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Transferences in parent–infant psychoanalytic treatments

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In parent–infant treatments, babies sometimes exhibit symptoms such as screaming, clinging, and fearful gaze avoidance of the analyst. The paper investigates if such phenomena may be regarded as transference manifestations, and if so, if they appear both in younger and older infants. Based on three case presentations, it is concluded that some babies are capable of forming both brief and enduring transferences. The term "indirect infant transference" refers to when a baby reacts emotionally to the analyst as long as the parent's transference remains unresolved. "Direct transference" refers to when a baby reacts in a non-mediated way to the analyst. The necessary tool of investigation for discovering these phenomena is a psychoanalytic method with an explicit, though not exclusive, focus on the baby. Discerning them in the clinical encounter may help us understand the baby's predicament and when and how to address the baby or the parent. These treatments constitute an empirical field awaiting more extensive clinical and theoretical investigation. Already now, they suggest that transference may be rooted in, and may appear during, very early developmental stages. The paper's positions are compared with those put forward by other parent-infant clinicians.

Keywords: transference, parent–infant psychotherapy, mother–infant psychoanalytic treatment, child psychoanalysis, containment

Introduction

In psychoanalysis, we investigate how unconscious and conscious parts of the patient's mind interact with each other and with the corresponding parts of the analyst's mind. The patient's contributions to this interaction – especially those emanating from his Unconscious – we name *transference*. Our clinical method aims to investigate and resolve it as far as possible: "It is on that field [of transference] that the victory must be won" (Freud, 1912, p. 108). Any method named psychoanalytic must thus account for how transference appears and is handled. This is the case whether we aim to resolve it more completely in classical psychoanalysis or to a lesser extent in brief psychotherapy.

Recent years have seen an increasing interest in psychodynamic parent–infant therapies. Parents seek help for 'baby worries' (Salomonsson, 2010), that is, functional disturbances in the infant, lack of joy and self-esteem concerning motherhood, and attachment and bonding problems within the mother–infant relationship. It has long been known that in such psycho-

therapies the *adult* may exhibit, like any other patient, transferences to the therapist (Fraiberg, 1980). This paper asks if we can discern transference in the *baby* as well. It will discuss three possible answers: (1) transference in babies does not exist; (2) it exists as a redundant phenomenon and should be left unaddressed by the analyst; (3) it exists and needs to be addressed through some kind of analytic intervention. If (1) is the case, we need to unravel the situations where we erroneously believe infant transference is at work. If (2) is the case, that is, if the infant's interactions with us are coloured by her[1] unconscious urges and affects, we must conceptualize how they are connected with the parent–infant difficulties and with our countertransference. This is so though we refrain from formulating any interventions addressing the baby's specific relationship with us. If (3) is the case, we must also ask how we need to address the baby's transference.

It has been claimed (Flink, 2001) that the infant is not actively involved in therapy since she does not understand verbal communications. The analyst's interventions to the parent would thus be incomprehensible to the baby and she would remain an outsider in treatment. Thus, no impetus would drive her towards creating unconscious images of the clinician. In classical terminology, no libidinal or destructive cathexis would be directed towards him. In an object relational language, she would not form any unconscious internal objects connected with him. In short, no transference would emerge.

The classical authors on parent–infant psychotherapy (Cramer and Palacio Espasa, 1993; Fraiberg, Adelson and Shapiro, 1975; Lebovici and Stoléru, 2003) explicitly consider the baby as actively involved in therapy. She is the "patient who cannot talk" and therefore needs "articulate spokesmen" (Fraiberg, 1987, p. 102), that is, a therapist. Nevertheless, as my literature review later in the paper will indicate, when it comes to transference – the unconscious dimension of a patient's relationship with the therapist – these authors refer to that of the parent and not of the baby. Referring to the three alternatives in the preceding paragraph, they would probably vote for (2). They would acknowledge the existence of an unconscious part of the child's mind and focus on how it is influenced by the parental "ghost in the nursery" (Fraiberg *et al*., 1975). They would explicate that the "mother's internal reality, her unconscious, constitutes the first world offered to the baby" (Lebovici and Stoléru, 2003, p. 279) and that this sometimes leads to pathology in the baby. They would also argue that treatment aims at liberating the mother–infant relationship from "projective distortions" (Cramer and Palacio Espasa, 1993, p. 82). *Nota bene*: this term refers to the mother's projections towards the child or the therapist, not the child's projections towards the therapist.

In principle, the task of demonstrating parental transference in these joint psychotherapies does not differ from other therapies. It is all a matter of choosing the appropriate method of investigation. The fact that human relationships are influenced by unconscious factors was known long before

[1]In the general discussions of the paper, the feminine gender will be used for the baby and the masculine for the analyst.

Freud. His specific contribution was to discover its existence in the psychotherapeutic situation, to name it transference, to trace its infantile origins and to study its links with outcome. This became possible when he had devised an instrument for studying and handling it, namely, the psychoanalytic method as we know it today. As analysts, we allow ample possibilities for the patient to create projective distortions about us, we pay attention to them and reflect on their connection with his emotional suffering, and then we transform these reflections into interventions addressed to him. This is everyday psychoanalytic practice. To discuss transference in connection with a *baby* in therapy with her parent is, however, more complicated. In parallel to technique with adults, we would obviously need to allow her to create projective distortions about us, pay attention to them, envisage their connections with her suffering and talk to her about it. But – since she will not tell us how she experiences us and her communications are less explicit and more difficult to interpret than adult verbal comments – how would such a thing be possible?

In the cases to be submitted, I used a method, mother–infant psychoanalytic treatment [MIP] (Norman, 2001, 2004; Salomonsson, 2007b, 2011), in which I sought to build up a relationship with parent *and* baby. I also sought to pay equal attention to the communications from both of them. This technique borrows from the notion of psychoanalysis as a process taking place in a dynamic field (Baranger and Baranger, 2009; Civitarese, 2008; Ferro and Basile, 2011); conscious and unconscious communications flow between the analyst and the patient(s), who thus affect each other. The adults' verbal and nonverbal communications contribute to the field dynamics but the baby's nonverbal communications are equally important. This is so, not only because they contribute to the session atmosphere but also because they may represent her efforts to communicate with mother and analyst. Further, although an infant does not understand an intervention's lexical content, its nonverbal (Norman, 2001) and emotional (Salomonsson, 2007b) components may affect her.

The therapeutic action of MIP thus relies not only on the analyst's containing the mother's anxieties but also those of the baby. Containment of the baby implies to 'translate' (Salomonsson, 2007a) the emotional content of her behaviour, that is, to express it in a more explicit and comprehensible form than her body language. The analyst might, for example, tell a baby who is looking terrified at mother: "I think you get afraid when you note that Mum does not look at you. Right now, she doesn't want to look at you because she is so sad, but she hopes being able to look at you again one day." Babies, too, may communicate in a skewed way, as when they do not convey affects in a straightforward way but resort to infantile defences (Fraiberg, 1982) such as gaze aversion. In these situations, we aim to enable the child to express her affects in a more comprehensible way. *Nota bene*: this description of MIP technique has not opted for any of the three answers concerning infant transference as formulated above. It merely describes that the therapist relates to the baby and pays attention to her communications – it does not indicate whether or not they represent transference.

