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Infantile defences in parent-infant psychotherapy: The example of gaze avoidance

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Findings from parent-infant observational research have stimulated the development of intersubjective models of psychotherapeutic action. These models have brought out the infant as an interactive partner with the parent. Conversely, interest in describing the individual psyche of the baby has decreased, especially the unconscious levels of his/her experiences and representations. In parallel, clinicians and researchers have been less prone to apply classical psychoanalytic concepts when describing the internal world of the infant. The author argues that this is inconsistent with the fact that psychoanalytic theory, from its inception, was founded on speculations of the infant's mind. He investigates one such concept from classical theory; the defence. Specifically, he investigates if selective gaze avoidance in young babies may be described as a defence or even a defence mechanism. The investigation links with Selma Fraiberg's discussion of the phenomenon and also with Freud's conception of defence. The author also compares his views on the baby as a subject with those suggested by infant researchers, for example, Stern and Beebe. The discussion is illustrated by vignettes from a psychoanalytic therapy with a 3 month-old girl and her mother.

Keywords: parent-infant psychotherapy, mother-infant psychoanalytic treatment, intersubjectivity, defence, gaze avoidance

In my consulting room, a mother is sitting with her baby daughter in her lap. The girl looks at various objects in the room and, at times, at me as well. If the father is present, she also looks at him. The only thing she does not look at is her mother's eyes. Her gaze passes from a lamp or a chair, moves towards mother's face and then, with astute precision, avoids her eyes. Then she continues looking at some other object, while the mother's face turns sad or dismayed. The father takes it less seriously: "It'll pass away soon. Don't worry, dear".

I have made such observations in my work as a consultant psychoanalyst at a Child Health Centre (CHC). In Sweden, these are federally funded clinics where parents bring their babies for check-ups including inoculations, weighing and measuring, as well as getting advice on nutrition and other aspects of child care. Many parents have "baby worries", which they vent with the CHC health visitor. If she finds it suitable, she may recommend a few consultations with me. Parents rarely seek to understand their worries in-depth but rather ask for "tools" to deal with them. Nonetheless, I apply psychoanalytic conceptualizations to understand the case and to formulate interventions. Important results may thus be achieved in a few sessions. If a

lengthy therapy is needed and feasible, the analyst has a valuable opportunity to investigate how disturbed behaviour in an infant may be rooted in her internal world.

The paper's clinical example relies on work with a gaze-avoiding infant and her mother in interaction. It then uses the case to investigate a theoretical question that focuses on the mental processes in *the infant:* Can such a young psyche muster psychological *defences*? To take the question from another angle; are classical psychoanalytical concepts, in this case defence, relevant for explaining disordered behaviours in young and pre-verbal infants? These questions may seem gratuitous, since the dawning psyche is incapable of such complicated processes. The topic would also be meaningless to investigate, since "there is no such thing as an infant. Whenever one finds an infant one finds maternal care, and without maternal care there would be no infant" (Winnicott, 1975). Finally, the study would be redundant from a clinical standpoint, since we always treat a baby jointly with her parent(s). Yet, the first objection actually begs the question. Regarding the second point, Winnicott's dictum should not be interpreted as a prohibition to study the baby in his/her own right. The third objection is true per se, but it does not prevent us from focusing on the psychological mechanisms beneath a baby's behaviour.

The paper is part of a project that investigates if the psychoanalytic concepts that we use for older individuals are applicable to infants as well. Earlier papers investigated infantile sexuality (Salomonsson, 2012), transference (Salomonsson, 2013), and primal repression (Salomonsson, 2014). Undoubtedly, such a project is fraught with heuristic difficulites. Can we really speak of the infant as being a subject? Is s/he a creature who feels, remembers, wants, thinks, and perhaps has some sense of self-reference or "This is I". To link the question to psychoanalytic concepts, is s/he capable of desiring the other, deploying emotions from the primary object to a therapist, and separating drive impulses into those that are forever shrouded in oblivion and those that are dynamically repressed – topics that were investigated in the previous papers? Indeed, can we conclude *anything* about the mental life of someone who neither understands nor produces speech? These points are discussed in the section "The baby as subject or inter-subject". One might also claim that since classical psychoanalytic theory was founded on work with verbal patients it is inapplicable to non-verbal individuals. This will be discussed in the sections "Frustration, pain, defence, and hostility in the baby – Freud's views" and "The defence concept applied to infants". Finally, overviews of other researchers' and clinicians' views are presented in the sections "Gaze avoidance and infant research", "Gaze avoidance in infant observations" and in the section on Fraiberg's paper.

The clinical work is inspired by three methods; (1) mother-infant psychoanalytic treatment (MIP; Norman, 2001, 2004; Salomonsson, 2014), (2) therapeutic consultations (Winnicott, 1941, 1971b) transferred to parent-baby work (Lebovici *et al.*, 2002; Lebovici and Stoléru, 2003), and (3) therapy focusing on parental projective distortions that impinge on the

relationship with the baby (Cramer and Palacio Espasa, 1993; Fraiberg, 1980; Lieberman and Van Horn, 2008).

1 MIP is a variety of psychodynamic therapy with infant and parents (abbr. PTIP). It springs from Freudian, Kleinian, Winnicottian and Bionian influences. Many other PTIP modes are also based on psychoanalytic theory but compared with MIP, they have integrated attachment theory to a greater extent (Acquarone, 2004; Baradon *et al*., 2005; Barrows, 2003; Daws, 1989; Emanuel and Bradley, 2008). Similarly to MIP therapists, these authors emphasize the link between the baby's disorder and the parents' unconscious relationship with him and they, too, emphasize the child's clinical participation. In their clinical work, however, they address him to a lesser extent than the MIP therapists. The latter address the baby to contain his anxieties directly and thus not only to contain the mother's worries. MIP also differs from Françoise Dolto's (1994) technique of parler vrai (talking truth) to the baby. Her technique relied on the assumption that a baby is able to understand the verbal content of an intervention. The MIP therapist rejects this idea and claims that the baby does not understand the interventions' lexical meaning but may be affected and soothed by their emotional wavelength.
2 The therapeutic consultation focuses on the parents' "fantasmatic interactions" (Lebovici and Stoléru, 2003, p. 269) with the baby. These fantasies are conceptualized in terms of parental unconscious infantile sexuality. Often, both parents participate in sessions (Casanova, 2000). Countertransference is an important source of information, especially since it stimulates the analyst's enactments (Fr: l'énactions) and productions of metaphors. A posteriori, he can reflect on these similae to grasp what is going on inside and between the parents and the baby.
3 Parent-infant therapy, finally, focuses on how parental "ghosts" or unconscious representations cause the child to suffer similarly to how the parent suffered in his/her childhood. Here, the baby is regarded as a catalyst that enables the ghosts to emerge during sessions.

Kirsten and her parents Myra and Don

I see Myra and 3 month-old Kirsten at the Child Health Centre. The mother gives a worried and unhappy impression. She accuses herself that their contact is not good. Two years ago she had an induced abortion in the 20th pregnancy week because the foetus had a lethal heart malformation. Half a year later, she miscarried in early pregnancy. After some months she and her husband Don conceived a child, and Kirsten was born 9 months later. At first, development was normal and breastfeeding started effortlessly, but at 3 weeks the girl got colic attacks and the mother did not manage to comfort her. Of course, this made her feel distressed and helpless.

