Psychodynamic Therapies with Infants and Parents: A Critical Review of Treatment Methods

Björn Salomonsson

Abstract: The theory of psychoanalysis has always relied on speculations about the infant's mind, but its clinical practice was slow in taking an interest in babies and their parents. The therapy methods that nevertheless have evolved during the last 50 years differ in their emphasis on support or insight, which roles they attribute to mother and baby in therapy, and to what extent they focus on the unconscious influences in mother and baby, respectively. They also differ to what extent their theories rely on classical psychoanalysis, attachment psychology, developmental psychology, and infant research. Each method also contains assumptions, most often tacit, about which kinds of samples for which they are most suited.

The article describes the most well-known modes of psychodynamic therapy with infants and parents (PTIP). There is a certain emphasis on methods that are less known to the U.S. readership, such as the French and Scandinavian traditions. It submits them and the other methods to a critical review.

From early on in the history of psychoanalysis, clinicians sought to modify its classical technique. Their aim was to reach patient categories beyond those that Freud and his contemporaries were treating. Their efforts resulted in therapy modes with a decreased frequency and duration, such as brief and focal psychotherapy. They also gave rise to techniques for psychotic and borderline patients, as well as groups and couples. One of the last patient categories to be reached by such efforts was the mother–infant dyad. Parent–infant psychotherapy was introduced on both sides of the Atlantic by Fraiberg (1980) and Dolto (1982, 1985) half a century ago. Today it is gaining increasing interest among psychoanalytic therapists. This article will review and delineate

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Björn Salomonsson, M.D., Ph.D., Psychoanalyst, Department of Women's and Children's Health, Karolinska Institutet, Stockholm.

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methods with a psychoanalytic focus on the internal worlds of infant and parent and their interaction. A second article will report on results from quantitative studies and how they might help develop therapy techniques further. The acronym PTIP will cover the various modes of Psychodynamic Therapy with Infants and Parents. There will be some emphasis on two therapy traditions that are less well known to the American readership; those suggested by French-speaking analysts (Cramer & Palacio Espasa, 1993; Dolto, 1982; Lebovici & Stoléru, 2003) and one devised by a Swedish analyst, Johan Norman (2001).

Two limitations will be pointed out at the start, which will lead to the article's two major questions. The American literature often uses "infant" for children up to 2–3 years of age. In contrast, European authors generally restrict it to pre-verbal children. The Latin word *in-fans* means "speechless" or "not talking." In agreement with Winnicott (1960) the term infancy will be referred to as "the phase prior to word presentation and the use of word symbols" (p. 588), and to therapies with babies up to 12, or at the most 18, months of age in company with a parent. This brings us to our first major question; can one really call an "in-fans" a therapy patient? Does he take part in the therapeutic process and is he affected by it? The survey of PTIP methods will provide different answers.

Second, the article focuses on methods based on psychoanalytic or psychodynamic theory (these terms will be used interchangeably). This theory describes man as struggling with unconscious urges that impact on his/her character, relationships, interests, passions, conscious attitudes, and cognitive capacities. Consequently, methods will be omitted if their main aim is to support the mother's ego and encourage her to change her behavior with the baby. Though they are widely used in child health care settings, for example, developmental guidance (Lojkasek, Cohen, & Muir, 1994), infant massage (Field, 2000), interaction guidance (McDonough, 2004), and Marte Meo (Aarts, 2000), they will not be covered here. The focus will be on therapy forms that help mother to get in contact with unconscious ambivalence toward her child, her partner, or her maternal role and also—to a varying extent—help the baby to get in contact with his unconscious affects. The last clause brings us to our second major question; psychodynamic therapy focuses on the patient's conflicts between conscious and unconscious urges. In contrast, far from all therapists would agree that this applies to an infant in therapy. The question is thus if unconscious factors, in the dynamic and/or the systematic sense, may be at work in a baby. The theories behind all PTIP methods agree that the *parent's* involvement constitutes a mix of conscious strivings to bond with the child and provide a fertile ground for attachment—and unconscious urges stemming

from his/her childhood. Therapy often reveals a clash between these strivings. In contrast, few methods speak of similar factors in the *baby*. As we will see, different positions on this point will affect therapeutic technique.

All PTIP modes build on classical psychoanalytic theory—sometimes in agreement with it, sometimes in increasing disagreement. Traditionally, it has regarded the mother as the primary object. She, or rather her body parts or functions, are involved in the baby's fantasies—or whatever term used to cover his primeval mental activities. This maternal primacy is stated more or less explicitly by all PTIP theories and is also reflected in the dominance of mothers and babies in case presentations. We will now begin with a survey of Freud's assumptions about the infant mind and their importance to his theoretical edifice. This will be contrasted with a realization that it took many years for analysts to devote their therapeutic efforts to clinical babies. Some reasons for this will be suggested.

THE FREUDIAN BABY

Freud did not work therapeutically with babies but was a keen observer of everyday interactions with their mothers. He used such observations to speculate on what went on in their internal worlds. These speculations in fact played a major role in his theoretical edifice. We will exemplify with the concept of *representations*. In the "Project for a Scientific Psychology" (Freud, 1895) he describes how the baby experiences satisfaction—a psychological event—in physiological terms; as a neuronal discharge. But his description of such experiences includes an interactive dimension; it presupposes an "alteration in the external world (supply of nourishment, proximity of the sexual object)" (p. 318) via "extraneous help," that is, by "an experienced person" who gets drawn to the child's state. Freud actually describes a relationship; a baby keeps crying until his mother listens and comforts him.

Freud's neurophysiological terminology may obscure to the modern reader his position that the infant forms representations of the mother. When a baby communicates his distress to "the helpful person" (obviously Freud's term for the mother) he will perceive her as hostile. Freud links the baby's painful experiences with his perception of a "hostile object" (pp. 320, 322, etc.). He then suggests that the baby is disinclined to keep the hostile mnemic image cathected, a process which he names a "primary defence [fending off]" (p. 322). The baby thus has representations of a hostile object who cannot comfort him—and he will defend himself against retaining them. "The Interpretation of Dreams" (Freud,

1900) contains similar references, though here Freud prefers the term *wish*; this is an effort at re-establishing "the situation of the original satisfaction. An impulse of this kind is what we call a wish" (pp. 565-566). Evidently, to recall a satisfying memory implies to re-evoke its representation. It arises from biological needs, it is charged with affects, and it involves an object.

The Freudian baby is thus from the very start a psychological being; disturbing events in his somatic being are not only *registered* biologically but also *experienced* subjectively. These biological events and their concomitant experiences are handled through interactions with the mother, which leave traces in the baby's mind. Truly, Freud wavers between describing the infant as being governed by biological forces and psychological motives. In a passage on infantile sexuality (Freud, 1905), it remains unclear if any representational activity is involved when the baby is "sinking back satiated from the breast and falling asleep with flushed cheeks and a blissful smile" (p. 182). Things become clearer when he writes about "infants in arms" (Freud, 1925-1926, p. 138). He suggests their anxiety arises when they are separated from the mother. As long as he labels this an "automatic phenomenon" and a "rescuing signal," he is applying biological terms. However, he also applies psychological terms when stating that the anxiety is a "product of the infant's *mental* helplessness" (p. 138, italics added), and that it is countered by repeated experiences of satisfaction which sum up to create the maternal *object*. "This object, whenever the infant feels a need, receives an intense cathexis which might be described as a 'longing' one" (p. 170). To sum up, Freud suggests two kinds of infant representations; a positive longing image of a mother who will provide satisfaction, and a negative hostile image of a mother who does not take away his suffering. The baby wants to do away with the latter, a process labelled defense.