Before presenting the first case, it is necessary to sketch the details of the MIP method. Sessions take place with the infant and one or two of her parents present, most often the mother. The duration and frequency of treatment are extremely flexible. They may last from a few sessions to a year of four-times-weekly analytic work. The reason for this elasticity is that the pathology of mother and child, as well as the mother's motivation and possibilities of continuing therapy, may vary considerably. Whichever length and frequency chosen, the setting allows the therapist to maintain a psychoanalytic attitude. He thus focuses on unconscious manifestations and regards transference and countertransference as the central arenas in which these manifestations occur. The question in this paper, as delineated in the paper's beginning, is whether transference also arises in the baby and, if so, what this implies for our technique and conceptualization of the therapeutic action.

In MIP, the baby is regarded as being prone to look for containment when she experiences the analyst's attention to her. Consequently, he tries to establish a relationship with her with the aim of becoming that container. His interventions utilize the baby's ability to process certain aspects of language while being adamant that she cannot understand their lexical aspects. The empirical material for the discussion is my experiences with some cases in MIP. Over the years, I observed that a baby sometimes related to me in a way that was often coloured by her intense negative emotions. Sometimes, they were restricted to me whereas she maintained a trustful attitude to her parent. This gave rise to the hypothesis that her emotions *vis-à-vis* me might reflect transference. In other words, she might harbour unconscious urges that she had hitherto been struggling with on her own – and which until now had emerged disguised as various functional symptoms. This hypothesis implied that she now rerouted these urges towards me and that this explained why she seemed fearful of me. If this hypothesis proved tenable, I further suggested that the baby's transference might be used as a tool for understanding her anxieties. Perhaps it might even be possible to assuage them similarly to the way we do it with adult patients – through interventions addressing the transference. If so, the question was how this could be done with nonverbal infants.

The cases were treated in my private practice and at the Mama Mia Child Health Centre in Stockholm where I work as a consultant. I will approach the following questions. They issue from the three alternatives formulated at the beginning of the paper: is transference a relevant concept for describing the infant's relationship with the analyst? If the answer is "Yes, but only in certain situations", what characterizes them? Do we need to address the parent and/or the infant about the transference? And, if we choose to address the baby, how does such a technique differ from other parent–infant methods?

The paper will focus on three cases. The first sets the ground for the theoretical discussion. During her first consultation, an 18 month-old girl suddenly became terrified of me while maintaining a trustful relationship with her parents in the consulting-room. This case started my reflections on transference in babies. Case 2 will demonstrate how a countertransference

enactment made a 7 month-old boy avoid looking at me. Such gaze aversion had occurred frequently with his mother and was the reason she had sought help. Due to my enactment, he thus seemed to transiently displace his symptom from mother to me. In the third case, a boy of 9 months, his fear of me appeared when his father felt uneasy with me. As this paternal transference was resolved, the boy calmed down. This was soon replaced by another kind of fear which no longer seemed connected with the father's unease. It rather reflected some internalized problem in the boy, which now emerged as a fear of me.

Case I: Jennifer, 18 months

I was contacted by the parents of Jennifer because of her lifelong insomnia. She had probably no nightmares but woke up several times in tears. A mild sleeping-drug had been of little help. Paediatric investigations failed to detect any underlying medical problems. In the first session, the mother seemed sad but said: "I'm just exhausted". She was trustful and friendly although I did not get close to her. The father was seriously concerned about the baby and his wife's health. During the first interview, I noted a strange countertransference phenomenon; I was suddenly overcome by an unpleasant feeling towards him. This brief and incomprehensible experience felt like a foreign body in my psyche since he seemed a friendly and concerned parent and I had no information contradicting these impressions.

During the interview, I talked with the parents and conveyed my empathy with their dire straits. Now and then I turned to Jennifer:

> *Analyst*: Mum and Dad tell me that you don't sleep well. They are so worried. It must be hard for you not to sleep.

Jennifer looked at me earnestly and perhaps sadly. My impression contrasted with the parents' description of her as cheerful. They were at the end of their tether because of her insomnia. We continued talking about these matters while I now and then was looking at Jennifer, making some comments on what her parents were telling me. Suddenly, a terror appeared on Jennifer's face while she kept staring at me. I was not able to pinpoint any specific behaviour in any of us, any terrifying words communicated, or any horrifying topic broached that might explain this dramatic change. She started screaming: "Out, out", while running to the door. The shocked parents tried in vain to console her.

Why did Jennifer suddenly become terrified of me? One might suggest it reflected a general fearfulness, but the parents had never seen such a character trait previously. Alternatively, it might spring from a general shyness or prudence. However, as a rule she was a cheerful girl. Since I found no external factors in the session to explain her terror, I hypothesized that it sprang from earlier experiences. In the beginning of the session she had been able to retain them as unconscious representations, and towards the end they suddenly became connected with me. As analysts, we have daily experiences of a lack of coherence between the way we behave with the

patient and how she experiences us. Such instances we label transference manifestations. I thus asked if Jennifer's fear could be conceptualized similarly. If this proved correct, unconscious forces were active – not only in relationship with me but perhaps also in connection with her symptom of insomnia and my transient countertransference towards the father. The ensuing mother–baby treatment allowed time for investigating these questions. Unfortunately, the mother would resume work in a few months time, which set a time limit for our investigation.

The second session, with mother and daughter only, began with Jennifer staring at me in panic and trying to escape into the waiting-room. The mother was taken aback and had a hard time to make her stay. At this point, I had to decide which port of entry (Stern, 1995) to approach. One might consider that Jennifer's panic reflected her mother's unease in coming to me. If so, the girl was the target of the mother's projections. Such issues could be addressed either directly to the mother ("How did you feel coming here today?") or to the girl ("Perhaps Mum was a bit uneasy coming here today"). Another entry would be to speak with Jennifer about her fear of arriving at an unknown place ("It's not easy coming to a new place"). The two latter alternatives would imply addressing the girl though not speaking with her directly about how she might be experiencing *me*. However, since I recalled her terrified look at me during our first consultation at the Child Health Centre, I thought the 'hot spot' was to speak with her about this fear though I did not know its origins. Thus, I told Jennifer:

> *A*: You are quite afraid of me, Jennifer. You don't know why, and neither do I. But I know that it's terrible to be scared. You really want to get rid of that scare. I hope I can help you with it.

As I was speaking, Jennifer slowly calmed down. At some point, I asked the mother to tell me more of how she experienced the present situation. She spontaneously started speaking about the delivery. An emergency Caesarean was necessary due to protracted labour. She felt the staff was dismissive when she asked for support. When Jennifer was 3 months, some breast-feeding problems including sore nipples emerged. While speaking of this, the mother seemed emotionally restrained. I pointed out the contrast between her painful experiences and the subdued account. She did not comment on this. All in all, my impression was that the mother's words did not calm the girl, whereas my attention to her panic made her slowly relax.

The third session Jennifer entered, once again in panic. A diarrhoea with an acrid smell soiled her pants. After the mother had changed her diaper and clothes, I addressed Jennifer.

> *A*: Perhaps you wanted to get rid of your 'scare' by making a poo, but now the smell became scary, too. It's really scary in here and you think I am scary, too.

As seen from this comment, I was still addressing Jennifer about her fear of *me* – not of coming to a new place generally or of her being the carrier of the mother's projected anxiety with me. Another observation supported,

as I see it, that my chosen port of entry was relevant. After I had touched a toy animal or a piece of furniture, she refused to touch it. She wanted to sit down on a little chair but my mere looking at it made her shrink back. Had she been afraid generally of the toys because they were new or unknown to her, she would have shunned them constantly. However, she was playing with them until I touched or looked at them. From then on, she kept shunning them.

