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The function of language in parent-infant psychotherapy

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Parent-infant psychotherapy, a rather new field in psychoanalysis, raises questions of how to conceptualize the clinical process. Previous publications have used semiotic concepts to account for the therapist's non-verbal communication and investigated the countertransference, including what the baby might grasp of its variations. The present paper focuses on another argument for using verbal interventions to a baby in therapy; they present him with a symbolic order that differs from that of the parent. The qualitative difference between the parent's and the analyst's address is conceptualized by Dolto's term parler vrai. The therapeutic leverage is not the analytic interventions' lexical content but their message that words can be used to expose conflicts. Thereby, one can transform warded-off desires into demands that can be negotiated with one's objects. The reasons why this address catches the baby's attention are discussed. A prerequisite for such attention is that the infant brain is prewired for perceiving words as a special communicative mode. Relevant neuroscientific research is reviewed in regard to this question. The presentation relies on concepts by Dolto, Lacan and Winnicott and findings from neuroscience and developmental psychology. It also briefly discusses Chomsky's linguistic concepts in relation to these therapies.

Keywords: parent-infant psychotherapy, symbolic order, neuroscience, language development, Dolto

Nicole is a young physician and a mother of a 9 month-old girl, Valérie. She just started a new assignment at a hospital. Tomorrow, she will lead a case conference on her patient and needs to study the medical records and the relevant literature at home. But Valérie will not fall asleep. Nicole picks her up, cuddles and feeds her, walks around with her saying, "It's time for bed, darling, it's dark outside and all little babies are asleep". Yet, nothing helps. Valérie keeps whining and seems restless and unhappy. Finally, Nicole puts her to bed again and says, "Now, really, Valérie. Mum's got to be on her own. I'm in charge of a sick lady and I must read my books to help her become well again." A minute later, the girl is asleep and sleeps through the night.

Nicole admits to me that in her final address to the girl, her tone of voice was more decided and sprang from an attitudinal change; from being pleading and concerned to recognizing her vexation and wish to prioritize her medical duties. "Still, I wonder what made Valérie fall asleep instantly at that point. Was it because my tone of voice became sharper? Was it that

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inside, I felt more determined? Or, was it also because I told her explicitly *why* I wanted her to sleep?" Nicole meanders between three explanatory models; (1) a change in the non-verbal components of her communication, (2) an internal change of balance in her priorities, and (3) the explicit verbal explanation about the sick lady.

All three models contain enigmatic factors. Model (1) can be corroborated with experimental research on infants. Their sensitivity to emotional communication has been well demonstrated (Bornstein *et al*., 2004; Carver and Vaccaro, 2007; Kugiumutzakis *et al*., 2005; Leppänen *et al*., 2007; Sorce *et al*., 1985; Tronick, 1989, 2007). From a psychoanalytic perspective, our challenge is to investigate every individual example separately, in this case the connections in Nicole between model 1 and 2; when she got in contact with her desire to prioritize her job, how did this interior change emerge in her non-verbal communication? Model (2) might seem plausible to psychoanalysts who acknowledge the phenomenon of unconscious communication (Freud, 1912, 1915). Still, the question remains how alterations of emotional states – conscious or unconscious – are transmitted to another person regardless of age. Freud (1912) provides a well-known metaphor: Similarly to a receiver that converts the sender's electric telephone signal into sound waves, "the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious…" (p. 116). If the analyst fails to remove the resistances "which hold back from his consciousness what has been perceived by his unconscious" (p. 116) he cannot fully grasp what the patient tells him. At first, Nicole resisted listening to her unconscious anger and frustration. This probably made of her a Gestalt in which conscious and unconscious communications intertwined in a muddled way, which put Valérie in the frustrating position of deciphering mother's communications. But if so, how can Valérie pick up elements in Nicole's address as they vary according to the permeability between her Conscious and Unconscious? Model (3) is the most enigmatic, since it presupposes that verbal language per se was important to little Valérie. She would thus discern some difference between mother's initial words "It's time to go to bed, darling" and the ensuing "Now, really, Valérie, Mum's got to be on her own". Could one accept that her differential reactions did have something to do with mother's verbal address – and yet not fall into the trap of claiming that she understood the literal content of Nicole's communication? If so, what constituents of language did Valérie grasp?

The story of Nicole comes from everyday life. Parents address vocally their infants in various ways; cuddling sounds, songs, exclamations, screams, and coherent verbal messages. Sometimes they report that the baby seems affected by the words per se, though they cannot pinpoint how. Parent-infant therapists need to study these observations seriously, especially clinicians who not only address the parent(s) in treatment but also the baby. Do they actually believe that model (3) is relevant, that there is a distinctive point in using adequate language with a baby? Of course, they talk to the *parents* about how their painful feelings are connected with the baby's disorder. Such links have been studied extensively (Cramer and

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Palacio Espasa, 1993; Fraiberg, 1980; Lebovici and Stoléru, 2003; Lieberman and Van Horn, 2008; Stern, 1985). These clinicians speak *to the mother*, for example, when her unconscious fantasies fetter the baby to maladaptive behaviours such as clinging, whining, or gaze avoidance. They also suggest to her that *the baby's* avoidance might spring from his feeling of disappointment or confusion in the relationship.

Some therapists' arsenal includes a specific element; apart from addressing the mother, they also speak to the baby about her internal state and its connection with her behaviour and mother's emotions. One, Françoise Dolto, will be covered further down. Another analyst was Johan Norman (2001, 2004) and I have also published reports on this method (Salomonsson, 2007a, 2007b, 2011, 2012, 2013a, 2013b, 2014, 2015). Up till now, Norman and I mainly relied on models (1) and (2) in explicating how the analyst's address might impact on the baby. This paper will only briefly summarize these two models and move on to focus on two other objectives. One is to investigate whether model (3) provides yet another argument for speaking to the baby. The hypothesis is that when the analyst speaks to the baby he makes evident to him/her, not only that a *symbolic order* exists – which s/he of course already knows from the parents – but that *his use of it has characteristics that differ from that of the parents, which helps the baby handle the distress more efficiently*. The second objective is to examine *if neuroscientific studies warrant such address*, that is, if they support that the baby's brain can specifically register verbal communication.

Since this paper aims to elucidate clinical interventions, a brief clinical vignette will illustrate the discussion.