As I am listening to mother's story, Kirsten looks at me with a serious, though not sad, look. Whereas some objects capture her interest, she never looks at Mum. Little by little, she gets distressed and starts

screaming. During the mother's efforts at comforting her, the girl avoids Mum's face by closing her eyes tightly. Myra's comforting is friendly, though slightly jolting and tense. I sense her frustration behind her jaunty comment, "Hey girl, let's be happy, shall we". As Kirsten's gaze avoidance and screaming continue, my countertransference impotence is mounting. I suggest the mother search out the baby's eyes. As a result the girl looks at the ceiling lamp but not at Mum, which makes her devastated.

The CHC health visitor has reported that the father, Don, is very worried so I invite the entire family to the next session. This time the atmosphere is more defensive. When I point out that Kirsten looks at me but does not smile, Mum interjects that she smiles at home. Kirsten starts screaming and Myra has a hard time consoling her. Don says he has noted Kirsten's gaze avoidance towards Myra but not towards himself. He has been on Google and asks me if Kirsten has an "attachment disorder". Since many of the parents I see have read a lot about attachment on the internet and often regard such issues as incurable diseases, I answer: "I tend not to think in such labels. What strikes me is a question; how could you all enjoy more being together". They receive this as a critique that they do not play enough with the girl. They appear ambitious, orderly and sympathetic, as well as anguished and touchy.

In general, I find it more difficult to get in contact with a baby when both parents are present. This is probably because in most cases the relationship disorder centres on the baby and one parent, most often the mother. Thus, I often suggest a mother-baby therapy. Indeed, Kirsten's gaze aversion is restricted to Mum. Nevertheless, I suggest we continue therapy with the entire family because both parents worry and fear that Kirsten is autistic. I voice that perhaps she is a girl with a difficult temperament born into a family with two concerned parents who want everything the best for her. I focus on their guilt feelings and the anxiety beneath their Google searches. As yet, I do not feel I have any mandate for a more deep-reaching therapy. After some weeks Dad gets more relaxed, stating that the girl is quite OK and that Mum is more spontaneous at home. He shows an iPhone home video where Mum is dancing and singing with the girl who is laughing.

One day Myra begins the session, "I have always felt awkward when meeting people's eyes. I feel uncomfortable, like they're staring at me." She says this also occurs with me, though she conceals it. In fact, I have never noticed any gaze avoidance on her part. She adds that Kirsten's eyes are sad, which increases her guilt feelings. She also speaks of her restrained relationship with her mother: "My Mum does not understand how worried I am." At this point, I decide to start working with mother and daughter only, because it seems clear that Kirsten's gaze avoidance involves Mum, concretely as well as emotionally, to a much greater extent than it involves Dad. I wish to apply a technique that will allow more anxiety to emerge and include the girl as an active therapeutic subject (Salo, 2007). I no longer feel satisfied with explaining Kirsten's behaviour as the mere effect of a temperamental disposition, because this cannot

explain why she looks at me and her father while shunning mother's eyes. I suggest to Myra, "Something seems to be troubling you and Kirsten – and we need to approach it". Myra confirms that she is in deep pain and that the girl's avoidance has not been taken seriously by the Child Health Centre staff. The parents' confidence permits me to change the therapeutic frame and I add that Don will be welcome back on a later occasion. Up till now, the family has seen me once weekly for 6 weeks. I now suggest we increase the frequency of sessions and Myra willingly accepts. Therapy will last 5 months. The first weeks we meet four, then two, and finally one time per week.

Mother-baby therapy: the first two sessions

Mother and child arrive for their first joint session. No matter how Myra holds or addresses her, Kirsten shuns her eyes. In glaring contrast the girl looks at me with a persistent and curious, though sometimes also a blank and sad, gaze. Mother reports that after delivery she felt so happy. Finally she had got her first child! When the colic attacks started she felt helpless and exhausted. As Kirsten started avoiding her eyes Myra accused herself, though she could not specify any error she was committing. As mother is speaking, Kirsten's whining develops into a heart-breaking sobbing and crying – with her eyes firmly closed.

I reflect on the possible psychodynamics behind her gaze avoidance. I guess the emotional stress during the weeks of colic laid the ground for Kirsten's forming a negative internal image of mother. This was further darkened by Myra's discomfort when looking people in the eyes, a phenomenon presumably connected with her brittle self-esteem. This created a primal representation (Salomonsson, 2014) in the girl's mind: "She out there is bad and makes me bad. If I avoid looking at it, I feel better." Evidently, this formulation is but a clumsy and speculative verbalization of a representation that was pre-verbal yet impacting the girl's behaviour. I also reflect on the possible impact of the mother's abortion of a lethally ill foetus and her subsequent miscarriage. After pondering on these issues I address the girl.

> *Analyst to the baby*: Kirsten, you don't want to look Mum in her eyes. I don't know why. I think you got scared of Mum. Maybe she's like a ghost to you now. It gets even worse, for you and for Mum, when you don't look in her eyes. She feels pushed away and as if she's a bad Mum. I think you two love each other, but your "loves" don't come through.

As I address her, Kirsten is looking at me attentively. Her gaze is firmly directed towards me.

> *Mother to the analyst*: In the beginning I was so happy, I felt like being intoxicated! But when she stopped looking at me I felt she didn't love me anymore.
>
> *Analyst*: Yes, this must be very hard on you, Myra. I see now that you, Kirsten, are looking much at the ceiling lamp but never at Mum. This is hard on you both.

The second session, Kirsten starts squirming.

Analyst to the baby: Mum is afraid you don't like her. Yes, there is probably a Mum you don't like, one that you got scared of when you were little. That's why you don't look into her eyes. You make yourself lonely when you don't look at her. Things get worse then. You turn off Mum's comfort … Now I see a racoon on your sweater. It has big, black and scary eyes. Maybe that's how you feel about Mum's eyes. You just want them to get away. But when you turn away from Mum, things get even worse … What luck you've got a lonely mother!

The last sentence was a slip. Instead of "persistent" (*envis* in Swedish) I said "lonely" (*ensam*).

Analyst to the mother: I said "lonely" instead of "persistent". I wonder why.

Mother exclaiming to the screaming baby: Kirsten, why are you so sad?!

Analyst: Did you notice my slip?

Mother: Yes, I did.

Analyst: Why did I say lonely? … Do you feel lonely?

Mother: I guess I do sometimes.

Analyst to the baby: And you get lonely, too, Kirsten, when you turn off Mum. Now you are looking at Mum! And now you stopped.

Analyst to the mother: What about your loneliness?

Mother: Well … it's difficult for me to look at you. Sometimes, I'm looking at her while speaking to you. I hope it's OK with you.

At this point, the girl starts looking into Mum's eyes with a steady, calm gaze. The atmosphere becomes serene and calm.

Mother: It's hard to open up with people. I guess I'm a bit lonely. I don't really talk to people, except to my husband.

Analyst: Kirsten, you look Mum in the eyes now. Did you see, Mum? Yes, Mum smiled at you. It's like you're drinking Mum's eyes.

