Transference in Different Models of Early Intervention in Low Income Communities

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Abstract

This paper describes an early intervention experience involving two projects conducted with a low income population through a partnership between the nonprofit organization Habitare and an institution that supports pregnant women and mother–infant dyads. Two Habitare projects are presented through a case initially seen in the Flower Doll Workshop and subsequently followed in the Mother–Infant Therapeutic Consultations Project. The case concerns Jiane[3], a woman pregnant with her first child, who arrived at the workshop expressing irritation with her nausea. There, she found a welcoming environment that enabled her to speak about her anxieties and, through transference within the group, to have experiences that had not previously been possible. After her baby was born, she sought individual care, where she continued to have new experiences made possible by transference and countertransference with the psychologist.

Keywords: Therapeutic consultations; Flower Doll Workshop; transference; early intervention.

Transference

To understand the contemporary concept of transference, it is necessary to trace its historical development through Freud’s definitions. In Studies on Hysteria (1895), he states that unconscious representations cannot enter the preconscious directly and therefore need to connect with representations already belonging to the preconscious, forming a “false connection” that is mistakenly attached to the physician.

In 1900, Freud reformulated the concept of transference in relation to dreams. In The Interpretation of Dreams, he describes how affect can be displaced from an unconscious representation to a preconscious one when the representation of the analyst functions as a day residue in the dream, taking the place of the original objects and contributing to resistance.

Transference was not yet viewed as a fundamental part of the analyst–patient relationship necessary for the success of analysis. The case of Dora illustrates this understanding: transference is seen as a set of past fantasies or affective experiences that must be relived in the relationship with the analyst. The task of analysis would therefore be to identify, explain, and dissolve these transferences.

In The Dynamics of Transference (1912), Freud continues to regard transference as the most powerful resistance to treatment. He describes the individual’s development in terms of

libidinal impulses, distinguishing a part of the personality that becomes conscious from another that remains unconscious. This unsatisfied libidinal cathexis is then directed toward the physician. With the discovery of the Oedipus complex, Freud describes this unconscious libido as taking a regressive course: the force of unconscious libido becomes stronger than that of conscious libido, and the patient's infantile imagos, such as the paternal imago, are revived through the figure of the analyst.

A new perspective on transference neurosis appears in one of Freud's lectures in 1916, although the role of transference is still explained in relation to resistance. Freud describes greater intensity and persistence of transference as an expression of greater resistance. He distinguishes two types: positive transference, invested with affectionate feelings, and negative transference, involving hostile feelings.

Freud therefore maintained complete recollection, or the filling of gaps in the childhood past, as the ideal of treatment. Transference constituted resistance to this complete recollection because of the intense unconscious emotional content transferred from the original figures to the analyst.

In 1910, Freud introduced the term countertransference in The Future Prospects of Psycho-Analytic Therapy. He describes analytic therapy as resting on three factors: internal progress, increased authority, and the general effect of the work on analysts. Countertransference would thus be the patient's influence on the analyst's unconscious feelings. The analyst's own personal analysis would be essential, since no analyst could go beyond their own complexes and internal resistances.

After Freud, different theories emerged, each drawing on particular aspects of his developing thought. According to Racker (1982), two groups of analysts follow distinct techniques because of Freud's emphasis on two different aspects of the dynamics of transference:

> For one group of analysts, transference is predominantly resistance. The essential element of the analytic process lies in "remembering" repressed childhood itself, in "filling the gaps in memory," and transference is, according to Freud, an instrument for this purpose … For another group of analysts, the essential element of the analytic process lies in transference itself, that is, in reliving, while at the same time "preventing a new repression." (Racker, 1982, p. 48; translated from the Portuguese text)

Winnicott (1954) emphasizes the importance of considering the individual's developmental history when establishing a diagnosis. For him, transference in the classical sense would apply only to patients who did not experience failures of maternal care during the period of absolute dependence (1945). For those who could not rely on a good enough environment during that period, what is projected onto the therapist consists of experiences of abandonment and helplessness that occurred before the formation of a psychic apparatus capable of representing, and therefore repressing, such content.

Using Racker's (1982) classification, Winnicott would thus belong to the second group of analysts, since he regards transference as fundamental to establishing potential space between patient and analyst. Within this space, through the analyst's work, what has not happened can happen: an experience can be lived, allowing development to resume.

Differences therefore emerge between classical clinical practice and Winnicott's approach, which adopts a phenomenological and temporal understanding of human development as unfolding with the support of the environment. The theoretical differences arising from this new understanding of transference lead to changes in the therapeutic setting and a new emphasis in clinical work:

> Winnicottian clinical practice is, in fact, not a clinical practice of meaning, but of happening. It is not a clinical practice of the repressed, but of what has not happened. It is not a clinical practice of the unconscious, but of the a-conscious and the a-unconscious. It also became clear to me that this was a clinical practice in which the conception of transference underwent a profound transformation. Transference could no longer be understood as the result of displacement or projective identification. It is a transference guided by the search for what has not happened. (Safra, 2007; translated from the Portuguese text)

For Winnicott, who regards the setting as a metaphor for maternal care, the analyst in the transference performs the function of the good enough mother, offering the infant a welcoming, reliable, and containing environment indispensable to emotional development. In the analysis of patients who have developed a false self, or whose ego has not formed intact, as in the case presented below, Winnicott (1955–1956) emphasizes the need to give greater importance to management than to interpretation. The analyst must be good enough to adapt to the patient's needs, evoking hope that the true self will not be endangered and can therefore begin to live.

