersubjectivity" during this period. This state of mind continued to threaten her as an adult.

The Role of Correspondences and Matching

Our central focus in the early stages of the treatment was to find a way into Dolores's "closed system," as she later described it. Despite her verbalized longing to "find my face," she was shut down and inaccessible for long periods. Arranging our chairs at a more "biological" face-to-face distance helped to create more "immediacy" of my presence during periods of her profound dissociation. But a great deal of the work of "finding" Dolores was based on variations in the nonverbal correspondences and matching described in Paper II by the three infant theorists. These correspondences provided the most basic ways in which I sensed and entered her experience, promoting a feeling of "being with" and "shared mind," as described in Papers II and III.

The matching concepts of Trevarthen and Stern provided one foundation of the treatment. Trevarthen's concept is that each partner is able to be aware of the other's feelings and purposes without words and language by matching communicative expressions through time, form, and intensity. Stern's concept of tracking slight shifts in the partner's level of activation of face, voice, or body, and *changing with* the partner as a way of "feeling into" what the partner feels, adds further specificity to the concept of matching. I felt my way into Dolores's experience through the way her lower lip might tremble, through her rapid foot jiggle when she was anxious, through the muted quality of her face and movements, through her drastically lowered

level of bodily activity—the "deadness." I matched her very reduced activity level, her pausing rhythms and long switching pauses, the rhythm and contour of her words.

For Trevarthen, rhythm is perhaps the central mechanism through which immediate sympathetic contact is created in the earliest protoconversations (see also Jaffe et al., 2001). Since Dolores initially did not make much use of the facial-visual channel of communication, the early phases of the treatment were carried through my rhythms (of voice and body) rather than my face. Matching her rhythms constituted the *process* of how I reached for her, how I tried to sense her state, and she could come to sense mine. Both Stern and Trevarthen argue that matching of communicative expressions simultaneously regulates both interpersonal contact and inner state. Dolores gradually came to sense a "comforted" inner state as she became more aware of how I matched her. Thus matching of expressions through time, form, and intensity was a powerful nonverbal mode of therapeutic action.

The video heightened Dolores's awareness of my response to her. Perhaps the same results could have been accomplished without the video, but, in any case, Dolores felt that the video helped us. I agreed. Like Winnicott's (1971) child playing the squiggle game, who becomes aware that another is aware of what the child is aware of within, by watching the video Dolores discovered that I was seeing what she herself "carried" in her face and body, or "sensed" about herself, without being able to describe it verbally. Seeing my face seeing her, and hearing my sounds responding to hers, alerted her to her own inner affective reality. After reading this paper, she declared, "I recognized myself in your face recognizing me, for example, when you said, 'good but sad,' and I came to feel myself more and to feel more alive. I saw myself, and I saw you, recognizing me, and I felt the promise of an 'us' as a new possibility. And I came to feel an inner sense of feeling comforted."

Like Meltzoff's description of the infant's face gradually approximating that of the model by using the proprioceptive feedback from facial muscles, Dolores would find herself "putting on" my facial expressions while watching the video. By "wearing" my face, Dolores became more affectively aware of her own inner experience, presumably through the proprioceptive feedback of her face as well as the feedback from various physiological arousal systems (see Ekman, 1983). Meltzoff's concept that by imitating, the infant experiences that the

other is "like me," is in play here. As Dolores matched my various faces, she experienced that she was "like" me. But since I was trying to sense my way into *her* experience, she found *herself* in my faces. Dolores's matching also illustrates Stern's concept of "feeling-what-has-been-perceived-in-the-other." As she watched the video alone, Dolores experimented with letting herself "change with" my face and thereby to feel what I had perceived in her.

The description of mirror neurons, presented in Paper II, may illuminate Dolores's experience watching the films of my face interacting with her and matching some of my faces. By simply watching my face moving in heightened affective ways, simultaneous activation of mirror neurons in her own brain might provide her with a link between my action and her neuronal "participation" in my action (Pally, 2000; December 18, 2001, personal communication). But, as Pally observed, it was not enough for Dolores simply to watch my face in the video; she had to *make the faces herself.* In this way she presumably obtained more overt sensorimotor feedback from her own body. Her own actions of matching seemed to be important in giving her back her feel of herself.