Mother: Soon I can't look at her anymore! It's difficult being looked at. I must rest my gaze. I get embarrassed … Don asked if we had talked about my mother. I said no. I feel, and I guess I told her, that I am not satisfied with myself. But I don't judge her, not at all … she's just like me. She did the best she could do out of her conditions in life … (Myra is holding back her tears, her voice quivering).

Analyst: Kirsten, do you see Mum's face, it's so lively now. She's sad when speaking of her mother, your Granny. You've been crying a lot, Kirsten, and now Mum is also crying. Myra, while you mentioned Don's question I was indeed thinking about your mother. I had an image of her being with us here. She was holding you, Myra, in her lap as if you were her baby. I guess I was inspired by the way you're holding Kirsten now. Earlier, you were moving up and down, bending your knees while comforting Kirsten. You looked stressed. Right now, you began swaying your body from side to side in a slower tempo, as if you became more relaxed.

Mother: My mother is the kind of person, I'm the same I guess … one learns from one's parents … I guess she and I are … cold. If you stumble and fall she responds, "Up you go again".

Analyst to mother: Are you cold, really? Isn't it more that you're shy with your feelings? And you Kirsten, you are shy when you don't dare looking at Mum to get comfort.

Myra continues talking about her mother. When voicing some critique she adds, "Mother did her best".

Analyst to mother: Do you defend her because you fear that I'd think she's a bitch?

Mother: It's rather that I fear you'll make *me* think she's a bitch! ... I was sad when Kirsten was screaming constantly. So much carrying and comforting, it became kind of automatic. I forgot what I was feeling, I was swinging her up and down, staring into nowhere.

Analyst: Perhaps you wanted to tell me about your mother being auto ...

Mother: Yes, an autopilot, that's the word! My mother worked with children all day. When she came home she was tired and had to turn on her autopilot with us kids.

Comments to the vignette – The analyst's running theory

The vignette illustrates influences from the three clinical traditions outlined above. The MIP technique appears in my interventions to Kirsten: "You don't want to look Mum in her eyes ... I think you got scared of her." I assume that such communication touches her at significatory levels beyond the words' lexical meaning (Salomonsson, 2007). I also presume that she notices my attention to her distress and feels contained by it. Lebovici's focus on the therapist's enactment inspired me to utilize the slip to indicate my unconscious awareness of mother's solitude. His observation that the infant therapist is prone to use metaphors to understand his case was illustrated by my comment about the wide-eyed racoon on Kirsten's sweater. Finally, Fraiberg's approach encouraged me to investigate how Myra's cumbersome relationship with her mother, influenced her relationship with the baby.

Regarding theoretical preconceptions in clinical work, we are taught not to let them obscure our perceptions but to listen with "evenly suspended attention" (S. Freud, 1912, p. 111) and to utilize our "negative capability" (Bion, 1970, p. 125) to quench any desire to assert beforehand what goes on in the patient. Nonetheless, these ideals are impossible to constantly maintain (Strenger, 1997). I was not able to perceive the session as a Lockean tabula rasa. Rather, I was "writing" a running internal script with which I ordered observations, feelings, and thoughts. This script was inspired mainly by Freudian, Kleinian, Winnicottian, and Kleinian perspectives. I regarded Kirsten's avoidance as an intentional act, which I guessed aimed to protect her from unpleasant experiences. The mechanism, I assumed, was as follows: Her perceptions of Mum had been influenced by the pain and distress inherent in the colic and Mum's ways of handling her. These perceptions were then subjected to splitting mechanisms and projective distortions. This caused a terrifying internal maternal part object to emerge. Any contact with the external Mum, above all

looking into her eyes, entailed a risk for Kirsten to get in emotional contact with the feared internal object. Thus, *her aim was not primarily to evade contact with her mother's eyes but to avoid having a scary emotional experience*. This process was also fuelled by how mother perceived the girl; she was desperate about the colic and the gaze avoidance and accused herself of having caused at least the latter. This made Mum tense when she was with Kirsten. In addition, Mum had long-standing problems with her own maternal identifications. These factors contributed to creating a situation for Kirsten as described by Winnicott (1971a). Ordinarily, a baby who is looking at her mother's face sees "herself". Kirsten, however, met a mother who reflected "her own mood or, worse still, the rigidity of her own defences" (p. 112). The mother's mood was dampened more by the colic and her own slightly stiff character than by the loss of the two babies.

The hypotheses about mother's internal situation could be investigated in therapy. In contrast, speculations about Kirsten's internal world might be rejected as circular arguments scaffolding my theoretical preconceptions. Let us therefore revert to the consulting room. I was told about the loss of two unborn children, Kirsten's birth, some happy weeks followed by the colic, the mother's misery, and the father's worries. The gaze avoidance I could observe myself. I might explain it as a mere reflex behaviour. Indeed, if Myra's eyes had been harrowing, hostile, or avoidant, this would be correct. Kirsten would react to her mother's menacing eyes as to a barking dog or a flash of light. However, Myra did not have such eyes. Another option was that the baby harboured an earlier representation that was scary and clashed with Mum's entreaties to look at her. We would then enter the legitimate domains of psychoanalytic exploration and start interpreting Kirsten's internal world. This would presuppose that we regard the baby as being a subject. This assumption needs investigation.

The baby as subject or inter-subject?

Many psychoanalysts have become interested in parent-infant work. In their publications and conference presentations one notices a hesitation to use classical analytic theory to conceptualize their clinical work. One argument might be that an infant does not talk and cannot confirm the analyst's speculations. Another claim could be that in comparison with psychoanalytic terms, modern attachment concepts are better confirmed by systematic research. Yet, the relative paucity of psychoanalytic concepts is surprising when we recall that this theory contains a wealth of speculations on the infantile mind. Klein's well-known and controversial speculations about babies originated in her work with child patients. Winnicott also based his work with children, adults, and babies (1941). In fact, already Freud's writings contain abundant links between clinical observations of adults and speculations about babies. His theories about the dream, the formation of the unconscious, the pleasure principle, primal repression and repression proper, the primary and secondary processes, and sexuality all sprang from

intuitions about how the baby's mind is formed in interaction with his parent. In my conclusion, we must either accept that psychoanalytic theory is based on clinical observations, dialogues with the patient, ideas stemming from our countertransference, *and* speculations about the "baby within the patient" and how it was formed in infancy. Alternately, we discard such speculations – but then we can no longer call our theory "psychoanalytic" in any traditional sense.

When Freud writes about babies he clearly refers to them as subjects; they feel, wish, react, recall, cognize, and represent to themselves. His approach could be met with the argument that one cannot isolate and study a human subject – infant or adult – in itself. Proponents of intersubjective theories argue that an analysand is not an entity that can be studied from our side of the couch, so to speak. The analyst cannot escape his/her "system participation" (Levenson, 2005, p. 79). Accordingly, he cannot view the analsyand's emotional reaction as entirely intrapsychic or personal; it is also "the result of participation in larger social systems" (*ibid.*). To conceive of the therapeutic relationship as one Observing Analyst + one Observed Patient indicates an epistemological fallacy; we simply cannot "stand outside of what we observe" (p. 8). See also Stolorow (1997).