Intertwined with these episodes, another climate was dawning in which Jennifer was cheerful, enterprising and cautiously contacting; she placed her own teddy bear on the dreaded chair and walked around, uncertain where to place it. At such times, she would look cheerfully at me. The contrast between her cheerfulness and fearfulness was stunning. In my interchange with mother, I pointed out the differences in their temperaments; Jennifer was outgoing and dominant while the mother was more shy and restrained. She seemed unfamiliar with and charmed by Jennifer's enthusiasm. She was very fond of her husband, who was a supportive and devoted father. She felt content with life except for the girl's insomnia. My dialogues with mother changed little in Jennifer's fear or insomnia. In contrast, therapeutic effects seemed to take place in my direct address with her.

After a few sessions, Jennifer began to relax. She became charmingly mischievous and humorous. For example, she jested about whether she or I was to decide if her teddy bear should sit on her chair. One might argue that this positive development did not result directly from my interventions but rather indirectly from the mother becoming more relaxed with me. However, the latter alternative did not seem probable since our relationship did not change much. In contrast, Jennifer developed a trust in me and paid close attention to my interventions. This is not to say that I bypassed the mother. I told her how I interpreted Jennifer's insomnia. It seemed that some fear had accumulated from early on, the roots of which we might never understand. Jennifer could only express it through her insomnia and now, I suggested, through her fear of me. The theoretical assumption was that unassimilated internal objects were governing her. Though my brief countertransference displeasure towards the father was neither clarified nor talked about, it was silently interpreted as an experience akin to Jennifer's fears. I refer especially to its quality of un-assimilation or lack of 'alfabetization' (Ferro, 2006). I thus assumed it had characteristics similar to the girl's nightly terror. This is *not* to say that she woke up because she feared the father.

We thus never got to know which experiences, if any, had precipitated her nocturnal fears. The important thing was that they had not been adequately contained. Therapeutic effects were mainly obtained by re-establishing the container–contained link by working through her fear of me. During our 24 session treatment it disappeared completely, while her insomnia was significantly reduced. Three years later I contacted the parents for permission to publish material for this article. They gave their consent and added that, since 3 years of age, Jennifer has been sleeping well throughout the night. They thought this was only partly due to psychoanalysis and mentioned an allergy to milk protein as contributing to the insomnia. They did not think she had had any fears, a statement in stark contrast to my

clinical impressions. Their comments seemed to indicate a mixture of unresolved negative transference and gratitude.

We will now use the case to approach our initial questions on infant transference. We will also study how the transference concept has been used generally in child analytic literature.

The Freud–Klein controversy and the issue of infant transference

As Laplanche and Pontalis (1973) remark, the concept of transference is problematic. To some analysts, notably Kleinians, it connotes every phenomenon in the patient's relationship with the psychoanalyst. Other analysts use narrower definitions. Common to all is the reference to situations in which unconscious wishes constituted of "infantile prototypes" (p. 455) are actualized in the analyst–analysand relationship. This definition still leaves important questions unanswered; firstly, does transference occur ubiquitously or only in the analytic situation? In Jennifer's case, did she fear other people as well? Secondly, it is often claimed that transference is "unrealistic" (p. 456) as regards content and extent. But, perhaps this merely reflects the "unreality" of the analytic situation? I was observing Jennifer and addressing her from a psychoanalytic vantage point. We need to investigate if her fear was simply a reaction to my 'spooky' or unfamiliar behaviour. Thirdly, if her present fear was built on earlier terrifying experiences, how do we know about the links between the two? Freud (1914) spoke of experiences which "occurred in very early childhood and were not understood at the time but were subsequently understood and interpreted" (p. 149). He assumed that, even if such experiences might be understood *après-coup* in an analytic process, the patient could never recall them. If so, it would be impossible to excavate the roots to Jennifer's fear. Alternately, it might indicate a traumatic neurosis, where the "factor of displacement" (Freud, 1916–17, p. 363) had not succeeded in assimilating the excitation. If this was the case, we would need to investigate the sources of the trauma and how they precipitated as transference.

Let us approach these questions in Jennifer's case. As for the first question, her parents claimed she was confident with other people and that her fear appeared only with me. Regarding the second question, I maintained a psychoanalytic attitude but I was friendly, attentive and spontaneous with her. This makes it hard to explain why I could not even look at a toy without her having panic attacks. Thirdly, the parents denied any early trauma but only reported her insomnia. The only plausible explanation must be that an unresolved emotional problem was now displaced as a fear of me. Infantile prototypes were thus actualized in our relationship and the conditions were fulfilled for naming her fear a transference.

At this point, one might object that transference refers to a *sustained* colouring of an object relation rather than a temporary fear. This objection adheres to the Freud–Klein controversy in child analysis (Winberg Salomonsson, 1997). Anna Freud (1926) argued that transference cannot occur

in small children since their inner lives and unconscious processes are insufficiently developed. She referred mainly to the transference neurosis whose existence she doubted in small children. In contrast, Melanie Klein mostly used the term "transference situation" (Petot, 1990, p. 139), which referred to all unconscious fantasies "rooted in the earliest stages of development and in the deep layers of the unconscious" (Klein, 1952, p. 55). The problem with differentiating such fantasies from realistic relations is that, in the child's mind, "every external experience is interwoven with his phantasies" (p. 54). In Petot's words, "when the child comes for analysis, its 'real' relationships with real objects are already in a sense transference relationships … the attitude of the 3 year-old to its parents is not determined by the reality of their attitude, but by an internal imago, an imaginary or distorted representation of the parents" (p. 142). Petot refers to situations when internal objects, especially bad and destructive ones, are projected onto the therapist.

Klein's views have been modified by post-Kleinians (Spillius, 1983). For example, there has been a deepening interest in a detailed analysis of the patient–analyst interaction, with an increasing inclusion of the countertransference perspective. This is implied in the term 'transference as the total situation' (Joseph, 1985). Similarly, Anna Freud modified her "former opinion that transference in childhood is restricted to single 'transference reactions' and does not develop to the complete status of a 'transference neurosis'" (1965, p. 36). The Contemporary Freudian group now acknowledges: "The earliest internal influences on the child's development … [and] the existence of transference phantasies, anxieties and resistances from the outset of the analysis" (Sandler and Sandler, 1994, p. 387) as well the impact of countertransference (Piene *et al*., 1983) and negative transference (Anthony, 1986).

Whether one adheres to a contemporary Kleinian or Freudian view one question remains; when in life does transference begin? If a one day-old baby is screaming at the breast, does this express a transference of a negative imago to the 'real' mother? That sounds far-fetched. What about a baby screaming at the therapist? The minimal prerequisite for speaking of transference is that she has developed a relationship with him. This condition was fulfilled in Jennifer's case. However, as Anna Freud would perhaps object, we could neither confirm nor dismiss transference in her case, because without free associations we would lack the necessary investigatory tool.

