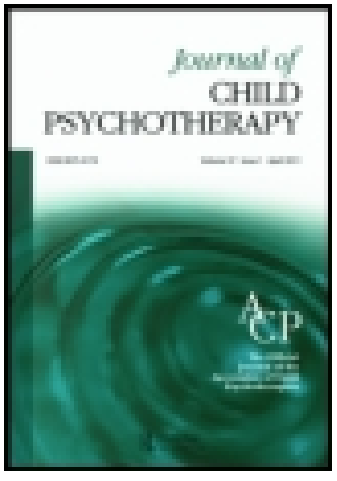

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Therapeutic action in psychoanalytic therapy with toddlers and parents

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Therapeutic action in psychoanalytic therapy with toddlers and parents

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Psychotherapy with toddlers and parents can focus on promoting attachment, facilitating development and improving interactions. Some techniques provide guidance to the parents, whereas others interpret to them their unconscious fantasies or 'ghosts' contributing to the child's disorder. A recent paper introduced a psychoanalytically oriented technique, which emphasised the therapist's interaction with the child in the presence of the parent(s). The child was addressed about his/her unconscious motivations in the session and the feelings towards the therapist. Also, the parent's transference onto the therapist was seen as a vehicle that might further the therapeutic process and was accordingly addressed. The present paper analyses the therapeutic action in such treatments. Whereas work with the parents resembles that of ordinary psychodynamic therapy, therapeutic action is more difficult to conceptualise regarding the toddler, whose understanding of verbal interpretations and the therapist's dialogues with the parent is more limited than that of an adult. However, a clinical vignette demonstrates a toddler's precise and swift reactions to communications from mother or therapist. The paper investigates evidence from neuroscience and psychological research as to which communicative channels – beyond words – toddlers might perceive and comprehend. In addition, it is claimed that the countertransference is key to explaining how the therapist understands such communication.

Keywords: parent–toddler; mirror neurons; facial communication; countertransference; mother–infant psychoanalytic treatment

Introduction

A previous paper (Salomonsson, 2015) presented a psychoanalytic therapy method with toddlers and parents that had been developed from parent–infant work. Various such extensions have been described by other authors (Fraiberg, 1980; Watillon, 1993; Cramer, 1995; Lebovici and Stoléru, 2003; Acquarone, 2004; Baradon *et al*., 2005; Harel *et al*., 2006; Slade, 2006; Pozzi-Monzo and Tydeman, 2007; Emanuel and Bradley, 2008; Lieberman and Van Horn, 2008). These all focus, in their interventions, on the parents' conscious efforts and attitudes, as well as on the unconscious fantasies beneath his/her interactions with the infant. This notion is covered by concepts such as parental 'ghosts in the nursery' (Fraiberg, 1980) or projections onto the child (Cramer, 1995). Therapists also closely observe and address the mother–infant interaction. Finally, their observations are directed towards the baby's attachment and are often described in terms of this theory.

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The technique described in the present paper was developed from mother–infant psychoanalytic treatment, which emphasises that the clinician should also address and contain the baby (Salomonsson, 2014a). It is assumed that unless his/her interventions comprise both members of the dyad, their relationship disorder might remain unsolved. The infant is seen as communicating actively with mother and therapist. The setting is conceived as a field (Ferro, 1999; Civitarese, 2008) in which unconscious and conscious communications roam about in a triangle of baby, mother and therapist. Regarding the *mother*, therapeutic action is conceived similarly to other methods; her unconscious conflicts about and projections onto the baby are addressed and, to the extent that this is possible, resolved. This will improve her relationship with the baby and maternal sensitivity. Regarding the *infant*, containment of his/her anxieties is essential. His/her distress will push him to turn his attention to the therapist, whose interventions s/he will grasp on a non-verbal level. In terms of the semiotic theory proposed by C.S. Peirce (Sheriff, 1994; Muller and Brent, 2000; Salomonsson, 2007), the baby grasps the communication on so-called iconic and indexical (Kloesel and Houser, 1998), but not literal, levels. Icons convey meanings merely by imitation as when, for example, a female frowning face signifies 'angry mum'. An index conveys energy or an intention, as when that face is interpreted as a rejection of breastfeeding. When the therapist formulates such interventions they are thought to have a direct, emotional effect on the baby. Simultaneously, they will affect the mother who perceives and understands them in the literal sense.

Due to the baby's limited understanding and expression of language, this method challenges us to clarify how the therapeutic action functions in parent–infant therapy. In contrast, such a task would seem easier concerning toddler–parent work. After all, two- to four-year-olds use quite a large vocabulary. When the therapist addresses the toddler in joint therapy, one might merely state that interventions will affect him/her directly, as in ordinary child therapy. However, two observations make this explanation insufficient. First, the toddler participates with his/her mother in interactions that may be distressing and difficult, or enjoyable and beneficial. To explain therapeutic action, one needs to take into account both the mother's and the toddler's contributions, as well as their interactions. In other words, one has to account for the entire *system* of mutual regulation and care-taking (Seligman, 1999). Second, the toddler will understand far from all of the therapist's or the mother's words, that is, in their literal sense. Yet, such dialogues seem to affect him/her. How does this come about? Might communicative modes other than the verbal be crucial for therapeutic action? If so, which are these modes and how sensitive is s/he to them? These are the main questions addressed in this paper.