Freud returns to the topic of representations in "The Unconscious" (Freud, 1915b), where he differentiates thing- from word-presentations. He suggests that all representations originate as unconscious thing-presentations. They are "the first and true object-cathexes" (p. 201) and thus the only ones existent in the infant's mind. When they get linked with "the residues of perceptions of words" (p. 202), word-presentations emerge. This linking "is not yet the same thing as becoming conscious, but only makes it possible to become so." Freud's division creates problems, as Maze and Henry (1996) have remarked. A baby has many conscious representations; mother's voice, a dog's barking, the scent of milk, etc. Since he cannot yet link words to them we cannot, according to Freud, label them conscious because "objects cannot become conscious through the medium of their own perceptual resi-

dues" (1915b, p. 202). Yet it is hard to deny that a baby who smiles at his mother is conscious that she is someone special or, to put it more generally, that the "thing" mother in front of his eyes differs from other "things" he is looking at, such as the ceiling or the lamp. To put it in imaginative words: "I know *she* is there and that *she* is different from the '*it-s*' around me, but I neither know what *she* nor the *it-s* are called."

In addition to a shift in the concept of representations, Freud's 1915 papers (1915a, 1915b) —compared with "The Project" (1895)—also imply a shift in the concept of defense; now it becomes tied to the aim of keeping *verbal* representations out of awareness. In "The Project" he had suggested that already the preverbal infant could defend himself against unpleasant experiences. Freud now suggests that "an instinct can never become an object of consciousness—only the idea that represents the instinct can" (1915b, p. 177). Ideas are thought-processes that can be verbalized. The aim of repression is now viewed as twofold; to keep out of awareness both the ideational content and the affective and unpleasant component. Freud refers here to a more "sophisticated" version of repression, one that is a key component in neurotic children and adults rather than in normal crying babies.

"The Unconscious" may give us the impression that Freud thought the differentiation between thing- and word-presentations was clear-cut. However, a close reading reveals that he noted that word-presentations also contain sense-perceptions. Though a baby does not understand a word's literal meaning, he may be attentive to its "sound-image" (1915b, p. 210), or its "thing-like" quality assembled from "auditory, visual and kinaesthetic elements" (p. 210). Thus, the dividing line between pre-representational and representational life is indistinct—and it does *not* coincide with the child's acquisition of language. We are returning to our first question; if a baby is sensitive to the thing-like qualities of words, perhaps a therapist's interventions might touch him. The question is; in what ways? As we will see, different PTIP modes look at this issue from various perspectives.

The concept of representation has been chosen to illustrate how important Freud's infant observations and speculations were to his metapsychology. Other such concepts include the dream psychology (1900), the formation of the unconscious (1915b), the pleasure principle (1920), primal repression and repression proper (1915a), the primary and secondary processes (1911), and infantile sexuality (1905). To Freud there was a straight, albeit subterranean, line running from the internal world of the infant to that of the adult. Our adult character is "based on the memory-traces of our impressions . . . The impressions which have had the greatest effect on us—those of our earliest youth—are precisely the ones which scarcely ever become conscious" (1900, p. 539).

PSYCHODYNAMIC THERAPIES WITH INFANTS (PTIP)

We have established that Freudian theory is firmly anchored in speculations on the internal world of the infant. This young creature is emotionally affected by biological events and also by the people around him; especially his mother seeks to silence his unpleasant experiences and offer him pleasant ones instead. In other words, Freud's baby is involved in passionate relationships from very early on—though specific dates of development are rarely provided. He also intuits that there is an infant-like remnant in every adult's personality. This might explain why psychoanalysts have been reluctant to treat babies and why it took such a long time for PTIP to develop. When a therapist is working with a baby, countertransference may be overwhelming. She or he is prone to a "massive identification with the child . . . it is not always easy to control one's reactions to [the baby's] positive or negative provocations" (Watillon, 1993, p. 1045). The analyst may shun his/her own primitive reactions to a screaming or subdued baby and to a helpless or rejecting mother.

The notion of psychoanalysis as a "talking cure" utilizing words as the major channel of communication has led to the mistake, according to Olinick (1985), that the primary data in psychoanalysis are words rather than "representations or signifiers of process" (p. 500). This might have prevented them from viewing the baby as a patient with whom they may communicate. One would expect that the one analytic school that continued and substantially enlarged Freud's baby speculations, the Kleinian school, would have promoted PTIP. In reality however, when Kleinian and post-Kleinian analysts speak of the infant world they often refer to infant-*like* parts of the verbal child's or the adult's personality, especially as it emerges in the transference (Joseph, 1985; Meltzer, 1992; O'Shaugnessy, 1988). As for analysts with an ego-psychological orientation, they warn against attributing mental capacities lying outside the baby's developmental timetable (Fonagy, 1996). They rely on developmental models delineating how behavior and facultative capacities "change in a regular way over the early years in accord with emergent maturational biological changes in the context of a range of environmental prods" (Shapiro, 2013, p. 8). Their apprehension of "adultomorphizing" the baby (Peterfreund, 1978; Stern, 1985) makes them reluctant to view the baby as an active participant in psychotherapy.

Another reason for the relatively slow development of PTIP might simply be organizational. Many analysts work in private practice and are contacted by people who acknowledge their emotional suffering.

In contrast, many "baby worries" emerge at a visit to the Child Health Center. A mother might complain about her child's somatic health or development without feeling that she needs psychotherapy herself (Stern, 1995). Alternatively, she might feel depressed or anxious and be suggested individual psychotherapy or pharmacological treatment. Neither case will result in a joint mother–infant treatment.

Nevertheless, though the delivery of PTIP was protracted several methods have now seen the day. The major methods will be introduced with some critical reflections added. Each caption contains the name of its major author. This should not make us overlook that many of their followers have published independent papers and books.

INFANT-PARENT PSYCHOTHERAPY (FRAIBERG)

Like many PTIP innovators Selma Fraiberg was a psychoanalyst. She formulated three intervention modes: brief crisis interventions, interaction guidance-supportive treatments, and infant–parent psychotherapy. The first was used for treating problems arising from a "circumscribed set of external events and when the parents' psychological capacities suggest that they can make use of a brief focused intervention" (1989, p. 60). To illustrate; a well-functioning couple who were very anxious about their newborn's well-being suffered from an unresolved mourning of another baby who had died earlier. After a few sessions, the parents' mourning was worked through and they could attach to the newborn as a separate young person. The second mode, interaction guidance, aimed at guiding and scaffolding parents with a limited psychological-mindedness. It was based on a psychoanalytic understanding of the family members but did not aim at fundamentally altering their psychodynamics. In lieu of using transference interpretations that might derail the parents' equilibrium, this was more of an "educational technique" (Sherick, 2009, p. 231). Similar techniques adopting a "non-authoritative therapeutic stance, using treatment goals identified by the parents, emphasizing already-existing family strengths, increasing parents' satisfaction and enjoyment from interaction with their infants, and suggesting alternative interpretations of the infants' behavior" (Vik & Braten, 2009, p. 290) have been developed by Aarts (2000), Beebe (2003), and McDonough (2004).