The intersubjective perspective provides new meanings to many traditional psychoanalytic terms, such as neurosis (Levenson, 2005, p. 65) and countertransference (Gerhardt *et al.*, 2000; Renik and Spillius, 2004, p. 1054). What about defence, the concept investigated in this paper? If I hypothesize that Kirsten's gaze avoidance reflects such an intra-psychic process, it presupposes that I consider her as a *subject*. At this point, intersubjective theorists raise objections though they do acknowledge that human subjectivity exists. Renik and Spillius (2004) define the latter entity as an individual's "various personal, idiosyncratic assumptions, concerns and motivations – including those that arise from membership in particular cultures and subcultures" (p. 1054). Such a definition concords with classical analytic theory. Problems rather emerge from their views on *how the analyst gains knowledge* about the subject, be he a baby or adult. Benjamin (2005) writes that an interaction "creates a space for both subjects' separate but recognizable centers of feeling and initiative. In that space there can be some consensual validation, not of the objectively true, but of *what we think we are talking about, what feelings and meanings we believe we are trying to convey about one another in this moment*" (p. 449, italics added). Such moments have been termed the "intimate edge" (Ehrenberg, 1992) or "the present moment" in the therapeutic relationship (Stern, 2004).

Benjamin's claim that we cannot achieve objective truth is hopefully shared by every analyst. What is new is her emphasis on what the two analytic participants believe they are conveying *about one another* – not on what the analysand is conveying *to her analyst*. To express it in a very simplified manner, the classical perspective is: Analyst → Patient (→ = observes). The intersubjective perspective is: Analyst/subject ↔ Patient/subject (↔ = interacts with). In my view, the analyst oscillates between ↔

and →, between interacting as subject with the patient/subject *and* forming hypotheses, based on observations and guesswork, about the patient/object. To be true, I am no neutral observer-analyst and I am coloured by my "power, freedom, and desire" (Benjamin, 2000, p. 46). But this does not prevent me from forming ideas – in fact, it will even add to these ideas – about my patient's power, freedom, and desire, that is, about him/her as subject.

Bohleber (2010) has made clear the differences between intersubjective thinkers' views on the individual subject from those of traditional psychoanalysts. To the former, the human mind is "no longer considered independent and isolated" (loc. 340). It is rather described, as suggested by two infant researchers (Beebe and Lachmann, 2002, p. xiii), as a "continuous, reciprocal mutual influence system in which each partner is contextualized by the other" (p. xiii). By extension, they avoid the concept of psychic structure and prefer "patterns of experience that are *in process*, that is, organizations that may transform" (*ibid.*, p13). In contrast, traditional psychoanalysis maintains that the self can "be understood and returned to itself by way of a detour through the other" (Bohleber, 2010, loc. 991), that is, via an analyst who listens to his/her subjectivity or countertransference. To Bohleber the subject exists as an entity, whether it is interacting with another subject or not – and one can legitimately say something about it. Perhaps, Benjamin's (2000) distinction between *subjecthood* and *personhood* might clarify the intersubjectivist thinkers' views on the subject. The former term refers to the other's independent existence or alterity. The latter refers to "personal subjectivity" (p. 45) and resembles Renik's definition above. Nevertheless, I cannot escape the impression that in these thinkers' view, the subject has a shadow-like quality; not until it falls on an object can we see it. If, as Benjamin writes, "the analyst and patient are equally participating and observing subjects as well as objects for each other" (p. 47), then with what legitimacy can the analyst say anything about that subject over there, that is, the patient?

This description of the subject's elusive status may seem strange to anyone familiar with Daniel Stern's writings (1985, 1990, 2004). As a clinician he emphasized the impact of the "present moment" in psychotherapy and everyday life. As a theoretician he suggested that intersubjectivity is a discrete motivational system. As a researcher he described "the subjective life of the infant" in *The interpersonal world of the infant* (1985, p. 5). As an author for a larger audience, he portrayed the inner life of a baby in a more poetic and evocative vein, in his *Diary of a baby* (1990). His view of the subject within an inter-subjective matrix is exemplified by terms like "schemas-of-being-together" (1995) or "Representations of Interactions that have been Generalized (RIGs)" (1985, p. 97). In line with Bohleber's and my critique, they tend to bypass the baby's subjectivity and reduce it to a process going on with the parent. See also a discussion by Green (Sandler *et al.*, 2000). Similarly, when the infant's mind is defined in terms of "expectancies of procedurally organized action sequences" (Beebe and Lachmann, 2014, p. 26), the focus is on what the baby imagines will hap-

pen in the interaction with mother, rather than on himself as subject, on "This is I".

Beebe and Lachmann suggest that the phenomenon of infant imitation (Meltzoff and Moore, 1977, 1997) indicates that the mind is dialogic in origin. "Procedural action-dialogues of the dyad" help the baby to organize his pre-symbolic representations, which are described as "generalized expectancies, procedural representations, or internal working models" (p. 33). They also have "self-regulatory" consequences, but the authors avoid speaking of the baby's internalized world or subjectivity. In contrast I conceive of, and I address, Kirsten in words that acknowledge her subjectivity: "I think you got scared of Mum", "You get lonely, too", and "You seem sad".

To clarify, I do think the mind originates in dialogue. The point of disagreement emerges when we look at our divergent terminologies. Many infant researchers' writings have a certain laboratory-like style. Interestingly, it reminds us of the writings of Freud, the scientist and nascent psychoanalyst in *The Project*. In my view, such a style risks that we distance ourselves from acknowledging and addressing the baby's passions in simple language. Furthermore, though I – similarly to infant researchers – regard the baby as an interactor, I also see her as a subject with some stability or individuality. A third difference seems to relate to the concept of *conflict*, which is a central notion in psychoanalytic theory (S. Freud, 1919; Rapaport and Gill, 1959). I apply it to babies as well, whereas Stern's model of self-development contains no terms like conflict or strife. He focuses on the baby's experiences of "shapes, intensities, and temporal patterns" (1985, p. 51), and her sense of agency, cohesion, and time continuity. As for his view on a baby's "intention" (p. 6), it has to do with a general direction but not with conflict. Consequently, he objects to Klein's "fantasy-based" (p. 254) suggestions that the baby divides her experiences into good and bad. In lieu, he claims that there exists a "non-psychodynamic beginning of life", in which the infant's experience is "not the product of reality altering conflict resolution" (p. 255).

Stern's baby diary (1990) contains beautiful descriptions of how the child proceeds from the World of Feelings, the Immediate Social World, and then the Worlds of Mindscapes, Words, and Stories. The focus is on the feeling tone and the form of vitality (Stern, 2010) in each developmental phase. The baby's representations are coloured by his emotional experiences of, for example, hunger and breast-feeding. But, unlike Freud (1915, p. 136) Stern does not indicate that this would make the baby incorporate the external world's pleasurable aspects and project his unpleasant experiences. Similarly, he criticizes Klein's idea that the baby carries out a "hedonically based split" (1985, p. 248) into good and bad experiences. This leaves no room for speaking of a baby in conflict.