The presented technique has been developed at a Child Health Centre (CHC). These are government-funded clinics in Sweden where parents bring their children for scheduled check-ups up from zero to six years of age. My task as a consultant psychoanalyst is to supervise the health visitor team and provide brief family consultations. The supervisions aim to promote the health visitors' ability to detect emotional problems and to support them in broaching these issues with the parents. Many parents share their worries about their baby with the CHC health visitor. If appropriate, she may recommend a consultation with me. My office is adjacent to the health visitor's office, which facilitates parents' acceptance of such a suggestion. If a lengthy therapy is needed and feasible, this is a valuable opportunity to investigate how disturbed behaviour in a child may be rooted in his/her internal world and in his/her interactions with the parent.

When embarking on a lengthy therapy, I tend to include mother and child as active therapy subjects (Salomonsson, 2015). I establish the therapeutic frame from the start to clarify what is allowed and what is not, and what is the aim of our work: to explore the conscious and unconscious urges lying at the root of the present disorder. They will manifest via play, words, body language, tone of voice, etc., whether they emanate from the child or the mother, or both. Both participants seek containment for such urges and will involve the therapist to achieve this – but they will also defend against displaying them and having them explored. Interpreting these impulses early on will lessen the anxiety of both parties. It will clarify to the toddler that therapy is not mere 'play-time', and to the parent that it involves something other than receiving expert guidance or advice. Interpretations may explicitly address an emotion or a conflict that I assume motivates a certain behaviour, or may be made indirectly through puns or games with the child and/or the parent. The latter type of intervention is spontaneous and unpremeditated, yet it is based on a psychoanalytic understanding of the situation.

The importance of containing the child's anxieties is inspired by Bion's work (Bion, 1962, 1970; O'Shaughnessy, 1988) and its applications to infant work (Norman, 2001). The mode of addressing the child is inspired by the technique used by Melanie Klein (1961, 1975). However, inspired by Lebovici (Lebovici, 2000; Lebovici *et al*., 2002), the atmosphere is more playful and less threatening. Compared to Klein's work, it invites the therapist to be more relaxed, probing and inquisitive when interpreting. Furthermore, the interplay between external and internal objects is visualised in the session, which provides a more solid foundation for interpretations compared with individual child therapy.

The therapeutic process in these treatments often seems to unfold in steps or shifts. The therapist may observe, for example, that the child is screaming or the mother is distressed. S/he will then make assumptions about the corresponding internal objects and ask what representations in the child urge him to scream; could it be a mother he is disappointed in, angry with, or longing for, or a father he wishes were present or absent? Similarly, the therapist may guess which representations are causing the mother's expression of distress. This procedure is comparable to any other psychodynamic therapy. What is specific to therapies with a toddler and a parent is that the two will affect each other, and both will also be affected by the therapist's interventions. Thus, we are dealing with a therapeutic system. A suitable analogy for this technique is couple therapy – although it is important to keep in mind that parent and child are developmentally dissimilar.

The paper applies a micro-perspective on the therapeutic process. This does not invalidate that the therapist has in mind a developmental perspective on the child. A toddler has, compared to an infant, a more secure sense of self and no longer depends on the parent's constant physical proximity. The exclusive relationship with the mother has waned and the father has long since emerged as a central character. The child's omnipotence and strong will, well-known ingredients of the 'terrible twos', reflect his strivings to achieve autonomy 'in the context of emotional closeness and autonomy' (Lieberman, 1992: 573). The drive towards separation and individuation is at its height, which facilitates the toddler's capacity to discern the therapist as a unique person worthy of interest and attention. He may be appreciative when he feels the therapist is standing outside of his power struggle with the parents. He may be aversive, petulant or scared when he realises that the therapist discerns his frightening fantasies and, so he fears, condemns him.

Despite the toddler's determination to carve out an autonomous existence, he is still dependent on the parent. This implies a technical problem: on the one hand, he masters language well enough to make us consider a 'talking cure' with him individually. On the other hand, the anxiety provoked in the very young child by being alone with the therapist, as well as the benefits to the therapeutic process of enabling the parent and the child to work together (Salomonsson, 2015), are factors which support the argument for joint treatment. The nature of the therapeutic action in joint therapy will now be discussed using clinical material.

Eric: almost three and almost unbearable

Barbara, a woman of 40, arrives with her two sons at my office at the Child Health Centre. Walter is five years old and Eric will be three in two months. The boys are playing calmly, with Eric imitating his older brother's games. Barbara speaks of Eric's strong emotions. His temper tantrums put a strain on the family and she deplores that she cannot give Walter enough attention. Meanwhile Eric looks happily at me and says, "I never angry." In contrast, Walter looks sad. Without warning he throws a building block towards his little brother's head. Walter looks terrified, whereas Eric has not apprehended any danger, and goes on playing cheerfully. While still in a state of shock after the near accident, I sense how hard Walter tries to be a nice boy, and to quench his rage against his irascible little brother. I also notice that although Barbara is embarrassed and in pain about Eric's and Walter's behaviour, she is remarkably vague and half-hearted in supporting them and setting limits. The episode indicates the extent to which Eric's mood swings put a burden on all family members, including himself. I suggest that both parents come for a consultation the following week.

When I meet with the parents one week later, they tell me that they are at the end of their tether. They add a story about Eric's earliest weeks of life: after a normal delivery, baby Eric started vomiting profusely. After four weeks, a pyloric stenosis was diagnosed. Barbara herself suffered from this during her infancy, a condition in which the upper orifice of the stomach is constricted and obstructs the passage of food. Eric immediately underwent surgical intervention. From a medical point of view everything went well, but emotionally these were terrible times. His father says, "Eric's first weeks feel like a fog. I got angry with him because of his constant vomiting. There wasn't a clean set of sheets in the house!" His mother nods in agreement. She was able to maintain breast-feeding and Eric was weaned at six months. At about that time his mood changed. He would yell during mealtimes and throw his head back. Later, his rage was directed towards every family member.

