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CHILD AND ADOLESCENT PSYCHOANALYSIS

Gaze avoidance in parent–infant psychotherapy: Manifestations and technical suggestions

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ABSTRACT

Infants express emotional distress through whining, crying, flailing, silence, etc., which can be viewed as communications that also afflict the caregiver(s). One expressive mode, subtle and often unnoticed except by the parents, is *infant gaze avoidance*. It often elicits parental feelings of rejection, shame and despair, and may be a reason for seeking parent–infant psychotherapy. In therapy, the symptom often discloses a disturbance in the dyad's emotional interaction. Therapy can bring about relief in the symptom and the relational disorder. Sometimes, the therapist discovers that the infant is avoiding the therapist's, rather than the parents', eyes. This challenges the therapist's expertise in establishing contact with the baby and in perceiving and processing emotional reactions to what may be experienced as the baby's dismissal. Gaze avoidance elicits theoretical questions approached in a previous publication: what does the child seem to avoid in the adult's eyes, and how can we conceptualize the psychodynamics behind the symptom? It also evokes technical questions: how can the therapist make contact with an infant who avoids the mother's or the therapist's eyes? How can the clinician exploit their emotional reactions, the countertransference, to understand and further the dyad's emotional communication? Two case vignettes are provided.

KEYWORDS

Gaze avoidance; parent–infant psychotherapy; countertransference; psychotherapeutic technique

This paper follows up an earlier article on gaze avoidance in infants (Salomonsson 2016). The primary aim then was to investigate the heuristic value of the concept "psychological defences in infants". Since gaze avoidance occurs among quite a few babies, especially when they are in distress, it served as a suitable test-case. The questions concerned whether a baby might handle distress in the relationship with the mother by avoiding her eyes and if so, how this should be conceptualized in psychoanalytic terms.

The case in that paper was a three-month-old girl. After delivery, mother felt exuberant, but three weeks later after a colic period, the girl stopped looking into her eyes. The mother felt the girl did not like her any more. In mother–infant therapy sessions, I

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suggested to the girl that "there might be a part of a Mum you don't like, one that you got scared of when you were very little". When the girl was crying, the mother comforted her with a jaunty attitude, which did not help. The mother revealed that she also felt awkward when meeting people's eyes and felt the same with me. She addressed her loneliness with her own mother: "She's a bit on autopilot, as it were."

That paper explicated the girl's gaze avoidance as an intentional act aimed to protect her from unpleasant experiences. Her perceptions of Mum had probably been influenced by the distress during the colic and Mum's tense ways of handling her. They were then subjected to splitting mechanisms and projective distortions, which led to the creation of a terrifying maternal part-object. To avoid this scary emotional experience the girl must then – according to the logic of projective mechanisms – avert her mother's eyes instead. These factors, plus the mother's tension, loneliness and timidity, contributed to a situation described by Winnicott (1971): normally, a baby who is looking at her mother's face "sees herself" (112). However, some babies meet a mother who reflects "her own mood or, worse still, the rigidity of her own defences" (112). I suggested this was the case in that this baby's mother, when interacting with her baby, had difficulties in integrating her agony about the colic and her discomfort with eye contact.

The 2016 paper concluded that the girl's avoidance of her mother's eyes had developed into a phobic mechanism. She concretely averted what she felt was the "the external danger [which] provided the illusion that the internal threat had been dealt with" (Sandler 1989, 104). The paper saw the symptom as a defence, directed "towards internal excitation (instinct)" plus "representations (memories, phantasies) [which] this excitation is bound to" (Laplanche and Pontalis 1973, 104).

Questions

Prior to the paper (Salomonsson 2016), infant gaze avoidance had been observed in parent–infant psychotherapy (Fraiberg 1982), infant observation (Cowsill 2000; Kernutt 2007) and the Still-Face paradigm (Tronick et al. 1978). The 2016 paper coupled infant gaze avoidance to psychoanalytic defence theory, a point over which Fraiberg had been more hesitant. It supported the view that a baby is capable of primitive mental actions aiming to safeguard their equilibrium. Over the years, I have observed this phenomenon many times in therapy sessions, which has engendered further questions:

Mother: Gaze avoidance often occurs with mothers who do not seem excessive, violent, intrusive or exceedingly depressive. What is it then in the baby's representations of mother's eyes that makes them avoid them? Does avoidance result from a constant constellation within the dyadic relationship, or can many kinds of relations lead up to it?

Analyst: The analyst can also be subject to the baby's gaze avoidance in parent–infant therapy. Does the baby react in a transference-like way (Salomonsson 2013) to the analyst's presence? Or is it a reaction towards both mother and analyst? Alternatively, is the mother's negative transference onto the analyst apprehended by the baby, which then makes him or her avoid the clinician's eyes?

Technique: Gaze avoidance challenges the mother–infant therapist. If the therapist feels urged to bring it up with mother, this creates a delicate situation as mothers often react with fear and shame when it is brought up. A negative therapeutic reaction and/or a premature treatment termination may ensue. It has been recommended (Norman 2001) that the

analyst seek contact with the distressed baby with the aim of "bringing the disturbance in the infant into the emotional exchange of the here-and-now of the session" (83), that is, into the analyst–baby exchange. This will make it "available for containment in the infant–mother relationship" (83). I regard this as one of two goals in mother–infant therapy, the other being to offer the mother herself analytic containment. However, if the baby avoids the analyst's eyes, getting in contact with the baby becomes harder. Perseverance is of help, but working with a baby whose eyes are askance may yield countertransference feelings of impotence and hopelessness. Can these feelings, specifically, help the analyst understand the present situation and formulate interventions accordingly?

Future development: Gaze avoidance often remains unobserved by child health centre nurses, shamefully concealed by mothers, and brushed aside by fathers who feel it will soon pass – which in many cases seems correct. Yet, are there any long-term psychological effects of what goes on in the baby's mind when averting mother's eyes?

The paper proceeds from two of my own cases of mother-infant therapy. This method has been extensively described elsewhere (Anzieu-Premmereur 2017; Baradon et al. 2016; Beebe et al. 2005; Jones 2006; Paul and Thomson Salo 2014; Pozzi-Monzo and Tydeman 2007; Salomonsson 2014, 2018). Briefly, the therapist observes and communicates with mother and child, acknowledging the baby's incapacity to understand the lexical levels of language as well as their ability to pick up and react to emotional signs within the relationship. The aim of therapy is to liberate affects and behavioural patterns that are forestalling positive development in both parties.