Or, perhaps Stern does speak of conflict in a baby but in another *façon de parler*? Let us look at his portrait (2010) of a hungry baby: "The world is disintegrating … uneasiness grows. It spreads from the center and turns into pain. It is at the center that the storm breaks out. It … turns into puls-

ing waves … [which] swell to dominate the whole weatherscape." (p. 31). Then he is picked by his mother and breast-fed: "At once the world is enveloped. It becomes smaller and slower and more gentle. The envelope pushes away the empty spaces" (p. 36). His language is clearly more evocative than Klein's blunt terms like "the good breast". But actually, both authors speak of a two-split world in the baby. Stern's hungry baby, too, is portrayed as feeling terrible and bad about himself. And, in the breast-feeding scene he feels wonderful and good.

My aim is thus to integrate Stern's poignant descriptions of the hungry baby with Freud's and Klein's idea that he is in a temporary conflict due to his two clashing representations. He loves his "envelope" mother until she shows another aspect of herself; she cannot take away the pulsing hunger waves immediately. This is an everyday situation and I agree with Seligman's critique (2006) of Klein, namely, that far from every infant suffers from "the terrors of omnipotent destructiveness and deprivation" (loc. 1598). We may only speak of clinical problems and conflicts when an infant, for example Kirsten, has colic and her relationship with mother gets marred by distress and guilt feelings. These babies must handle the conflict by erecting a defence: "I love my mother, she always comforts me. No, she doesn't. She is helpless when I'm helpless. She can't take my pain away at once. I close my eyes because I want her out of my life."

I thus suggest that (1) we can speak of the infant as a subject and that (2) this includes a propensity to get in internal and external conflict. To argue for the first point, let us imagine a baby who is lying peacefully in the cot while looking at a lamp. He is alone and contemplates a flower, a smell, or a memory trace. In his solitude he may smile to himself, dream, or sigh. At such times I suggest he is creating a subjectivity on his own. At other times he does this by interacting with others. I thus argue that we should neither reduce subjectivity to a contingent effect of interactive contexts nor neglect the baby's autochtonous mental activity.

I asked initially if we can conclude anything about someone who neither understands nor produces speech. Indeed, my ideas about the conflicting representations have an element of guess to them. This caveat applies to everyone who, like Stern, Beebe and myself, bases one's baby imagery not only on scientific research and clinical work but also on "pure imagination" (Stern, 1990, p. 3). We can merely formulate "hypotheses about the earliest phases of phantasy and of learning, of mental development generally, which can be credited with a considerable degree of probability" (Isaacs, 1948, p. 80). We can then integrate them with psychoanalytic metapsychology and investigate what happens when one representation comes in conflict with another. Can the baby, for example, defend against a representation – and might such a defensive process be reflected in her disordered behaviour? These questions do not imply that we regard the baby as the sole agent in a clinical disorder. Neither do we suggest that she can be studied in isolation. But once we take a perspective on her as being a subject, we can ask if psychoanalytic concepts can describe her internal world and its links with her behaviour.

Frustration, pain, defence, and hostility in the baby – Freud's views

In *The Project* (1895/1950) Freud lays out a scheme which connects the baby's frustration and pain with defensive activities and her view of the object as hostile: When a baby experiences pain and unpleasure, she couples this with a "mnemic image" (p. 320) of the object that she holds responsible for her pain. She then seeks to discharge or get rid of the unpleasure. In parallel, she comes to regard the object in a new way, as "hostile". The next time she thinks of or perceives this object, an unpleasant state arises. She tries to discharge the unpleasure and the object. In baby language it would run: "Blah, I see you again and I feel bad. Get away!" This will happen all the easier over time, since repeated experiences of pain will make it easier for the memory of the hostile object to re-emerge. This policy is unsuccessful, however, since the baby cannot delete it. What remains is to change *internally*. She achieves this by initiating "a repulsion, a disinclination to keeping the hostile mnemic image cathected. Here we have primary wishful attraction (*primäre Wunschanziehung*) and primary defence [fending off, *primäre Abwehr*]" (p. 322). The mental apparatus seeks "to obviate, by means of side-cathexis, the consequent release of unpleasure" (p. 325). If this functions swiftly, the release of unpleasure and defence will be slight; if not, "there will be immense unpleasure and excessive primary defence" (p. 325).

What does Freud's model imply for the baby's object relations? Her dilemma is that the first hostile object is also her first satisfying object and "sole helping power". This results in a conflict of ambivalence. Freud concludes that the baby learns to cognize in relation to a "fellow human-being" (p. 331). Some efforts result in the baby's perceiving a neutral object, such as 'This is my hand, it looks like Mum's hand'. Other representations are laden with negative affects that are linked with her screaming, and the information stemming from such screams will characterize the object. 'I scream because I feel bad. I scream to get rid of the bad. You don't and you didn't help me. You don't and didn't take away the bad. You're just like my scream.'

It is much harder for the baby to withdraw from internal demands than from external reality. To dampen the inner urges a "specific action" (p. 297) is needed, which at first is supplied by the external world. "The attention of an experienced person is drawn to the child's state by discharge along the path of internal change" (p. 318). "I feel bad, I discharge the bad by screaming. You hear it and come to me. You're no longer that bad, you're good." The screams serve multiple functions; they are communicative, they help bring about the specific action and, secondarily, they have an intersubjective and ethical function; "the initial helplessness of human beings is the primal source of all moral motives" (p. 318). Freud wavers between explaining these phenomena in biological and psychological terms but either way, he clearly links the baby's distress to hostile object representations and her defensive activity against them.

We can now ask if such a "primary defence" may account for Kirsten's gaze avoidance. Should we even call it a defence mechanism – or would that

imply capacities non-existent in a young baby? Must we stop at calling it a defensive behaviour? And, what could be the purpose of such a defensive activity; is it to ward off a drive impulse, an unbearable affect, or an unpleasant memory? My clinical observations and mother Myra's story indicated that the gaze avoidance was present even as she relaxed and talked friendly to Kirsten. Consequently, it must be motivated by something beyond the girl's need to ward off a present threat. This "something" must have emerged during the onset of the colic. The girl had created a gruesome imago or primal representation corresponding to Freud's "hostile object". It lay dormant for some weeks. Then it connected with the perception of Mum's eyes and Kirsten's gaze avoidance was set in motion.

Since there was no longer any colic, the avoidance of mother's eyes now served a defensive purpose akin to a phobic mechanism. Greenson (1959, p. 663) explains that anxiety which is linked and tied "to certain circumstances and conditions is more controllable and therefore less frightening than free-floating anxiety". It was less scary for Kirsten to fear Mum's eyes than her entire person. Her avoidance would resemble an "extrusive" phobia (A.-M. Sandler, 1989, p. 104) in which "internal danger was extruded onto the external reality, and the avoidance or flight from the external danger provided the illusion that the internal threat had been dealt with". Nevertheless, Kirsten's subdued character indicated that her avoidance only helped her half-way to deal with the internal threat.

We will now relate some findings from infant research and observations and then proceed to an author who devoted a separate paper to gaze avoidance: Selma Fraiberg.

Gaze avoidance and infant research

While the prevalence of gaze avoidance is less known, its clinical importance is illustrated by the many studies that have connected it with the mother's emotional state. Infants of mothers who have been instructed to mimic depression (Cohn and Tronick, 1983; Field, 1981) or sadness (Termine and Izard, 1988) tend to react with negativity and gaze aversion. Babies of clinically depressed mothers also tend to avoid their eyes, but they may look at other familiar people (Pelaez-Nogueras *et al.*, 1994). In contrast, Landesman (2011) did not find this tendency. Even mothers with subclinical depressed mood (Feldman, 2007) may have babies who show a decreased amount of mutual gazing. Gaze avoidance may also occur when a non-depressed mother returns after a sudden and unexpected separation from the baby (Papousek, 2007).