Eric's mother described how, by the age of two, he was "almost unbearable". She asked for help, but the health visitor reassured her that things would improve, suggesting that the difficulties were developmentally normal and a manifestation of the 'terrible twos'. As this prediction has remained unfulfilled, another health visitor now has asked me to see the family. The parents notice my interest in Eric's infancy and realise that they have never talked much about it. I suggest that Eric's strong feelings perhaps emanate from these times. There are several reasons why I suggest that Eric's mother, rather than his father, take part in the joint therapy. Barbara's anguish when talking about her newborn's operation is glaring. She also seems to identify with him, emphasising that she had the same malformation and operation as him. Finally, the impressions from our first encounter loom in the background; Barbara was pained by Eric's violence, yet notably ambivalent in putting a stop to it. Therefore, I suggest joint weekly therapy for mother and son. Meanwhile, the father will focus more attention at home on Walter. The parents agree to this plan.

The clinical material to follow contains some passages in bold which will receive specific focus in the section 'Comments on the vignettes'.

The first joint session: the operation is still present

Barbara arrives with Eric. His mood is quite different compared with our first meeting. He sits in her lap with a dummy in his mouth, clinging to her neck and avoiding my eyes. Mother reports, "He had at least seven fits of rage this morning, and I don't understand any of them!" I bring out two dolls and let one be angry, while the other is shaking her head saying she doesn't understand. Eric looks with interest but when I thoughtfully point out that he is sucking the dummy, he becomes sullen.

Analyst to Eric: *You didn't like it when I talked about the dummy, Eric ... Mum told me that you yell a lot at home. Maybe you think she doesn't like you because of it ... Maybe you also think that I don't like you, and that we are angry with you.*

My last comment is based on the assumption that Eric has begun developing a specific relationship with me, since he entered my office in such a frightened and avoidant mood.

Mother to analyst: *Funny, he seems scared of you now, but this morning he smiled happily when I told him we would meet you today.*
Analyst to Eric: *Yes, Eric, people can have many feelings, all at the same time. You like me and you're afraid of me.*

Eric clings to his mother and reaches for her blouse as if seeking her breast. At first, the atmosphere is romantic and I recognise in the countertransference similar boyish feelings towards my mother. But then he curls downwards in her lap and stretches one leg upwards to coil around her neck. Now I feel this has turned into a bizarre scene. At present, Eric seems to function far below his three years. Barbara says that perhaps she does not see Eric in his own right. She has been in psychotherapy years ago and suggests she has been 'projecting things' onto him ever since he was a baby. While this strikes me as a slightly artificial confession, I get a more genuine impression when she speaks of her feelings at the time of his operation.

Mother, crying: *All these tubes and machines, it was terrible. I was so scared he would die!*

Until now, Eric has been silent while sucking his pacifier. ***Now he suddenly starts looking and nodding at me as if he is about to confirm his mother's story****. I bring out a doll as I address him and point to its stomach.*

Analyst to Eric: *The doctors cut your tummy here. Mum was afraid you'd die. But you've become a strong and healthy boy.*

As I compare his size with that of the doll, I add: "In fact, you're nine times bigger."

Eric: *Jonny's bigger than me!*
Analyst: *Yes, there's always someone who's bigger. Mum was so afraid you'd die but now you're almost as big as Jonny.*

As we compare our sizes, Eric adds: "You're bigger than me."

Analyst: *I am. I wonder how small you were when the doctors cut your tummy.*

Eric's mother shows how little Eric was at the operation. She notes his interest and tries to take away his pacifier. Eric protests and starts clinging again.

This episode is the first of many to follow in which Eric's emotional state oscillates in parallel to that of his mother or myself. When his mother clearly and authentically expressed her feelings and memories from the hospital, and when I used the doll to

explain the surgery and his mother's feelings, the boy progressed instantly. Beginning with the passage in bold, he let go of his mother's body and became alert and curious. Nonetheless, her effort at taking away the pacifier failed and Eric regressed immediately.

During the rest of this session, Barbara speaks more about Eric's first months. She explains how she has always felt sorry for him and now links this to the similar operation in her infancy. "I have always felt close to him, much more than with Walter." She wonders if this has made her too indulgent with Eric. She moves on to describing her own childhood; a stern bourgeois upbringing by mother, stepfather and grandmother. Her father lived in Paris and the parents never lived together. She visited him regularly and describes the pain of commuting between two cultures with divergent values and habits.

By now I conceive of the psychodynamics of Eric's fits of rage and clinging as follows: mother's congenital malformation and operation have always been part of her family canon. It may be conceived of as a primal repressed trauma or an implicit memory. In contrast, her memories of Eric's operation are explicit and excruciating. Concerning the implicit memories of her operation and their influence on the atmosphere in her family, we must speculate; perhaps they combined in making her identify with the boy as a traumatised victim. Such a tendency is reinforced by her recall of Eric's operation. The overall result is that she is overindulgent with him. We discover a third source of this overindulgence, namely the acrimonious memories of her stern upbringing: 'I want to give Eric love and warmth, instead of the admonitions my mother gave me.'

As for Eric's affective intensity, it seems to result partly from his mother's overindulgence. He enjoys it, but he also protests when she hinders his efforts at separating from her. Another reason for Eric's intensity might be the operation, with the implied separation, and most importantly, his mother's difficulties in containing his anxieties at the time. His father's panic and vexation with his vomiting son also must have affected the climate of containment in the family; he could not be as affectionate towards his son as he wished, which was likely to have left Eric's mother feeling distressed and lacking support from her husband.