Infant–parent psychotherapy, Fraiberg's third therapy mode, was a clear-cut example of PTIP. She applied it to cases where the baby reminded his parents of "an aspect of the parental self that is repudiated or negated" (1989, p. 60), for example a childhood memory of a rejecting parent or a competing sibling. This unconscious "ghost in the

nursery" marred the parent's interactions with the baby, who then got engulfed in the parental neurosis. This might result in emotional disturbances in the baby. To illustrate, one mother had a five-month-old listless and subdued girl whom the mother felt did not attach well to her. Therapy revealed that the mother had been abandoned during *her* mother's postpartum psychosis. An extramarital affair had added an obsessive guilt that wiped out any joy at being a mother. A hypothesis was formed: "When this mother's own cries are heard [by the therapist], she will hear her child's cries" (1980, p. 109). The therapist promoted the emerging mother–baby attachment by encouraging the mother to talk about how she had felt abandoned during childhood. Thus, "the pathology which had spread to embrace the baby" (p. 111) could be withdrawn from the child.

Our first major question in the article's beginning concerned the role of the "in-fans" in therapy. Fraiberg regarded him as a "catalyst" (1989, p. 53) who intensified the emotional climate and sometimes also engaged in "eloquent dialogue" with the family members and the therapist. She did not, however, aim at becoming a specific relational figure for the baby. The intention behind the baby-therapist dialogues was rather to bypass the mother's customary perceptions of her baby, influenced as they were by her "ghosts." If such bypass was successful, their relationship might improve. Fraiberg's followers continue to explore such parental perceptions in terms of "negative attributions" onto the child (Silverman & Lieberman, 1999). A mother might, for example, complain that her baby is whining. Therapy reveals that her reproaches emanate from an unconscious suspicion that she is a cry-baby herself. When the little one internalizes her attributions and his self-image becomes that of a "whiner," the negative attribution has been "successful" from the mother's perspective. She will feel less ashamed of her weakness—but the baby will find no way out of his whining and the mother's reproaches.

A recent monograph describes this therapy mode in depth (Lieberman & Van Horn, 2008). It has been subjected to at least three randomized outcome trials (RCT; Cohen et al., 1999; Lieberman, Weston, & Pawl, 1991; Robert-Tissot et al., 1996) to be reported in the second article. Suffice it to say here that Fraiberg's method proved to be about as efficacious as Interaction Guidance (the study by Robert-Tissot et al.) and Watch, Wait, and Wonder (the study by Cohen et al.), though the effects were slower in coming. Compared with a non-intervention group, its results were superior (the study by Lieberman et al.).

As a clinician Fraiberg was deeply sensitive to the plight of parents and a keen and empathic observer of infants. She did not extend her closeness to the baby into also addressing him in order to build up a

therapeutic relationship. She restricted the ghost metaphor to unconscious structures in the *parent*—not in the *baby*. Reverting to our second major question, one could claim that this was because she did not think a baby possessed an Unconscious. Actually, Fraiberg was ambivalent about this issue. She did think that a baby as young as three months of age can erect a "pathological defense" (Fraiberg, 1982), such as avoiding the mother's eyes. This behavior served to specifically ward off the perception of a primary object that was eliciting pain and distress in the infant. She objected to calling it a defense mechanism, because the baby's ego was too immature for such an advanced mental activity. Then again, when explaining the phenomenon she used terms like "signal anxiety" and even "psychic conflict." These terms indicate her view that a baby might be influenced by unconscious experiences, though evidently she found it hard to integrate her clinical observations with her ego-psychological framework. She viewed pathology as the result of a mutual influence of unconscious aspects within mother *and* baby, though she was aware that they were neither on par nor identical; the baby is less mature than mother and interprets the world in his own right.

INFANT–PARENT PSYCHOTHERAPY (CRAMER AND PALACIO ESPASA)

The therapists of the "Geneva school" are affiliated to the University of Geneva. They have worked with less disadvantaged families than Fraiberg. Its main figure is Bertrand Cramer. Though he trained for a decade in the U.S., the major clinical works by him and his associate Francisco Palacio Espasa were published in French (Cramer & Palacio Espasa, 1993; Manzano, Palacio Espasa, & Zilkha, 1999). Some papers and a book (Cramer, 1997, 1998; Espasa & Alcorn, 2004) as well as a succinct introduction (Zlot, 2007) were published in English.

The dividing line between the traditions of Fraiberg and Cramer/Palacio Espasa is subtle. The Swiss therapists focus more on the mother's psychopathology and also address it more consistently, for example, her masochistic and narcissistic issues. Yet, this focus on "the conflicts of parenthood" (Zlot, 2007, p. 14) does not make them overlook the dynamics behind the *infant's* symptoms, which might express "a repressed tendency in the parent" (Cramer & Palacio Espasa, 1993, p. 85). This creates a "core conflictual relationship" between the baby and the repressed part of his parent, which will be enacted in therapy and become its focus. Its pathogenic mechanism may originate in the moth-

er's anxiety and guilt; if she has not managed to mourn her own childhood injuries, resentment may color her expectations from the baby. This comes very close to Fraiberg's notion of the "ghost in the nursery." But, the Geneva therapists rather describe it as the mother's "narcissistic scenarios" (Manzano et al., 1999), which prevent her from seeing the baby in his own right. As a result, the child becomes involved in a relationship he cannot comprehend. The therapist confronts the mother about her misperceptions. By including the baby in his "joint focal attention" (Cramer, 1998, p. 156), he also observes the baby's reactions. Therapy should promote insight about "the mother-infant *relationship* in order to liberate it from projective distortions" (Cramer & Palacio Espasa, 1993, p. 84).

The Geneva therapists seem to regard the baby as less of an active therapy participant than did Fraiberg. When one baby reacts to an emotionally charged comment by the mother, the authors merely name such instances "chronological coincidences" (Cramer & Palacio Espasa, 1993, p. 84). Addressing our question about unconscious strata in the baby, the Swiss therapists seem uncomfortable with applying it to babies.