The solution to this dilemma is, in my opinion, to paraphrase Klein and suggest that *transference-like* phenomena operate "throughout life and influence all human relations" (Klein, 1952, p. 48), whereas we may speak of *transference* only when we can investigate it accurately, that is, in the analytic situation. This view coincides with that of Muir (1991). She restricts transference to "those aspects of the primary relationship that are current and unresolved, that also get taken out of the family and projected into a therapeutic relationship" (p. 66). Actually, such a relationship is set up with the specific aim of cultivating transference. The analyst gathers it by maintaining the frame with the child and paying close attention to her communications and to countertransference. Thus transference is sucked into the

analytic situation "like a vacuum cleaner" (Cohen and Hahn, 2000, p. 2). The interplay between transference and its resonant countertransference stimulates regression and places the analysand of any age in a "formally childlike role" (Stone, 1961, p. 21).

To illustrate the two concepts: if a baby starts crying at a stranger on the bus one could, at the most, call this a transference-like phenomenon. In contrast, Jennifer's fear emerged while a psychoanalytic setting and frame of mind were being erected. Thus, it *might* reflect a transference, a conjecture to be investigated in a psychoanalytic process. Having now delimited the term transference to the analytic situation, we run up against another problem; to what extent is a child able to deploy fantasies onto the analyst? To a post-Kleinian like Meltzer (1967), the answer is evident; the "flux and fluidity" (p. 4) of children's internal object relations make them prone to transference. In contrast, Anna Freud claimed that, since the child has its "past relationship or fantasy firmly fixed to the persons of the parents" (Sandler, Kennedy and Tyson, 1990, p. 92), she cannot cathect the analyst. However, if Anna Freud were right, why did Jennifer fear me? I conclude that it must result from a process by which she was displacing affects connected with her *experiences* of people around – in essence, her parents. The italics emphasize the reference to her internal objects as they emerged in the container–contained relation with the analyst. These affects were uncanny and possibly connected with her sleep disorder. My friendly yet neutral psychoanalytic attention made them surge anew but also promised their containment. This dual motor propelled her to behave like any patient; she transferred her anxiety to our relationship.

In contrast, the term transference neurosis should be avoided since this term historically refers to older patients. In Jennifer's case, I label her fear of me a *direct* and *stable* infant transference in which she projected onto me a bad internal object. As long as I was the carrier of these projections, she feared me. Conversely, she projected onto her parents the good internal object, as when she was running to her mother for protection. The term 'direct' refers to the fact that her transference did not seem to pass via the mother's transference. There were no signs that mother feared me. To sum up, Jennifer's fear signified an infant transference, the resolution of which took place in dialogues and play. Our work also made mother more relaxed and understanding of Jennifer's temperament, but the bulk was done in direct communication with the girl.

To revert to the questions formulated in the paper's introductory section, transference seemed a relevant term for describing Jennifer's fear. It occurred early in treatment when negative internal objects were being projected onto me while remaining uncontained. The vignette demonstrates that substantial results were achieved by addressing the girl. We will postpone our investigation of how this technique differed from other authors' methods until we have investigated their views on babies and transference. This will be done after we have answered a new question emerging from Jennifer's case. She was 18 months old and spoke a few words. Might trans-

ference also occur in younger infants? This will be approached by the case of a 7 month-old boy.

Case II: David, 7 months

David's mother Irene explains on the phone that she worries because her son has been avoiding her eyes since he was 4 months old. The ensuing mother–infant therapy will last five months, with twice-weekly and then once-weekly sessions. All in all, we worked for 39 hours. The entire therapy was video-recorded upon maternal consent. The aim was to document the treatment for myself in order to study the analytic process.

David was born by Caesarean delivery due to a breech presentation. Irene worries that this might have affected him negatively but she does not know how. At 2 months old he got a viral infection and was hospitalized with her: "I hadn't understood how ill he was! It was terrible with all these tubes and machines." After some days they returned home and David was fine. At 4 months old, he started avoiding her eyes while yet looking at the other family members.

The first time I meet mother and son, he is breast-feeding calmly while playing with her hand. He never looks into her eyes but often gives me long happy smiles. She does not seem depressed but feels pain, guilt and stress in caring for her children. Her husband, she says, does not understand the depth of David's problem. I am impressed by her pain and self-accusations. The next session, she talks about her premonitions during pregnancy. She had feared that her concerns about her elder child might harm the foetus. "That's why David was born with a frown on his forehead." While she is speaking, David avoids her eyes constantly. In despair she asks him: "What did I do wrong to you?" Much of the ensuing therapy centres on her guilt, frustration and humiliation concerning these issues.

During a session in the third week, David is looking happily at me while avoiding mother's eyes. It is humiliating to her and bewildering to me. I feel he is pushing me into becoming his favourite. I suggest some images that enter my mind, such as their being two magnets with the identical poles repelling each other. David looks attentively at my accompanying gestures. When I, out of frustration, suggest she be more active in capturing the boy's gaze, this only leads to his rejecting her even more. By the end of the session, I feel even more frustrated with his consistent avoidance of the mother.

> *Analyst* [to David]: Well, David, one could really feel angry with you when you don't look Mum in her eyes.

As a consequence of my unassimilated countertransference frustration, when saying the word "angry", I knock my hand gently on the little table between us. He gives a start and cries briefly.

> *A*: David, you got scared of me. You see, I feel so little and weak when I cannot help you and Mum get in contact. That's why I knocked on the table and you got scared.

The boy calms down and I continue.

A [to the mother]: It is easy to sense your guilt when he's avoiding you. I tasted the guilt myself right now – and his reproach, too.

The next session the boy is clearly avoiding *my* eyes.

A [to David]: You don't want to look at me today.

Mother: I got a lot of response from David since we were here the other day. If I said: "David, look here", he didn't turn to me. But other than that, he looked into my eyes." [Mother lifts him up and searches his eyes but he avoids her.]

A [to David who is literally turning his back on me]: You really want to decide if you're gonna look at me or not, don't you!

M: Yeah, right! When we got home after the previous session he had a hard time falling asleep. Unusual! Was it his reaction to what happened here? Or was he tired? I don't know.

A: I want to listen, Irene, but first I'd like to tell you something, David. Today you look away from me, perhaps because we haven't seen each other for so long, since last Thursday.

D: Aaah.

A: Aaah. Last time, I banged the table [He looks happily at me for some seconds] and you started. Now, you are looking at me. Mum says you were in a bad mood after the last time we met. Silly Björn banged the table. Then Silly Björn was gone from you. Now that you come back to me with Mum, you are looking away from me. That's easy to understand. [He looks at me for a bit longer.]

M [Smiling to David]: Was that it, David?

A [to David]: Was it the same when you were little, David? [He looks happily into my eyes.] Mum had so many things to worry about…

D: Hehe.

A: Yes, and one might turn away the eyes when one is sore and disappointed. When one has turned away from that person, it becomes unpleasant to look her in the eyes.

M [Smiling at David]: Was that it, David, was that it?

This case was submitted to investigate if phenomena similar to Jennifer's fear might occur in younger infants. One difference was obvious; her fear of me was persistent whereas David's avoidance was temporary. Was its impact strong enough to merit the label transference? One could object that it simply represented a "habitual mode of relating" (Sandler *et al.*, 1990, p. 80). However, David had no problems with looking other people in their

eyes – including me save for the session referred above. One could also retort that it simply resulted from a countertransference enactment. This was true but, since he otherwise avoided his mother consistently, I drew yet another conclusion. He avoided me because I had come to temporarily represent an internal object which he otherwise projected onto his mother. Similarly to Jennifer's case, I therefore label his gaze avoidance of me a *direct* negative transference. Unlike her case, it was brief and contrasted to his prevailing positive or even idealized transference characterized by his constant smiling at me while avoiding his mother.