The second joint session: two lovers

Mother and son arrive for their second joint session. She is carrying him with his coat on and a pacifier in his mouth; once again, a rather bizarre scene.

Mother: *I've been thinking ... I get into a state of alert as soon as he's whining and I complain that he can't separate from me. But it's me who can't separate from him! Maybe he's angry because he wants to free himself from me and I won't allow it.*

While his mother is speaking, the boy is peering at me cautiously. Mouthing his dummy, he orders his mother to make room behind her back in her chair. This leaves no space for her and she moves to another chair. Now he indicates that he wants to sit in her new chair and she lifts him over to her again. An intimate and sensual atmosphere develops, as he fingers the buttons of her cardigan.

Analyst to Barbara: To me that looks more like a husband attending to his wife.

Barbara gives an embarrassed laugh and starts talking about her youth. She was in therapy and studied at university while living close to her father in Paris.

Mother: *What happened to my life? All my ambitions as a youngster, I just let them disappear! Today I live like a housewife from the '50s. It's not my husband who wants it like this. I guess it has more to do with my mother. She was a professional woman, but so inaccessible and intellectual. I don't want to be like her.*

Analyst: *Eric, you're clinging onto Mum. You're fingering her cardigan, as if she belongs to you … You like her but I think you're angry with her as well. You want to be a big boy like the other guys at pre-school, but Mum's holding you back. I think you and I should try to help Mum grow up. Do you want to?*

Eric nods eagerly.

Analyst: *OK, so what about you coming the next time without a dummy?*

Eric nods again.

The third joint session: struggling with the dummy

On the third session with Mum, Eric arrives without a dummy. Soon he starts yelling, "Dummy, dummy, I want my dummy!" After some minutes of unbearable yelling, Barbara tells me that this is just like the temper tantrums at home. I suggest she gives him the dummy and Eric calms down while sneering at me.

Analyst to Eric: *I guess you're angry with me because I suggested that you come without the dummy.*

I get the impression that Eric is nodding. Barbara continues reflecting.

Mother: *Strange, not only did I study in Paris, I also took painting lessons. Now my paintbrushes have all dried up. It's sad.*

I bring out a sheet of paper and draw a line in the middle. On the right-hand side I draw a big building and an easel. On the left-hand side a dummy and a lot of threads, like a ball of cotton waste.

Analyst to Mother: *You put your professional and artistic interests in quarantine, especially after you became pregnant with Eric. Now you maintain your confinement by claiming that he is a three-year-old baby, like when you carry him around with his coat indoors.*

I point to the right-hand side of the drawing and add:

University, art lessons, all is gone! The other, messed-up side, the one reigning at home, is flooding you. You just don't know how to get out of it.

The boy listens as he watches mother reflecting on my comments. He lets go of his dummy and puts it in the pocket of Mum's jeans. After some minutes he takes it out again and comments, "It's a dummy." Then he puts it back in her pocket again.

Analyst to Eric: *When you came to me today, you really wanted that dummy. You were angry with me. Now you let go of it and put it in Mum's pockets. Maybe you're done with it.*

Eric shakes his head first but then nods in seeming agreement.

Analyst: *Then you took out the dummy again. I guess you were angry with Mum and me about the dummy. You wanted it back, but changed your mind again.*

Eric shakes his head while caressing Mum's hair: "I like Mum!"

Analyst: *Yes, you like her – especially when you can rule over her and she does what you tell her to do ... But when she is not like that you get angry.*

The fifth joint session: Eric's mother is angry with me

Two sessions later, Barbara describes her two childhood worlds: her responsible, intellectual, emotionally-restrained Stockholm mother, and her Parisian father who wanted her to be chic and marry some rich man.

Meanwhile, Eric is sitting in her lap. She transmits her anger at feeling emotionally imprisoned in her two parents' homes during childhood. It was hard to commute between them, their atmospheres being so different. Then she continues that she is about to apply for a job, which would involve organising aid and education for needy children.

At this point, Eric jumps out of her lap to sit on a chair that is higher than his mother's. He throws the dummy through the opening between its seat and back support, picks it up again and repeats the game. Meanwhile, he is observing me and looking content and proud. He tells me that he and his family went to a party, and there was a clown and a ghost. The ghost was scary, he explains, "But it was cool, too!" *Barbara adds that she has come to object to my suggestion that Eric let go of his dummy. "After all, we agreed with him that we would give it away to Santa Claus at Christmas. We shouldn't let go of it for your sake but for Eric's!"*

At this point, Eric lifts his thumb in a gesture signalling 'I like this'. He also shakes his head, as if agreeing with his mother's protest. *We all smile at this scene. The hour is drawing to a close, but Eric says he wants to stay in my office, "'til it gets dark, well no, the whole week!"*

Comments on the vignettes

Several rapid shifts, indicated by bold text, occur in interactions between Eric and Barbara. The first takes place when Barbara speaks about Eric's operation and how she felt about it. The second occurs when I suggest to Eric we should help his mother grow up so that she will not stop him from becoming a big boy. The third happens when I create a drawing to illustrate her resentment of having given up her interests in academia and art. The fourth shift is Eric's mother's disclosure that she has applied for a job and that she disliked my suggestion about the dummy. In each of these scenes, Eric stops whining and clinging and becomes playful and inventive, and his verbal and body expressions become easier to interpret. In short, he abandons a regressive state and moves to a more advanced level of functioning. Parallel shifts take place in his mother. In the first scene, she becomes open about her anxiety concerning the operation. In the second and third scenes, she discovers her anger with her life as a 'housewife'. In the final scene, she discovers her anger with me.