Gaze avoidance poses technical challenges in therapy, and the session vignettes aim to show how one can work with such cases. They will also account for my emotional reactions, as I discerned and analysed them when studying the videos post hoc. These reactions will be discussed in the countertransference section. Between psychotherapist and patient(s), just like in any human encounter, meaning-making is "co-constituted through embodied multimodal actions, rather than simply constructed through talk … the interacting partners co-create moment-to-moment an emerging relational context, which is primarily understood nonconsciously" (Avdi et al. 2020, 2). Such interchanges are suitably studied through a microanalytic procedure (Beebe and Lachmann 2014). The researcher may focus on the participants' interpersonal coordination by studying, for example, postural convergence (Sharpley et al. 2001) and synchrony (Koole and Tschacher 2016). Such observations are presented in the vignettes. Importantly, here they will not be analysed second-by-second, as in the works by Beebe and Avdi et al., but in larger chunks of time. The aim is to focus on gaze avoidance, its handling in parent–infant therapy and the informative value of countertransference.

Case 1. Avoiding the analyst's eyes: Flora and Ingrid, five months

Flora was referred to me by her child health centre nurse when her daughter Ingrid was three months old. Arriving alone at the first session she told me:

> I'm already 40 years old and was never keen to have children. Then my IUD [intrauterine device] didn't function well, so I had it removed, and my husband and I let chance decide. Everything happened very quickly and now I have a child, but I can neither think nor speak of myself as "Mum". I even shudder when I utter that word! When I was pregnant, I just couldn't tap my tummy to feel the baby's movements.

As delivery was approaching, Flora had panic attacks and was offered a Caesarean section, which technically went well. She describes Ingrid as gentle and good-natured and easy to soothe. She sleeps and breastfeeds without problems and they have a good contact. Notably, however, upon my question Flora cannot describe any personal or specific traits in Ingrid. I get the impression that Flora likes being with her daughter and that she accepts the sacrifices of parenthood without any gross complaints. Long ago, Flora had a burnout condition. She is ambitious, both as a professional and a mother, and undertakes many internet searches about parenthood and child development. As for her parents, she describes them as barely capable of talking about feelings.

In the second session, I see Ingrid for the first time. Flora sneers at "Super-Mums who are so in love with their babies". Meanwhile, Ingrid avoids my eyes and does not respond to my contact efforts. Flora does not observe this. Towards the end, mother and daughter have a delightful lengthy eye contact. We decide to meet once weekly in therapy with the girl as well. In the sessions to come, Flora complains about her own mother and their splintered communication. The mother–baby relationship is slowly warming up. Ingrid meets her mother's eyes now and then but *consistently avoids my eyes*. When I bring it up, Flora says this does not occur at home. She is preoccupied with her relationship with Granny, and her maternal self-esteem is very low. "Earlier, I felt it was not appropriate for me to reproduce," she says with barely withheld tears.

In my countertransference to the baby, I am bewildered. Flora has described Ingrid in relaxed and positive terms, so I am surprised to see her insistent gaze avoidance when I first meet her. True, I have seen many mothers' favourable reports about the baby sharply contrasting with my own impressions of them. In such cases, the mother's carefree rendering seems to be a defensive effort at concealing her worries about the baby's behaviour. As for Flora, however, I feel she is sincere when she speaks of Ingrid's good-natured and happy mood and their good contact. So why does Ingrid not look into my eyes? In front of such questions, all the clinician can do is to wait until things emerge more clearly.

The ninth session below was video recorded, like other sessions, with the parents' consent. Flora enters the office carrying Ingrid. I say hello to Ingrid, who glances furtively at me for a split second while I am fixing my chair. She then looks down with a wary look.

02.00/ Mother Flora: "She's a bit morning-shy … You wanna stand up?"

Mother raises Ingrid to a standing position, with Ingrid facing the analyst.

Mother: "We were at the Child Health Centre yesterday, a new super-nice nurse, Nadya."

Ingrid seeks Flora's and my eyes swiftly, but when we turn towards her, she shies away. Her face is serious or blank.

02.55/ Analyst (concerned and with a tone of voice indicating some disbelief. Meanwhile, Ingrid is still glancing very swiftly at him and then casting down her eyes):
"Is it like Mum's saying, that you're a bit morning-shy?"

Mother turns the standing girl to face herself. The girl avoids her eyes.

M: "Yeah, a bit … You wanna stand this way instead? You can change later if you want to."

The girl yawns, which mother confirms.

A (smiling): "Mum's looking tenderly at you. Mum's tired as well."
M: "Sure!"

Flora says Ingrid wakes up in the night and is breastfed. Flora cannot fall asleep again. Intermittently and without any smile, Ingrid seeks out the analyst's eyes and quickly retracts, especially when he reciprocates her glances, which are a bit lengthier now.

04.00/ M: "In the night one, or I, start thinking about things that need to be fixed. Good and bad things."

Flora says her husband agreed to do more things at home. Ingrid is looking down more now.

05.05/ A (concerned tone, leaning sideways to make contact with Ingrid): "How are the two of you?"

Ingrid is here avoiding both mother and analyst. Mother wants to deny this fact and any worries about it; she claims the girl is "morning-shy" and reports about the positive new nurse. By smiling and commenting on Flora's tender look, the analyst seems to quench his apprehension and collude with the denial. However, his somewhat sudden question about "how are the two of you?" indicates such concern.

05.30/ M: "Well, a bit … As soon as one understands something new about her, she changes. We tested not changing diapers before bedtime, 'cause when we did change, she woke up inconsolable, as if one had committed an assault. Now we don't care about changing … "

At the word "assault", the analyst rises instantly a bit from his forward-leaning position. Ingrid is held en face by mother, gives Mum a quick glance that she does not respond to, and then pushes her head into the back of mother's armchair.

M: "What's the matter?"

The frowning analyst looks apprehensive.

06.30/ M: "Time to tank!"

Breastfeeding begins. Now and then, Ingrid groans and flails her arms and legs, but she gets a good feed. The analyst looks incredulous and concerned. Perhaps to avert these feelings and convince himself that everything is alright, he is nodding his head several times.

M: "I've a great confidence in Nadya. I asked her if I need to worry, since there's been no great change in Ingrid's sleeping behaviour, but she said no. I've had a bit of a tummy ache about what will happen next."

0710/ A (more energetic and decisive, leaning forward, making hand gestures to illustrate his suggestions): "You're really worried – and you tell me again that you need to have confidence in anyone you're sharing your worries with."