Clinical material: Irene with her son David, seven months

Forty year-old Irene tells me that her second child David, today 7 months old, was born by caesarean delivery due to a breech presentation. She fears this affected him negatively. Two months old he got a viral infection and was hospitalized with her: "I hadn't understood how ill he was! All these tubes and machines were terrible." After some days they returned home and David was fine – but at 4 months he started avoiding her eyes while looking at his father and Betty, his 3 year old sister.

During our first meeting, David is breast-feeding while playing calmly with mother's hand. He never looks into her eyes but gives me long happy smiles. Irene speaks sadly of her pain, guilt, and stress with her children. She fears that her concerns about Betty during pregnancy might have harmed David: "He was born with a frown on his forehead." As he avoids her eyes again she exclaims: "What did I do wrong to you!?" We start therapy twice weekly focusing on her guilt, frustration and humiliation, and his gaze avoidance. From the third hour and onwards, the sessions are video-recorded for my personal use with the mother's consent.

During the fifth session mother reports that Betty was crying when she left her today at preschool. "It was excruciating, I felt so guilty. Already during my pregnancy with David I had such a bad conscience about Betty. She looks in my eyes, and *David* looks at everyone but me!" After having

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talked about this for a while, I suggest to Irene: "If you hold David in front of you he can look at you and we can talk about the feelings that emerge in both of you."

Analyst: I see that you avoid Mum, David. Let's work with this, shall we? Mum doesn't dare to approach you and move her head closer to yours.
(As she lifts him up towards her, he avoids her eyes more insistently. She tries to kiss him but he recoils).
Analyst: When you, Mum, hold David it seems that you're approaching and rejecting at the same time.
(He climbs on her, avoids her eyes and cries).
Mother: I can't fling myself at him, he must want to do this, too!
Analyst: Well, David, I think you really want to come close to your Mum. But you're terribly afraid!
(He whines more).
Analyst: Now it's getting scary for you.
(David stands on her lap, whining, and avoiding her eyes).
Analyst: You're hurling yourself backwards from mother, looking at me. "Björn, help me with this monster looking at me."
(He looks away for a short while, gives a little laugh, and folds back into mother's lap without eye contact).
Analyst: Another round in the boxing match! (David grabs her décolletage). You want Mum's breast? The usual solution... You're thinking of breast-feeding him now, Irene?
Mother: Yes... but it doesn't really solve the problem.
Analyst: It's like getting a fix.
Mother: Yeah!
Analyst: David, you needed a fix when you got afraid, coming close to Mum.

During the remainder of the hour David often screams in despair. Yet, Irene also relates that the past weekend was "like magic. I was breast-feeding and for the first time he looked into my eyes at length. It really gave me hope! Still, it's so hard to forgive myself."

Analyst: Shouldn't you be given a second chance, Irene? What kind of love is that? (David smiles at me). And you David, you need to forgive Mum ... Maybe you, Irene, need to forgive David as well. Perhaps you're thinking: "You silly kid, avoiding my eyes!" Yes, Mum's angry with you as well, David. Now you calmed down.
The atmosphere is now serene and calm. She caresses his hair, his eyes are open, and there are some brief moments of eye contact. At one point she says to him, "I love you".
Analyst: David, you sense Mum's odour, she's quite irresistible... Only her eyes keep troubling you.

Therapeutic work dealt with Irene's sense of being rejected by David, her guilt in accommodating for him without feeling that she abandoned his older sister, and her vexation with the husband. I also clarified to David his disappointment and anger with Mum, his repudiations, the fear of her eyes,

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and his yearning for her. My countertransference paralleled many of Irene's emotions. When he avoided her eyes, it was humiliating to her and bewildering to me. When he smiled at me I felt favoured at Mum's expense, which made me feel embarrassed. As he avoided her eyes I felt sorry for him but also annoyed and curious.

Perhaps David had noted how Irene's conflictual feelings were expressed in her ways of holding him, tone of voice, etc. This plausible hypothesis would go along models (1) and (2); he had been affected by mother's non-verbal communication and affective states. What might be contentious is the extent of my verbal address to David and the assumption that it might help him. This would follow model (3), presupposing that language per se was important to therapeutic progress. Yet, David did not understand 'you're terribly afraid' or 'help me with this monster looking at me'. Instead, it was perhaps *the mother* who listened and understood my words. We could then discard all three models and state that she was the real patient. With the help of my words to David, Irene grasped his internal situation. This made her change her behaviour, which made him calm down. Yet in my technique, the words were not merely addressed to Irene but also to David about his distress and avoidance. The intention was to "alter the origins of representation as [I participated] therapeutically with a parent-infant pair (Scheftel, 2015, p. 1272). Thus I spoke to both members of the pair, which faces us with a crucial question; to what extent was David affected by my words?

Babies and signs: A brief summary

An outline will first be provided of previous work, which focused on ideas subsumed under model 1 and 2; the first model suggests the baby is affected by the analyst's address via his non-verbal communication. The second implies that the baby is influenced by internal changes in either or both adults present; the mother changes internally due to therapeutic work and the analyst through his work in the countertransference. To account for the various communicative levels on which humans produce and understand verbal or non-verbal signs, I have applied semiotic concepts of C.S. Peirce (Kloesel and Houser, 1992, 1998). All signs may be interpreted as *icons, indices* and *word symbols* in various combinations. Many analysts working with adult patients apply semiotic theory to conceptualize the nature of their work (Chinen, 1987; da Rocha Barros & da Rocha Barros, 2011; Gammelgaard, 1998; Goetzmann & Schwegler, 2004; Grotstein, 1980, 1997; Martindale, 1975; Muller, 1996; Muller & Brent, 2000; Olds, 2000; Van Buren, 1993). Now if, as Olds (2000) states, life "requires the presence of systems in which signs function" (p. 507), we could regard the newborn as fit for reading the signs that his family conveys to him; smiles, frowns, sighs, kisses, etc. He is also a producer of signs that the family captures; his screaming, cooing, smelling, smiling, etc. In other words, mother-infant interaction is an intercourse of signs, and semiotic terminology helps us conceptualize what goes on inside and between mother and baby. The argument is that though a baby neither uses words nor understands their lexical

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meanings (Norman, 2001), s/he is affected by other 'wavelengths' in our interventions once we seek contact with him/her.