I assume these shifts reflect how Barbara and Eric momentarily experience and influence themselves and each other. In different terms, their conduct changes

according to qualitative shifts in their internal objects. To study such links is every psychodynamic therapist's daily work; how the patient's conscious and unconscious experiences relate to behaviours, symptoms and character traits. In individual *adult* therapy the therapist can check, with increasing validity over time, if his assumptions are correct; not least by following up how the patient's relationship with him evolves in the transference–countertransference interplay. But in therapy with toddlers and parents, their maturational differences make it more difficult to prove the connections between external behaviour and internal experience. Barbara and Eric's dialogues concerned chairs and dummies, not housewives or professional women. Did some traffic beyond words affect Eric as he was witnessing his mother and me talking about such seemingly incomprehensible topics? If so, what characterised this traffic and how did the therapeutic action depend on it?

One option is to conceive of the traffic as an *unconscious communication* between mother and son. According to Freud (1915: 194), 'the Ucs. [Unconscious] of one human being can react upon that of another, without passing through the Cs. [Conscious]'. He also asks if 'preconscious activity can be excluded as playing a part in it'. Two individuals involved in such interchange neither know what they are communicating nor even that they are communicating at all. And, since it does not pass conscious awareness, it must rely little on words. How does this come about? We might refer to concepts like projective identification and countertransference, but that merely begs the question and forces us to explain how such processes function. The psychoanalytic literature contains many references to unconscious communication, as when Rucker and Mermelstein (1979: 150) claim that it is 'the most basic and perhaps the most powerful level of human contact […] the quality of any human interaction reflects a system of unconscious cues and counter-cues'. The challenge, however, is to demonstrate how this traffic of cues actually works.

So far, we cannot decide which constituents in Barbara and Eric's interaction cause the shifts. In a broad sense, we understand therapeutic action as coming about through work with mother and toddler, respectively – and through the interaction between them. The interventions have similar aims for both mother and son; to lift repressed notions, to make them aware of feelings that are more true to themselves and to enable them to express them unequivocally. For example, I address Barbara about the incongruity when she complains about not having enough 'integrity' in her life while she is accepting Eric coiling his leg around her neck. She 'wakes up' and becomes embarrassed, since her infantile sexuality has been brought to the table. She then becomes annoyed with her housewife's existence and expresses a wish to resume her youthful ambitions. Such a sequence reflects everyday therapeutic work, and its mode of action needs little further explanation. However, the action on Eric is harder to understand. As I address his erotic beleaguering of Mum and anger when she bars him from becoming a big boy, he listens and nods attentively – but why? Put more broadly, what is he perceiving in the therapeutic interchange and how does it affect him? The next section will focus on this question.

Therapeutic action in mother–toddler therapy: various perspectives

To understand how the prompt shifts in Eric come about, we will first consult neuroscientific and psychological research on emotional communication. It is important to note that such studies are based on experiments rather than therapeutic interactions. In addition, they view events from outside and refrain from speculative interpretations.

However, speculation is also an essential tool for any therapist who seeks to comprehend a patient's internal world. To anticipate our conclusions, it is clear that therapeutic action cannot be explained by experimental research alone. We will also need to bring in those instruments of observation and interpretation that are specific to the psychotherapeutic situation, especially the countertransference.

Mirror neuron research

Research on the mirror neuron system (MNS) has led to a claim that it can explain the neural basis for emotion recognition in human interactions. This has led to an increased interest in neuroscience amongst psychotherapists. It has been shown that the motor component of the MNS functions already at six months of age (Nyström, 2008; Nyström, *et al*., 2011). Thus, it is active in a boy of Eric's age. The MNS is also involved when we recognise another person's mental processes, and fires even if the other is merely simulating an action in her mind (Decety, 2002). Iacoboni (2009: 666) concludes that the MNS provides 'a prereflective, automatic mechanism of mirroring what is going on in the brain of other people', including their emotions.

A present-day view holds that the child becomes 'increasingly aware of the resonance between [his] own bodily actions and those of others' (Gaensbauer, 2011), such as when he understands how his own and others' emotions are connected. Via 'embodied simulation' (Gallese *et al*., 2007) he seeks to produce a shared body state, thus establishing 'a direct experiential line' (p. 144) to that which he observes in the other. The latter authors suggest that the MNS is active in such understanding, for example when an analyst and a patient are 'unconsciously picking up and responding to subtle cues from the other' (p. 146).

From a philosophical perspective, Fred Alford (2014) questions this way of understanding how the analyst comprehends the patient. He argues that empathic understanding presupposes 'whole people who recognise in others both similarity and difference' (p. 3). Empathy also relies on the use of countertransference, which requires the analyst to make use of his imagination rather than of some 'unmediated pure communication' (p. 6) between his and the patient's neurons. To exemplify, the thoughts about my mother helped me interpret the atmosphere in Eric's clinging. However, my mother was not 'broadcasted' from Eric or Barbara's neurons. Rather, it was a fantasy produced in my brain. Similarly, Eric clings to Barbara when she speaks of her life as a housewife. Rather than referring to mirror neuron communication between the two, I suggest that Eric's clinging evokes various feelings in Barbara, which in their turn lead to her associations such as the one about housewives. This tallies with Hickok's view (2009) that mirror neurons register global associations rather than interpret specific intentions.

