Summary

Panel on sexuality

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How does sexuality enter the psychoanalytic situation and how primary will it become there? To answer, we must separate adult from infantile sexuality. I do not think *adult* sexuality is a primary clinical phenomenon. In contrast, *infantile* sexuality is central to every analytic situation. Helping the patient to find ways of negotiating it within the constraints of external reality and her internal resources is our major goal.

In Freud's model (1905) the infant wants to survive, form "affectionate" bonds and enjoy sexual pleasure. The latter is illustrated by thumb-sucking, a meaningless activity in terms of survival and attachment formation. Soon, sexual pleasure will become conflictual, either because people around the baby fails or refuses to satisfy it, or because the baby herself will regard id impulses as dangerous. Thus, sexuality throws the baby into external and internal conflicts. These conflicts will peak in the Oedipus situation.

Patients, whether children or adults, seek us because they cannot satisfy their infantile sexual urges. They cannot make these urges comply with their self-esteem and intellectual capacities, other people's demands, or the constraints of reality. When Freud investigated infantile sexuality, his data were baby observations and reconstructions from adult analysands. Later, he got confirmations from child cases, like Little Hans (1909). I argue that joint psychoanalytic treatments of mothers and babies may add to our knowledge of the infantile sexuality in both participants. However, experiences from such treatments have not been integrated within classical psychoanalytic theory. This is deplorable, since they could help us gain access to deep strata in the primeval mind.

One probable reason that such treatments have not been used much to enrich analytic theory is a countertransference phenomenon. Our fear of the infantile world drives us to observe the mother more closely than the baby. Thence, to learn about infantile sexuality we make a

detour to older patients, with whom we reconstruct its roots in their infancy. An alternative possibility is to form a more direct intuition of the baby's sexuality. Clinically, one may investigate functional disturbances in the baby, together with the mother. Via psychoanalytic interpretations based on observations of behaviour and countertransference, we may understand them as resulting from a clash between the infantile sexuality of mother *and* baby. This will be illustrated by a case of a young baby boy with breastfeeding difficulties. They were found to result from the mother's and son's ambivalent positions towards each other.

The theoretical part of the presentation continues with Freud's suggestion that infantile sexuality arises by "leaning onto" or *Anlehnung* to (Freud, 1905, p. 182) the self-preservative instinct. It then brings out Laplanche's alternative thesis: Infantile sexuality arises consequent upon the mother-child communication. Through the concept of the *enigmatic message*, his interaction theory makes room for unconscious as well as observable wavelengths. The parents' infantile sexuality creates, so to speak, the baby's infantile sexuality.

In parallel to the mother-baby interaction, and in agreement with Laplanche (1999), I suggest that the analyst's task is to guard the enigma in the analytic situation. Its essential features, such as the analyst's neutral and withdrawn position, the use of the couch, the relative absence of eye contact, the feeding-like rhythm of daily sessions, etc., are in essence infantilizing features. By utilizing them skilfully and impeccably, the analyst provokes the transference. As I see it, it is always rooted in the patient's and the analyst's infantile sexuality. This will be illustrated by analytic work with a woman patient. I will show that even our simple, everyday and polite farewell interchange had its roots in infantile sexuality. Thus, to say that a clinical phenomenon is or is not transference is unfruitful. It is rather a question of which semiotic perspective we apply to such events.

To answer the panel's second question: If we use Freud's definition of transference, we must respond: Non-sexual (in the infantile sense) elements do not exist in the transference. Regarding aggressive elements, I view them as responses to the inevitable sexual frustrations in the analytic situation, which hark back on frustrations in childhood and infancy. Thus, every analysand and baby has good reasons for complaining: "I desire what I will not get, and I get what I do not desire."

The panel's third question is: Do erotic tendencies manifest in one participant or are they always a product of the analytic couple? Is sexuality always present in mental interactions like the container-contained, the holding situation, the therapeutic alliance, etc? My position is that concepts like container-contained and holding may tempt us to disregard infantile sexuality in clinical discussions. I agree with Danielle Quinodoz (1992) that the container is a "dynamic encounter between begetters". The container-contained relationship thus also has a sexual element. I also find it hard to accept Winnicott's (1960) idea that there is a time in infancy of pure holding, which entails "total environmental provision" including the mother's physical holding, "which is a form of loving". To my mind, we can never settle that infantile sexuality is absent in any of the participants. Observing a mother-infant interaction, we can never dismiss that an enigmatic traffic is running alongside that which offers environmental provision.

To sum up: Infantile sexuality exists in every analytic situation in the form of an enigmatic traffic between the two participants. Actually, the analytic situation is constructed to enhance such traffic. Studying transference implies a focus on how this sexuality, and the patient's reactions to it, is emerging in the clinical situation. The enigmatic setting and the analyst's own infantile sexuality adds fuel to the transference. Finally, the infantile sexuality of the two participants contributes to container-contained, holding, the therapeutic alliance, in fact any interaction whether psychoanalytic or not.