M: "Otherwise I can't trust what they're telling me!"

Flora says the advantage of the expected sleep change is that the risk of sudden infant death will decrease. She assures that she has not been worrying about it. She is quite garrulous. Her nurse told Flora about unfounded worries about her own kids, which calmed Flora.

A (concerned look, sighs once):	"You've got a two-step-worry: you worry about something and then you must check if you've got confidence in the person you're asking."
M:	"I must make sure that the one I'm asking doesn't have an agenda! If you ask somebody who works for a company making baby formulas, they won't answer in a non-nuanced way."

"*Non-nuanced" is a slip; her conscious intention was to say "nuanced". The slip escapes me.*

09.15/ A:	"I get that. Not only do you need to trust the person, you also need to feel an immediate connection."
M (hardly waiting for the analyst to finish):	"Yeah, I've heard many horror stories about terrible nurses. I was lucky, though. I was very worried when Rose finished. Now I'm happy with Nadya, her office is next to Rose's. I got confidence in her already at a distance!"

Ingrid is still breastfeeding at a good tempo, fingering her mother's hands. Flora is eager to tell her story and rarely looks at Ingrid.

10.00/ A (stressed and quick breathing):	"I remember our first encounter, you seemed to have confidence in me as well."
M:	"Yeah, otherwise I wouldn't have come back. Rose suggested I could see someone else if I felt I didn't click with you."
11.00/ A (smiling):	"Would you be able to tell me if you'd felt that way?"
M (baby groaning at the breast):	"Now, yes. Back then, no, I don't want to be rude … It's hard to tell the first time you see a person. You know, these Internet dating sites, I tried them a few times, you don't have a chance, you need to meet the guy a few times, he could be a convicted criminal, one doesn't want to be with that kind of man!"

Flora's worries surface about the baby's sleep and survival, her search for confidence in the helping person and her brittle trust. She trusts Nadya but paints a contrasting conversation with someone who has a "non-nuanced" agenda. Frightening words pop up about assault and criminals. The analyst emphasizes her need of trust, but his body language points to tension and worry, indicating that he has picked up the strain between Flora's confidence in her helpers, including him, and her fear of any encounter where trust is absent. She confirms her confidence in him, and thus the transference can be interpreted as being positive. However, the sudden violent words may intimate a negative transference that as yet has not been addressed.

The analyst is facing a choice: to point out to Flora that she followed up his question about her first impression of him by speaking of criminals – or to ask about her relationship with the girl. In other words, he can focus on a possible negative transference onto him, or to the mother–infant relationship. Pushed by concern about Ingrid's gaze avoidance, he chooses the latter.

13.40/ A (interrupting Flora's lengthy comment about dating sites):	"You're talking about the uncertain first impressions on these dating sites. Did something similar happen when Ingrid arrived? Were you uncertain whether to 'date' Ingrid or not?"

Flora negates this and says she felt immediately attached to Ingrid. She quickly learnt "Mum-things", such as changing diapers, but she didn't want to be part of the "Mum-collective". The coronavirus pandemic has made her feel isolated. At 18.45 on the video, breastfeeding comes to an end. The girl is still slightly jittery, lying comfortably in her mother's lap, fingering her mother's hand, which neither Flora nor the analyst notices, and groaning a little. Flora speaks of her loneliness during the pandemic. The analyst explains (20.55) that he asked about her first feelings about Ingrid, because he has noted the girl's reserve with him. Flora does not recognize this behaviour from home.

20.50/ A (relaxed, curious):	"Then why does Ingrid avoid *my* eyes? I understand if my question might worry you. Could we talk about that without your feeling … "

Ingrid's rapid hand movements slow down, and her groaning subsides.

21.50/ M:	"I think it has to do with how I react when I'm here. It's rough coming here 'cause we're talking about troublesome things!"
A:	"A bit afraid?"
M:	"Not afraid, it's not like a horror movie. But I'm tense and anxious, with a tummy ache while thinking 'how rough will it be today?'"

Flora takes Ingrid up to hold her on her shoulder, en face. Ingrid gets a bit more tense.

A:	"Do you feel free to talk with me about it?"
M (on the verge of crying):	"It bothers me that I get so emotional and cry. We don't exactly talk about cookie recipes here, but deep things that I've pushed aside. Like yesterday with Nadya, I told her about the Caesarean due to my delivery phobia. My body went defensive just by telling her! It's like a trauma!"

Ingrid makes some brief efforts at looking at Flora, making a funny lip sound. Flora smiles.

24.30/ A (making a gesture as if ripping his abdomen):	"Coming to me, or to Nadya, it's like you have an operation wound and now the surgeon, me, is going to rip it up again."
26.00/ M (Ingrid standing on her lap, not looking at Mum's face, sucking the sleeve of her cardigan):	"I'm exhausted after our sessions. To tell you the truth, I appreciate the upcoming Christmas break!"
A:	"I get that. And not only do you feel we rip up old wounds, but you don't feel comfortable telling me 'Help me, this is rough, I've so much shit from those days!'"
M:	"Might be, I didn't consider speaking to you that way."
A:	"It would be like going to a surgeon without having the right to say 'Ouch, this hurts!'"

M laughs, showing that she understands the paradox she is caught in. Ingrid is standing on her lap, pressing her head towards Mum's shoulder.

The mother reveals her anxiety and tummy ache before sessions, talking about "deep things", and the exhaustion afterwards. A theme of violence is resurfacing, via the delivery phobia, the Caesarean and the analyst's surgical gesture. He conveys he is open to talk about her negative transference onto him, which is an intervention addressing the container–contained relationship.

The analyst now suggests that Ingrid avoids his eyes because she feels he is doing something that brings about changes in her Mum. Tearful, Flora reveals (31.30) how anguished she was when the analyst shared his observation about the girl's gaze avoidance. It hurt deep inside because of the "entire Mum-thing". The girl is standing on her lap, making many brief efforts at looking at Mum but always turning away after a second. Later, Flora adds that Ingrid only avoids her eyes in the consulting room, not at home, because it is only here that the mother feels so sad and distressed. Flora thus proposes that the gaze avoidance reflects the girl's apprehension about changes in the mother's internal state that are somehow elicited by the analyst's presence.

36.00/ M: "Yeah, I notice that she's looking down from me all the time now … I noticed already at home today that she avoided my eyes. Maybe she felt that I had some tummy ache. She wasn't crying, but maybe she felt unsure of how to handle me! This was on our way to … "

A: " … to the scalpel man."