For another critique of attributing a complex construct like intentions to one neural network, see Churchland (2011). When Eric coils his leg round Barbara's neck, she and I observe his motor action and our MNSs are obviously activated. However, to attribute intentions, especially unconscious ones, behind his action implies something much more complicated than neuronal mirroring, namely, to imagine what goes on in his inner world and what elicits this unusual behaviour. Barbara thinks he is clinging 'to get closer' to her, and she is both delighted and embarrassed about it. My interpretation is that he does it to establish a sensually exciting and controlling relationship with her. Already the fact that our interpretations differ indicates that intentions are complex constructs, which rely on the observer's perspective. Vivona

(2009) cautions against automatically transferring neuroscientific findings to psychoanalytic conceptualisations. In summary, sober caution is recommended in relying on the MNS to explain specific interactions in the therapeutic sessions.

Perception of faces in non-therapeutic research

The question thus remains: through which channels is Eric's internal world affected when his mother voices her anger with me or when I speak to her or him? As for the literal meaning of my words, he understands quite a few. However, there are many terms and ideas in my comments to his mother that he cannot understand, for example, the meaning of university, painting class, housewife, etc. Therefore, other communicative modes must be affecting him as well. One option emerges from Swedish studies on reactions to facial expressions. Adult subjects subliminally observing another person's face adjusted their own facial muscles according to the displayed emotion (Dimberg *et al*., 2000). They were briefly exposed to a happy or an angry face. When perceiving the happy face, their smiling muscles were activated, whereas exposure to an angry face activated frowning muscles. These reactions were 'controlled by rapidly operating *affect* programs that can be triggered independently of conscious cognitive processes' (p. 88, italics added). To explore connections between facial perception and affective experience, another study was performed (Andreasson and Dimberg, 2008). Subjects experienced a movie as more funny if, unknowingly, they were induced to make a 'happy' expression by holding a pencil between their teeth. This applied mainly to subjects who evinced 'a higher level of empathic accuracy' (Dimberg, *et al*., 2011: 26).

Before thinking about whether Eric relies on this kind of facial reading, it is important to note that the Swedish researchers use the term 'unconscious' differently from its traditional psychodynamic denotation. As Beebe and Lachmann (2014) explain, they address *nonconscious* processes that can 'usually be brought into awareness by calling attention to them' (p. 70). The term 'nonconscious' and Stern's term 'implicit knowledge' (2008: 183) cover something different to the concept 'unconscious', which refers to processes that are 'kept out of awareness for dynamic reasons, such as conflict' (Beebe and Lachmann, 2014: 70). Barbara's despair at the operation, her desire for her clinging son, or her anger with me only emerged through therapeutic work on conflicts that had been dynamically unconscious. They related to a different paradigm from the *'affect* programs' triggered 'independently of conscious cognitive processes', which were shown by the Swedish researchers.

Facial communication in psychotherapy research

Dimberg and colleagues do not explain their findings in psychoanalytic terms, but their results indicate that facial reading relies on the capacity for empathy; people who are good at understanding emotions react to facial expressions in a stronger and more varied way. Especially for such people, 'important aspects of emotional face-to-face communication can occur on an unconscious level' (Dimberg *et al*., 2000: 88). With the caveat that these studies concern adults I suggest that Eric and Barbara, who have been in close emotional contact since birth, are expert readers of each other's facial emotional communication. I suggest that Eric unconsciously perceives when his mother's face moves from constrained cheerfulness to honest sadness about the operation, or when she explicitly shows her anger with me about the dummy. Her

words, gestures, tone of voice, facial expressions, etc., then unite to form a consistent message. I further suggest that this makes him perceive her as less opaque and unintelligible. These moments are important because they diminish his anxiety and help him make a progressive move.

These speculations would be better supported if some naturalistic research, rather than laboratory experiments, were to demonstrate connections between facial communication and emotional experience in therapeutic or comparable situations. The Saarbrücken group (Krause and Merten, 1999; Benecke and Krause, 2005; Merten, 2005; Krause, 2010) video-recorded interactions between therapists and patients, as well as naïve subjects who were either mentally healthy or disordered. They assessed the emotions signalled through facial expressions via the Emotional Facial Action Coding System, EMFACS (Friesen and Ekman, 1984). In contrast to the Swedish researchers, they interpreted their findings in psychoanalytic terms. In one study, two subjects were instructed to discuss a political topic. An interaction between a man with conversion hysteria and a healthy subject was replete with subtle, swift and inappropriate facial cues, which each participant tried to adjust to that of the other. 'The unconscious conflict was dramatically choreographed in a condensed form, and the partner was very quickly involved in the enactment conflict' (Krause and Merten, 1999: 107).

These researchers conceptualise such interactions via a 'dyadic model including explicit and implicit representations, wishes, and conflicts of both participants' (Merten, 2005: 326). This would provide one answer as to how unconscious communication may come about without passing the conscious system, namely, via swift and subtle facial movements. A similar indication is found in this group's research on the 'lead-affect', that is, the most prominent affect. If the faces of therapist and patient only expressed positive emotions, this correlated with a bad therapeutic outcome. In contrast, if their facial interchange varied in a lively and complementary way and according to the emotional content of the conversation, outcomes were clearly better. Similar results were found by a Swiss group (Ramseyer and Tschacher, 2011) measuring synchrony of movements of the upper body parts of therapist and patient. Here, too, positive outcomes were associated with a high, though not perfect, level of synchronous interchange.