As noted above, the encounter between analyst and patient takes place in potential space, the third area of human experience, where playing is possible and where transference is also possible:

> From this perspective, transference is understood as a form of playing. The patient moves toward finding the analyst, and the analyst, in turn, allows themselves to be found through the patient's particularity and way of being. The analyst is there, available to be used by the patient and, at a certain point in the course of analysis, to be destroyed. The destruction of the analyst as a subjective object is a fundamental moment in analysis. Yet the analyst's willingness to occupy the place of the subjective object also implies the capacity to play, to live within potential space. (Safra, 1999, p. 99; translated from the Portuguese text)

Analysis is therefore possible only when both analyst and patient can experience potential space, using it as a space of co-creation and genuine communication between them (Winnicott, 1971).

The Flower Doll Workshop

The flower doll was originally devised by Françoise Dolto (1949/1993) for use with patients in regressed states, with the aim of bringing primitive conflicts to the surface. Our Flower Doll Workshop, by contrast, aims to offer a therapeutic environment of care, drawing on the work of Aiello-Vaisberg and Granato (2004) and on the therapeutic consultation model (Winnicott, 1971a/1984). The workshop invites participants to make a cloth doll with a plant-like head in a group setting, making it possible to reach a larger number of women. The group meets weekly for one hour, usually over a period of three months.

The population served lives in precarious socioeconomic circumstances, in environments marked by mistrust and helplessness, which can make it difficult to express subjectivity through speech. The use of the flower doll as a material medium can therefore support genuine self-expression and the integration of emotional states, without imposing speech as the only means of expression. Here, a material medium refers to any material that enables symbolic representations of emotional content to be created.

As in the setting of therapeutic consultations, each workshop meeting has a beginning, a middle, and an end. Its principal intervention is holding (Winnicott, 1945): the therapist remains present and sensitive to the group's needs in order to sustain a space in which spontaneous gestures can emerge. The flower doll as a mediating material is introduced to the pregnant women as a mother introduces the world to her infant, in small doses. It offers participants an opportunity to play, as Winnicott (1968/1994) proposed in the Squiggle Game.

Jiane attended the Flower Doll Workshop regularly. The pregnant women sat in a circle and freely discussed various subjects while making their dolls. Jiane was 24 years old, came from a rural area of Minas Gerais, had been married for five years, and had lived in São Paulo since her marriage. During the workshop, she spoke little. In the first meetings, all the women were quieter and preoccupied with sewing. They remarked that they had no sewing experience. Some, like Jiane, also had no experience of motherhood and were expecting their first baby.

Usually more observant than outspoken, Jiane tended to join conversations about the discomfort and nausea of pregnancy. She experienced frequent nausea and vomiting, leading her to experience pregnancy as something dreadful, with no positive aspects. We consistently received her expressive accounts with care and acknowledged how difficult this period of nausea must be. The other pregnant women also supported her, suggesting foods that might ease her nausea.

This illustrates how transference between Jiane, the psychologists, and the other pregnant women enabled her to experience care and emotional welcome.

During meetings, Jiane often complained about her sewing and expressed dissatisfaction with it, saying, "My doll looks awful," while nevertheless persisting. We commented on how afraid she seemed to be of sewing and how critical she was of her work, while also recognizing that she was managing to make her doll, that she sewed well, and that the doll was taking shape, just as her baby was. Here, the doll made it possible for Jiane to project her insecurities and dissatisfaction concerning her pregnancy.

Therapeutic Consultations

In the Parent–Infant Therapeutic Consultations Project for Prevention and Mental Health Prophylaxis in Infancy, we offer care to infants and their parents and/or caregivers[4] when developmental difficulties associated with dysfunctional relationships are identified, or when the women seek the service on their own initiative, as in the case described here.

Jiane began treatment when her daughter Bela[5] was seven months old. Care was provided by a psychologist and a co-therapist who was a fifth-year psychology student. Approximately 40 sessions took place before discharge. Because of Jiane's marked depression and suicidal ideation, treatment had to extend beyond the four-session model. During sessions, the trainee sat on the floor and played with Bela, commenting and often also speaking with the mother. Meanwhile, the psychologist listened more closely to the mother without neglecting Bela, who frequently sought her gaze.

Jiane had black hair that she always wore tied back. She always wore the same trousers and, regardless of the cold, wore flip-flops. The only accessory suggesting a more delicate femininity was her earrings, which she always wore and changed regularly. She described them as the one object she could not live without.

When she introduced us to Bela, we saw a smiling, fair-skinned girl with brown hair who always wore matching pink or purple clothes and some decoration in her hair. It seemed that a delicate femininity could be openly expressed through her daughter.