THERAPEUTIC CONSULTATIONS WITH BABIES (LEBOVICI)

We are now moving to the French arena. Serge Lebovici headed the Centre Alfred Binet, a child psychiatric outpatient clinic in Paris, and was active there between 1980 and 2000, the year of his demise. He was the president of the International Psychoanalytic Association 1973–1977. His interventions were akin to Winnicott's therapeutic consultations (1971) and Fraiberg's brief crisis interventions (1989). We recognize Fraiberg's thinking when reading that the "mother's internal reality, her unconscious, constitutes the first world offered to the baby" (Lebovici & Stoléru, 2003, p. 289). Whereas Fraiberg often suggested that the mother's *trauma* might build up to forming the "ghost in the nursery," Lebovici focused more on fantasies stemming from her *infantile sexuality*. These differences could depend on divergent theoretical foci, with Fraiberg being oriented toward ego-psychology and Lebovici to drive psychology. He often interpreted to mothers how their unconscious sexuality colored the relationship with the baby. For example, one mother sought help for her seven-month-old son's insomnia. In treatment, it emerged that she had become frigid because she kept thinking about him while making love to her husband (p. 283). Lebovici noted that she held him in a way that only allowed the boy to look at the wall behind her, which distressed him. He suggested that she hold

him with a hand between his thighs. Now, the boy calmed down and the eyes of mother and son met. Lebovici thus linked the boy's insomnia and distress not only with the mother–infant interactive *behavior* but also with how it was compromised by the mother's sexual *fantasies*.

Perhaps Lebovici's most interesting contribution (2000) was to unravel what happens in the mind of the PTIP therapist, notably his *enactment* (Fr: *l énaction*) and *metaphorizing function*. The two are constituents of the empathic function, which rests on two pillars; the analyst's parental function and creativity. Already Emde (1990), among many authors, had suggested that the therapist's empathy is rooted in, and similar to, "the mutuality experiences provided within the early mother-child relationship" (p. 884). Lebovici added that empathy also involves the therapist's creativity. An empathic response consists not only in "feeling into" the patient but also in "forgetting about oneself" (2000, p. 227) and letting one's associative processes interact with the patient's. This would correspond to a mother's committed smalltalk with her baby. Widlöcher (2001) has called this aspect of empathy "co-thinking"; it is a "process of communication" involving "the reciprocal development of associative activity" (p. 254) between therapist and patient.

The term "co-thinking" (Fr: *co-pensé*) resembles Beebe and Lachmann's (2002) notion of "co-constructing interactions." The latter concept relies on mother–infant research and covers how we humans are "always monitoring and regulating our inner state at the same time as we are tracking our partner's words and actions" (p. 26). The term co-thinking focuses on what happens in the therapist's mind and here, according to Lebovici, enactment and metaphor occupy special positions. Enactment refers to spontaneous sensations in his body—sometimes acted out in a spontaneous gesture—which might indicate an unacknowledged affect in mother or child. A therapist's spontaneous metaphor might reveal what he or she assumes—unconsciously rather than consciously—is going on between mother and infant. If he submits it to the mother it might also help improve her symbolizing capacities and liberate similar dawning capacities in the baby, according to Lebovici.

To illustrate a metaphor in PTIP, an example of Lebovici's technique from a DVD with English subtitles (Casanova, 2000) will be referred. A mother in treatment with her husband and their six-month-old daughter says her baby is constantly curled up against her breast. She describes them as an idealized unit, but Lebovici's countertransference indicates that she is annoyed with being a mother. He tells her, "It's as if you were holding a steering-wheel in your hands but it, not you, is driving the car." At first, she takes this metaphor to portray her vexation that the child is "holding the steering-wheel." Then her comments open up in an unexpected direction. She starts crying and tells of her

guilt feelings about her elder son. He was involved in an accident resulting in a cerebral handicap. The steering-wheel of the family car had prevented the parents from observing when he fell into the water.

One could suspect that the link between Lebovici's steering-wheel metaphor and the mother's sad story was coincidental. However, he claimed that such metaphors often conveyed relevant information because they functioned as tools for circumventing the resistances in the countertransference. In such a situation, the imagery of a metaphor might clarify what was indistinct in the analyst's thinking. To assess if it revealed something important about the patient's internal world, it must be followed up during the session. As it happened, the steering-wheel metaphor opened up to this mother talking about guilt feelings vis-à-vis her handicapped son and how they disturbed the relationship with her little girl.

Concerning our question about the "in-fans" in treatment, Lebovici suggested that the baby should be present in the session since this enabled the therapist to probe into the unconscious meanings of the parent's spontaneous behavior or comments. Another reason was that the baby's presence stimulated the therapist's metaphoric function. In contrast, he was not prone to intervene *to* the baby. Concerning a baby's Unconscious, he would probably have agreed that it exists from very early on, but he would never have agreed with his compatriot Dolto that a baby can understand verbal import. It is time to turn to this clinician.

DIRECT AND BRIEF THERAPY WITH BABY AND MOTHER (DOLTO)

Françoise Dolto was a Parisian psychoanalyst who was active from the 1940s up to the 1980s. Two books were translated into English; her dissertation (Dolto, 1971a) and a case study of an adolescent, "Dominique" (1971b). In another English volume various authors describe her work and biography (Hall, Hivernel, & Morgan, 2009). Long before researchers like Beebe (Beebe & Lachmann, 2002), Sander (Condon & Sander, 1974), Stern (1985), and Trevarthen (Trevarthen & Aitken, 2001), she spoke of the young infant's ability and efforts at communicating with his caretakers. In contrast to them and other PTIP therapists, Dolto was convinced that a baby may understand some literal meaning of the therapist's words. Her work has met with severe criticism by some American analysts (Anthony, 1974; Axelrad, 1960), albeit not specifically concerning her PTIP method. They claim that she is omniscient

and that she makes sweeping and prejudiced generalizations. Before concluding whether such critique should be directed to her PTIP method as well, it is necessary to know more about it and its theoretical foundations.

Here is one example of her clinical work (Dolto, 1985): A mother at the delivery ward with her fourth child learns from her husband that things are not going well with the children at home. Her worries are aggravated by the news that her own mother has died. At this point the newborn stops breast-feeding and Dolto is called in for a consultation. She addresses the baby: "Everything was OK when you were inside Mom's tummy. Then you were born . . . Mom had milk and you were calling for it . . . One day you heard, together with Mom, it was Dad who told you, that things weren't going well at home. Maybe you told yourself 'Poor little Mom, I'd better get back into her tummy, 'cause everything went well as long as I was there'" (p. 211). Dolto thought the baby's refusal to suckle resonated with the mother's mourning and worries about the home situation. She even argued that the girl understood the therapeutic intervention verbally. Dolto asked the girl to nod if she had understood. When the girl turned her head toward Dolto, she took this as a confirmation. Already here, we can establish that at this point Dolto was wrong; an overwhelming body of research (for a summary, see Karmiloff & Karmiloff-Smith, 2001) refutes that a young baby can understand spoken words literally. Thus, the reason that she turned her head toward Dolto could not be that she had understood her words.

Before taking a more general stand on Dolto's PTIP method, let us go deeper into her arguments. She was convinced that when parents conceal the truth about embarrassing facts, it may stunt the baby's development. In the vignette, Dolto guessed that the mother tried to protect her baby by hiding that she was mourning her mother and worrying about the older siblings' well-being. This created a paradoxical situation to the girl who, perhaps, was sensitive to the painful affects beneath the mother's well-meaning efforts at caretaking. Another paradoxical situation is when parents conceal that Daddy is not the biological father. A child may sense something on an unconscious level and suffer until the double-entendre is revealed.