Facial reading in infant and toddler research

I suggest that swift and unconscious transfers of facial and bodily emotional expressions take place between the three participants in the therapy sessions presented above. There is abundant research indicating how accurately infants can perceive and respond to another person's affective state. From only a few months of age, babies differentiate between various facial emotions (Nadel and Muir, 2005; Reddy, 2008). Even very young children 'experience emotions as shared states and learn to differentiate their own states partly by witnessing the resonant responses that they elicit in others' (Decety, 2010: 261). When this resonance is violated, as in the still-face paradigm (Tronick *et al*., 1978; Adamson and Frick, 2003), infants only a few months old often react aversively.

In contrast to babies, toddlers have developed a theory-of-mind-like processing, which allows them 'to entertain several perspectives and a decoupling mechanism between first-person and second-person information' (Decety, 2010: 259). At almost three years of age, Eric can read many emotional subtleties in his mother's face and

build a model of her as a separate person. As stated earlier, there are many words in the interchange between his mother and me that he fails to fully understand. But other components in our communication affect him, and here I have focused on facial reading. This impact has been further investigated by a group under Joseph Campos (Sorce *et al*., 1985; Campos *et al.*, 2011; Walle *et al*., 2012; Dahl *et al*., 2013; Walle and Campos, 2012, 2014). In the visual-cliff experiment, 12 month olds were subjected to a frightening situation: crawling across a plexi-glass shelf covering a precipice. If a mother standing on the other side of the cliff expressed joy or reassurance, most babies crawled across it to reach her. In contrast, if she posed fear or anger, very few babies crossed the cliff. This evocative experiment can be seen on YouTube (Campos, 2014).

These researchers registered a shift in the children's perceptivity at around 18 months. At this age toddlers develop an ability to distinguish authentic from fake emotional displays (Walle and Campos, 2014). In one experiment, parents were instructed to react with fear, exaggerated or ordinary, respectively, when looking at a toy. In another set, an actress displayed appreciation, feigned appreciation, or genuine dislike when seeing a plate of pasta. 19 month olds were clearly more skilled than children three months younger in differentiating authentic from inauthentic emotional display. These findings applied especially to babies whose parents reported that they were prone to suppressing emotional display in daily life. Perhaps their infants had been more exposed to masked display, which allowed them 'greater perceptual attentiveness' for detecting such communication (ibid.: 498).

The children in these studies are challenged about how to interpret emotions. In the visual cliff experiment, the baby wants to crawl across the glass to reach mother but her face says, 'This is dangerous'. Or, in the experiment with the 'dangerous' toy the parent's face expresses 'Beware!' but the child discerns something fishy about it. In either case, the child gets into an emotional conflict. In the words of Campos' group, '*emotion regulation involves the management of conflicting goals* … What is being regulated … is *a conflict between the goals of one person and those of another, and, on occasion, a conflict between the goals of a single person*' (Campos *et al*., 2011: 28). To manage such conflicts implies arriving at a 'negotiated outcome' (ibid.). For this to come about, both participants need to communicate as clearly and unequivocally as possible. However, when Barbara complains about Eric's tantrums but does little to stop them, or when Eric says he loves his mother while coiling his leg around her neck, their communication is muddled and confusing. In the therapeutic process, this kind of interchange must therefore be clarified, and its unconscious determinants must be interpreted.

Countertransference as research instrument

The research studies described above allow us to conclude that a toddler like Eric is able to unconsciously read facial expressions swiftly and accurately. He can also link such reading to his theories of mind about other people. His mother's and my emotions are exposed in our faces and will affect him differentially. One last question needs to be answered: the fact that Eric possesses these abilities does not explain how I, the therapist, intuit which ideas or representations are embedded in his or mother's emotional displays. We now know that Eric may perceive Mum's face as funny, tense, angry, nice, etc. But how do I conclude that he wants to possess her or that she needs to grow up? This question must also be approached in order to understand the therapeutic action. I claim the answer can only be found if we leave experimental research studies and enter psychodynamic theory.

I suggest that my understanding of what goes on inside and between mother and son is substantially based on the *countertransference*. For example, when Barbara mentions her difficulties in separating from Eric – while he is fingering her cardigan – I notice my divergent feelings. I admire her courage in admitting her personal problems. I get annoyed when she, driven by his cravings, lifts him over to her chair again. I indulge in boyish romantic feelings towards my mother. And, I seek to establish clarity and the Name of the Father (Lacan, 1998). All these impressions lead me to intervene calmly: 'To me that looks more like a husband attending to his wife.'

Similarly, my countertransference is involved when I see Eric with the dummy in his mouth. The very first session I meet a cheerful and open boy. In our next meeting he is clinging to his mother and sucking his dummy. This makes me feel frustrated. To put my implicit reaction in explicit terms: 'Come on, Eric, you can do better than this, you know how to talk!' My other feelings involve empathy with his sudden regression and curiosity as to why it happened. As one session follows the next I notice how Eric uses the dummy to avoid what the French psychoanalyst Françoise Dolto labelled oral castration (for reviews of Dolto's concepts see Dollander and de Tychey, 2004; Hall *et al*., 2009) and, in addition, that his mother foments it. The two are not yet able to enter a new kind of relationship, in which Barbara can communicate 'through other means than feeding [the child], removing its excrements, and covering it with kisses and hugs' (Dolto, 1982: 93), and in which Eric can stop clinging to mother's body and instead declare what he wants. When I suggest he take out the dummy I am instituting a 'symboligenic castration' (ibid.: 47). I try to help him become a member of the speaking human community. For this to come about, castration must be instituted slowly and with affection, otherwise it will be traumatising. My paternal countertransference implies not only setting limits and encouraging his emancipation, but also respecting his failures and taking interest in them. I do this by telling him, 'I guess you're angry with me because I suggested you come without the dummy.'