To summarize, David's case illustrates that transference may also occur in young infants. His avoidance did not simply reflect a transference flaring up when I knocked the table. Rather, it seemed to be an off-shoot of his deeper emotional problems. It falls outside the scope of this paper to account for how they were resolved in the analysis. Suffice it to say that the turning-point came when I realized that it was insufficient to state that David avoided mother's eyes. In fact she also avoided *his* eyes in the sense of not letting out her feelings through her gaze. I formulated this in simple words to David: "I think Mum is shy. That word means that you don't dare show your feelings." When I spoke like this, he looked briefly in my eyes. While listening to this interchange, mother confirmed that she was a shy person generally. These sessions lead to a warming up of their contact, to an increase of eye contact, and to her improved self-confidence. Treatment was terminated when he was 12 months old. Since then, I have received two messages from Irene that their relationship and David himself are developing well.

Transference in infants: A review of the literature

Let us now study other parent–infant clinicians' views on transference. Firstly, a nosological clarification is needed. Psychoanalytic literature abounds with references to "infantile transference", ever since Abraham in 1909 (Falzeder, 2002, p. 88) referred to the resurgence of infantile-like attitudes in adult patients. This connotation is still valid today. The term refers to adults or verbal and autistic (Tustin, 1981) children, and to differentiate I will use the term '*infant* transference' for transference in babies.

Most major parent–infant clinicians agree that the core component of therapies is "to understand how the parents' experiences shape their perceptions of and feelings and behaviour to the infant, with the infant contributing to interactional difficulties through physical or temperamental characteristics that have a particular meaning for the parents" (Thomson-Salo, 2007, p. 962). They also agree that earlier experiences may colour the parents' relationship with the therapist, a phenomenon often labelled parent–therapist transference. In contrast infant–therapist transference, as it has been described in this paper, is not mentioned.

When Selma Fraiberg (1987) examines transference in child analysis (Chapter 9) she does not exemplify with infant cases. Nor do the chapters on 'the ghosts in the nursery' (4), a therapy with a 5 month-old boy (5), the adolescent mother and her infant (6) and pathological defences

in infancy (7) refer to transference in the baby. The concept refers to parents, as when a "therapist who conjures up the ghosts will be endowed in transference with the fearsome attributes of the ghost" (Fraiberg, 1987, p. 121). Similarly, her followers (Lieberman and Van Horn, 2008) explore "how the parents' problems affect the parent's feelings and behaviors toward the infant" (p. 65). In contrast, infant transferences are not explored.

Daniel Stern studies the "infant's representations viewed clinically" (1995, p. 99). His examples refer mainly to constellations such as an infant's micro-depression with a depressed mother (p. 99) or his being the family "re-animator" (p. 102). Stern addresses the importance of the "infant's representations as (imagined) port of entry" (p. 134) for therapeutic interventions. Nevertheless, there are no accounts of specific infant–therapist relationships and no mention is made of infant transference.

Winnicott considered therapeutic work possible with mothers and babies, due to "the fluidity of the infant's personality and the fact that feelings and unconscious processes are formed then" (1941, p. 232). He used a "set situation" (p. 229) where he and the mother refrained from contributing to the clinical interchange, "so that what happens can fairly be put down to the child's account" (p. 230). He did, however, not describe any specific relating on the infants' part towards him; neither when illustrating their behaviours in the set situation, nor when treating a little girl by encouraging her to express aggression towards himself.

The Parent–Infant group at the Anna Freud Centre (Baradon *et al.*, 2005) exemplifies with therapist–baby dialogues in which the baby is a "partner in the therapeutic process" (p. 79). The aim is to "scaffold [the baby's] communications … and represent them to her parents" (p. 75). The vignettes indicate that the therapist tries to attain *contact* with the baby rather than to resolve infant transferences. The concepts "transference" (p. 119) and "positive and negative transference matrix" (p. 29) refer to how the parents' relationships with their own parents appear in relation to the therapist or the baby. Baby–analyst transferences are not mentioned.

The Tavistock clinicians build more explicitly on Kleinian and Bionian theories. The volume edited by Emanuel and Bradley (2008) illustrates expert clinicians' work with under-fives. Among its abundant references to transference, none concerns the kind discussed in this paper. The editors describe the baby's propensity to projective identifications by which is meant those directed to the parents. The clinician may also be affected by them and use them to "consider their impact on her own emotional state, a helpful gauge of her client's state of mind" (p. 5). We do not find any discussion of how they might influence the infant–therapist relationship and, consequently, the term transference does not occur in this context. The intervention process is described as the therapist's attempt to "make contact with the infant or child, observing his play and attempting to understand the meaning of his communications, while also engaging the parent" (p. 6). This is not a description of infant transference. The therapist should be "sparing in addressing" the transference, by which is meant, again, the one emanating in the parent (p. 6). The same use of transference in connection

with parents, not babies, is obvious in another chapter (Miller, 2008). Miller's point is that we have a limited mandate to work with the transference, that is, the one from the parent. Similarly to the editors' introduction, she views countertransference as a valuable tool for understanding the predicaments of mother and baby, but the baby–therapist relationship is not delineated.

Another volume from the Tavistock Clinic focuses more specifically on infant work (Pozzi-Monzo and Tydeman, 2007). One chapter by Thomson-Salo and Paul on work with babies in groups describes how:

> Infants transfer onto us and the other group members' feelings and ideas that derive from their caregivers. The therapists become significant to the infants before the mothers do and how infants initially behave with the two of us [the therapists] is transferred from how they are with their mother.
>
> (2001, p. 145)

This would indicate instances of infant transference as defined in this paper. For example, 7 month-old Tom has a conflictual relationship his mother. Smilingly, he touches the therapist's hand and mouths his finger, whereupon mother starts playing with him. "Some infants relate positively to us from the first, as though they have left aside the difficulties with their parents" (p. 145). In contrast to the vignettes in this paper, however, Thomson-Salo and Paul seem not to aim to interpret or resolve the baby's transference. They rather use it as a springboard to enhance the mother–baby contact.

It is probable that the contrast between Thomson-Salo and Paul, and me, respectively, in our use of the term transference has to do with preconceptions and techniques. If one thinks babies leave aside "difficulties with their parents" while relating positively to the therapist, this could be boiled down to a simplistic formula of what goes on in the baby's mind: "Mum is bad but you, Dr, you're good. That's why I prefer being with you". In my preconception, a baby having difficulties with mother is prone to a negative transference, according to another simplistic formula: "Dr, you're bad just like Mum, that is, as I unconsciously and partially experience her. That's why I shun your eyes. Doing that might even help me get more relaxed with Mum". Which of these two views one takes is related to one's preconceptions. It also has to do with how much attention the analyst is paying to the baby's relationship with him and how much space he is allowing for negative feelings to become directed to him. This issue is intimately related to countertransference, as seen in my knocking the table with David.