What does gaze behaviour in an infant tell us about his/her future development? In a normal sample, a stable gaze towards mother at 4 months was shown to predict a secure attachment at one year of age (Koulomzin *et al.*, 2002). These researchers suggested that the future insecure infants' tendency to look away might be an adaptation to maternal intrusion or overstimulation. In addition, infant temperament might have played a role as well, they suggest. In Tronick's (2007, p. 283) model, maternal depression "disrupts the mutual regulatory process and constitutes a break in intersub-

jectivity". He finds gaze avoidance more often among infants of intrusive than of withdrawn depressed mothers. In this way, children of intrusive mothers avoid being overwhelmed by stimulation.

Gaze avoidance in infant observations

Kate Cowsill (2000) describes a continuous observation of a baby, "Tom". A fair amount of stress was introduced from the start. His delivery had been traumatic and he was in incubator treatment for five days. Another root was his mother's anxious character, which was hidden beneath a layer of intellectual understanding of a child's needs. At 3 weeks, he started avoiding mother's eyes. Cowsill links Tom's avoidance also to mother's behaviour. For example, she tended to be intrusive and she sometimes avoided his eyes. She speculates that the mother's exaggerated liveliness might be due to her "huge anxiety about her son's capacity to be lively and to be alive" (p. 78). This becomes all the more understandable when the author later learns that the death of Tom's maternal grandfather was due to suicide. We notice here a similarity to the theme of death in Myra's case. Her first two foetuses had died before Kirsten was born. Myra said these events now lay behind her, but it is plausible that her guilt and mourning had never been worked through. This may have affected her view on Kirsten as a replacement child (Reid, 1992). My probes on this theme did not yield much, however.

Cowsill does not discuss the defence concept per se but applies it to explain Tom's tendency to "block the introjection of multiple stimuli and to minimise the projection of what appeared to be painful and indigestible affects" (p. 65). Pursuing a Kleinian model, she concludes that Tom avoided mother's eyes to maintain a split; the good internal object was preserved, while the bad one was projected onto her eyes. If he avoided looking at her, he would suffer less from "unbearable experiences" (p. 76). Cowsill's model has much in common with mine concerning Kirsten's avoidance.

Kernutt (2007) describes interaction with a baby and a mother who, similarly to the mothers in Cowsill's and my description, seems benevolent, ambitious, tense and not quite in tune with her emotional self. In the author's interpretation, the baby girl experienced her mother as the consistent "instigator of the contact", which prevented contact starting from a "spontaneous gesture" (p. 206). This triggered a "reactive response" in the girl who retracted in isolation to maintain the integrity of her true self. The term "reactive response" seems close to my use of "infantile defence". Kernutt links this to the "rigidity of [the mother's] own defences" (p. 208). The result was that the girl looked into mother but was not mirrored (Winnicott, 1971a) and thus did not see herself. The risk for this baby was, according to Kernutt, that her gaze avoidance might not so much preserve her True Self as contribute to maintaining a False Self.

Fraiberg's "pathological defenses in infancy"

In a posthumous article, Selma Fraiberg (1982) discusses gaze avoidance, freezing, and fighting. These phenomena may occur when the baby's

"human partners fail in their protective function and he is exposed to repeated and prolonged experiences of helplessness" (p. 614). This leads the baby to sense that "something is out there" which he vaguely connects with his painful experience. If pain is associated with mother, he must ward off "the person on whom he is absolutely dependent and who is associated with pain and disappointment" (*ibid.*). At this point, Fraiberg stops investigating whether the behaviour might reflect a defensive process. "The questions seem to lead nowhere: thinking the unthinkable" (*ibid.*). The "unthinkable" dilemmas are that the baby must ward off someone he depends on and that his ego is not developed enough to launch any defence mechanisms. From another perspective, the baby is facing a conflict; not only externally, vis-à-vis his mother. It also creates an internal conflict; his love and dependence crash with his anger and frustration. This will cause the baby to react "through a behavior that serves as defense" (p. 613). Note that Fraiberg avoids using the term "defence mechanism".

Fraiberg describes gaze avoidance as belonging to a "psychobiological system" (p. 621) which is set in motion because the baby regards his mother as a *real* threat. Alternately, she says that his anticipation of seeing Mum's face functions as a signal anxiety, and that his perception gets "caught up in conflict in the early months of life, so that registration appears to be closed off selectively" (p. 622). By invoking terms like "signal anxiety" and "conflict", Fraiberg applies a psychological explanatory model. She avoids the term repression, which would imply that a painful stimulus was barred from entering consciousness. Instead, she calls it a "cutoff mechanism *in perception* which selectively edits the mother's face and voice and apparently serves to ward off painful affects" (p. 632, italics added). Fraiberg uses a full-scale psychoanalytic model of signal anxiety, conflict, and the warding off of painful affects. Nevertheless, she hesitates between a psychological and a biological theoretical model to explain gaze avoidance.

Let us return to Kirsten and see which of the two models shows the best fit. If Myra had maltreated her daughter, Kirsten's behaviour would be a biological response to danger. Had the girl avoided everybody's eyes we would suspect an incipient autism spectrum disorder. None of these alternatives were corroborated. In contrast, there was much emotional pain beneath Kirsten's screaming and Myra's story. According to psychoanalytic theory, if a behaviour aims to reduce psychic pain or conflict it involves a defence. In my argument, we need not hesitate in applying a psychological explanatory model to gaze avoidance, and we may safely speak of it as a defence. To check if this position fits with traditional psychoanalytic theory, we will now return to the origins of the defence concept.

The defence concept applied to infants

Freud was interested in defence methods because he wanted to link them with the various mental disorders he met with in clinical practice. Since he only treated youngsters and adults, he focused on rather advanced defences. This might tempt us to think that he did not apply the defence concept to infants. But, in his speculations on infants he actually suggested that they

use *other* defences than older individuals: "Before its sharp cleavage into an ego and an id, and before the formation of a super-ego, the mental apparatus makes use of different methods of defence from those which it employs after it has reached these stages of organization" (Freud, 1925–1926, p. 164). According to Laplanche and Pontalis (1973, p. 109), "the theoretical question of whether the mobilisation [of defence mechanisms] always presupposes the existence of an organised ego capable of sustaining them is an open one". Defence modes may vary in psychic maturation but their basic way of operation is the same: The mind is facing an idea but finds it incompatible, and therefore tries to treat it as *non arrivée* but fails. The memory-trace and the attached affect cannot be eradicated. The second best alternative is for the ego to aim at "turning this powerful idea into a weak one, in robbing it of the affect – the sum of excitation – with which it is loaded" (Freud, 1894, p. 48). The reason is the "aversion" to unpleasure (Freud, 1892, p. 221) in the psychic apparatus.