I will now turn to our two main questions: Do the therapist's words only work via the *mother* to increase her comprehension of the dynamics behind the disturbance – and/or via the *baby* who interprets our verbal address on an iconical and indexical level and feels contained by it (Kloesel and Houser, 1998; Muller and Brent, 2000; Salomonsson, 2007a)? Or, might they also convey to the infant that the analyst is using the symbolic order in another mode than the one he is used to from his mother? Could it be that her use of words has been obfuscated by conflicting affects that she does not dare to acknowledge? Does the analyst speak in a different way? If so, what are their respective characteristics? And, could the baby react differentially to them? If so, would it affect our argument if we could demonstrate that a baby not only perceives the emotional import of non-verbal communication but also perceives *language as a specific mode of communication*? Specifically, can the technique of speaking to a baby be integrated with today's neuroscience and developmental psychology? Does David's brain register my words differently from any other sound I might have produced?

Parler vrai to babies: Another argument for verbal interventions to a baby

In de Saint-Exupéry's (1946) novel *The Little Prince*, the fox is teaching the boy to tame him and create a bond. He says: "Sit down a bit from me, in the grass. I'll look at you from the corner of my eye and you'll say nothing. *Language is a source of misunderstandings*" (p. 80, italics added). I interpret the fox as follows: Our interpretations of verbal communication may be contradictory at various levels of signs. All words can be (mis)understood in numerous ways depending on the situation, the tone of voice, etc. For example, how does one pronounce the word 'Thanks'? It is easy to imagine various emotional situations and to find, for each of them, appropriate ways of pronouncing the word; with gratitude, warmth, coldness, embitterment, rancour, irony, ecstasy, etc. Such 'hyper-semiosis' applies to all verbal communication. Despite this fact, parents use language to successfully help their baby regulate affects and solve conflicts. They can say "Thanks" with warmth when he gives them an enchanting smile, and with vexation when a splash of poo stains their clothes at the diaper changing board.

What may affect a receiver is whether the sender is conscious or not of her affects, and whether verbal and non-verbal facets of her communication coalesce or diverge. As for Irene, she was enmeshed in guilt vis-à-vis her children anger with her husband, and panic at recalling the stay at the hospital. It was not clear to which extent her affects were unconscious or merely unspoken, that is, preconscious. I take this to reflect that she, like any other woman with a young baby, was still in a state of *primary maternal preoccupation* (Winnicott, 1956). In such a situation, the border between the Unconscious and the Preconscious is more permeable, and we see a "re-emergence of previously repressed fantasies into pre-consciousness and

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consciousness" (Pines, 1993, p. 49). One example is her idea that David was born with a frown because she had worried about his sister. This created a jumble in her which, I speculate, made David confused and scared. My aim with speaking to him was to indicate that words can be used to *parler vrai*, that is, to say loud and clear what is the matter. Françoise Dolto (1982, 1985, 1994a, 1994b) used this expression to describe how she addressed infants in a plain and truthful manner. Her argument proceeded from Lacanian theory, some parts of which we need review briefly with examples from David and his mother.

A distressed baby like David expresses various *demands*, behind which *desires* lie concealed both to him and mother. 'Desire' designates a volatile phenomenon of the mind, "a function central to all human experience, [it] is the desire for nothing nameable" (Lacan, 1954–55, seminar May 18, 1955, p. 210). Its kernel was always inaccessible and no object can fully satisfy it. Desire yearns for "object a", defined as "a hollow that any object might fill" (Dor, 2000, p. 188). Mother Irene becomes its first protagonist by assuming the role of the Other whom David demands, cries and yearns for. But, at bottom he wants the unreachable "desire for her desire" (Lacan, 1966/2006, p. 462). As for Irene, her desire is both directed towards her son and backwards towards her own infantile objects. Desire thus roams forever, within and between mother and baby, like in a hall of mirrors.

The analyst's task is "to teach [the patient] to *name*, to articulate, to bring desire into existence" (Lacan, 1954–55, seminar May 18, 1955, p. 214). But since desire is not nameable, no interpretation can abolish the "discrepancy between what is fundamentally desired and what can make itself understood in the demand. It is this discrepancy that is the measure of the impossibility of re-finding the original *jouissance* with the Other" (Dor, 2000, p. 192). This position differs from Freud's (1905) idea that "the finding of an object is in fact a refinding of it" (p. 222), because such refinding is as futile as capturing one's shadow. Klein (1975) expresses this insight thus: "A satisfactory early relation to the mother ... implies a close contact between the unconscious of the mother and of the child. This is the foundation for the most complete experience of being understood and is essentially linked with the preverbal stage." Later in life, we love to talk with a "congenial person, [but] there remains *an unsatisfied longing for an understanding without words* – ultimately for the earliest relation with the mother" (p. 301, italics added).

We seem to have reached an impasse; our interpretations aim to describe the patient's desire but can never pinpoint it. Like an asymptotic curve, our words approach the x-axis of desire without reaching it. This dilemma faces us with all patients. A second problem, specific to parent-infant therapy, has already been mentioned; babies will not grasp the lexical meaning of interpretations. Yet, Dolto (1994b) insisted one should *parler vrai* to them, arguing that "we only exist by being linked with others through words" (Ledoux, 2006, p. 188). Importantly, verbal address would only work if it was *vrai* to Dolto as well. Otherwise she would be submitting to the baby the kind of communicative jumble – where melody, facial communication, and literal content convey contradictory meanings – which was harmful to

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him. Dolto said things to the infant that his parents had been silent about, as it were for his own good. When I told David that he was hurling backwards from Irene as from a monster, the aim was to describe an emotional truth I believed both avoided. Mother's eyes represented an aspect of her internal reality that he was struggling to comprehend and integrate; her vexation, frustration, and guilt juxtaposed with love and concern. Maybe, in David's mind her eyes had also been "infected" by his vengeance and anger – or in other terms – the projections of "bad feelings" and, thus, he had better shun them.

Language substituting for desire

One may agree with the previous description of David's internal dilemma without supporting the idea of *speaking* to him about it. Dolto has indeed been criticized, and rightly so, for sometimes proclaiming dead certain positions about speculative matters (Anthony, 1974; Axelrad, 1960) and for writing in a "prescriptive" style (Bacon, 2013, p. 526). She sometimes claimed that a baby could capture the lexical meaning of her words, which is contradicted by common sense and experimental research (Karmiloff and Karmiloff-Smith, 2001). Yet, common sense has never objected to parents speaking to babies or to the notion that it is better to address them warmly than harshly. *But is it helpful if the analyst is practising parler vrai with babies about excruciating matters*? This section will elaborate on this question. The answer depends on how we envisage the baby's external and internal situation and our prime task as therapists. In Dolto's view, mother-infant dyads are caught up in a "complex and ambiguous web of competing and conflicting demands and desires, of unconscious determinations and ancestral voices" (Bacon, 2002, p. 260). Who or what is good or good enough, parent or infant; all these issues are unclear. The infant cannot hold together and make meaningful his self by an inside truth, but rather, "like words in a sentence, by law or grammar or force … [The baby] is continuously being formed in and informed by language and speaking" (p. 260).