In other papers (Thomson-Salo, 2007; Thomson-Salo and Paul, 2001; Thomson-Salo *et al.*, 1999), the views of these Melbourne clinicians come closer to the ones advanced in this paper but, as we shall see, they are not identical. Their idea of "direct work with the infant" is to enable the parents to "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). One clinician, Ann Morgan, suggests that parental projections may affect the infant negatively, 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" (Thomson-Salo and Paul, 2001, p. 15), and that this aims at offering "the infant an experience (rather than the promise of a relationship)" (p. 16). This is described in terms of a mutual infant–therapist fascination and as a link between the two, 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, a space which allows growth" (p. 14). This gap will become "a transitional space" (p. 16).

The reason that a gap has previously not existed in the baby is often that the parent has identified him with "some internal object in the parent's mind rather than [having built] an empathic relationship with the infant" (p. 18). Having created the space, 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). Although these publications might seem to match my definition of infant transference, I note a difference; a therapist who is making a link with a baby is not necessarily aiming at creating a setting in which her transference to him may flourish and be talked about. I completely agree that infants are "subjects entitled to an intervention in their own right" (Thomson-Salo, 2007, p. 961). The question is if this implies that one regards – or does not regard – the infant's communications from a transference perspective and if one aims at resolving such a transference. The answer is determined by the therapist's preconceptions, as delineated above.

The final Anglo-Saxon clinician to be referred is Stella Acquarone (2004). She considers it "a resistance on the part of the therapist not to confront the baby's primitive transference and the countertransference" (p. 164). It is, however, hard to find examples of such confrontations. Even in the case of an 8 month-old boy (p. 188), who is calm with his mother but wary of the therapist, Acquarone handles this by pedagogy to the mother about his feelings rather than by addressing him. Thus the baby's transference remains uninvestigated.

Among French analysts, Bernard Golse asks if "babies know how to transfer" (2006, p. 135). His cautious response stems from the problems inherent in attributing transference mechanisms to children who are too young for *après-coup* experiences (Golse and Roussillon, 2010). He notes that if transferences do exist, the negative seem more visible than the positive. Golse asks if our often intense countertransference towards babies proves their capacities for transference. In the end, he leaves this question unanswered. Possibly, Golse's and Roussillon's *après-coup* perspective renders it more difficult to detect any transference. As I see it, the concept of internal object makes it easier to explicate how these dreadful, part-object-like and unassimilated internal 'ghosts', *nota bene* those of the infant, are transferred onto the therapist.

Some French clinicians work with a more direct baby address than is common in the Anglo-Saxon world. The most well known was Françoise Dolto (1985). She addressed the baby, convinced that: "Everything can be said to a baby about things that may promote his perception of

reality" (p. 95). Nevertheless, Dolto seemed not to view the baby's relationship with her in terms of transference. Although she aimed to make herself available to "the individual's most archaic drives" (Ledoux, 2006), that is, to the patient's transference, she did not, as far as I have learnt from her writings, apply this stance to the infant's relationship with her. She rather explicated to the baby his fantasies and their pertaining affects. The same impressions apply to her present-time compatriot, Myriam Szejer (2011).

One French-speaking analyst, Annette Watillon (1993), explicitly considers the baby's transference to her. She claims that all parent–infant analysts "agree on the intensity and immediacy of the baby's transference on to the therapist" (p. 1044), a surprising statement in view of this literature survey. She views the baby's "interference" as "a vital aspect of therapies … Even a tiny baby will play its part in the issues involved in the treatment" (p. 1038). She regards the therapeutic encounter with child and parent as one of "dramatization … [a] re-presentation [which] will allow each protagonist to effect a more tolerable (because detoxified) re-introjection of the relevant objects" (p. 1041). The baby transfers in order to find a different outcome to the conflict. She suggests the therapist should "understand, verbalize and demonstrate *to the parents* what the child is thereby staging" (p. 1044, my italics). Thus Watillon's openness to baby transference does not imply that she addresses the baby. The reason is, she writes, that such an address might arouse parental jealousy and collude with her own "unsatisfied infantile parts which seek love and understanding" (p. 1044).

The Swedish analyst Johan Norman (2004) reported on a 6 month-old boy. At 3 months, the parents were informed that he might have a severe illness. Later, they received reassuring information but the mother still worried and the boy was whimpering constantly and sleeping badly. When Norman spoke of the baby–analyst relationship, he referred to Bion's *K* link (Bion, 1962) and to projective identifications. He suggested, somewhat cautiously, the term transference to cover the boy's notion of a containing relationship with him. In contrast, he did not seem to conceive of the boy's panic as having a specific transference import.

To conclude, all the clinicians referred would probably agree with Barrows (2003) that "the prime aim of infant mental health work is the promotion of the infant's psychological well-being" and that "direct work with the infant might offer one way forward (p. 286)". Most of them would also agree with his observation that, paradoxically, very little such work has been undertaken. In my opinion, the infant's specific relationship with the therapist has been investigated even less often. Consequently, the literature contains very few references to infant transference. When it is indeed considered, the observation is followed up by the therapist's comment to the *parent*, not by working it through with the baby. I see no other explanation than the fact that these therapists do not view the *child*'s communications as signifying a transference with its own specificity and course, one that needs to be verbalized with its creator, the child.

Case III: Vance, 9 months

So far, I have brought out two cases exemplifying *direct* infant transferences. This evokes the question of whether *indirect* transferences exist. The final case will investigate this question and, if the answer is in the affirmative, how the two forms are connected.

Vance's parents are busy professionals. Mother Arlene has been on maternity leave and now the father, Hans, will take his share. Father and son will go to Arlene's home country to stay with grandmother. Arlene will visit them regularly but they wonder if the boy will miss mother. They consult with me at the Child Health Centre to get advice. I meet a gentle mother and a conscientious though somewhat restless father. The project of visiting mother's home country has already been cancelled, they tell me. Its *raison d'être* was Hans's anxiety of being alone with the boy: "I am used to a faster tempo than that of a baby. They say I was a hyperactive child". He wants to sit by his computer while taking care of Vance, but he is also worried and somewhat ashamed of his plan. I suggest he and Vance see me for some sessions, "to perhaps discover what is special about Vance's tempo and how it differs from yours."

In the first father–infant session the boy is anxiously clinging to father's lap, avoiding my eyes.

Father: This is quite unusual!

Analyst [to father]: How did you feel coming here today?

F: No problems. I thought this was going to be exciting!

A: Last time you talked about how difficult it is being alone with Vance.

F: Yeah, but that's already much better now. Now I can see his day-to-day progress.

The father does not acknowledge any anxiety about seeing me. Later in the session, he speaks more openly of his guilt of prioritizing his work and the project of separating Vance and mother by bringing him to grandmother.

The second session, one week later, the boy is again anxious. He uses a pacifier, whines a little, clings to Dad, and avoids me. The father gets stressed.

F [to Vance]: Are you scared, Vance, just like Dad was when we arrived today?

A: What were you afraid of when coming to me?

F: I don't know! Maybe that you, the expert, will discover that I'm not a good father.

A: And what would be wrong with you as a father?

F: I couldn't tell you. But I have the feeling you know it all!

[Evidently, today father is less defensive about his fears of me, that is, his transference. After a while, he speaks of his own infancy.]

F: Mum used to say that already at the delivery ward, I was rooting in a corner of the bed as if trying to get away from it.

A: She implied that you were hyperactive?

F: Mmm.

A: It's as if you were branded already then. Now you think I will brand you as a bad father.

F: It's even worse. It's as if I'm asking myself, 'What does this man know about me that I don't know about myself'?!