43.00/ M: "So many things poured forth today. Some things I pushed aside without knowing it, other things I knew I did. Five months passed since she arrived and I'm still crying when talking about the delivery or the months before! What if I become pregnant again, will this black hole come back? … I'm tired now, but it was also an easier session today, because I got it out of me, things that I've been thinking about but not talking about. Look, she's smiling at you!"

A: "OK, our time is up."

The last piece of conversation indicates that Flora sees Ingrid's gaze avoidance, it does not terrify her and she has had many troubling things on her mind that she did not bring up yet. I wonder if Ingrid's brief final look at me signals a more profound change in her attitude to me. Given the rapid changes that often occur in these therapies, the next session might give a hint.

Case 1. Next session, a brief excerpt

Flora enters with Ingrid. Both seem more relaxed.

A: "Ingrid, you're looking at me today."

M: "'Cause I'm much calmer."

A: "Mum's been afraid of coming to the surgeon."

Ingrid is looking at me, with an open face and a more upright position. One brief smile.

M: "I've infected her with my worries. Contagion … it's like a spill-over thing. I've seen the same thing with my dog, he captures how I'm feeling … "

The girl munches her mother's hand.

A: "I guess Mum's cosier today, that's why you want to eat her up."
M: "I was robbed of a happy pregnancy! 'Cause of the pandemic? There must be more to it."

The girl looks enchanted at the analyst's hands. When he retracts them, she waves her hands, perhaps a sign of imitation. The mother details her fears before delivery. Medical appointments were cancelled due to the pandemic. Thinking of a vaginal delivery caused alarm. She could hardly walk into the office of the doctor who was to decide about the Caesarean section. She felt suicidal, had a breakdown and felt she was "in a haze". As Flora talks about her distress, the girl resumes her behaviour from the previous hour; she looks very little at me and mother and moves in a jumpier way. The mother pays less attention to her compared with the session's beginning.

Avoiding the analyst's eyes: a psychoanalytic model

Ingrid sometimes shunned her mother's eyes, but her avoidance of my eyes was already more consistent in the first joint session. As I had met many babies where gaze avoidance signalled a disturbed mother–infant relationship, I sought to help them improve their contact. This aim contrasted with that of Flora, who talked about Ingrid's positive development and their fine relationship. With me, Ingrid either looked down, or smiled obliquely with her lips but without any smiling eyes. Previously, this observation had worried me less than the fact that Flora felt alienated as a mother. When Ingrid vividly pulled her hair, she would say "You must be cautious with the Holy Mother." This joke had an underlying implication: motherhood was a quasi-religious undertaking that she could not live up to. This made me focus more on her story than on the baby's avoidance of me. There were several reasons for what I believe, in retrospect, was my one-sided perspective. One was Flora's urge to talk about her mother, the second was that gaze avoidance was absent at home. Flora's effusive, quick and sometimes acerbic accounts clarified that she trusted me. In contrast, it made me blind to what emerged only in the ninth session; sessions also evoked intense anxiety, tummy ache and fears of being overwhelmed by unforeseen topics in our dialogue.

With the acumen that follows from hindsight, I realize that *Ingrid was more perceptive of her mother's anxiety than I was*. She reacted with gaze avoidance, most of all towards me. My comment to Ingrid that she avoided me because I did bad things to her mother may have been correct in a roundabout way. I assume she had a vague sense that:

> when we come to this guy, Mum changes in a way I don't grasp. She smiles towards him, but she also speaks faster and louder, forgets me, becomes jerky and often changes my body position. This makes me distressed and that's why I don't want to look or smile at him.

The session unveiled that the mother feared me, not because of any overt antipathy, but because I encouraged her, and she became more inspired, to talk about difficult matters: the excruciating events during pregnancy and delivery and her doubts about the girl's development. Consciously, she felt confidence in me and revealed painful things. The sudden emergence of violent words ("assault", "criminal") pointed to a contrasting yet unconscious current: her fear that opening up to me was equivalent to

being assaulted by a "scalpel man". This expression, invented by me, showed that I resonated with this violence theme, and that Flora could smile at the simile and express relief that "so many things poured forth today".

To conclude, I propose that the girl avoided my eyes because she intuited that I was the source of mother's distress in the consulting room. I refer back to the "analyst" thoughts in the earlier section "Questions" and its hypotheses as to why a baby may avoid the analyst's eyes. One question related to whether a baby might react in a direct transference-like way to the analyst's presence (Salomonsson 2013). This was not the case with Ingrid. Rather, it was mother Flora's negative transference onto me that had neither been disclosed nor elaborated and talked about. The girl's apprehension of Mum's distress made her avoid my eyes.

Case 2. Avoiding mother's eyes: Debbie with Lenny, six months

Debbie and Lenny, Part 1

Debbie, a 35-year-old professional woman, consulted me when she was seven months pregnant with her second child. Some years previously, she had difficulties bonding with her newborn daughter, and the two were in joint therapy with me, where we worked through her ambivalence towards motherhood. Now pregnant again, she feared the next child would disrupt her relationship with the daughter, which in the meantime had developed into a warm and mutual one.

The boy, Lenny, was born and everything went well. Two days after delivery, however, the parents learnt that he had a congenital malformation to be operated on later. The doctors said it would be a minor routine operation. Suddenly, at 1½ months of age, Lenny became gravely ill. The malformation proved to be more complicated than the original diagnosis, and at two months he underwent advanced surgery. All went well, but the threat of his imminent death caused huge worries and rekindled Debbie's ambivalence. Would he, and did she want him to, survive? She was considering a third child to replace Lenny while struggling with guilt, rejection, love, panic and anger at fate's injustice. Her husband worried, too, but was more stable. After surgery and follow-ups, she and Lenny, now four months old, started a bi-weekly mother–infant therapy, with the occasional participation of the father.

Six weeks into the therapy Lenny was 5½ months old. According to the mother, his development had been proceeding completely normally, and the child health centre nurses making regular check-ups were not worried at all. Lenny had been fed with formula milk during the preoperative procedures. After surgery, when mother offered him the breast, he clearly preferred the bottle and since then had been receiving only formula feeding. His mother was mourning that she could not continue with breastfeeding. Yet, she felt she had accepted it, and now she was much more preoccupied with what she feared were the lethal effects of the malformation and the operation. With me in the consulting room, Lenny is a happy and likeable chap, often smiling and looking at me. With his mother, as we shall see, things are different.