Most PTIP therapists would agree that already a baby may intuit that "something is wrong" and that the parents are inauthentic. Fraiberg and Cramer would no doubt agree that such a situation might constitute a ghost in the nursery and thus be harrowing to the baby. However, they would have talked to the *parents*, not the child, about it. Dolto's reason for addressing the child was that the parental superego had been imposed on the child, with the result that "instinctual urges

whose affects have not succeeded in expressing themselves . . . disturb the child's somatic and cognitive functioning and engender anxiety . . . [The therapist's] role consists in re-establishing the flow between all this" (Dolto, 1982, p. 30). This, she claimed, should be done directly with the child.

It is easy to argue that such sensitivity to parental skewed communication may exist in older children—but not in babies of some months of age, let alone in a newborn as referred to above. This question touches on a greater issue, namely, how one regards the infant's self development. This is a vast topic, and only the views of Winnicott and Dolto will be compared here. Winnicott speaks of the baby's absolute dependence which the good-enough mother must meet in order for the *true self* to emerge in a healthy and spontaneous way. In Dolto's view, parents and infants are caught up in a "complex and ambiguous web of competing and conflicting demands and desires. There is little certainty about who or what is good, or good enough" (Bacon, 2002, p. 260). The infant's self is "fragmented and fragmentary, held together and made meaningful not by an inside 'truth' [corresponding to Winnicott's true self], but, like words in a sentence, by law or grammar or force" (p. 260). Indeed, the infant does not speak but he is "continuously being formed in and informed by language and speaking" (p. 260).

Dolto's mistake in attributing linguistic comprehension to a young baby unfortunately clouds another important angle of investigation. This is hinted at in the last sentence by Bacon above, that *the baby is formed in and informed by language*. The question is thus if language might have another function in the baby's development than to convey lexical meaning. Dolto's answer is that maturation comes about only to the extent that he manages to substitute his *désir* with demands that are acceptable to the community, and that this substitution comes about through the adult's spoken words which introduce the child to the symbolic order. Already "before the age of words, the presence of a mother speaking to her infant is a nourishment more valuable than the milk she offers at the breast" (Dolto, 1994). The ultimate aim with mother's talking is to institute "symboligenic castration," which helps the child "displace his drive towards another object" (Dolto, 1982, p. 48). Dolto's term castration thus takes on a wider meaning than in Freud's writings. It implies that "at each decisive moment of the child's development [he must suffer] a rupture, a separation from the mother to whom he is attached, in a vital dyad which always risks becoming harmful if he absorbs himself in it completely" (de Sauverzac, 1993, p. 198, quoted in Dollander & de Tychey, 2004). Castration will thus help the child enter the symbolic community. This happens, for example, when a child begins to accept that the *milk* is offered and thence belongs

to him whereas the *breast* belongs to the mother. Not until the child accepts this can he be weaned successfully, learn to speak, and express what he wants from the world.

To claim that a child must displace his drive impulses for development to proceed optimally is, evidently, part of the Freudian canon. Why then should a therapist use *words* to stimulate this process? Parents have many ways of communicating with their babies. They speak, frown, shake their head, sigh, get tense, smile, raise their voice, giggle, etc. This might lead us to oust verbal communication from any prime position in the world of communication. Perhaps the infant simply experiences words according to the present emotional quality of his interactions with the parent; as a comforter, an intimidation, or a captivating sound (Markova & Legerstee, 2006). However, infant research (Gervain, Macagno, Cogoi, Peña, & Mehler, 2008) indicates that very young babies regard speech as a special mode of communicating. The newborn is more sensitive to perceptual patterns typical of infant-directed speech, like *mama* and *dada*. Two-month-olds show a brain lateralization similar to that of adults when they listen to speech (Gervain & Mehler, 2010). Young infants also grasp that words, in contrast to general sounds, can be used for categorizing objects (Ferry, Hespos, & Waxman, 2010). It is as if the baby were thinking when his parent is speaking: "It is something special, this combination of facial movements and peculiar sounds that I cannot produce. It seems to indicate something, but I just don't get it."

In the PTIP session, the therapist's position is different from that of the mother. The latter is entangled in a relationship disorder with her baby, which diminishes her possibilities of understanding what takes place on an emotional level and of addressing her baby about it. The therapist is in a better position to understand the emotional background to the baby's plight and, to use Dolto's expression, *parler vrai* to baby and mother about it. To sum up, some of Dolto's conclusions were simply wrong; a very young infant has no lexical language comprehension and one cannot take his/her nod as a proof of the correctness of an interpretation. However, this does not automatically annihilate the rationale in speaking with the baby about painful matters. To frame this in terms of the article's two questions, Dolto would have argued that a baby's unconscious forces contribute to the pathology as long as his instinctual urges do not get a satisfactory outlet. Second, he needs to be addressed in a PTIP process and thus be introduced into the symbolic order.

MOTHER–INFANT PSYCHOANALYTIC TREATMENT (NORMAN)

Another analyst who would also have answered the article's two questions in the affirmative, though relying on another theoretical framework and with different arguments than Dolto, was Johan Norman. His writings follow in the traditions of Freud, Klein, Bion, and Meltzer. His basic tenets were "(1) that a relationship can be established between the infant and the analyst; (2) that the infant has a primordial subjectivity and self as a basis for intersubjectivity and for the search for containment; (3) that the infant has an unique flexibility in changing representations of itself and others that comes to an end as the ego develops, and (4) that the infant is able to process certain aspects of language" (Norman, 2001, p. 85). His technique, Mother–Infant Psychoanalytic treatment (MIP), utilized the "disability" of every infant, that is, the fact that the ego is immature. This made a baby prone to become involved in an emotional disturbance with mother—but also to look for containment from whoever offered it. This immaturity was thus a window of chance for undoing the effects of trauma. Norman thought, just like Fraiberg, that a baby may contribute actively to parent–infant pathology but he went one step further and addressed, not so much the parents but more so the baby, about these processes. He did not, however, agree with Dolto that a baby understands the lexical meaning of words. Another difference was that he worked in lengthy treatments to contain the baby's agony thoroughly, whereas Dolto worked in brief consultations.

Norman's 2001 paper contains a case of six-month-old "Lisa" in therapy with her mother. Mother became depressed after delivery and was in hospital and received ECT and medication during Lisa's third and fourth months of life. When the two came for therapy mother was still depressed. She complained that the girl had not recognized her when she returned from the hospital. This could be interpreted as Lisa's initial reaction to the long separation, but Norman noticed that Lisa was still avoiding mother's eyes. It was thus an instance of gaze avoidance (Fraiberg, 1982). Norman greeted the girl and told her his name. As he noticed her attention he continued: "You don't seem afraid of me when we talk to each other, but I see that you avoid looking at Mother" (p. 89). He then told Lisa that mother had been away from her in a hospital, that she was avoiding mother whom she felt was ruined, and that she was afraid of her ruined mother. Norman noticed that Lisa was looking at him attentively while avoiding Mum's eyes. During this first session, Lisa began to seek contact with mother by sucking her blouse. Mother

made vague efforts at comforting Lisa and then looked out the window. Norman had referred mother to therapy of her own but concluded that the ensuing improvement of her mood did not result so much from that treatment. It rather emerged because "Lisa had managed to wake her mother up" (p. 89), which was a result of his containment of the baby's pain of separation and dread of rejection.