Our work with the father's negative transference, and his memories of negative attributions by his mother, bears fruit. The third session one week later, Vance is looking at me calmly from his father's lap. The father is joking:

F: Today I'm not scared, so Vance is calm. I was thinking at home that maybe you don't know everything after all!

In this third session, my contact with Vance is smiling and lively. He starts playing with some wood blocks, which he alternately hands to Hans and me. Hans starts speaking about his parents during adolescence.

F: When I was 12–13 years old, Mum and Dad quarrelled. They stayed married but I sort of lost contact with my father who buried himself in work. These were troubling times for me.

At exactly this point, Vance starts whining and clinging to his father. He avoids looking at me. This time, father neither gets upset nor tries to divert Vance's attention. He reflects:

F: It's remarkable how sensitive he is. That's encouraging – and scary. What if he gets friends who are not nice to him; will that cause him pain?

A: What about *you* being sensitive?

F: Well, I was considered a hard guy, but inside I was not.

Vance calms down and resumes playing with us. Ten minutes later, Hans returns to his childhood. He used to listen to his father's stories about nature. Positive expectations and sorrow blend in this story. He wants to do similar things with Vance in the future. Once again, Vance whines for a while, avoids me and clings to the father.

As long as Hans held back the painful adolescent memories, the resulting mixture of unconscious affect and defence was somehow communicated to Vance. This incomprehensible paternal gestalt disrupted the container–contained link between them. Vance handled the change in atmosphere by projecting this gestalt onto me. I became his phobic object while the father's lap was a safe haven. When father relaxed, the boy was all right with me again. Thus, Vance's transference was *indirect* in that it followed his father's transference. After some weeks, Hans had developed a stable trust in me. Meanwhile, Vance started playing with us. Smilingly, he kept handing out wood blocks and taking them back again.

During the fourth session, a change occurred. Vance started walking proudly towards the door while Hans and I were looking warmly at him. After walking a metre he stopped on the spot, turned around and flung himself into his father's lap while crying inconsolably. At that time, I did not understand the reasons for his change. Some weeks later, I realized that I had no more slots open at the Child Health Centre. I suggested we continue at my private office and Hans accepted. The first session at my office Hans said he appreciated its personal milieu. Vance, however, soon started crying. He avoided my eyes while looking through the window. As I was following him, I noticed the withering leaves outside. In my countertransference, a sad feeling emerged of this being the first autumn day of the year. As I remained in a sombre mood of transience, brevity and solitude my thoughts meandered to visualizing a baby transferred to a foreign and faraway place. Now I began to focus on a 'detail' to which the parents had referred but which we had not elaborated on. When Vance was 7 months old, they took him to Arlene's home country. Father and son remained there while she returned to Stockholm.

> *A*: I'm thinking about that trip when Vance was 7 months old. We haven't talked about it actually.
>
> *F*: I don't want to think about it. It was not a good trip.
>
> *A*: Why not?
>
> *F*: This thing about the foreign language, it was a new setting for Vance. Everybody was nice to him but he missed Mum. Arlene and I haven't been honest to ourselves; when we came home, Vance was quiet and sad. Arlene was sad too, but we didn't dare talk about it.
>
> *A*: Perhaps Vance experienced the move to my office similarly to his move to Mum's home country, especially when she went home again to Stockholm.

Some sessions later, Vance wants to be the intrepid explorer again. He looks proudly at me, walks towards the door, gets panicky while looking at me and then runs to Dad. Hans becomes amazed but not excessively worried.

F: He has many feelings inside. I know he must go through them!

Similar situations of Vance leaving us for one or two metres, getting into a panic, looking at me in fear and rushing to Dad, recur many times. At one such occasion, I address him:

A [to Vance]: Maybe you're afraid that I'll take you to Mum's place. You were there once with Dad.

[Vance is looking earnestly at me.]

A [to father]: Perhaps it's a good idea to tell Vance what happened there.

F [to Vance]: At first, you and I were with Mum and Granny and the others. Do you remember the chickens we were looking at? Then Mum went home and you and I remained. You were sleeping with Granny and I visited you much, but not as much as I should have done. I didn't know better!

The boy calms down while listening to his father. According to the terms indirect and direct transference, Vance's behaviour now seemed to match the latter. His fear seemed to spring from unelaborated emotions linked with his separation from mother two months earlier. They were heralded in his panic by the door at the Child Health Centre, but the move to the new office gave them new impetus. This awoke my concordant identification (Racker, 1968) in the countertransference, in the form of my autumnal sadness. As I started addressing Hans about their journey, he got in emotional contact with hitherto suppressed worries about it. Due to the parents' guilt about the journey and the separation, the boy's reactions had been insufficiently acknowledged and contained. Vance's direct transference seemed rooted in his projecting a nameless dread (Bion, 1962) onto me. I thus came to represent the uncontained separation trauma, perhaps mixed with a fear that I would separate him from the parents again. During this 'second act' of the therapy, his fear of me erupted now and then. I met it with interventions confirming that he was afraid of being sent away, of being left alone without Mum, of me as a threatening figure, and that all these feelings were accepted by me and his father. The mother later took part in a session and confirmed that the boy had been quite different when returning with his father. She addressed her bad feelings about it. After some weeks work, Vance became able to look at me with candour and joy. His negative transference waned and therapy was ended after 22 sessions when he was 13 months old. The father asked for a follow-up when Vance was 18 months old. He showed no fear or apprehension when meeting me and seemed to be a happy chap according to the father's reports from their home and the nursery.

Final comments

Once we have conceptualized an infant's emotions *vis-à-vis* the analyst as transference, we must logically ask if it may occur in other situations. In

the theoretical section on transference, I differentiated between transference-like phenomena and transference. I reserved the latter term for the analytic situation since it is specifically constructed to boost such reactions and to provide an instrument for investigating them. To be true, if an infant looks in terror at a stranger on the bus, it might occur because she is projecting an internal object to him. However, we lack the possibilities of investigating it. In contrast, if a baby is crying during a Child Health Centre visit, we could ask the mother how she is feeling about seeing us. Perhaps she will indicate that she is anxious and thus the baby's crying seems more comprehensible. The clinician must discern if such behaviour is part of a relationship disturbance or perhaps a transitory indirect reaction to the mother's anxiety.

As with all psychoanalytic concepts, 'direct' and 'indirect' transference simplify a complex clinical reality. Nevertheless, the following could be stated; the more we observe a direct negative infant transference, the more we need to address the baby. Jennifer's persistent fear demonstrates this. During Vance's indirect transference, it was more important to address the father about his fear of me. When a direct transference emerged connected with Vance's early separation, it was essential to address the boy about it.

I emphasize that far from all babies respond with a direct transference. One precondition for it to emerge is that the clinician focuses on the baby's relationship with him. Otherwise, her internal objects will not become projected onto him – or the clinician will not discern that her crying and shunning might represent such a mechanism. It merits another study to decide the import of other factors, such as the impact of the child's and/or the parent's disorder. One reasonable hypothesis is that direct transferences will occur mainly among children who are on the verge of becoming enmeshed in a relationship disorder with the parent. This is based on the assumption that, as the relationship problem keeps boosting the child's anxiety, she/he will be prone to look for an outlet for it. Meeting with the therapist would provide an opportunity to channel the anxiety, thus resulting in an infant transference.