In the 19th session, Debbie had mentioned her sensitivity about atmosphere, tone of voice and facial expressions. For example, she sensed an insincere quality in her parents' dialogue. I suggested, "Talking about insincerity, you tell me you are so worried about

Lenny. What about addressing him sincerely about it"? In response, she turned to him in a factual and neutral tone:

> I think all my life there'll be a dimension of worry when I can't relax, uncertain if you're going to make it. Maybe you'll feel a demand to prove that you can make it, and we'll be so proud of you. I really want you to be the person you are, but it'll be hard to be cool.

For half a second, Lenny was looking at her and then turned aside. I was moved by her struggle to be sincere and by his avoidance, which she did not notice. I suggested we look at the video at a later session.

In the 22nd session, two weeks after the 19th, Lenny is now six months old, and he and his mother have been in therapy for two months. Debbie and I have just been watching the video clip from the 19th hour. She comments that she needs to go to the hairdresser but does not notice Lenny's gaze avoidance on the screen. A quarter of an hour into the 22nd session, the following interaction takes place.

Analyst:	"Lenny, you don't want to look at Mum. Debbie, after we looked at the video, you commented on your haircut and your new sun cream. What I tried to convey then was – Hey Debbie, try to get 'under your skin' and tell Lenny about your worries! The second he was looking at you, I think he tried to get in contact 'beneath your sun cream' so to speak. You are struggling with being sincere."
17.46/ Mother Debbie:	"I think, if there's something I … "
Analyst:	"Wait a second! (to Lenny:) Lenny, right now you could have looked at Mum but then Mum must dare look into herself. Debbie, you've said your husband fell in love with your eyes because they were full of life. But life is both tragedy and joy."
M:	"I wrote a little text this morning, how I was feeling, I could read it here now."

The boy keeps looking at me.

M (reading from her cell phone):	"I miss when I was taking care of myself, was interested in things, living in the present and dared planning for the future. I felt strong and happy. I miss the mother, spouse, and daughter I was then. I miss my husband's eyes, his warm hands, I miss feeling proud of what is mine, I miss feeling confident, unafraid, curious and inspired, I miss having the courage to love all the way through."
19.50/ A (sighing):	"Could you explain this to Lenny now? All your longing and loss?"
M (holding and looking at him):	"I miss that I can't enjoy you, Lenny. I'm looking for faults instead of being happy when things are going well. I'm afraid that I'm constraining you."

20.23/ Lenny looks at her for a second. She smiles. When he turns away, she looks dejected.

A (noticing that he's looking rapidly at her and turning away again):	"Lenny, Mum's talking to you, she's serious."
M to L:	"I really want to try. On Friday I'm going to a church to plan your christening. A huge step for me, thinking that you'll be alive then, that everything will be good. We'll sing 'A world full of

life', your sister loves it: 'There's a place for everyone'."

21.30/ He looks briefly at her and I lean forward.

A: "Did you hear, Lenny, everyone has a place. You too."

21.53/ He stretches his head upwards, avoiding her. She tries in vain to make him look at her.

A (moved): "Powerful words, Debbie. How do they touch bottom in you?"
M: "When I wrote it in the morning, I was in contact with myself. But right now, talking to Lenny, I digressed and listened to his breathing. The contact disappeared, with myself and with him."
A: "It must be difficult for you reading out these words while worrying about his breathing. You get scared. "
A to L: "Mum's so worried, Lenny. She looks at you and is very happy, and then a north wind appears. Shhhh! You know, a wind that makes you shudder."

He smiles at me.

24.22/ A: "You were there again with eye contact, Lenny. Mum, too, has a world full of life. One would like to 'sschpout' [neologism from 'spout'] the padlocks inside of her so she could tell you how fine you are, how worried she is, and that she was thinking about your breathing."

Lenny is captured by my sounds and movements, looking into my eyes.

A: "You look at Mum and register all this, Lenny. You looked at her again but left her eyes again to look into my eyes 'cause I'm not worried about you. It's safer for you to look at me."

Looking at the old video clip was my initiative to show Debbie that Lenny avoided her eyes. I got the idea that his behaviour emerged due to her suppression of intense and conflicting emotions about him. The idea emanated from the countertransference; my remarks about her sun cream comment sprang from a frustration of not reaching her emotionally. The same can be said of my reaction to her "padlocks". The neologism "sschpout" was accompanied by my gesture of zeal and frustration. She was wearing a mask and as I noticed it, I wished to reach beneath it. I thus guessed that Lenny wished something similar.

Debbie and Lenny, Part 2

Some minutes after the previous clip, Debbie says to Lenny: "I want to have contact with you and with my inside and I want to chase away my demons".

28.30/ A to D: "There's another possibility of saying, 'I want to have contact with you, Lenny, and with my inside and, you bet, I've got plenty of demons'!"
M: "All these demons make everything that I long for disappear! They take over entirely. I feel deprived. That's why I can't love all the way through!"
A: "What do you mean by 'love all the way through'?"
M: "To receive someone with open arms, saying 'we're gonna fix this, we'll solve it, you're our boy, there's a place for you'."

A:	"You just looked at Lenny, what happened?"
32.00/ M:	"I thought that maybe he doesn't breathe as fast as I imagine … What a relief!"
A:	"So you're preoccupied with his death and check his breathing. But, to love all the way through, doesn't that include abstaining from guarantees about the future?"
M:	"Maybe it's as simple as you say … "
A:	"Can you love Lenny without any guarantees? You're bypassing that challenge by checking his breathing all the time. And you've told me that when one of your parents dies it'll be unbearable."
M:	"Lately I've noticed that such thoughts about my parents have become less scaring. Nowadays, my focus is on my children. Me as mother, not as daughter. That feels all right."

Avoiding the mother's eyes: a psychoanalytic model

Babies, of course, cannot explicitly formulate to themselves the muddled object they may be involved with. They can merely avoid their mother's eyes and their unclear emotional message, with the aim of evading an unpleasant experience. To say that the baby is trying to regulate distressing affects is correct, but it does not indicate which primal representations (Salomonsson 2014) are involved. In Lenny's case, I assumed them to be something like: "mother cares a lot about me, but she is not clear and lucid about her worries. This makes her hard for me to grasp."

In the interaction between Debbie and me, this opacity emerged in the sun cream dialogue. I accepted this shallow conversation initially because for me, too, it felt easier than to plunge into the distress that Lenny's gaze avoidance stirred up in me. Yet, I soon felt uncomfortable with being a small talk partner and suggested that she try to get "under her skin" and tell Lenny about her worries.