The Role of Difference

As important as these matching interactions were, matching alone did not fully characterize the nature of my interventions. "Matching" is too global a concept. Instead, in most of my responses, similarities and elaborations, as well as differences, were apparent. For example, I might repeat her phrase, which was punctuated with stops and starts, but bring it into a more coherent rhythm. I might add a rising intonation at the end of the sentence, with a feeling of questioning and opening, as if to hold open other options. I might elongate and emphasize a particular word, giving us a longer moment to absorb its impact. If I saw a shift on her face, such as a sudden sadness or a smile, I tried to put it into words. Usually my face showed the varying emotions that I sensed in her, even though her face usually did not. I might repeat her phrase but then add a "sinusoidal" greeting contour, heightening positive affect. I might elaborate a moment of humor with more rising and playful contours than hers, expanding the range of playfulness. At many points I verbally elaborated on what she said; I might link it with an earlier comment or anticipate the ending of the session.

These varieties of matching responses with subtle elaborations and differences were aspects of the regulation of positive states, but they also provided forms of distress regulation in which I both entered her experience but also slightly added something of my own. They often held open the possibility of just slightly broader ranges of experience, similar to Loewald's (1980) concept that the therapist holds an image of where the patient might be able to go. The moments when I exactly matched without altering were rare. I consider them to be very particular forms of distress regulation, consistent with Stern's concept of "share without altering," in which I had no agenda but to stay in her feeling, with exactly the range of nuances that she expressed. For example, joining a sad and dampened state without shifting it is a powerful way of sharing and accepting the distress (see Cohen and Beebe, 2002). As Schore (1994) argues, expanding the capacity of the patient as well as the analyst to stay in distress states, and to find more modulated ways of regulating them, is essential to transforming the distress. Cassidy (1994) argues that distress regulation is an essential aspect of the attachment process. On the positive side, Stern and Trevarthen note that expanding the capacity of both partners to join in positive states is essential to creating a secure attachment bond. Schore (1994) notes that expansion of positive states in the dyad will ultimately alter the opiate circuits in the brain associated with positive affect.

The Role of Self-Regulation

Various nonverbal movements of self-regulation provide powerful additional information about the inner experiences of both partners as well as about the state of relatedness. The contribution of my own self-regulation is visible in the videotapes when I rested my face in my chin and then slowly moved my hand up my face. This movement suggests a self-soothing, and holding of distress. Varieties of head tilts function in many ways, including questioning, marking shifts of attention, and accenting ongoing verbalizations. Sighing is a release of one's own distress, but it also can communicate an entering of the other's distress. My own self-regulation movements not only highlight the moments in which I am experiencing particular stress, but also communicate to Dolores my participation in her distress. In one session later on in the treatment, when Dolores noticed that I was rubbing

my feet together (a self-soothing movement that I recognize from my childhood), she commented that I was doing it while she was refusing an interpretation that I was offering. This moment also illustrated her remarkable ability to hold both our experiences in mind.

More global forms of Dolores's self-regulation are seen in her drastically lowered level of bodily movement, her childlike, barely audible voice, her long periods of silence, her inability to look at me. Ongoing nonverbal signs of Dolores's self-regulation movements are harder to depict because she is seldom in the videotaped segments analyzed. At one moment, however, a rapid foot-jiggle is visible, expressing a moment of tension or anxiety. Another powerful form of self-regulation was her wearing sunglasses at the beginning of every session in person. This presumably provided her with a safer distance: she could see out, but I could not see in. The light was also dampened, perhaps lowering the level of stimulation and providing some soothing. Whether and when she would take off the sunglasses was a complicated interaction for us. Earlier in the treatment I accepted long periods, perhaps half an hour, with her sunglasses on. But, as the treatment progressed, I became more impatient and gradually more insistent that she take them off after five or ten minutes.