Therapeutic progress was dramatic though not sudden; mother and baby started paying attention to each other in a new way and the girl began looking into her mother's eyes. The mother's condition improved partially and the girl's avoidant behavior disappeared. Norman describes the vicious interactive circle:

> Lisa's mother had a psychic pain that she could not bear. As Lisa's distress and sense of rejection increased her mother's own distress and pain, the mother was reluctant to open up the emotional links. As a defence against pain, Lisa's mother was rejecting Lisa. The mother's capacity to symbolize was severely impaired and with that her capacity to metabolise Lisa's distress. Both Lisa and her mother appeared to feel threatened by the other's pain and rejection. They were locked in mutual avoidance. (p. 90)

This formulation coincides with the views of Fraiberg and Cramer. Cramer, however, might focus more on the mother's pathology, for example, the narcissistic affront engendered by the child's rejection. Fraiberg would have recognized Lisa's avoidance of mother but she would probably not have addressed the girl as directly. Her focus would rather be to help mother understand which "ghosts" were marring her contact with the baby.

Another difference between Norman's and Fraiberg's work was that his technique presupposed that the mother was highly motivated and willing to leave the baby "in his hands." Fraiberg's patients were often less advantaged from an educational and socioeconomic perspective. This might lead a mother to a diminished motivation for insight-oriented work and to an increased wish for support and attention of her own from the therapist. To such a mother, his baby focus might perhaps be felt as an abandonment.

Norman's technique was often questioned with the argument that babies did not understand what he was saying to them. His method of containing the infant's anxiety evidently implied an effort at directly modifying her internal mental state. This raises fundamental problems not only about the child's capacity of comprehending words, but also of her capacity of memorizing interventions and subjecting them to cognitive elaboration. If we, however, make explicit on which levels of signification the analyst-baby interchange takes place, some of the

"mystery" about these treatments vanish. Semiotic theory emphasizes that human communication takes place at various levels, among which the verbal is only one. Today many analysts use concepts coined by the American philosopher of semiotics C. S. Peirce (Kloesel & Houser, 1992; Muller & Brent, 2000) to explicate what takes place between them and their adult patients (Chinen, 1987; da Rocha Barros & da Rocha Barros, 2011; Gammelgaard, 1998; Goetzmann & Schwegler, 2004; Grotstein, 1980, 1997; Martindale, 1975; Muller, 1996; Muller & Brent, 2000; Olds, 2000; Van Buren, 1993). For example, rather than seeing the drive as a psychobiological force as did Freud, they see it as a "messenger of information" (Grotstein, 1980). In order to further our understanding of the therapeutic process in MIP, two papers were written (Salomonsson, 2007a, 2007b) which apply semiotic theory to such treatments. They analyze in detail the various levels of signification in the interactions between analyst, infant, and mother. A similar perspective is in fact applied by infant researchers who apply a microanalysis to mother–infant interactions (Beebe & Lachmann, 2014; Tronick, 2007). Without using a semiotic conceptual apparatus, they investigate nonverbal mother–baby communication and how repeated interactive mismatches may lead to emotional disorders in the child.

When describing the therapeutic process, most PTIP therapists do not use psychoanalytic concepts as much as those stemming from attachment theory and developmental research. Norman, in contrast, used Bion's concepts such as the model of container/contained, the function of reverie in transforming beta- to alpha-elements, etc. (Bion, 1962, 1965, 1970). He also used some Freudian concepts such as primal repression (Freud, 1915a, 1915b) to explain incipient psychopathology of the baby. It is relevant to study if other classical concepts may help us understand further infant pathology and the PTIP process. It has been suggested that the sexuality of mother *and* infant may play a role in breast-feeding problems (Salomonsson, 2012). Another example is a study of primal repression (Salomonsson, 2014). That article argues that unless a PTIP is instituted early, vicious interactions like the ones between Lisa and her mother may become "fossilized" into primal repressions. Temporary states of suffering in the baby may then develop into recalcitrant character traits, for example, of nervousness or gloominess. Another paper (Salomonsson, 2013) investigates the role of transference in PTIP. It has been found that a baby in MIP sometimes develops a specific relational behavior with the analyst. The paper clarifies the conditions for calling such phenomena transference from the baby to the therapist.

THE INFANT AS SUBJECT (THOMSON SALO AND PAUL)

In Melbourne there is a group of PTIP therapists, many of whom are psychoanalysts. They work at the Royal Children's Hospital and their infant patients often suffer from physical illness. Their work contains similarities with Norman's technique, such as an emphasis on dialogue with the baby. One example is when a therapist not only explains to the parents that their child is cross but also address the young, as when telling a 14-month-old boy: "You're cross—and it'll be all right" (Thomson Salo, 2007, p. 964). On a note similar to Norman, the therapist tries to "understand the infant's experience in order to enter treatment through the infant's world rather than primarily through the parents' representations" (p. 965). The aim of relating to babies in their own right, or recognizing them as a subject, is to bring about a "change in their thinking, feelings and behaviour, and the parents as well" (p. 965).

The infant focus applied by these clinicians (Thomson Salo, 2007; Thomson Salo & Paul, 2001; Thomson Salo et al., 1999) is, however, not identical to that of Norman. They work directly with the infant to enable the *parents* "see more easily that their fantasies of having totally damaged or killed off the infant are not reality" (Thomson Salo et al., 1999, p. 59). This comes close to Fraiberg's "ghosts" and Cramer's "parental projections." Ann Morgan suggests that the therapist should make contact with the baby to understand "the experience from inside the infant's world rather than looking from outside as if it were inexplicable" (in Thomson Salo & Paul, 2001, p. 15). This comes about through a mutual infant–therapist fascination, in which the baby is viewed "as a subject in her own right which then allows a gap to be created between mother and baby" (p. 14). Such a gap has previously not existed because the parent has identified the baby with "some internal object in the parent's mind rather than [having built] an empathic relationship with the infant" (p. 18). Once again, we hear echoes of Fraiberg and Cramer. Having created such a space by addressing the baby, the therapist works with parental projections and also "with the infant so that the mother sees her differently . . . the therapist becomes a container for the hate and the toxic projections for which the infant was previously the receptacle" (p. 18).

We note a difference compared with Norman's stance; a therapist who is making a link with a baby is not necessarily encouraging the baby's stormy feelings to flourish vis-à-vis mother *and* therapist. If an infant is a subject "entitled to an intervention in [his] own right" (Thomson Salo, 2007, p. 961), the question is if this implies that one regards—or does not regard—the infant's communications as directed

toward the therapist. This question is essential once we focus on the baby's negative emotions. Paul and Thomson Salo (in Pozzi-Monzo & Tydeman, 2007) describe how "some infants relate positively to us from the first, as though they have left aside the difficulties with their parents" (p. 145). This suggests a more supportive stance than that of Norman. He would probably have suspected that the baby was warding off some taxing emotion, which risked being overlooked by the clinician.