From its inception, psychoanalytic theory "has tended to understand the very organization of the psychic apparatus in terms of defence" (Loewald, 1952, p. 447). Loewald sets aside defence involved in neurotic mechanisms, which presupposes an ego as "a specialized structure within the psychic apparatus". Then he switches to speaking of "defence processes and operations" (p. 445). This silent shift, which we also noted in Fraiberg's paper, illustrates that the term "mechanism" is unclearly defined. Freud began using it in the 1890s (1892) but did not clarify it. Laplanche and Pontalis (1973, p. 109) suggest he chose the term to emphasize that "psychical phenomena are so organised as to permit of scientific observation and analysis". This is plausible but does not explain what is needed for a defence to qualify as a mechanism. Klein (1975, p. 53) also spoke of "mechanisms, anxieties, and defences operative in earliest infancy" though without clarifying what is a mechanism. In one paper (Klein, 1930) she describes "the earliest defence set up by the ego" that is initiated by "the subject's own sadism and the object which is attacked". They differ fundamentally "from the later mechanism of repression" (p. 25). Here, she reserved "mechanism" for more advanced defences. Another paper (Klein, 1935) does not make clear how far back in development she is prepared to speak of defence mechanisms. A similar varying use of the two terms is seen in yet another paper (Klein, 1991). Here, phenomena such as infant manic defence, turning away from the loved object, inhibition of greed in feeding difficulties, etc., are sometimes called "defences", sometimes "defence mechanisms".

Klein did not clarify the difference between defence and defence mechanism, probably because she was less interested in structural topics than in the fantasies involved in a defence. In contrast, one would have expected that Anna Freud, who wrote extensively about defence mechanisms (1937), had clarified what she meant by "mechanism". However, I cannot find that she did this. Sandler (Sandler and Freud, 1981, p. 238), in a discussion with her, merely states that it involves a "sort of mental machinery" that is "independent of the particular object concerned". In another paper (J. Sandler, 1993, p. 342) he suggests that it works via "changes in the representational world". Lichtenberg and Slap (1972, p. 776) approach a clearer

definition when they refer to "definable tendencies that govern how contents are handled". "The repetitive use of a specific cognitive process in a conflict situation establishes it as a preferred mechanism by which to regulate conflict; it then may properly be called a mechanism of defense" (p. 778). Following these definitions, is (1) Kirsten's gaze avoidance a "preferred mechanism" by which she regulates her conflict, and (2) is it "independent" of the object? As for the first question, the answer is yes; she consistently avoids her mother's eyes. As for the second question, the answer is no; only her mother's eyes are avoided. Averting Mum's eyes has similarities to a phobia in that an internal threat is externalized and avoided. Still, in order to call it a phobia, we would have needed to see Kirsten avoiding everybody's eyes.

In the end, are we to call Kirsten's gaze avoidance merely a "psychological defence" or a "defence mechanism"? Laplanche and Pontalis (1973) define *defence* as a "group of operations aimed at the reduction and elimination of any change liable to threaten the integrity and stability of the biopsychological individual" (p. 103). They are not only directed "towards internal excitation (instinct)" but also towards those "representations (memories, phantasies) [which] this excitation is bound to and to any situation that is unpleasurable for the ego as a result of its incompatibility with the individual's equilibrium and, to that extent, liable to spark off the excitation. Unpleasurable affects, which serve as motives or signals for defence, may also become its object" (p. 104). As for the term *defence mechanism*, they apply it to various "types of operations through which defence may be given specific expression". Mechanisms are chosen depending on "the type of illness", "the developmental stage reached", and "the extent to which the defensive conflict has been worked out" (p. 109). *Since the term "mechanism" has so many limitations, I stop at calling Kirsten's avoidance a psychological defence – not a mechanism.* Its mode of working is phobia-*like* in that she avoids an object to make a psychological gain. But, the avoidance is limited to the eyes of one person. In her case displacement, the typical mechanism in phobia, has thus not been generalized.

The case in Fraiberg's paper complies with this definition; the dyadic interactive flow had been disrupted, which frightened the baby. Therefore she shunned that part of mother which was the central medium of communication and which conveyed her depressive ambivalence towards the child; her eyes. Another case was described by Norman (2004) who was working with a 6 month-old boy and his mother. She had received alarming medical information about him. Though it was subsequently retracted, the mother was still terrified and the boy began avoiding her eyes. During the sessions, he whimpered and wailed and sometimes sucked energetically at her blouse. When he looked at "emotionally neutral things … there was … a split between the libidinal object and the frightening-bad-mother object. He cut the emotional links to the libidinal object and … projected the frightening-bad-mother object on his mother and then cut the link with the mother" (p. 1110). In contrast, when he sucked her blouse, "it was a displacement and substitute as the mother's emotional presence/breast/face/gaze evoked threatening affects and was thus averted" (p. 1118). To explain this

phenomenon Norman used the term "infantile repression". Similarly to Fraiberg, he concluded that the boy warded off unpleasant experiences with mother.

Norman and Fraiberg thus agree, as I claim in Kirsten's case, that these babies harboured unpleasant representations of their mothers, and that avoiding their eyes aimed to minimize the risk of having them sparked off once again. This position is compatible with Freud's (1895/1950) position in *The Project* about the hostile object. To Freud, a baby's notion of satisfaction was linked with having food and shelter. Today, infant researchers have taught us much about the infant's sensitivity to perturbations in the dyadic interchange (Tronick *et al.*, 1978; Trevarthen and Aitken, 2001). The finely tuned interactive process risks collapsing when mother is depressed. In Freudian terms, exchanges of libidinal messages are replaced by overwhelming unpleasant affects. They are unleashed when the baby is facing a situation he cannot handle, as when mother's wishes of loving and caring for her baby clashes with unconscious wishes of being alone, staying aloof, or rejecting the child. This ambivalence will result in frightening primal representations in the child. In response, he will defend against them by rejecting his physical mother. Now he becomes a frightening Gestalt to the mother, and she takes his gaze avoidance as a proof that he does not love her. A defence has been erected in the infant.

Implications for technique

I have argued that classical psychoanalytical concepts, in this case defence, should be used more consistently to explain infant behaviour and disorders. I have also argued for viewing the baby as a psychoanalytic subject. This, I claimed, contrasts with the intersubjectivist view of the subject as more of a volatile entity seen primarily as an interactor. Nevertheless, my clinical vignettes contain elements that are endorsed by intersubjective therapists; I shared my slip with Myra and I disclosed my affects (Maroda, 2002) when I saw Kirsten meeting Mum's eyes. It might seem inconsistent that I use such a technique while I question the explanatory value of intersubjective concepts.

My response concerns both clinical and theoretical issues. Kirsten's avoidance was not a solipsistic symptom but was part of a relationship disorder. It was not enough, however, to address the mother's subjectivity and how it coloured her interaction with the child. My view of the baby as subject inspired me to address the girl as well about what I presumed were her experiences. There were thus two subjects in the room – indeed, with myself there were three. Had I not focused on all three, we would not have reached the points of affective breakthrough and a behavioural change in the baby. I refer to how my slip brought Myra closer to her sense of loneliness, which had an immediate impact on Kirsten's eye contact with mother.