Soon another focus prevailed: Lenny's avoidance of his mother's eyes. I managed to understand his predicament better by paying attention to the countertransference. Debbie's shallow contact with her anguish was also reflected in *our* contact. My ensuing frustration also emanated from an identification with Lenny, who was looking eagerly at *me*. From one perspective I was a man disheartened by not reaching Debbie. From another angle, and by identification with Lenny, I felt like a baby unable to reach Mum emotionally.

There was thus an imbalance between our foci: I was preoccupied with emotional interpersonal contact – between Debbie and me, and between Debbie and Lenny. She was focused on suppressing her worries about Lenny's health and mourning the losses of her lively eyes and a promising future with her family. Simply put, I was focusing on *his* internal world, she on *hers*. The focus on Lenny's internal world raises questions about when and why he shuns his mother's eyes – and when he does not. When Debbie said to Lenny, "I'm looking for faults instead of being happy … I'm constraining you", he looked at her for the first time. What happened? First, one might argue that until now he had avoided her because she looked depressed. Such responses have been amply demonstrated in babies in the Still-Face paradigm (Tronick et al. 1978). However, Debbie did not look depressed but enigmatic and a bit absent when looking at him. Second, Lenny behaved differently from most babies in the Still-Face situation.

He did not scream or wring his body but avoided her eyes in a calm and self-absorbed way – and with great precision. Finally, had he been replicating the typical behaviour of Still-Face babies, we would still need to explain what went on in his budding mind.

My idea is that Lenny's looking at, as well as his avoidance of, his mother's eyes has to do with how he feels, in the moment, about her and their contact. I have suggested (Salomonsson 2017) that problems may arise in the parent–infant relationship when a parent is soothing a distressed child while being emotionally absent or obscure. When parents refrain at length from *parler vrai* (Dolto 1994), that is, from speaking in a way that genuinely reflects their feelings, this creates a *double entendre*, a mismatch between *what* and *how* something is being said. Debbie does speak with me and Lenny about her inner turmoil, although without recognizing the wall between her inward calamity and outward appearance. I would *not* claim that this makes Lenny wonder, "What is she actually feeling?" Rather, he feels "something ain't right". He does not get peace of mind when he looks into her eyes because he cannot find a comprehensible Mum-subject in her eyes. He keeps on searching, although in a literally oblique way. He looks at everything *but* Mum's eyes: her hands and clothes, the walls, the pictures – and my eyes. This is painful to his mother, since it shows his interest in eye contact with all other people except her.

Importantly, Lenny does not seem angry when avoiding his mother's eyes. Rather, his behaviour has a mundane, discreet quality. This probably explains why this sort of behaviour often passes under the radar of healthcare nurses. Another explanation may be that mothers are ashamed of bringing it up. But when a therapist observes it and addresses it, the mother's pain surfaces and gaze avoidance can be talked about. Returning to the "Mother" item in the earlier section "Questions", I do not conclude that avoidance of the mother's eyes results from a constant dyadic constellation but that many kinds of relations can lead up to it. I do, however, think that in general it expresses the child's reactions to what they experience as an incomprehensible alteration in the mother's emotional Gestalt.

A note on countertransference in parent–infant psychotherapy

In the two presented cases, the analyst's attention to the countertransference opened up an understanding of the motives of the gaze avoidance and the emotional dyadic climate linked with it. "Attention" implies to closely observe communications and behaviours in the session, to let oneself become inundated by projective identifications of the mother and baby, and to allow them to blend with facets of one's own personality. This process has been summarized in a classical paper on countertransference (Pick 1985):

> We have to allow for the problems involved not only in digesting the patient's projections, but also in *assimilating our own responses* so that they can be *subjected to scrutiny*. The analyst, like the patient, desires to eliminate discomfort as well as to communicate and share experience. (158, emphasis added)

Loewald (1986) stated that when we enter into our patients' conflicts and archaic mental states, we "recognize in them variations of our own" (286). But, as Brenman Pick suggests, neither patient nor analyst desires *only* to communicate and share experience; they also wish to *eliminate* any discomfort in the interaction. To illustrate from Case 2, our

chit chat was also fuelled by my characterological tendency to be a nice guy. Brown (2010), like Brenman Pick and others, emphasizes that the patient projects into "a *specific site* in the analyst as though the projective identification were a 'smart bomb' aimed at an affectively resonant location and guided by an empathetic 'GPS' system" (672, emphasis added). If so, Debbie had managed to identify one of my "specific sites", which made our tendencies to socialize collude momentarily. I left this complicity, realizing that our "sun cream talk" was averting Lenny's and Debbie's distress. This exemplifies a situation described by Skolnikoff (1993):

> As the analyst becomes more emotionally engaged with the patient … [he] begins to become aware of the development of more elaborate, preconscious countertransference attitudes in response to the patient's transferences, as well as to conscious conflicts within himself. (300)

Whereas many analytic publications refer to countertransference with adult and child patients, they are less vocal on parent–infant therapy, although the topic has recently received more attention (Baradon et al. 2016; de Rementeria 2011; Diaz Bonino and Ball 2013; Ogbuagu 2019). Authors emphasize the heavy impact of countertransference in such work but few, with the exception of Avdi et al. (2020), document in detail its modes of working. One reason may be "the hypothesis that the therapist's provision of warm sensitive, attuned responsiveness leads to the caregiver's enhanced capacity to provide the same to the infant. [This] has led to an emphasis on strength-based, supportive interventions" (Birch 2008, 20). If we are preoccupied with "saving the baby", we may be tempted to overlook that "our concealed feelings of worry, revulsion, anger, and fear have an impact even though we do not openly express them" (20). Birch focuses on cases of child neglect, which was absent in the two children presented here. Nevertheless, I think the temptation to rescue the patient is generally more active in therapies with infants and their parents than with adult patients alone. The reason is probably the mixture of commitment, care and impotence that befalls anybody in front of a distressed baby. Also, the analyst's own infantile helplessness clashes with their professional desire to be of help through maintaining a psychoanalytic attitude.