WATCH, WAIT, AND WONDER (COHEN ET AL.)

This technique (WWW; Lojkasek et al., 1994) originated from the Hincks-Dellcrest Center in Toronto. It has been compared with Fraiberg's mother–infant psychotherapy in an RCT (Cohen, Lojkasek, Muir, Muir, & Parker, 2002; Cohen et al., 1999), which will be referred to more fully in the second article. Suffice it to state here that the WWW method seemed quicker in creating positive outcomes than Fraiberg's method. The Toronto clinicians' method proceeds from their observations that most PTIP techniques focus on changing the *mother's* behavior with, or representations of, her infant. To emphasize their different perspective, they describe their method as being *infant-led.*

One important foundation of the WWW is attachment theory; if a mother does not perceive and respond to her baby's signals, a secure attachment will not develop. This theory acknowledges how important the caregiver's physical presence is to the baby. Therefore, the authors emphasize the mother's participation in sessions, and they agree with many of the previous authors that her interaction with, and view of, the baby may be marred by her ghosts (Fraiberg), attributions (Lieberman), projections (Cramer), or fantasies (Lebovici). Importantly however, they criticize these methods for overlooking the importance of the *infant's* presence and participation in therapy.

To allow the infant to lead the session the mother is asked to get down on the floor, observe the baby, and interact with him though only at his initiative. Her role is compared to that of a play therapist with an older child; she becomes an "observer of her infant's activity, potentially gaining insight into the infant's inner world and relational needs" (Cohen et al., 1999, p. 433). The baby inspires the mother to observe, reflect and change her ways with him. He will have "the therapeutic experience of negotiating his relationship with his mother, and thus begins to master his environment" (p. 433). The therapist, finally, "engages in a parallel process of watching, waiting, and wondering about the interactions between mother and infant" (p. 437). He or she empowers the mother to describe how she experiences her infant's play and their

relationship. This allows her "to examine her internal working models of her relationship with her infant and to modify or revise them to be more in line with her new experiences" (Lojkasek et al., 1994, p. 214). This work occurs during the second half of the session, when therapist and mother discuss what transpired between her and the baby.

The emphasis on the infant's presence and activity, and the advice for the adults to follow his lead, might lead one into thinking that the WWW method is similar to Norman's approach. However, there are clear-cut differences which emerge from the following quotation:

> The therapist does not instruct, give advice, or *interpret* the infant's activity or play but *provides a safe, supportive environment* . . . so that the mother can express her own observations, thoughts, feelings, and interpretations of her infant's activity and their relationship. The mother and the therapist *discuss the mother's observations of her infant's activity* and attempt to understand the themes and relational issues that the infant is trying to master, focusing on the inevitable problems that emerge as the mother begins to struggle with following her infant's lead. (Cohen et al., 1999, p. 434)

The added italics indicate that the therapist neither addresses the baby directly nor interprets the meaning behind his activity. Rather, he or she and the mother discuss what they think the baby is doing.

THE PIP TEAM AT THE ANNA FREUD CENTRE (BARADON ET AL.)

Another technique influenced by attachment theory is Parent–Infant Psychotherapy (PIP) at the Anna Freud Centre in London. A volume by this group (Baradon et al., 2005) illustrates a trend among some present-day PTIP therapists; they wish to integrate Freudian metapsychology with infant research, attachment theory, and developmental psychology, but they do not always acknowledge that this creates theoretical tensions. The authors use a "psychoanalytic framework," which assumes that "unconscious material is to be addressed because it shapes the pathology" (p. 33). Accordingly, they suggest that "the bulk of interventions will address impingements of conflict, phantasy, negative affect and maladaptive defences" (p. 33). This amounts to a classical Freudian approach, but beyond this statement they mostly speak of promoting "the parent-infant relationship in order to facilitate infant development" (p. 25), and supporting the baby's "attachment needs" toward his "caregivers" (p. 8).

These British authors view the baby as propelled by a *need* to engage a *caregiver* to help him with *attachment* and *emotional regulation.* They are more hesitant to attribute to him a *wish* to enroll a parental *object* to become the target of his *drives*. Consequently, the words "drive" and "object" are rarely mentioned. Thus, the Freudian influence on their frame of reference is not conspicuous. This also becomes evident in their use of the term sexuality, by which they refer to that of the mother, not of the child. Indeed, this restriction applies to most authors cited earlier (Salomonsson, 2012).

Like many therapists presented so far, the PIP therapists also focus on the baby. Their aim is not so much to interpret *to the baby* what might go on in his mind. It is rather to promote his efficacy in engaging his parent's care. The baby is regarded as a "partner in the therapeutic process" (p. 79); when a therapist engages directly with the baby her aim is to "scaffold [the baby's] communications . . . and represent them to her parents" (p. 75). The overall aim is to support the baby's "beginning mentalization and emotional regulation" (p. 75). The therapist observes the infant's contact with her as evidenced by his voice, facial expressions, and eye contact. The use of countertransference to understand therapeutic processes is also emphasized. Video-recordings are sometimes used (Woodhead, Bland, & Baradon, 2006) to clarify to parents how they interact with the child.

THE IMPACT OF THE SETTING AND THE CLINICAL SAMPLE

This survey has been cursory and simplified, with many legitimate candidates excluded due to considerations of space. Another fact needs emphasis as well; almost all the referred authors worked in public health clinics, though in varying settings with different samples. Fraiberg founded in 1972 an infant mental health program in Ann Arbor, which later moved to San Francisco. Some years later Cramer founded a similar center in Geneva. Dolto's "Maisons Vertes," which are still in operation, were walk-in facilities where mothers with babies could receive instant psychotherapeutic interventions on a brief and improvised note. As for Norman, when he started working with babies he was a consultant analyst at a Child Health Center in Stockholm, but his published cases were drawn mainly from his private practice. This enabled lengthy high-frequency treatments, a modality he strongly recommended: "The analytical setting, with its containment of the strong emotional expressions in both mother and infant [is a] prerequisite for the process to evolve and for the working through" (Norman, 2004).

The various forms of PTIP were devised for patients living under different circumstances. Many of Norman's parents seemed reasonably well motivated and psychologically minded. In this, we recognize similarities with the Geneva sample. In contrast, Fraiberg often treated adolescent or immigrant mothers with a low educational and economic status (Dowling, 1982), which also seems to apply to the PIP team in London. The Melbourne therapists treat severely sick children and their parents. Such factors will influence the parents' trust in the clinician, motivation for analytic work, and economic and practical means of taking part in therapy. These differences make it hard to compare the methods. This overview is therefore but a skeleton that helps us understand the major questions that any PTIP method must face. When we try to imagine how various authors have approached them, we should also recall that their ways of working were probably not always "according to the book." Norman's technique had more supportive elements, and he addressed the mother's suffering more consistently, than what emerged in his writings. Similar discrepancies could most probably be found among the other authors.