The Role of Interactive Regulation

One of the most essential aspects of what was reparative in this treatment was Dolores's sense that she could affect me and that I could affect her. She could sense, and see, and see again in the video, how her agony affected me: how it shifted my face and voice, created tenderness in me, and was comforting. She frequently told me how I affected her, both by making her feel cherished and by making her feel "kicked out," imagining that "the man" was the one that was important to me and she was not. After reading this paper, she commented on how important it was to her that I had understood "about the profound loss of feeling my impact on the other, of finding my impact on their face."

The basic concept of the mutual-regulation model—that each partner affects the other—is broader than the concept of matching. Each partner senses in herself an ongoing receptivity (or lack of receptivity) to the other, in adjusting, coordinating, and being "influenced," and each has an ongoing impact (or failure of impact)

on the other. This is the bedrock of the entire treatment, the foundation of all human communication. Matching is a very specific form of this more general process of bidirectional interactive regulation.

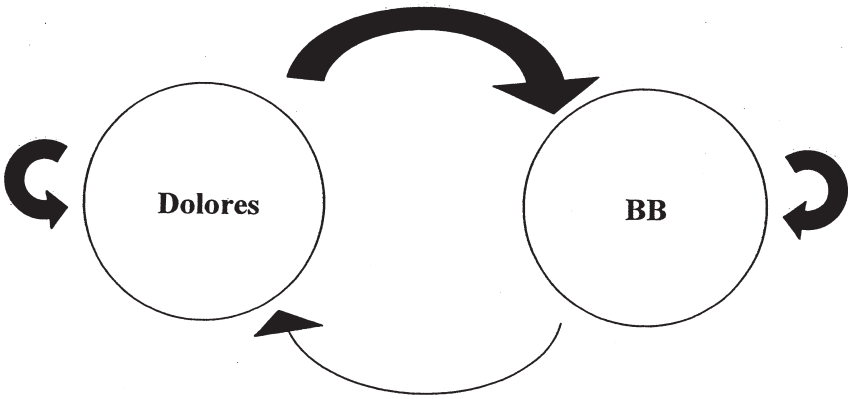
Balance Model

When we began the treatment, Dolores could be characterized as preoccupied with self-regulation, largely sacrificing engagement (see Figure 1). She was emotionally withdrawn, rarely looked, and frequently was silent for long periods. Essentially she refused a face-to-face exchange. When she did speak, she was hesitant, slow, and childlike. Her inner state was one of "icing over" deadness, or terror. However, she did participate in slow dialogic rhythms with me, even though in a halting, fragmented way. And she did at times try very hard to communicate verbally.

For my part, at the beginning of the treatment I could be described as being in a state of "therapeutic hypervigilance": not taking my eyes off her, tracking every shift in her body or voice, straining to catch her words, but drastically lowering my level of activation (in retrospect so as not to frighten her), and, when I was not speaking, frequently (out of awareness) keeping my body *perfectly still*. This was, however, a very "active stillness" (J. Gerhardt and P. Carnochan, November 25, 2001, personal communication). I did not intrude or "chase." While my body might be still and I listened while remaining verbally silent, my face remained open, expressive, and receptive (J. Kaufmann and P. Kaufmann, August 12, 2001, personal communication). I often leaned forward but remained contained within my own space (S. Tortora, June 2, 2002, personal communication). When I did speak, my vocal rhythms often matched her slow rate, and I participated in very slow, turn-taking rhythms; I tolerated very long "switching pauses," never hurrying her. My primary mode of interaction was to "go with" the shifts of tone, rhythm, activation, or face that I saw in her, as described by Stern. These adjustments, which I made largely out of awareness, moved me into her range. Much of my nonverbal behavior with her was based on what the infants had taught me. After reading this paper, Dolores declared, "You insinuated yourself into an interaction with me, into my closed system, where I had shut everything out."