In other words, not only is countertransference powerful in parent–infant work but so is the resistance against reflecting on it. To use Lebovici's expression (Lebovici and Stoléru 2003), the parent–infant therapist identifies themself with the participants in a "relatively controlled hysterical movement" (361). The word "controlled" implies a capacity to reflect on such identifications and the feelings that they evoke. Such endeavours unavoidably flounder again and again. In such "micro-crises", the analyst is pushed to reflect on their part in the interaction. In Case 1, Flora said Ingrid was "morning-shy". I had noticed that she looked down and avoided my eyes warily. Nevertheless, I went along with mother's probable denial and confirmed that Ingrid was "morning-shy" and that mother was looking tenderly at her. What made me abandon this collusion? One spur was Flora's report about her insomnia and her statement that "good and bad things" had happened to her, words that elicited my curiosity. Another was my retraction to a state of mind, where I began reflecting on a growing feeling that I was taking part in a spurious interchange. This led me to ask, "How are the two of you?"

I wish to emphasize the pendulum-like motion of the countertransference: between relief and worry, smile and apprehension, and between turning a deaf ear to one's emotional reactions and listening to them. As long as I took part in the conversation about Ingrid being "morning-shy", I felt relieved that although she was avoiding my eyes, it was a mere trifle. Then came my worry and my question to Flora. Regarding the movement from my apprehension towards a smile, one can see it once again later in the same case. I became worried when Flora spoke of her difficulties in confiding in, and trusting, me or any other helper. She idealized the nurse, who provided reassuring answers without addressing her anguish. Only when I realized that this idealization implied that she did not confide in *me* about matters I really would like to listen to – her anguish, uncertainty and low self-esteem – did we start talking about her doubts about opening up to me.

Some final words are warranted on countertransference in cases of gaze avoidance. How are we to explain the analyst's taxing experience? One answer can be found by utilizing Winnicott's (1971) explanation, as referred earlier, of what happens to babies who meet the mother's mood or rigid defences: "Their own creative capacity begins to atrophy and … they look around for other ways of getting something of themselves back from the environment" (112). Working with a baby who is consistently looking aside evokes that very frustrated infantile part in the analyst, who feels impotent, rejected and helpless. This may lead to efforts to get something from mother instead of focusing on the baby. This forestalls "that which might have been the beginning of a significant exchange with the world" (113). Yet, by getting in contact with such countertransference frustration and working it through, the analyst comes to resemble those babies who "do not quite give up hope and they study the object and do all that is possible to see in the object some meaning that ought to be there if only it could be felt" (113). This resilience and persistence is of central importance in parent–infant work.

Future effects of gaze avoidance

The emotional traffic between parent and child forms the basis of the budding personality. This is to state the obvious, but the question is how to react when we as professionals observe roadblocks in this traffic. In my experience, gaze avoidance in infancy is one such sign that should alert us: something in the baby's mind might be developing in an unwelcome direction. I do not refer to temporary avoidance in connection with a brief separation or a common cold, for example. I refer to lengthy symptoms, especially if they are accompanied by other signs of infant distress, and/or if the mother or both parents are distressed by the avoidance.

On the other hand, one could claim, as is often done by nurses, parents and grandparents, that "the child will outgrow it". True, gaze avoidance is much rarer among adults. This might lead us to conclude that they will leave it behind during development, as they do with crying, flailing, kicking, etc. Gaze avoidance could thus be considered an innocuous symptom. However, I hypothesize that if a baby avoids mother's eyes at length, it does not only indicate that they are avoiding a threatening *external* experience; it also heralds that the baby is establishing an *internal* structure, an internal object or a *Weltanschauung,* which will compete with more benevolent introjects. I would even

speculate that it might indicate the beginning of a psychic retreat (Steiner 1993), which functions like the shell of a snail; it provides a frail creature with an armour that stabilizes psychic structures, although in a rigid way that obviates emotional contact. The therapist trying to help such a patient in adulthood will be frustrated and dismayed. In fact, comments about eye contact are not infrequent among patients with narcissistic and depressive traits. They range from embarrassment and shame to guilt, hostility and convictions of the therapist's inimical eyes.

The suggestion of a link between infant gaze avoidance and adult emotional disorder must remain a conjecture. Nevertheless, it seems unlikely that a behaviour with such a strong negative impact on the caregiving mother would abate without leaving any trace in the child's development. Once again, here I address cases of long-standing gaze avoidance. Any baby can avoid their mother's eyes when the baby has been crying or is grumpy. In contrast, the two submitted cases refer to lengthier gaze avoidance where maternal distress was involved in the baby's symptom.

Conclusions

A previous paper (Salomonsson 2016) investigated if a baby's gaze avoidance might be interpreted as a defence against unpleasure. I thus attributed to the baby much sophistication when I assumed the symptom was a way of managing their reactions vis-à-vis a mother with whom they had an ambivalent relationship. In the present paper, I have extended this idea by suggesting that babies react to a *double entendre*, which arises when the mother cannot conflate her unconscious emotions and their expressions with her conscious intentions and their verbal expressions. I have also emphasized countertransference as a tool for comprehending gaze avoidance and helping baby and mother with it. By scrutinizing one's personal reactions to the baby's "contact avoidance", as well as one's identification with the child, the analyst becomes more skilled in imagining how the child is feeling.

The work with Ingrid and Flora is still ongoing. Gaze avoidance has not returned, and mother speaks more calmly about her panic around delivery. As for Lenny, he is now almost three years old. We worked in mother–infant therapy twice weekly from 4 to 7 months of age. Then, I saw him a handful of times up to 11 months. I still see his mother, who confirms that Lenny's gaze avoidance has not returned. He is a lively, cheerful and strong boy. His mother loves him dearly but she is still haunted by dark premonitions when he catches a common cold. Her worries rest on a combination of the traumatization that his initial life-threatening condition subjected her to, and personal problems from earlier in life.