In a second paper on Dolto, Bacon (2013) goes beyond saying that the infant builds up his self *like* words in a sentence. The words are now presented as the very building blocks of the subject's Preconscious and Unconscious. The infant builds up his subject by being immersed in the speech from people around him. The parents' words become the seeds of the baby's budding Preconscious and Unconscious. Just like Freud, Dolto emphasizes the role of frustration when the mental apparatus divides into the Unconscious and the Preconscious, but specific to her is the accent on the mother's language in this process: "By speaking with her child of what [the baby] would like but which she is not giving to him, [the mother] makes known to him the absence of an object or the non-satisfying of a demand for partial pleasure, while at the same time giving value to … this desire" (Dolto, 1984, pp. 63–5, translated by Bacon, 2013). For example, a parent might tell the child: "I know you want to be with me but you know, I want to speak with Grandpa on the phone. Then I'll be with you again".

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In everyday life, parental speech is more equivocal than in Dolto's statement and contains "ambiguities, shifts, and transformations" (Bacon, 2002, p. 260). Exemplifying with Doctor Nicole, at first she was using *parler faux* with her daughter. Distressed and annoyed, she tried to harmonize her maternal and professional duties. As long as she blocked these emotions from entering her awareness, she kept pleading to Valérie in vain. Not until she told the emotional truth the ambiguities dissolved, the girl's distress vanished, and she fell asleep. In contrast to this non-clinical example, if such ambiguities become preponderant and if the baby is used to not being clearly told what he wants but will not get, he may suffer and develop symptoms.

The question is if we can apply these ideas to the clinical situation: Will *the therapist's words to a baby* be of help? Dolto would answer yes, arguing that "speaking to a baby and putting words to what he is experiencing participates in founding his [psychic] structure" (Ledoux, 2006, p. 189). Parents need to "talk about [the baby's desires] because they are always justifiable, even though one does not want to help him with them" (Dolto, 1994b, p. 108). In my view, this position also applies to the analyst. Until now, David has been closing his eyes in front of a mother whom he loves, fears, resents, reproaches, and fails to comprehend. Irene's contribution has been, I assume, her conflicts with speaking clearly about the desires she intuits in him and in herself. She does realize that breast-feeding David does not remedy his whining, but she cannot find ways of addressing him about how their desires are clashing. At this point, I comment on his wish for a 'fix' and the need to forgive his mother. I am thus acknowledging his desire of the breast *and* comparing it to an impossible panacea or what Dolto calls a "short-circuit satisfaction" (p. 97).

There is an austere element in Dolto's *parler vrai*, for example, when she speaks of subjecting a child to *symboligenic castrations* (1982). Only through them can the child gain access to sublimation and the symbolic order. Readers who are more in line with Winnicott's thinking may find this hard to accept. Dolto would neither deny that there exists "an intermediate area of experiencing, to which inner reality and external life both contribute" (Winnicott, 1971, p. 2), nor that "psychotherapy has to do with two people playing together" (p. 38). But she cautions that the transitional object may prevent a child from "addressing his pain and give him the illusion that he is still at the breast" (Dolto, 1994b, p. 143). The analyst's words should counter this illusion.

I agree with Bacon (2002) that Winnicott viewed the identification of mother and baby as "the sine qua non of good-enough mothering", whereas to Dolto it was "a dangerous realm of imaginary relations which is and has to be subject to castration in order for a speaking subject to emerge" (p. 260). These two emphases lead to different techniques. Dolto focused on truthful words of frustration that should inspire the child to embrace the symbolic order. *Language should substitute for desire*. Winnicott focused on how a child maintains an illusion that the breast is part of him and under his magical control. This illusion is kept until the child is ready to drop it and then create a new game or jingle.

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The baby's response to *parler vrai*

Which claims have I been making so far? Do I contend that an infant responds to the lexical meaning of the analyst's words? No, I do not. Do I claim that he pays attention to me as someone who 'parle vrai' and if so, does his attention differ from the one he pays to his mother? Yes I do, arguing that I speak differently from her. Then, as one reviewer of this paper asked, why would he be more likely to appreciate truthful speech? First of all, I do not think an infant initially appreciates *parler vrai*. Like all patients, he is caught up in conflicting desires and maladaptive defences. David's gaze avoidance is one example and he would prefer to 'close his eyes' to my interventions, too. But when he encounters my persistent address it catches his attention. Two questions emerge: What distinguishes the mother's from my ways of speaking, and how and why would David react differently to them?

As to the first question, how the analyst's and the mother's communications differ, I have already mentioned the extent to which our verbal and non-verbal communications coalesce or diverge. Here, I would add my elaboration within the countertransference. Working with David and Irene, I was subjected to their agony, I identified with them by feeling helpless, incredulous, empathic, and frustrated. I also observed how the two countered their agonies with maladaptive defences. Finally, I decided to put words to these intra- and inter-personal conflicts: "David, I think you really want to come close to your Mum. But you're terribly afraid." In other words, I immersed myself in the quagmire of David's helplessness and Irene's despondency. Then I exited from that state and took up courage to speak out. Freud (1912) compares the analyst to the surgeon, "who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skilfully as possible" (p. 115). I do not put aside my feelings, but I stay with them for a while and then take the next step; to pluck up courage and 'operate skilfully', that is, to *parler vrai* about painful matters.

The second question could be split in two; does the child *confirm* that he has been impacted by my words, and does he pay any *specific* attention to them, as opposed to those of the mother? In my view, the baby will not give an unequivocal validation to my interventions, and here I am at odds with Dolto. In a paradigmatic example (1985), she asked an infant to nod if she had understood her interpretation. Dolto took her nodding as a confirmation. I strongly disagree with this technique and theoretical position. What signs do I then rely on when I intuit that my address has affected a baby? Here, I cannot provide an unequivocal answer. Sometimes, the slow clinical progress makes me feel he has been captured by my address. This was the case with David. At other times, there comes a moment when the baby suddenly looks earnestly at me, after which ensues an affective change; he might start sobbing or, in contrast, become relaxed.

