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OTHER WRITINGS

The Set Situation paper was published 15 years after Winnicott's first publication in the *British Journal of Children's Diseases* in 1926 (Winnicott and Gibbs, 1926). The first book *Clinical Notes on Disorders of Childhood* (1931) was aimed mainly at children's doctors and already showed the application of psychoanalytic thinking to medicine. Melanie Klein had published *The Psycho-Analysis of Children* in 1932 before he was supervised by her for his child case. His membership paper for the BPAS, 'The Manic Defence' (1935), which remained unpublished until 1958, reflected his interest in her ideas and followed her own paper on 'A Contribution to the Psychogenesis of Manic-Depressive States' (1935). In 1936 Winnicott had read 'Appetite and Emotional Disorder' to the Medical Section of the British Psychological Society (BPS), a setting in which he would give significant papers throughout his career. In 1939, his first discussion of *Aggression* was given to teachers, establishing his ongoing commitment to the dissemination of psychoanalytic ideas beyond psychoanalysis itself.

A. Aichhorn had published *Wayward Youth* in 1925 which Winnicott refers to in 'The Antisocial Tendency' (1956, in C. Winnicott *et al.*, 1984). Klein had given a paper to the Medical Section of the BPS 'On Criminality' in 1934 in which she had remarked on the 'common tendency to overestimate the importance of unsatisfactory surroundings' in understanding delinquency. She further claimed that 'the best remedy against delinquency would be to analyse children who show signs of abnormality' (pp. 280–281) – a position with which Winnicott would eventually disagree. In 1940 John Bowlby published his paper 'The Influence of the Early Environment in the Development of Neurosis and Neurotic Character' (*IJPA*) and in 1944 his study on 'Forty-Four Juvenile Thieves' (*IJPA*) which would lead him to take up a radically different position from Klein's.

EDITORS' INTRODUCTION

This early paper of Winnicott's continues to attract historical debate (Aguayo, 2002; Reeves, 2006) among contemporary theorists for its attempt to establish the conditions for a scientific study of early infantile processes and the emotional foundations of infant mental health. It has been seen as containing the bases for much of Winnicott's later work (Davis, 1993; Reeves, 2006) but as also demonstrating a distinctively Kleinian approach (Likierman, 2007). It is a significant paper in the history of psychoanalysis because it is willing to conjecture about psychic processes on the basis of consistent empirical data and to hypothesize about the close links between the psyche and the physiological processes discernible in the infant. It was first given at a meeting of the BPAS in April 1941, with the title 'Observations on Asthma in an Infant and Its Relation to Anxiety' (Reeves, 2006: 292, n. 3). The paper was revised for later publication in the *IJPA*, and both Rodman (2003) and Reeves (2006) argue for Melanie Klein's close involvement in the final version. Without an original version, however, these readings, though convincing, remain part of wider speculative debates tracing Klein's influence. Although the child with asthma appears in the published paper, the brief is much wider, and the paper is centred on the accumulated data from Winnicott's paediatric practice and his development of a common consultative procedure for all mothers and babies attending his clinic at Paddington Green.

Winnicott was always convinced that children's symptoms – shyness, eczema, asthma, enuresis – are never exclusively physiological but always a response to conflicts; this is illustrated here in the two clinical vignettes, but it is there from his first book, *Clinical Notes on Disorders of Childhood* (1931); another statement of it appears in the paper, 'What Do We Mean by a Normal Child?' (1946), and a later paper, 'Symptom Tolerance in Paediatrics: A Case History' (1953).

The paper represents an evolution in psychoanalytic ways of thinking, and both Freud and Ferenczi are important predecessors for the ideas expressed. The development of first-generation thinkers emphasizes the essential relation of child and adult as the condition of the child's relation with himself or herself, and there are clear parallels with Freud's account of the *fort/da* game based on observations of his grandchild. But Winnicott describes a situation formally set up with a much younger baby as the basis for his own hypotheses about human infants. This involved putting a spatula on a table near the baby and observing the baby's reactions. Like Ferenczi, Winnicott sees the infant coming to assume the capacities of a human subject through the encounter first with others, and then with the self that emerges through those encounters and their internalization. Davis offers a reading of this paper as transitional between a medical and a psychoanalytic model (1993: 65) even as she locates the seeds of most of Winnicott's developed theories and concepts here.