Translations of summary

L'évitement du regard dans la psychothérapie parents/bébé : manifestations et propositions techniques. Les bébés expriment leur détresse émotionnelle par le biais de leurs gémissements, pleurs, agitation, silence, etc., que l'on peut considérer comme autant de modes de communication qui affectent également celui ou ceux qui leur prodigue(nt) des soins. Parmi ces modes, il en existe un qui est particulièrement subtil et qui passe souvent inaperçu excepté chez les parents: l'évitement du regard par le bébé. Cet évitement du regard, qui suscite souvent chez les parents des sentiments

de rejet, de honte et de désespoir, peut être une indication de psychothérapie parents/bébé. En thérapie, ce symptôme révèle souvent des troubles de l'interaction émotionnelle au sein de la dyade. La thérapie permet de soulager le symptôme et les troubles relationnels. Il arrive parfois que le thérapeute découvre que le bébé cherche à éviter son regard plutôt que celui de ses parents, ce qui remet en cause son savoir-faire, l'établissement de liens avec le bébé, la perception et l'élaboration des réactions émotionnelles suscitées par le rejet du bébé. L'évitement du regard soulève des questions théoriques déjà abordées dans une précédente publication ; qu'est-ce que le bébé cherche à éviter dans les yeux de l'adulte et comment pouvons-nous conceptualiser la dynamique psychique qui sous-tend ce symptôme ? L'évitement du regard pose aussi des questions techniques : comment le thérapeute peut-il parvenir à entrer en relation avec un bébé qui évite le regard de sa mère ou son propre regard ? Comment le clinicien peut-il tirer parti de ses réactions émotionnelles et de son contre-transfert afin de comprendre et de promouvoir la communication émotionnelle au sein de la dyade ? L'auteur illustre ses propos par deux vignettes cliniques.

Blickvermeidung in der Eltern-, Säuglings- und Kleinkind-Psychotherapie: Erscheinungsformen und Vorschläge zur Behandlungstechnik. Säuglinge drücken emotionale Not durch Verhaltensweisen wie Jammern, Weinen, wildes Strampeln, Schweigsamkeit etc. aus, die man als Mitteilungen sehen kann, die sich auch auf die Bezugsperson(en) auswirken. Eine subtile Ausdrucksform, die häufig nur von den Eltern bemerkt wird, ist die Vermeidung des Blickkontakts bei Säuglingen, die oft elterliche Gefühle von Zurückweisung, Scham und Verzweiflung hervorruft und ein Grund für die Aufnahme einer Eltern-, Säuglings- und Kleinkind-Psychotherapie sein kann. In der Therapie legt das Symptom häufig eine Störung in der emotionalen Interaktion der Dyade offen. Eine Therapie kann das Symptom lindern und eine Besserung der Beziehungsstörung herbeiführen. Manchmal bemerkt ein Therapeut/eine Therapeutin, dass der Säugling sich von seinen/ihren Augen statt denen der Eltern abwendet. Dies fordert die fachliche Kompetenz des Therapeuten bzw. der Therapeutin heraus, den Kontakt mit dem Baby herzustellen und Gefühlsreaktionen auf etwas wahrzunehmen und zu verarbeiten, was möglicherweise als Zurückweisung durch das Baby erlebt wird. Die Blickvermeidung führt zu theoretischen Fragestellungen, die in einer früheren Publikation behandelt wurden: Was scheint das Kind in den Augen des Erwachsenen zu meiden, und wie können wir die Psychodynamiken konzeptualisieren, die sich durch das Symptom ausdrücken? Außerdem wirft die Blickvermeidung Fragen zur Behandlungstechnik auf: Wie kann der Therapeut/die Therapeutin den Kontakt zu einem Säugling herstellen, der den Augen der Mutter oder des Therapeuten ausweicht? Wie kann der Kliniker seine Gefühlsreaktionen, die Gegenübertragung, nutzen, um die emotionale Kommunikation der Dyade zu verstehen und voranzubringen? Es werden zwei Fallvignetten vorgestellt.

L'evitamento dello sguardo nella psicoterapia genitore-infante: sue manifestazioni e suggerimenti di tecnica. Gli infanti esprimono sofferenza emotiva gemendo, piangendo, agitandosi, con il silenzio ecc. tutte manifestazioni che possono essere viste come comunicazioni che affliggono anche i(l) caregiver. Una modalità espressiva sottile e spesso ignorata tranne che dai genitori è quella dell'evitamento infantile dello sguardo. È questo un tipo di condotta che non di rado suscita nei genitori un senso di rifiuto, vergogna e disperazione, e che può diventare anche uno dei motivi per cui si richiede una psicoterapia genitore-infante. In terapia, il sintomo è spesso rivelatore di un disturbo nell'interazione della diade. La terapia può portare sollievo tanto al sintomo quanto al disturbo emotivo. Talvolta al terapeuta capita di scoprire che l'infante evita gli occhi suoi, invece che quelli dei genitori. Quando ciò avviene, viene convocata la sua capacità di creare un contatto con il bambino, oltre che di percepire ed elaborare la reazione emotiva a ciò che potrebbe venire da lui esperito come un rifiuto da parte del bambino. L'evitamento dello sguardo fa sorgere domande teoriche già affrontate in una precedente pubblicazione: che cos'è che il bambino evita laddove evita gli occhi dell'adulto, e come si possono concettualizzare le dinamiche psichiche sottostanti il sintomo? La situazione evoca altresì domande di natura tecnica: come può riuscire il terapeuta a stabilire un contatto con un infante che evita gli occhi della madre, o magari i suoi? Come fa il clinico a sfruttare le proprie stesse reazioni emotive, il controtransfert, per comprendere e promuovere la comunicazione emotiva della diade? Vengono qui proposte due vignette cliniche.

La evitación de la mirada en la psicoterapia padres-bebé: manifestaciones y sugerencias técnicas. El bebé expresa su malestar emocional mediante el quejido, el llanto, la agitación, el silencio, etc., que

pueden ser considerados como comunicaciones que también afligen a quien los cuida. Un modo expresivo, sutil y a menudo inadvertido salvo por los padres, es la evitación de la mirada por parte del bebé. Esta expresión produce a menudo un sentimiento de rechazo, vergüenza y desesperanza en los padres y puede ser motivo para buscar una psicoterapia padres-bebé. En terapia, el síntoma a menudo revela una perturbación en la interacción emocional de la díada. La terapia puede aliviar el síntoma y el desorden relacional. El terapeuta a veces descubre que el bebé está evitando sus ojos, en lugar de los de sus padres. Esto desafía la habilidad del terapeuta en establecer contacto con el bebé y en percibir y procesar las reacciones emocionales a lo que puede experimentarse como un rechazo por parte del bebé. La evitación de la mirada suscita preguntas teóricas que fueron abordadas en una publicación previa del autor: ¿qué parece que evita el niño en los ojos del adulto? y ¿cómo podemos conceptualizar la psicodinámica detrás del síntoma? También suscita preguntas técnicas: ¿cómo puede el terapeuta hacer contacto con un bebé que evita los ojos de la madre o del terapeuta? ¿De qué manera puede el clínico explorar sus reacciones emocionales, la contratransferencia, para comprender y alentar la comunicación emocional de la díada. Se presentan dos viñetas clínicas.

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