These impressions might seem like weak points of anchorage to confirm an intervention. But in my view this uncertainty applies, more or less, to analysands of any age. Children in analysis rarely provide a 'yes' or 'no' to

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an intervention but will rather change the play or create a new fantasy story. And in psychoanalysis with adults, how often can we claim that we have provided a correct interpretation to which the patient responds that she has gained insight into her Unconscious? Isn't our work much about containing the patient's anxiety and confusion, to which she responds with some relief and a sense of being understood, which enables her to move a bit from a locked and unfruitful functioning? I also argue that we cannot exactly discern which constituents in our interventions helped the patient make this move; the lexical content, our tone of voice, rhythm, gestures, etc. – or how these components matched similar modes in the patient, that is, how our interaction was working.

Let us now return to the baby. Why would he pay specific attention to my words? I have already brought out their sincerity and truth. What does their veracity consist of? One factor has been mentioned, that of the coalescence between verbal and non-verbal communication, that is, there is no dissimulation. The second factor is that I address the child's *psychic conflict* and this captures his focus because *he wants to develop*. To be true, David wants to short-circuit his internal conflicts by craving for Mum's breast and avoiding her eyes. But he also suffers, he is stuck and cannot progress. To exemplify with an older child; a 3 year old girl is very attached to her pacifier. The parents suggest that she will get a doll if she gives them her pacifiers. In the end, she agrees and some distressful evenings follow. The parents report that what made her accept giving up the pacifier was not the doll but, as she repeatedly announced to them, "I'm a big girl now, no dummy anymore".

"Who does not grow, declines". Rabbi Hillel's words in the Talmud capture an idea central to psychoanalytic theory; that of an innate drive for development. In Freud's (1920) words, children are dominated by "the wish to be grown-up and to be able to do what grown-up people do" (p. 17). In Winnicott's words, they are "moving from absolute dependence to relative dependence, and towards independence" (1962, p. 62). Already Bibring (Glover *et al.*, 1937) spoke of a developmental drive or "tension", which "enables a curative process to take place as soon as the fixations and regressions have been resolved" (p. 169) in analysis. It is "positively experienced and serves to motivate and propel the individual toward the acquisition, mastery, and integration of the new function" (Settlage *et al.*, 1988, p. 358). See further contributions by Gitelson (1962), Heimann (1962) and Anna Freud (1963).

The parler vrai mode can be seen in the light of this developmental drive. There is a certain poignancy and clarity in my address, which David registers. To be true, he distrusts it at first, but in the end, he will appreciate it because he intuits that I want to help him realize his wish to move on. To extend Freud's metaphor, perhaps David thinks of me like we think of the surgeon; we do not necessarily love him, but we would be disappointed if he did not lance the boil. In the metaphor, the boil represents the covert conflicts that is the covert conflicts that roam about in him and mother and that need to be opened up. In another framework, we could state that David is about to develop an insecure attachment. Note, however, that I do

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not seek to directly promote attachment, encourage him, or scaffold the mother-infant relationship, aims often pronounced by clinicians from that tradition. I tend rather to verbalize his inner conflicts which, if we wish to phrase it in that terminology, thwart the building up of a secure attachment.

Language development: Findings from neuroscience

We will now embark on our second investigation; whether the technique of speaking to a baby gains support from – or is refuted by – neuroscience. I have already contested the idea that a baby would understand the lexical meaning of words. Yet, I speak to him. The central question is then *if the infant brain is capable of discerning language as a specific mode of communication*. If not, the concept 'verbal communication with babies' would be a *contradictio in adjecto*. The infant would actually be listening to my word-sounds as to any other vocalization. We will now consult relevant neuroscientific and developmental research, though *not* because it could confirm the effectiveness or validity of a psychoanalytic intervention. Such confirmations can only be reached in the analytic situation, not in the neuroscience lab. The aim is rather to see if these researchers can teach us if the baby differentiates language as a special mode of communication.

A survey by two prominent neuroscientists (Gervain and Mehler, 2010) covers language acquisition in the first year of life. Babies are "born as citizens of the world, ready to learn any natural language" (p. 201). They can *discern* phonetic contrasts (Kuhl, 2004) and rhythms (Nazzi *et al*., 1998) of any existing language, whereas they *prefer* their mother's language to others (Moon *et al*., 1993) and her voice to that of other women (DeCasper and Fifer, 1980). These effects are probably instigated *in utero* (Moon *et al*., 2013; Voegtline *et al*., 2013).

Two-month-old babies prefer words from a human voice to similar but artificially produced words (Vouloumanos and Werker, 2004). At that age they become selectively interested in their native language (Mehler *et al*., 1998) although they had been able, while merely a few days old, to sort languages according to their rhythmic and prosodic variations (Mehler *et al*., 1988). Such variations also explain why newborns preferred a story that had been read aloud by their mothers during the third semester compared with a novel story presented postpartum by their mother or another female voice (DeCasper and Spence, 1986).

Preference of mother's voice thus begins *in utero*. However, this might simply be related to her prosody and other non-linguistic components. If so, the referred studies would say nothing about whether the foetal or newborn brain registers language as a *specific modality*. The question is "whether evolution has endowed humans with a genetically determined cortical organization particularly suitable to process speech or whether fast learning quickly specializes the auditory network toward speech processing during this initial period" (Mahmoudzadeh *et al*., 2013, p. 4846). These researchers found that the hemispheres of 3-day-old premature babies of 28–32 weeks' gestational age reacted differently to a change of voice quality

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(female vs. male) than to a change of phoneme ('ga' vs. 'ba'). All these stimuli elicited a higher response from the *right* cortex, which simply reflected the auditory stimulation. This finding was thus unsurprising. Remarkably, however, only the ga-ba paradigm led to a response in those *left* areas that are known to process speech. Thus, there probably exists "an early organization of the immature human brain into functions useful for deciphering the speech signal" (p. 4850). It is as if the baby were realizing, 'Aha, "ga" differs from "ba". It doesn't matter if it is uttered by a dark or a light voice, it's the "ga" versus "ba" that matters.'