The emphasis on a methodology based on invariant procedures, empirical observation, a large sample, and a replicable situation with consistent elements provides a link with later work. The concentration is on the normal situation and what constitute deviations from it across a deliberately loose age range, about 5 to 13 months, accounted for by known facts about infant development: at 5 months infants grasp an object, but it is not till 6 months that they drop it deliberately. The upper age limit refers to the baby's widening interest in the world around him: while the anxieties are still evident, the baby's positive interest encompasses too many things, and any information deriving from his interest in the spatula is less clear.

Every encounter with the spatula involves:

(a) Consistent elements

1. The setting and the mother, and what they show of family dynamics and the mother's approach to mothering.
2. The child, and what he does at different moments in the encounter.

(b) A series of three stages

1. The baby displays interest but restraint, what Winnicott calls 'the period of hesitation'. This is accompanied by physiological changes, and Winnicott hypothesizes about these bodily changes, which cannot be known exclusively by observation, from a psychoanalytic perspective.
2. The baby's desire for the spatula can first be observed physically, in changes in the mouth, the tongue, and the saliva, then the infant mouths it, engages in free bodily movement, and plays with it.
3. The process of losing interest: the baby may drop it, as if by mistake, then deliberately; he may get down on the floor with it or lose interest.

Winnicott makes a claim about the psychic processes in operation and about the physical links with emotional development, which represent a step forward on two related levels. He insists on the importance for normal development of all the stages. In 'Appetite and Emotional Disorder' (1936) he describes a child whose only response belongs to the throwing-away stage. Davis (1993) links this with the antisocial tendency and its importance in the work with evacuated children in the 1940s.

In his play, the baby shows a rudimentary awareness of the distinction between inside and outside but also seems to be enjoying a process that actually involves completion. In his extended discussion of the riddance stage, Reeves (2006) disputes the parallels between Freud's account of the *fort/da* game (1920) and the younger child's ultimate loss of interest in the object that previously fascinated him. He suggests that the baby's final loss of interest in the spatula in this last stage – 'the leaving behind is everything' (Reeves, 2006: 278) – is very different symbolically from Freud's attention to his grandchild's

capacity to lose and retrieve the cotton reel repeatedly. He proposes that Winnicott's assimilation of his own account to Freud's owes much to Klein and her reading of Freud's example as support for her theory of early infantile states (2006: 281).

Winnicott does describe this phase in terms of a model of internalized objects, where the child gains reassurance about the fate of his internal mother and her attitude, but he argues that there is a complex relation between symptoms, anxiety, physiological processes, and unconscious states which demonstrates the baby's realization of the existence of a world outside himself. The mental conflicts produced by the desire for the spatula and a fear of retaliation or prohibition by another about that desire – that is, a fear of an anticipated external situation that appears to be present internally whether the actual mother is disapproving or not – can nonetheless be dispelled by the experience with the real mother. The expectation of disapproval may echo Klein's account (Likierman, 2007), but, even at this stage in the evolution of Winnicott's own thinking, the early primitive superego forms the basis for a rather different emphasis in the matter of infantile fantasies. Its corollary, the infant's assumption about the mother and her insides, can produce a concern for her that leads to a relation between whole persons. This emphasis on the baby's fantasies prioritizes the idea that the development of the baby's rudimentary sense of self and his relations with more than one person are dependent on the distinction between external and internal as given by the real relation with the baby's real mother or caregiver. Winnicott's insistence that infant behaviour cannot be accounted for except on the assumption that the infant entertains fantasies that are full of content, but not attached to word presentations, offers a different approach to fantasy.