CONCLUSIONS

Two major questions were formulated initially: (1) Which role does a PTIP mode attribute to a baby in therapy? (2) If it claims to work by helping parents come to grips with their unconscious attitudes toward the baby, does it speak of similar struggles in the infant? Does it even speak of an Unconscious in the infant? The survey indicates that all PTIP therapists view the baby's participation as essential. They wish him to be affected by the therapeutic process, and they seek to comprehend his nonverbal communication to help the process evolve. The main dividing line is (a) if they regard him as a *catalyst* fuelling the therapeutic process in the mother, or (b) as someone who needs to *communicate with* the therapist. Whichever alternative the therapist opts for, it has repercussions on question (1) and on his technique. In model (a), he is more prone to talk to the mother *about* her baby. Model (b) will lead him more into talking *to* the baby about her suffering. Improvement will be seen as coming not only via the mother's changed perception of her baby but also via the baby's direct contact with the therapist which, in its turn, helps change his relationship with the mother.

As for question (2), no author seems comfortable with attributing to a baby an Unconscious in the *systematic* sense. Norman, however, assumed that "the infant has an unconscious in the *dynamic* sense of the

word" (2004, p. 1107, italics added). Questions (1) and (2) are in fact related. The more a therapist is prone to speak of unconscious forces at work in a baby, the more he will intervene directly to the young. If he thinks the baby harbors conflicting affects vis-à-vis mother, then addressing both participants seems logical. Norman's case of Lisa is a case to the point. He did not think that the depressive mother's lack of emotional availability was the only root to the problem. He also thought the girl was active in avoiding mother's eyes.

Cases of gaze avoidance are suitable for discussing further question (2). Most clinicians would not use the term "unconscious" in connection with a baby, except for Dolto and Norman, whereas Fraiberg was ambivalent. She wrote (1982) that "something within us resists the word [defense] and its connotations" (p. 614), but she did regard a baby's gaze avoidance as the result of a defensive process. The issue can be resolved if one studies existent definitions of the defense concept. Traditionally, it has been defined as a process by which a conscious mental instance wards off an unconscious instinctual urge. Laplanche and Pontalis (1973) regard defense in a more general way, as a "group of operations aimed at the reduction and elimination of any change liable to threaten the *integrity and stability of the bio-psychological individual*" (p. 103, italics added). Fraiberg's and Norman's descriptions of gaze avoidance comply with this criterion; the interactive flow between mother and child has been disrupted, which frightens the baby. Therefore she shuns that part of mother which is the central medium of communication and which conveys her depressive ambivalence toward the child; her eyes.

Laplanche and Pontalis add that a defense is not only directed "towards internal excitation (instinct)" but also toward 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). Fraiberg would agree that her gaze-avoiding babies had unpleasant representations of a depressed mother, and that their avoidance aimed to minimize the risk of having them sparked off once again. This position is actually an extension of Freud's position in "The Project" (1895) referred to above; an object who cannot satisfy the baby is perceived as hostile. Freud's notion of satisfaction was bound up with the provision of food and shelter but today, not the least thanks to infant research, we know that the baby also seeks to regulate affects in cooperation with the parent. Fraiberg's and Norman's babies avoided mother's eyes because depression prevented her from regulating the baby's affects. Therapies

revealed that mother's conscious wishes of loving and caring for her baby clashed with unconscious wishes of being alone, staying aloof, or rejecting the child. This ambivalence created out of mother a Gestalt that frightened the child who, in response, rejected mother. Thereby the baby became a frightening Gestalt to the mother who took the gaze avoidance as a proof that the child did not love her.

Any PTIP therapist would agree that such a mother is caught up in an unconscious conflict with her child. Many, however, would claim that the child is *not* capable of having a similar conflict. This article indicates that such a view departs from basic assertions in Freudian theory. It is often claimed that the reluctance to attribute unconscious forces to a young baby relies on the notion that her ego is too immature to produce such advanced mental operations. This was Fraiberg's argument—whence she proceeded to describe precisely such phenomena. Another explanation to this reluctance is related to the influence of infant research. Stern (1985) agrees with object relations theoreticians that the baby has a "very active subjective life, filled with changing passions and confusions" (p. 44). However, to him such descriptions only concern "internal state fluctuations and social relatedness that could contribute to a sense of self" (p. 44). He disagrees that a baby experiences the world in terms of pleasure/unpleasure. He also objects to the notion that trauma and high-intensity affects play a crucial role in constituting the baby's self, and that they result in representations of a "good" and "bad" mother. Consequently, Stern's term infantile vitality affects does not "reflect the categorical content of an experience" (Sandler, Sandler, & Davies, 2000, p. 86).

Stern suggests that sleep or feeding problems during "the formative phase of core relatedness," from about three months onward, "are not signs or symptoms of any intrapsychic conflict within the infant . . . They are the accurate reflection of an ongoing interactive reality, manifestations of a problematic interpersonal exchange, *not psychopathology of a psychodynamic nature* (Stern, 1985, p. 202, italics added). If Norman's six-month-old Lisa is too old to apply to Stern's description this is not so for a similar case of Fraiberg (1982); that boy was three months old. Stern thus indirectly helps us realize that Fraiberg thought of gaze avoidance as indeed reflecting a psychodynamic pathology to which unconscious forces within baby and mother alike were contributing factors. Actually, this formulation parallels descriptions by Beebe and Lachmann (2014), despite the fact that they do not use psychoanalytic terminology. They microanalyze videos of four-month-old babies and speculate that their interactions with mother emanate from "expectancies." These patterns "repeat over time and form generalized action-sequence procedural memories. These expectancies involve anticipa-

tion of what will happen, as well as memories of what has generally happened in the past" (p. 3). The term "unconscious" is absent but we can infer it; the expectancies of babies with gaze avoidance and feeding problems may emanate from unpleasant memories of being with mother. The infants shun her eyes or breasts, and PTIP treatment allows us to infer the unconscious dynamics behind such symptoms.

It is true that unconscious forces cannot be revealed directly. The therapist needs a setting to *interpret* the unconscious meaning behind the patient's symptom. Therefore, mundane observations of babies provide no proofs of unconscious influence. We observe a crying baby on the bus and infer that he is hungry. So does the mother and starts breastfeeding him. If he calms down, we will never know whether his crying was indeed motivated by hunger or by some unconscious conflict. Another baby does not look Mum in the eyes and we infer that he is shy. Perhaps, however, his avoidance reflects a conflict with his mother. If she seeks help with a PTIP therapist, and if they get in good contact and mother is motivated, they may uncover unconscious affects and fantasies in all the three relationships between mother, infant, and therapist. Sometimes the baby will show that the intervention, or to put it more cautiously, the containment has affected him. This he will demonstrate via smiling, playing, laughing, new bodily movements—or if his psychic pain has been addressed—via crying and screaming. He neither speaks nor understands words, but he has a mind that seeks to avoid unpleasure, experience pleasure, and create relationships that help him reach these goals. This article has pointed to the need of investigating if such assets may be used in PTIP to a greater extent than is done today.

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Department of Women's and Children's Health
Karolinska Institutet, 171 77 Stockholm, Sweden
bjorn.salomonsson@ki.se
bjorn.salomonsson@comhem.se