The infant researcher Reddy (2008) discusses a fundamental problem when we investigate how babies can know others' minds. In her view, the mind is not a separate continent but a process construed as we interact emotionally with others. This position comes close to Beebe and Lachmann's (2002) notion of mother and baby co-constructing interactions, and to Trevarthen and Aitken's idea of primary intersubjectivity (2001). Reddy argues for a 'second-person methodology where the scientist would need to engage with people' (2008: 33). Although this perspective also has its epistemological difficulties (Bohleber, 2010; Salomonsson, 2014b) we may claim that the psychotherapeutic situation is such a methodology. When the therapist clarifies the countertransference and seeks to understand how it might reflect the patient's inner world, s/he is making use of the type of two-person methodology that Reddy advocates. However, the validity of countertransference as a research methodology is open to a critique, since it is person- and situation-specific and therefore has little reliability. Indeed, another therapist might not have thought about his/her mother when seeing Eric's clinging. Thus, when therapists turn their 'unconscious like a receptive organ towards the transmitting unconscious of the patient' (Freud, 1912: 115), this involves a creative act. This tallies with Gabbard's view (2001) that countertransference is formed partly by the therapist's pre-existing internal object world as well as by feelings that the patient induces in him. Heinz Racker (1968) suggested that the analyst's insight into the transference depends on his capacity to identify 'both with the analysand's impulses and defences, and with his internal objects, and to be conscious of these identifications' (131). He added that this ability

depends upon the degree to which the analyst accepts his countertransference. Similarly, Betty Joseph (1989) stated that the analyst's guide to the patient's most important anxiety 'lies in an awareness that, in some part of oneself, one can feel an area in the patient's communications that one wishes not to attend to – internally in terms of the effect on oneself, externally in terms of what and how one might interpret' (p. 111).

Countertransference therefore comes about inevitably because we submerge ourselves in the therapeutic situation. It is also one of our most valuable investigatory instruments. On the other hand, its reliability and validity are restricted. Thus we must remain uncertain about the explanatory value of our interpretations. Still, this uncertainty is an unavoidable effect of the second-person or dialogic view that Reddy advocates.

Summary: an unfinished puzzle

In order to understand the therapeutic action in psychodynamic mother–toddler therapy, I have presented clinical material of a mother and her toddler son. They demonstrated that cure does not merely come about through interventions to the mother, which then secondarily affect the boy. Direct therapeutic work with him is also essential, and the paper investigated what assets he might possess for perceiving, interpreting and progressing during the sessions. First, two explanatory models were tested; the MNS and the concept of unconscious communication. I concluded that mirror neurons cannot explain the creative act involved in an empathic understanding of the other person. I also stated that the concept of unconscious communication is descriptive and does not explain the interactive mechanism.

Research was then described, demonstrating that babies react to alterations in the adult's emotional states and communications. These studies, plus research specifically on toddlers, suggested that a child like Eric is an able reader of his mother's emotional state. Other studies indicated that face-reading is essential also in communication between adults, whether in an experimental or a therapeutic setting. These findings enabled us to bypass the objection that the toddler cannot be affected by his mother's or his therapist's dialogue since he does not fully understand it. Instead, he is affected by *shifts in facial and probably also bodily and auditory communication of emotions.* The therapist's interventions, or the mother's emotional reactions, are perceived through these proto-verbal channels and will induce progressive shifts in the child.

As a complement, I brought in the countertransference to explain how a therapist comes to understand his patients. I also highlighted its limitations as a research instrument. In the end, we must conclude that the therapeutic process in these treatments is complex and elusive. The mother is affected by the therapist's direct address and by her son's behaviour. Vice versa, the same goes for the toddler. The two also interact and change according to the other's behaviour as well as to their present state of mind. In the child, changes are elicited only partly through verbal communications. Even more important are the gestures, sighs, laughter, frowns, crying, smiles, etc. that emerge in the session. Research from various domains indicate that both adults and children have well-developed capacities of perceiving and interpreting such communication. In the end, the therapist must rely on the countertransference to understand what goes on inside and between mother and child.

Clinical epilogue

The treatment lasted 15 sessions. In the last session Eric asks, "Doctor Björn, why do you have a plaster on your finger?" I answer that I happened to cut it. He recalls when we put a plaster on his finger during a session. He adds that his father once cut his finger in the kitchen, and that his big brother broke his arm. At this point, Barbara reaches for her own arm, indicating her deep identification with her sons. He sees my bike helmet and asks why it is there. I answer and he tells me about his Ninja swords at home, of which he is very proud. The session continues on these lines; a world where castration looms but where benevolent figures help him with guidance and plasters. Once again, symboligenic castration becomes possible, this time on a phallic level.

Barbara watches in amusement and tells me it is time to leave. "One can go on in therapy forever, but that makes no sense," she says. I ask Eric what he thinks and he responds clearly, "I wanna quit. It's boring here." I let him know that's OK with me. His mother broaches another topic and Eric impatiently gets at her. Barbara tells him distinctly to behave properly. I bring out two crayons and say, "Here are my Ninja swords. Wanna fight?" We fence a little. "My sword is the best!" he claims. His mother, who early in therapy claimed that Eric must not play with 'war toys', now looks proudly at her battling son.

As they leave, Eric wants to shake hands with me. "I grab your hand hard!"

Analyst: *You sure do, Eric. Goodbye!*
Eric: *Goodbye!*

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