These processes have been further elaborated by psychoanalytically informed developmental researchers who have given the names 'social referencing' (Emde, Klingman, Reich, and Wade, 1978), 'secondary intersubjectivity' (Trevarthen and Hubley, 1978), and 'the domain of intersubjective relatedness' (Stern, 1985) to the moment when the baby is said to make a quantum leap in acquiring a sense that the mother, and therefore the baby himself, has a 'mind' with potentially interesting mental contents. Interest in the mother's expression and its meaning to the baby replaces the prospect of persecution that Winnicott notes. The beginnings of the acquisition of a 'theory of mind' observed and described here are developed further in 'Primitive Emotional Development' (Chapter 2, this volume).

The symbolic aspects of the spatula and the important difference represented by saying the spatula stands for a breast, and/or that it stands for a penis – or rather, what the baby later knows as a penis – are both understood in this approach as a quality of the mother, that leads to a sense of people more generally, a taking in of the world of others. Winnicott emphasizes the spatial connections involved in the initial recognition of persons and their interrelation, and behaviour is not reduced to symbolic equivalences, though that

dimension is also present. Awareness of the existence of external reality is seen as offering a limit to what is possible in a fantasy world where, in the most primitive state, the object works according to magic: if it vanishes when not wanted, this can mean its annihilation, a terrifying situation to which Winnicott refers in relation to the link between not wanting and being satisfied. Importantly, fantasy is not what the individual creates to deal with frustration; this he calls 'fantasying', an activity that is intent on going nowhere. The distinction between fantasy and fantasying refers to the centrality of illusion in his account. This is further developed in the paper on transitional objects and transitional phenomena (Chapter 5, this volume) but its most sustained discussion is to be found in the paper, 'Dreaming, Fantasying and Living', Chapter 2 of *Playing and Reality* (1971d). There he links fantasying to a paralysis of action deriving from an early environmental failure to provide a sufficiently adequate going on being for the infant to manage instinctual demands in their internal and external manifestations.

The adult lacks a capacity for living creatively and for dreaming. 'Fantasying' here involves a lack of spontaneity, a paralysis of action. The idea of 'fantasying' highlights what is involved in the possibility of using both the mind and the body (and, importantly, their inter-relation) as a creative function.

The baby's encounter with the spatula as a whole experience in the controlled conditions of the set situation forms one basis for Winnicott's understanding of what happens in analysis and the importance of regularity and reliability as the condition for richness of experience. His link between spatula and interpretation as glittering objects, ways of approaching the patient's greed, anticipates his interest in play and his questioning of interpretation as the central factor of psychoanalytic treatment.

The Observation of Infants in a Set Situation[1] (1941)

For about twenty years I have been watching infants in my clinic at the Paddington Green Children's Hospital, and in a large number of cases I have recorded in minute detail the way infants behave in a given situation which is easily staged within the ordinary clinic routine. I hope gradually to gather together and present the many matters of practical and theoretical interest that can be gleaned from such work, but in this paper I wish to confine myself to describing the set situation and indicating the extent to which it can be used as an instrument of research. Incidentally I cite the case of an infant of seven months who developed and emerged out of an attack of asthma while under observation, a matter of considerable interest in psychosomatics.

I want, as far as possible, to describe the setting of the observations, and what it is that has become so familiar to me: that which I call the 'Set Situation', the

situation into which every baby comes who is brought to my clinic for consultation.

In my clinic, mothers and their children wait in the passage outside the fairly large room in which I work, and the exit of one mother and child is the signal for the entrance of another. A large room is chosen because so much can be seen and done in the time that it takes the mother and her child to reach me from the door at the opposite end of the room. By the time the mother has reached me I have made a contact with her and probably with the child by my facial expression, and I have had a chance to remember the case if it is not a new patient.