Newborns can also detect simple speech structures, such as immediate repetitions (Gervain *et al.*, 2008). They utilize this ability to grasp primitive artificial grammar, as when they differentiate repetition-based ABB patterns ('mubaba', 'talulu') from unstructured ABC patterns ('mubage', 'talupi'). What unites 'mubaba' and 'talulu' is a primitive grammatical rule; one syllable is followed by a dissimilar one that is repeated immediately. Such ABB 'words' evoke stronger responses in the speech-processing area of the left hemisphere and also frontally, a finding which may indicate "the formation of a memory trace" (p. 14224) of these patterns. Thus the neonate brain can detect structural regularities in, and create memory traces of, language. Three- to four-month-old babies also grasp that words have a specific function; unlike tones they can be used for categorizing toy animals and other objects (Ferry *et al.*, 2010). The neuroanatomy underlying these abilities is well mapped today (Sato *et al.*, 2012).

The implication of these studies is that a psychotherapist who speaks to a baby should be aware that though the child perhaps imitates his facial expressions and pays attention to his para-linguistic communication (gestures, tone of voice, rhythm, smiles, frowns, etc.), she cannot understand any lexical meaning. On the other hand, she does perceive speech as a specific input and not only as a 'voice melody' (Fernald, 2004; Vouloumanos and Werker, 2007). Infant-directed speech (IDS; Fernald, 1993; Kaplan *et al.*, 1999) will capture her attention more than adult-directed speech (Pegg *et al.*, 1992). The therapist can also feel confident that the infant can discern some emotional meaning of words, such as approval and disapproval (Fernald, 1993). To conclude,

> infants may analyze speech more deeply than other signals because it is highly familiar or highly salient, because it is produced by humans, because it is inherently capable of bearing meaning, or because it bears some not-yet-identified acoustic property that draws the attention of the rule-induction system. Regardless, *from birth, infants prefer listening to speech over listening to closely matched control stimuli.*
>
> (Marcus *et al.*, 2007, p. 390, italics added)

The therapist can thus feel certain that the baby's brain the baby's brain is wired to register his/her talk as a special form of communication.

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Further critique against verbal interventions to the baby

Up till now, we investigated our third explanatory model for speaking to a distressed baby in a clinical situation, namely, because we wish to convey a *truthful use of the symbolic order*. A pertinent question remains: Why should, specifically, *the analyst* talk to a baby? All parents speak 'motherese' or IDS to their babies. So, what can the therapist's words add to these daily verbal communications? One could also contend that the referred neuroscience studies merely corroborate Chomsky's (2006) well-known argument: Every child is born with genetically determined language structures that form a 'universal', 'transformational' and 'generative' grammar, out of which s/he constructs a personal internalized language. To phrase the objection in other terms: The child comes to the world with a wondrous ability to grasp, within a few years' time, how to use sounds from parents, siblings, etc., to create sentences that express his wishes, fears, agonies, and joys. What could then an analyst – who sees the baby a few hours a week – append?

I approach this question via a quotation by Litowitz (2014) who addresses the role of language in the creation of intersubjectivity: "Adults use speech to appeal to babies to do or don't do something, see or don't see the world in some way, be or don't be some kind of person or another. It is during the course of these activities that the child acquires language, which incorporates his interpretation and representation of the other's intentions and affects" (p. 304). Cowley *et al.* (2004) similarly state: "In engaging with the baby, caregivers exert pressure on how she acts: they nudge the child towards new ways of behaving. Even when interaction still relies on 'analogue' patterns, co-operation and conflict ensure the development of more complex semiotic capacities" (p. 110).

To Chomsky (2006), linguistic competence is innately based and "develops in early childhood" (p. 4). A biological anthropologist, T.W. Deacon (1997), argues that what is innate is not the grammatical rules but the child's ability to adapt to and make guesses about the language s/he hears. Children *discover* language, "though not by introspection of rules already available in the brain" (loc. 1827). "Languages have had to adapt to children's spontaneous assumptions about communication, learning, social interaction, and even symbolic reference ... languages need children more than children need languages" (loc. 1865). It is another matter that children's capacity for making such discoveries does rely on innate neurological structures as referred above.

When Deacon writes that children's "language experiences are embedded in a rich and intricate social context" (loc. 1778), he implies that both young and old will change language according to the reactions they meet. A linguist – and a child in a healthy interaction – can compare the phrases 'I love you', 'I hate you', and 'I loved you'. They will establish that the first two phrases' grammatical structures differ from the third, and the child will figure out new phrases along these patterns: 'I like you' and 'I liked you'. The therapist's task is fundamentally different; to understand when a mother's words 'I love you' only mean 'I love you' or also, on an

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unconscious level, 'I hate you', 'I wished I love you', 'I wish I will love you', 'I wish you love me', etc. His/her challenge is to grasp what happens to a child who must construe parental communications that contain discombobulated intentions. Alternatively, if the child correctly interprets the mother's misinterpretations of his and her internal states – or if he misinterprets the parent's unambiguous declarations.

Distressed babies often face communications that are coloured by parental "ghosts in the nursery" (Fraiberg *et al*., 1975), "negative attributions" (Silverman and Lieberman, 1999) or "projective distortions" (Cramer and Palacio Espasa, 1993). This may be a heavy burden, as shown in various therapy reports (Anzieu-Premmereur and Pollak-Cornillot, 2003; Arons, 2005; Baradon *et al*., 2005; Beebe, 2003; Berlin, 2002; Calvocoressi, 2010; Emanuel and Bradley, 2008; Jones, 2006; Keren *et al*., 2006; Likierman, 2003; Pozzi-Monzo and Tydeman, 2007; Salo, 2007; Tuters *et al*., 2011; von Klitzing, 2003; Watillon, 1993). If words only meant their lexical content, such babies would have fewer problems. If David's mother's words, 'I love you', were *vrai* in the full sense of the term, that is, expressed the entire emotional truth, they would not create distress. But, "the sounds and rhythms of language systems are much more than signals. They are *indices or addresses to information about affect states and relationships*, as well as about concepts and objects" (Litowitz, 2014, p. 299, italics added). For example, Irene's 'I love you' probably also comprises that she feels guilty about David's older sister worries about David's relationship with her, is mortified by his gaze avoidance, angry with his father, and feels bad about herself as a mother. In Dolto's terms, her 'I love you' is not to *parler vrai*.