To sum up, I asked at the beginning of the paper if transference in babies exists at all, or perhaps only as a redundant phenomenon to be left unaddressed by the analyst. Alternatively, it might exist and needs to be addressed through analytic interventions. I have provided arguments and clinical illustrations suggesting that it does indeed exist. If we use a technique focusing on parental transference, we might regard it as redundant and leave it unaddressed. If our technique opens up for a dialogue with both baby and mother, we sometimes run into clinical situations in which the infant develops a specific emotional relationship with us. Since it seems to ensue from the baby's projections of internal and often terrifying objects, it merits labelling as transference and to be talked about with the baby. My argument is simply one of urgency; if a baby is staring at me in terror I must handle this like any other emotionally intense situation – through containment and interventions.

The vignettes demonstrate that clinical work should be adapted according to the two types of transference – if and when they might appear during treatment. These concepts may help us understand the baby's predicament and when and how to address her. These treatments provide new empirical material to an old debate in child analysis, that is, whether transference is rooted in early development and if it appears at all in children. I answer both issues in the affirmative; even babies may sometimes form transferences of different kinds.

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Translations of summary

Übertragungen in psychoanalytischen Behandlungen von Mutter und Säugling. In Mutter-Kind-Behandlungen zeigen Babys bisweilen Symptome wie Schreien, Anklammern und ängstliche Vermeidung des Blicks des Analytikers. Der Beitrag untersucht, ob solche Phänomene als Übertragungsmanifestationen betrachtet werden können und ob sie, falls die Vermutung zutrifft, sowohl bei jüngeren als auch bei älteren Säuglingen auftreten. Gestützt auf drei Fallvorstellungen gelangt der Autor zu dem Schluss, dass manche Babys sowohl kurze als auch dauerhafte Übertragungen entwickeln können. Der Begriff „indirekte Säuglingsübertragung" bedeutet, dass ein Baby emotional so lange auf den Analytiker reagiert, wie die Übertragung der Mutter unaufgelöst bleibt. „Direkte Übertragung" bedeutet, dass ein Baby auf unvermittelte Weise auf den Analytiker reagiert. Das Untersuchungsinstrument, das erforderlich ist, um diese Phänomene aufzudecken, ist eine psychoanalytische Methode mit expliziter, wenngleich nicht exklusiver Fokussierung auf das Baby. Diese Phänomene in der klinischen Begegnung auszumachen kann helfen, die Schwierigkeiten des Babys zu verstehen und zu entscheiden, wann und wie das Baby oder aber die Mutter anzusprechen sind. Diese Behandlungen konstituieren ein empirisches Feld, das in größerem Umfang klinisch und theoretisch erforscht zu werden verdient. Sie legen bereits jetzt die Vermutung nahe, dass die Übertragung in sehr frühen Entwicklungsstadien wurzelt und auftaucht. Die hier vertretenen Positionen werden mit den Standpunkten anderer Kliniker verglichen.

Transferencias en el tratamiento psicoanalítico de padres e infantes. En el tratamiento de padres e infantes, los bebés a veces exhiben síntomas, como gritos, aferramientos y evitamiento temoroso de la mirada del analista. Este artículo investiga si tales fenómenos pueden ser considerados manifestaciones de la transferencia y, si fuera así, si aparecen tanto en infantes menores como mayores. Basado en tres casos, se concluye que algunos bebés son capaces de formar transferencias tanto breves como duraderas. El término "transferencia indirecta del infante" se refiere a cuando el bebé reacciona emocionalmente al analista siempre y cuando la transferencia del padre o la madre permanezca irresuelta. Por "transferencia directa" se refiere a cuando un bebé reacciona de una manera no mediada al analista. La herramienta de investigación necesaria para descubrir estos fenómenos es un método psicoanalítico con un foco explícito, pero no exclusivo, en el bebé. El discernirlos en el encuentro clínico puede ayudarnos a comprender la situación difícil del bebé y en qué momento y de qué manera abordar al bebé o al padre o a la madre. Estos tratamientos constituyen una campo empírico que espera investigaciones clínicas y teóricas más amplias, pues estas ya sugieren que la transferencia tiene sus raíces, y aparece, durante etapas de desarrollo muy tempranas. Se comparan las posiciones de este artículo con las planteadas por otros clínicos de padres e infantes.

Les transferts dans les traitements psychanalytiques parents-nourrissons. Dans les traitements parents-nourrissons, les bébés présentent parfois des symptômes tels que cris, agrippements et évitement craintif du regard de l'analyste. L'auteur de cet article se pose la question de savoir si ces phénomènes peuvent être considérés comme des manifestations transférentielles, et si tel est le cas, si ces manifestations apparaissent aussi bien chez les tout petits nourrissons que chez les nourrissons plus âgés. Étayant

sa réflexion sur trois cas cliniques, l'auteur parvient à la conclusion que certains bébés sont capables d'établir des relations de transfert à la fois brèves et durables. Le terme de « transfert indirect du nourrisson » se rapporte aux situations où le bébé réagit à l'analyste avec émotion tant que le transfert du parent demeure irrésolu. Le « transfert direct » se rapporte quant à lui aux réactions non-médiatisées du bébé à l'analyste. Une méthode analytique axée explicitement, mais non exclusivement, sur le nourrisson est l'outil de recherche nécessaire à la découverte de ces phénomènes. L'observation de ces phénomènes dans le cadre d'une rencontre clinique peut nous permettre de comprendre la souffrance du bébé et nous aider à déterminer nos modes d'intervention auprès du bébé ou du parent ainsi que leur timing. Ce type de traitement constitue un champ empirique qui demeure en attente d'une investigation clinique et théorique approfondie. Pour l'heure, ces traitements indiquent déjà que le transfert prend racine et apparaît dès les premiers stades du développement. L'auteur de cet article compare ses positions avec celles d'autres praticiens des traitements parents-nourrissons.

Transfert duplici nella cura del genitore e bambino. Nei trattamenti della relazione genitore-bambino, i bambini esibiscono spesso comportamenti sintomatici, per esempio piangono, o dimostrano un attaccamento eccessivo al genitore, o evitano impauriti lo sguardo dell'analista. Questo lavoro si propone di stabilire se tali fenomeni possano essere considerati manifestazioni di transfert, e se, in tal caso, si manifestino sia nei neonati che in bambini più grandi. Sulla base di tre presentazioni di casi, si conclude che alcuni neonati siano capaci di formare transfert sia brevi che durevoli. Il termine 'transfert infantile indiretto' si riferisce a una reazione emotiva del bambino nei confronti dell'analista che corrisponde a un transfert irrisolto da parte del genitore. Il termine 'transfert diretto' si riferisce invece al transfert del bambino nei confronti dell'analista non mediato da quello del genitore. Strumento indispensabile di ricerca su questi fenomeni è un metodo psicoanalitico che si concentri specificamente, sebbene non esclusivamente, sul bambino. La possibilità di individuare questi fenomeni nella prassi analitica ci consente di comprendere il quadro clinico del bambino, nonché di valutare i tempi e le modalità di intervento per entrambi i soggetti. Si tratta per il momento di studi empirici che richiedono ulteriore ricerca clinica e teorica. Sembra comunque già chiaro fin da ora che il transfert affondi le sue radici e si renda manifesto nelle primissime fasi dello sviluppo. I presupposti di questo lavoro vengono confrontati con quelli avanzati da altre ricerche sulla cura del genitore e del bambino.

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