The theoretical part of my response is that in order to understand the process of change in PTIP treatments, we need to conceptualize what happens in the mother's *and* the baby's internal worlds. I have suggested that Kirsten used gaze avoidance to defend against painful affects which were

linked to early experiences with mother. This concords with my effort at conceptualizing her subjective experiences. Today, concepts from baby–mother interaction research are devised to describe the baby's world. In the section "The baby as subject or inter-subject", I argued that these concepts do not give full credit to the baby's subjectivity, which becomes concealed behind a focus on the baby's interaction with the parent. Second, I suggested we use another language, both when we build theories about the baby's mind and when we address him in clinical work; we may speak of his passion, lust, anger, despair, sadness, and falling apart, and suggest that he wants, avoids, hates, yearns, and fears. My technique thus contains many elements of intersubjectivity, including utilizing and disclosing my own subjectivity, with the aim of uncovering the subjectivity of mother *and* baby.

I thus end my investigation of one aspect of the baby's subjectivity, namely, the use of defence. Starting from a case of a gaze-avoidant girl, I have postulated that she has painful emotional experiences when interacting with her primary object. Her gaze aversion aims to relegate these experiences from consciousness and to maintain contact with mother. This follows the classical analytic description of a defence. This concept is thus applicable and essential for understanding certain disturbed behaviours in babies. The clinical consequence is that our interventions should *also* address the baby about why she defends herself and how we could help her deal with the frightening affects in a more healthy way.

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Translations of summary

Au sujet des défenses infantiles dans la psychothérapie parents-nourrisson. L'exemple de l'évitement du regard. Les découvertes issues de la recherche faite à partir de l'observation des relations parents-nourrisson ont favorisé le développement de modèles intersubjectifs concernant l'action psychothérapeutique. Ces modèles ont permis de mettre au jour que le nourrisson est un partenaire interactif du parent. Inversement, l'intérêt porté à la description du psychisme individuel du bébé a diminué, particulièrement en ce qui concerne les niveaux inconscients de ses expériences et représentations. Parallèlement, les cliniciens et les chercheurs ont eu moins tendance à faire usage des concepts psychanalytiques classiques pour décrire le monde interne du nourrisson. L'auteur de cet article argumente que ceci entre en contradiction avec le fait que la théorie psychanalytique a été fondée depuis le début sur des spéculations au sujet du psychisme du nourrisson. Il interroge l'un des concepts tirés de la théorie classique, à savoir celui de défense et s'attache à montrer plus spécifiquement que l'évitement sélectif du regard chez les nourrissons peut être décrit comme une défense, voire même comme un mécanisme défensif. Il relie cette interrogation à la discussion de Selma Freiberg de ce phénomène, ainsi qu'à la conception de la notion de défense chez Freud. L'auteur compare également sa conception du bébé comme sujet aux points de vue d'autres chercheurs sur la prime enfance, tels que Stern et Beeb. Il illustre la discussion à l'aide de vignettes extraites de la thérapie psychanalytique d'un bébé de trois mois et de sa mère.

Infantile Abwehr in der Mutter-Kind-Psychotherapie: Das Beispiel der Blickvermeidung. Forschungsergebnisse aus der Mutter-Säugling-Beobachtung haben die Entwicklung intersubjektiver Modelle der psychotherapeutischen Wirkung angeregt. In diesen Modellen erweist sich der Säugling als interaktiver Partner der Mutter. Umgekehrt sank das Interesse, die individuelle Psyche des Babys, vor allem seine Erlebensweisen und Repräsentationen, zu erforschen. Parallel dazu ist bei Klinikern und Forschern eine sinkende Neigung zu beobachten, die innere Welt des Säuglings mit Hilfe klassischer psychoanalytischer Konzepte zu beschreiben. Dies steht, so der Autor, im Widerspruch zu der Tatsache, dass die psychoanalytische Theorie seit ihren frühen Anfängen auf Spekulationen über die infantile Psyche beruhte. Er untersucht eines dieser klassischen theoretischen Konzepte, nämlich die Abwehr. Sein Hauptaugenmerk gilt insbesondere der Frage, ob die selektive Blickvermeidung junger Säuglinge als Abwehr oder sogar als Abwehrmechanismus beschrieben werden kann. Dabei knüpft er an Selma Fraibergs Diskussion des Phänomens sowie an Freuds Abwehrverständnis an. Er vergleicht darüber hinaus sein Verständnis des Babys als Subjekt mit anderen Konzeptionen, die von Säuglingsforschern, beispielsweise Stern und Beebe, formuliert wurden. Die Diskussion wird illustriert durch Vignetten aus einer psychoanalytischen Therapie mit einem drei Monate alten Mädchen und seiner Mutter.

Le difese infantili nella psicoterapia genitore-bambino. L'esempio dell'evitamento dello sguardo. I risultati delle ricerche osservative della relazione genitore-bambino hanno sollecitato modelli intersoggettivi di azione terapeutica. Da questi modelli è emersa la rappresentazione di un bambino che si pone come partner interattivo con il genitore. Per contro, si riscontra un minor interesse per la descrizione della psiche individuale del bambino, soprattutto per quanto riguarda il livello inconscio delle sue esperienze e rappresentazioni. In parallelo, sia i clinici che i ricercatori si mostrano meno propensi ad applicare i concetti classici della psicoanalisi alla descrizione del mondo interno dell'infante. L'autore sostiene che tutto questo è in discordanza con il fatto che sin dall'inizio la teoria psicoanalitica si è basata sulla formulazione di ipotesi speculative sul funzionamento della mente del bambino. L'autore esamina uno di questi concetti della teoria classica, quello di difesa. Nello specifico, si chiede se si possa descrivere come una difesa o addirittura un meccanismo di difesa l'evitamento selettivo dello sguardo nei bambini piccoli. Tale indagine si collega alla discussione di questo fenomeno di Selma Freiberg, nonché al concetto di difesa di Freud. L'autore mette a confronto la sua visione del bambino come soggetto con quelle proposte dai ricercatori quali, per esempio, Stern e Beebe. La discussione viene illustrata da vignette cliniche tratte dalla psicoterapia psicoanalitica di una bambina di tre mesi con la madre.

Las defensas infantiles en la psicoterapia de progenitores y bebés. El ejemplo de la evitación de la mirada. Los hallazgos de la observación de progenitores y bebés estimularon la elaboración de modelos intersubjetivos de acción psicoterapéutica que apuntaron al/a la bebé como socio/a interactivo/a del progenitor. En cambio, disminuyó el interés en la descripción de la psiquis individual del/de la bebé, especialmente en los niveles inconscientes de sus experiencias y representaciones. Paralelamente, clínicos e investigadores se inclinan menos a aplicar conceptos psicoanalíticos clásicos cuando describen el mundo interno del infante. El autor sostiene que esta actitud es incongruente con el hecho de que, desde sus comienzos, la teoría psicoanalítica se basó en especulaciones acerca de la mente de las y los bebés. Este trabajo estudia uno de esos conceptos de la teoría clásica: la defensa. Más específicamente, analiza si la evitación selectiva de la mirada en las y los bebés pequeños puede describirse como una defensa o, incluso, como un mecanismo de defensa. Esta investigación se vincula con el análisis de dicho fenómeno por parte de Selma Fraiberg y con la concepción freudiana de la defensa. El autor también compara su propia visión del/de la bebé como sujeto con aquellas propuestas por investigadores de bebés, por ejemplo, Stern y Beebe. El análisis se ilustra con viñetas de una terapia psicoanalítica de una bebé de tres meses y su mamá.

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