Jiane's presenting complaint was that she was always very sad and tearful, often thinking about throwing herself under a bus. She reported that, although she had left rural Minas Gerais to escape a family that "mistreated" her, she had never managed to detach herself completely from them. Guilt about being far away and not caring for her mother continued to trouble her.

Jiane was the daughter of her mother's first marriage. Soon after she was born, her mother ran away and married her stepfather, with whom she had three more children. Her stepfather called Jiane his daughter, as he did his other children, but was very violent toward both the children and their mother. Jiane described suffering as she watched her mother being beaten and said she felt compelled to help her. Tearfully, she described feeling that her mother treated her differently from the other children. Her mother had always taken medication for depression and did not show her affection. Instead, she told Jiane to help with housework and care for her siblings, and criticized her, saying that nothing she did was good enough.

In response to this suffering, the main intervention was holding, intended to provide a safe and welcoming setting. The countertransference involved considerable tenderness, as though the psychologist needed to mother her, offering experiences Jiane had not previously had because of the failures of a mother whose own capacities were impaired.

Jiane described several attempts to make things in order to achieve financial independence. It was therefore extremely important that, within the transference, the psychologists could value what she produced. Eventually, she brought homemade chocolate truffles for us to taste and to affirm her creative capacity. This enabled her to experience something that had not happened in childhood because of her mother's rigidity.

Once she felt safe in the therapeutic relationship, Jiane disclosed that she had become pregnant in an attempt to keep her husband, since he wanted a child. She had been very depressed since moving from Minas Gerais and had been unable to carry out household tasks. This account allowed us to connect her projections of hatred and inadequacy toward

the doll she had sewn in the workshop with her descriptions of pregnancy as unpleasant and nauseating: these expressed a pregnancy she herself had not wanted.

Gradually, Jiane was able to express the hatred she felt toward her daughter for taking up so much of her time, and toward her mother for not having given her good things. At the end of sessions, when Bela sought her lap and breast, Jiane often refused to breastfeed because she was very angry. She would say, “These bad things can pass through the milk.” This evoked anger and discomfort in the therapists. Her statement showed how anger and love represented split-off parts of her self.

Hatred, as Winnicott describes it, emerged as an indication that Jiane could now become angry about failures in childhood and failures in the analysis, which she expressed when one of the psychologists was absent. This created room for the true self to begin experiencing reality.

While the trainee played with Bela during sessions, Jiane pointed out that things were different at home: she did not play with her daughter and wanted her to stay quietly occupied on her own. Her lack of a model and of patience for being fully present with Bela expressed her hatred and aspects of her enactment of transgenerational patterns. Jiane acknowledged that being unable to play with her daughter while the trainee could do so irritated her, as though she could not offer her daughter good things, just as her own mother had not offered good things to her. This transferential anger enabled Jiane to speak about these feelings and integrate her ambivalence into her true self, saying, “It seems we have two different sides.”

Alongside the trainee’s work with Bela, we also supported interaction between mother and daughter by involving everyone in play. We pretended that Bela was feeding us and all sat together to play. Eventually, Jiane brought toys she had bought for her daughter and reported that she was now able to play with her at home.

Soon, Jiane was able to enroll Bela in daycare, allowing some separation from her daughter. She began seeking ways to become independent, took courses, and obtained work as a manicurist. She eventually decided that she was ready to work for herself and would see clients in her home.

We then brought treatment to a close, highlighting how Jiane had become a whole person, with desires and the capacity to carry them out. The ending was also important in allowing her to express anger and sadness about our leaving her. At this point, transference was again essential, enabling her to experience separation differently. She could describe her anger, sadness, and insecurity. At the final meeting, she brought us her plans, showing that she would be able to continue her existence after this separation.

Discussion and Conclusion

In both early intervention models, the workshop and the consultations, the existence of potential space between patient and analyst was fundamental to analysis taking place. Within this process of happening, transference enabled the patient to have previously unavailable experiences that were essential to the constitution of her true self and, therefore, to the continuation of her development.

The group workshop also enabled her to project aspects of her hatred and insecurity onto the doll and thus express her discomfort with pregnancy. In this way, she could integrate parts of her self that did not want the pregnancy.

The individual sessions, inspired by therapeutic consultations, enabled the mother to relive primitive experiences within a trustworthy setting and through the holding and handling provided by the psychologist and trainee. Jiane could speak about her anxieties and ambivalent feelings, allowing these aspects to be integrated into her self, reducing her depression and strengthening the mother–infant bond.

In the authors' assessment, this case illustrates the considerable effectiveness of their early intervention projects in helping prevent pathological patterns in parent–infant relationships from becoming entrenched, thereby supporting the healthy development of the dyad.

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4. Although the proposal is to work with the child and parents/caregivers, most sessions take place with only the mother and infant. Various everyday circumstances have prevented fathers from attending, and Habitare has been reflecting on these factors. We intend to present and discuss them on a future occasion.

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Translation note: Author affiliations and contact details reflect the original document. Quotations are translated from the Portuguese text and are not reproduced from published English editions. The date 1985 given for Freud's Studies on Hysteria in the original has been corrected to 1895. The bibliography otherwise retains the publication details supplied in the source; English title translations in brackets are provided for readers' convenience.

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