As Litowitz notes everybody uses language to deceive, as when a parent tells the baby, 'It's bedtime, darling', when he actually wants to watch the news on TV. This is everyday life. The question is to what extent such deceptions permeate the interaction, and how far the parent's affects and wishes are conscious to him or her. Interpreting and communicating with a baby will always be a mixture of distortion and clarity. Distortions arise when a parent's conceptions of the baby are more motivated by *her* desire than that of the child. The paradoxically good outcome arises when the baby manages to set aside the pleasure principle and slowly learn the symbolic order to express himself more clearly. Conundrum arises when a boy like David cannot grasp the varying meanings of Irene's verbal and nonverbal communications and 'solves' the problem by avoiding her eyes. A negative spiral is set in motion; he becomes incomprehensible to the mother, which frustrates her and makes her renewed words of 'I love you' appear even more bewildering to him.

We can now chisel out why Chomsky's ideas, though incontrovertible for understanding how linguistic structures develop, cannot explain why the mother's and the analyst's words impact differently on a baby like David. Wilson (1994) distinguishes between Chomsky's theory of deep structures and Lacan's view of unconscious functioning. "Chomsky is interested in *invariant, biologically given linguistic capacities* that are independent of one's actual exposure to a given language. Lacan was interested in the concrete effects of specific, actually spoken speech on a given subject" (p. 152, italics

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added). Let us bracket the justified critique that Lacan relied too little on non-verbal communication in his definition of the symbolic order (Arfouilloux, 2000; Rosolato, 1978; Salomonsson, 2007b). The point is that Chomsky "employs a minimalist approach to theorising in order to explain the production of well-formed utterances [whereas] psychoanalysis always looks for richer and more varied explanations" (Tuckett and Levinson, 2010, under the caption of 'Linguistics and psychoanalysis'). To Chomsky (2006), the use of language is "a creative activity" (p. 88), "an instrument for the free expression of thought and feeling" (p. 88), and the study of it will bring to light "inherent properties of the human mind" (p. 90). He uses simple sentences to investigate surface and deep grammatical structures. Psychoanalysts also study simple sentences, such as Irene's 'I love you', but our purpose is different; to interpret how they cover unconscious wishes, fears, and worldviews. We also theorize why and when such multi-layered communication arises in complex and conflict-ridden human interactions. Thus, Chomsky's use of the term 'unconscious' differs from that of psychoanalysis (Olinick, 1984).

Meltzer (1983), in a thoughtful and appreciative critique of Chomsky, suggests a two-step theory of language development. First, the child realizes its "instinctual capacity for inner language, for the internal and external 'public-ation' (Bion) of states-of-mind" (p. 109). In a second step, this language is adapted to "the description of external reality by means of verbalization, meaning the delineation of morphemes within the 'strings' (Chomsky) of phonemes" (p. 109). First-step language communicates states of mind through projective identifications. This would correspond to the adult's "appeal" that Litowitz speaks of, and Cowley's "nudge", and what I have referred to as communication on iconical and indexical levels. Chomsky's theory does not account for this first step, because it is "bound to an information-theory conception of language [and] conceives of a grammar as conventional, a carrier for bits of meaning which can be introduced into the empty containers of the carrier in infinite variation, some sensical and others non-sensical" (Meltzer, 1983, p. 109).

Cowley and coworkers (2004), coming from the fields of linguistics and mother-infant interaction research, express a similar view: "Social semiosis brings infants to language – not thanks to word-based properties – but through their capacities for attuning to the kinetics of speaking, moving, talking persons ... language is grounded in behavior jointly conducted by infants and members of their cultural worlds" (p. 110). Bruner (1990), finally, suggests that we are innately tuned to and actively search for prelinguistic "readinesses of meaning" that exist prior to language (p. 72). Corresponding to Meltzer's first step, these malleable representations are "triggered by the acts and expressions of others and by certain basic social contexts in which human beings interact" (p. 73).

We can now sum up three arguments for an analyst speaking to a baby: (1) His address contains more than a mere lexical word-stream and its non-verbal components impact on the baby, (2) the baby pays attention to an analyst who attends to him and he notices emotional alterations in the clinician, and (3) the baby becomes interested in an analyst who tries to *parler*

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vrai about the conflicts – within and between him and the mother – that make their interaction *faux*.

Epilogue: The function of language – in simple language

David and his mother Irene were in therapy for 35 sessions covering 4 months. One year later, she sent a photo of David. She wrote that their contact was warm, joyful, and relaxed and that the gaze avoidance was gone. So much for the follow-up. I will end with a theoretical epilogue expressed in unsophisticated words. Let us imagine a baby with weaning problems. Here is how I would describe his dilemma in artless terms: 'Life is hard. The baby yearns for something he can never have. He could have the breast again if Mum allowed it, but then he would merely return to a source of delight that he must leave in the end anyway. Otherwise he cannot move forwards – and that is his destiny; day after day, year after year, to the end. The journey is replete with interesting and beautiful things, and with fears, failures, sadness, and suffering. But one invention will help him: language. He already sucks things with his mouth to learn about their taste and texture. Although he doesn't yet perceive his eyes or ears he knows they help him to locate himself, his dear ones, and his toys. He also uses his hands to grab a rattle or Mum's wisp of hair. These are all tools, and so are words.'

'He has been inundated with words from day one. Whether they were about fears, joys, or trifles we knew he did not grasp their meaning, but we wanted to whet his appetite. He hears Mum talking to him, and suddenly he gets food. At other times Dad is talking, or somebody is on the radio. Language is behind it all. It takes a long time to master, but it is the foremost tool we humans have yet invented. We don't get everything we wish for, but words help us get some of what we yearn for the most; love – something we learned about long before knowing its name.'

'When the baby is sad and grumpy he might recall when Mum's breast took away such bad feelings. But he might also recollect her discomfort when he craved for it again. Here, words will be of help. He will learn one; "kiss". One day he'll walk up to Mum and say "kiss". Perhaps she'll give him one. But he doesn't want to be glued to her lips because he wants to resume playing. Years ahead, he will fall in love and yearn for a kiss from his girlfriend: "Your lips are awesome". She will understand and kiss him. Very much later he'll be ailing and tired of life. But as his daughter enters his room he'll smile: "I'm glad you came. My back hurts." She'll kiss his forehead, he'll smile and vaguely recall joys from days gone by.'