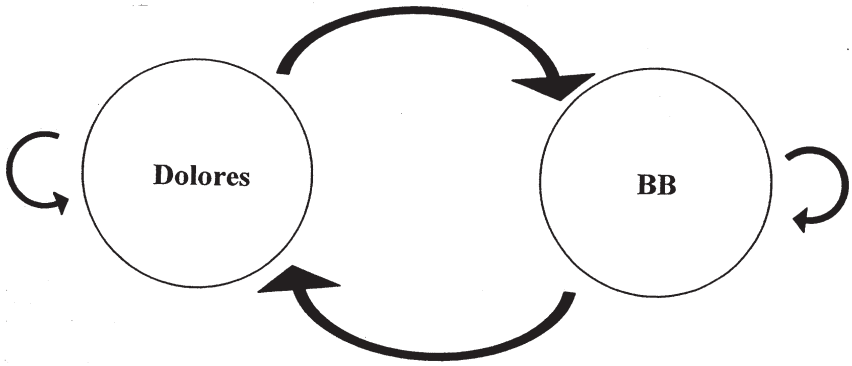
Ten years into the treatment, we have both shifted our positions toward the "midrange," with a greater balance of self- and interactive

Initial years of treatment



Dolores was preoccupied with self-regulation: withdrawn, muted, gaze-avoidant, regulating terror and deadness. She was intermittently verbally responsive, but childlike. Nonverbally she showed tentative tracking of BB's rhythm.

9th and 10th years of treatment



Dolores's self-regulation is less extreme with greater range. She gazes tentatively, is still frightened, but can feel "comforted." She is verbally responsive, reflective and generative, "thinking together." She is nonverbally responsive.

BB's self-regulation has returned to her usual range, with higher activation, not "careful." BB's tracking of Dolores's verbal and nonverbal behavior is more midrange, no longer hypervigilant.

Figure 1. Transformation of the interactive system in the treatment of Dolores.

regulation (see Figure 1). We have regained face-to-face relating, in large part. Dolores is far less preoccupied with drastic forms of self-regulation, and she is much more engaged. She talks more, her voice is more audible, and her vocal rhythms are fluent. She participates in a fair amount of mutual gazing, looking and looking away in a more usual adult pattern. She reports a "comforted" inner state, at least some of the time, particularly when we are physically together rather than on the telephone. She talks about how hard it was to "relax her grip," to relax "holding on to herself," and says that she still has trouble with this.

For my part, I am no longer "hypervigilant" in my attention to her, and I am no longer dramatically altering my own self-regulation patterns in an attempt to make contact with her. I am not struggling to dampen down my arousal. My range of body movement is not inhibited, my level of activation of voice and face are more within my usual range, my speech rhythms are not as slow, and I am not as "careful" with her as I once was. I can be more relaxed and playful. The narrative is far more coherent. The treatment progresses in a more usual verbal interchange, and the nonverbal communication is generally more in the background. The verbal–nonverbal distinction is not as rigid: verbal and nonverbal create more of a seamless process. A videotape of my face taken ten years into the treatment shows far more movement in me, particularly head movements. There are no periods where my body is perfectly still. My smiles are softer and have more of a range, my expressions are less "officially nice" (M. Heller, February 18, 2002, personal communication), and I even allow myself a blank face at one moment. I seem to feel less pressure to be "on," and I am not straining or trying so hard.

In this particular videotape Dolores has given me a book, and with her permission I allow myself the pleasure of reading a passage that is particularly meaningful to our relationship. There is "space" for me now, too (M. Heller, February 18, 2002, personal communication). In her outside life, Dolores's relationship with her new boyfriend is progressing. She has become much more involved with professional colleagues as well as friends, so that she is less isolated. But she is still having trouble producing work on her own.

Concrete versus Constructivist Theory of Mind

At the beginning of the treatment, Dolores could be seen as partially stuck in a "concrete" theory of mind (see Paper I): it was difficult for

her to know that how things appeared to her might not be how others saw those same things. She tended to misread her current reality, and conflate it with the experience of the abusive mother or the loss of the good mother. I addressed her difficulty in comparing old realities with her current life and her difficulty holding together different ideas from different eras of her development. Increasingly, though, Dolores had access to a constructivist theory of mind, which was a precious resource in the treatment. Increasingly she was aware of how her mental life was both similar to, and different from, that of others. For example, she could acknowledge that I might not actually be kicking her out to go to the man, even though she so strongly felt that I was.