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Translations of summary

La fonction du langage dans la psychothérapie mère-bébé. La psychothérapie mère-bébé, un champ relativement nouveau en psychanalyse, pose la question de savoir comment conceptualiser le processus clinique qui y est à l'œuvre. De précédentes publications ont fait usage de concepts sémiotiques pour rendre compte de la communication non-verbale du thérapeute et exploré la dimension du contre-transfert, y compris ce que le bébé peut saisir de ses variations. L'auteur de cet article soutient un autre argument quant à l'utilisation de la communication verbale avec un bébé en thérapie; cette communication est fondée sur un ordre symbolique qui diffère de celui du parent. La différence qualitative entre le discours du parent et celui de l'analyste a été conceptualisée par Dolto autour de la notion du *parler vrai*. Le levier thérapeutique n'est pas défini par le contenu lexical des interventions, mais par le message qui se voit ainsi transmis, à savoir que les mots peuvent être utilisés pour exprimer des conflits. Ainsi, il est possible pour le sujet de transformer des désirs refoulés en des demandes qui pourront être négociées avec ses objets. L'auteur discute des raisons qui font que l'attention du bébé est captée par un tel discours. Une des conditions préalables à cette forme d'attention est que le cerveau du bébé est préraccordé à la perception des mots comme étant un mode particulier de communication. L'auteur passe en revue les travaux de recherche en neurosciences consacrés à cette question. Il s'appuie sur les concepts de Dolto, Lacan et Winnicott, ainsi que sur les découvertes des neurosciences et de la psychologie développementale. Enfin, il discute discute brièvement des concepts linguistiques de Chomsky et les met en rapport avec ces therapies.

Die Funktion der Sprache in der psychotherapeutischen Arbeit mit Mutter und Kind. Die Psychotherapie für Mutter und Säugling, ein relativ neues Feld der Psychoanalyse, wirft Fragen bezüglich der Konzeptualisierung des klinischen Prozesses auf. Frühere Publikationen haben die nonverbale Kommunikation des Therapeuten mit semiotischen Konzepten zu erklären versucht und die Gegenübertragung einschließlich ihrer Wahrnehmung durch den Säugling erforscht. Der vorliegende Beitrag konzentriert sich auf ein weiteres Argument zugunsten verbaler, an das Baby adressierter therapeutischer Interventionen. Sie stellen ihm eine symbolische Ordnung zur Verfügung, die sich von derjenigen seiner Mutter unterscheidet. Diesen qualitativen Unterschied erklärt Doltos Konzept des „parler vrai". Der therapeutische Hebel ist nicht der lexikalische Inhalt der analytischen Interventionen, sondern deren Botschaft, dass Worte benutzt werden können, um Konflikte aufzudecken. Dadurch wird es möglich, abgewehrte Bedürfnisse in solche zu transformieren, über die man mit seinen Objekten verhandeln kann. Erläutert werden die Gründe, weshalb solche Interventionen des Therapeuten die Aufmerksamkeit des Babys zu fesseln vermögen. Eine Voraussetzung dafür ist die vorverdrahtete Fähigkeit seines Gehirns, Worte als einen spezifischen Kommunikationsmodus wahrzunehmen. Der Beitrag erörtert die einschlägige neurowissenschaftliche Forschung bezüglich dieser Frage. Ihm liegen Konzepte Doltos, Lacans und Winnicotts sowie neurowissenschaftliche und entwicklungspsychologische Forschungsergebnisse zugrunde. Auch Chomskys linguistische Konzepte kommen im Zusammenhang mit diesen Therapien zur Sprache.

La funzione del linguaggio nella psicoterapia genitore-bambino. La psicoterapia genitore-bambino, un campo piuttosto recente della psicoanalisi, pone delle domande rispetto a come si possa concettualizzare il processo clinico. Finora la bibliografia ha utilizzato concetti derivati dalla semiotica per esaminare le comunicazioni non verbali del terapeuta, studiando inoltre il controtransfert e anche ciò che del suo variare il bambino potrebbe essere in grado di cogliere. Il presente lavoro si concentra su un altro argomento a favore dell'uso di interventi verbali rivolti al bambino nel contesto terapeutico: questi ultimi lo mettono infatti di fronte a un ordine simbolico che differisce da quello del genitore, e la differenza qualitativa tra il parlare del genitore e quello dell'analista è concettualizzato dal termine della Dolto 'parler vrai'. Il potere terapeutico non risiede tanto nel contenuto lessicale degli interventi analitici, quanto piuttosto nel messaggio da essi veicolato, e cioè che si possono usare le parole per mettere in luce i conflitti. Il soggetto può quindi trasformare i desideri respinti in domande che gli sarà possibile negoziare con i propri oggetti. Vengono qui anche discusse le ragioni per cui questa modalità di parola cattura l'attenzione del bambino [BS1]. Un prerequisito di tale attenzione è che il cervello del bambino sia predisposto a percepire le parole come speciale modalità comunicativa; viene qui peraltro commentata la letteratura neuroscientifica che si è occupata della questione. Più in generale, l'articolo si basa su concetti della Dolto, di Lacan e di Winnicott, oltre che su scoperte provenienti dal campo delle neuroscienze e della psicologia dello sviluppo. Vengono pure brevemente discussi, in relazione al tipo di terapie qui trattate, alcuni concetti della linguistica chomskiana.

La función del lenguaje en la psicoterapia padres-bebé. La psicoterapia padres-bebé, un campo más bien nuevo en psicoanálisis, suscita preguntas respecto a cómo conceptualizar el proceso clínico. Las publicaciones anteriores han usado conceptos semióticos para dar cuenta de las comunicaciones no

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verbales del terapeuta y han investigado la contratransferencia, incluido lo que el bebé puede captar de sus variaciones. El presente artículo se centra en otro argumento para utilizar intervenciones verbales dirigidas al bebé en terapia: se presentan con un orden simbólico que difiere del de los padres. La diferencia cualitativa entre el discurso de los padres y el del analista está conceptualizada en el término de Dolto: *parler vrai*. El apalancamiento terapéutico no es el contenido léxico de las intervenciones analíticas, sino su mensaje de que las palabras pueden ser usadas para exponer conflictos. Por ello, uno puede transformar los deseos mantenidos a raya en demandas que pueden ser negociadas con los objetos de uno mismo. Se discuten las razones por las que este discurso capta la atención del bebé [BS1]. Un prerrequisito para tal atención es que el cerebro del bebé está programado para percibir las palabras como un modo especialmente comunicativo. Se revisa la investigación neurocientífica relevante respecto a esta cuestión. La presentación se basa en conceptos de Dolto, Lacan y Winnicott y hallazgos de la neurociencia y la psicología del desarrollo. También se discute brevemente los conceptos lingüísticos de Chomsky en relación a estas terapias.

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