Dolores's tremendous difficulty mourning the loss of the first, good mother derived in part from a concrete theory of mind in which she believed that she would get the first mother back. This belief became a life-saving fantasy: she felt that it was all she had to hold on to to stay alive. Two developments were necessary before we could analyze this fantasy: access to her "constructivist" theory of mind increased, and her relationship with me became sufficiently strong and "real" to her that she could tackle this immense loss (J. Kaufmann and P. Kaufmann, August 12, 2001, personal communication). The analysis of her wish to continue waiting for the first mother to return and of her difficulty using our relationship to become alive because it was not "the real thing," did not take hold until the ninth and tenth years. It was, however, essential to the treatment. It is here perhaps that the necessity for the explicit, verbal mode of psychoanalytic technique for the treatment is seen most vividly. The nonverbal and implicit relatedness created the foundation of the treatment, but it would not have been sufficient for the treatment to flower (see Bucci, 1985).

The Transformation of Implicit Relational Procedures

Dolores can be described as struggling with multiple, inconsistent, and often contradictory implicit relational models, stemming from her three primary caregiving situations, the first good mother, the abusive mother, and the adoptive family (see Lyons-Ruth, 1999). Within the model with her first good mother, Dolores had to deal with the radical inconsistency of two realities: she felt this mother really loved her, yet this mother had "left her for dead." Retaining contradictory, unintegrated images of this first mother was Dolores's way of "using" the image of the good mother, who, if Dolores could only wait long

enough, would return to reclaim her rightful place as "the real thing." This coping strategy had, however, derailed Dolores's development and prevented her mourning. In the course of the treatment, she and I together developed a fourth model, in which we struggled to integrate in the same person the good mother and the abandoning mother, and we also developed our own new ways of relating.

The description of this treatment is one response to Lyons-Ruth's call for greater attention in psychoanalysis to how implicit and nonverbal modes of intimate relating are transformed, and to the analyst's specific, collaborative participation in this process as a "new kind of relational partner." She suggests that new ways of "being with" must be created at the enactive, procedural level as well as the symbolic level. The building blocks for transformations of the system occur in micromoments, small, mutually constructed sequences, over an extended period of time. Much of the detailed description of Dolores's treatment was an effort to illustrate how these transformations can occur in those ways. Lyons-Ruth suggests that these transformations of implicit ways of "being with" cannot occur through verbal instruction; instead, they are created through mutually participatory, collaborative "action" dialogues, which are constructed predominantly outside verbal awareness. Because implicit relational knowing is predominantly outside awareness, and seldom in focal attention, Lyons-Ruth argues, much of the subtlety and complexity of what the analyst knows is never put into words. It is for this reason that my examination of the videotaped interactions revealed much about my behavior that I could not have described without them and why it was difficult to find a language to describe them.

Conclusion

The variety of forms of implicit nonverbal intersubjectivity, including matching, difference, and their subtle intertwinings, patterns of self- and interactive regulation and their balance, and patterns of distress regulation, are many, difficult to catalogue, and probably unique to each psychoanalytic pair. Nevertheless we urgently need to study them. Interactions in the nonverbal and implicit modes are rapid, subtle, co-constructed, and generally out of awareness. And yet they profoundly affect moment-to-moment communication and the affective climate. They organize modes of relating, Stern's (1985) "ways of being

with." Implicit, procedural, and emotional memories organize transference expectations and provide a degree of continuity and emotional functioning from childhood to adulthood (Clyman, 1991; Grigsby and Hartlaub, 1994; Sorter, 1994; Bucci, 1997; Stern et al., 1998; Lyons-Ruth, 1999; Knoblauch, 2000). Critical aspects of therapeutic action occur in this implicit mode, may never be verbalized, and yet they powerfully organize the analysis. The collaborative participation of the analyst in this process is an essential, but little-explored arena. We can teach ourselves to observe these implicit and nonverbal interactions simultaneously in ourselves and in our patients and thus expand our own awareness and, where useful, that of our patients.

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