If it is an infant, I ask the mother to sit opposite me with the angle of the table coming between me and her. She sits down with the baby on her knee. As a routine, I place a right-angled shining tongue-depressor at the edge of the table and I invite the mother to place the child in such a way that, if the child should wish to handle the spatula, it is possible. Ordinarily, a mother will understand what I am about, and it is easy for me gradually to describe to her that there is to be a period of time in which she and I will contribute as little as possible to the situation, so that what happens can fairly be put down to the child's account. You can imagine that mothers show by their ability or relative inability to follow this suggestion something of what they are like at home; if they are anxious about infection, or have strong moral feelings against putting things to the mouth, if they are hasty or move impulsively, these characteristics will be shown up.

It is very valuable to know what the mother is like, but ordinarily she follows my suggestion. Here, therefore, is the child on mother's knee, with a new person (a man, as it happens) sitting opposite, and there is a shining spatula on the table. I may add that if visitors are present, I have to prepare them often more carefully than the mother, because they tend to want to smile and take active steps in relation to the baby – to make love to him, or at least to give the reassurance of friendliness. If a visitor cannot accept the discipline which the situation demands, there is no point in my proceeding with the observation, which immediately becomes unnecessarily complicated.

THE INFANT'S BEHAVIOUR

The baby is inevitably attracted by the shining, perhaps rocking, metal object. If other children are present, they know well enough that the baby longs to take the spatula. (Often they cannot bear to see the baby's hesitation when it is pronounced, and take the spatula and shove it into the baby's mouth. This is, however, hastening forward.) Here we have in front of us the baby, attracted by a very attractive object, and I will now describe what, in my opinion, is a normal sequence of events. I hold that any variation from this, which I call normal, is significant.

Stage 1. The baby puts his hand to the spatula, but at this moment discovers unexpectedly that the situation must be given thought. He is in a fix. Either with his hand resting on the spatula and his body quite still he looks at me and his mother with big eyes, and watches and waits, or, in certain cases, he withdraws interest completely and buries his face in the front of his mother's blouse. It is usually possible to manage the situation so that active reassurance is not given, and it is very interesting to watch the gradual and spontaneous return of the child's interest in the spatula.

Stage 2. All the time, in 'the period of hesitation' (as I call it), the baby holds his body still (but not rigid). Gradually he becomes brave enough to let his feelings develop, and then the picture changes quite quickly. The moment at which this first phase changes into the second is evident, for the child's acceptance of the reality of desire for the spatula is heralded by a change in the inside of the mouth, which becomes flabby, while the tongue looks thick and soft, and saliva flows copiously. Before long he puts the spatula into his mouth and is chewing it with his gums, or seems to be copying father smoking a pipe. The change in the baby's behaviour is a striking feature. Instead of expectancy and stillness there now develops self-confidence, and there is free bodily movement, the latter related to manipulation of the spatula.

I have frequently made the experiment of trying to get the spatula to the infant's mouth during the stage of hesitation. Whether the hesitation corresponds to my normal or differs from it in degree or quality, I find that it is impossible during this stage to get the spatula to the child's mouth apart from the exercise of brutal strength. In certain cases where the inhibition is acute any effort on my part that results in the spatula being moved towards the child produces screaming, mental distress, or actual colic.

The baby now seems to feel that the spatula is in his possession, perhaps in his power, certainly available for the purposes of self-expression. He bangs with it on the table or on a metal bowl which is nearby on the table, making as much noise as he can; or else he holds it to my mouth and to his mother's mouth, very pleased if we *pretend* to be fed by it. He definitely wishes us to *play* at being fed, and is upset if we should be so stupid as to take the thing into our mouths and spoil the game as a game.

At this point, I might mention that I have never seen any evidence of a baby being disappointed that the spatula is, in fact, neither food nor a container of food.

Stage 3. There is a third stage. In the third stage the baby first of all drops the spatula as if by mistake. If it is restored he is pleased, plays with it again, and drops it once more, but this time less by mistake. On its being restored again, he drops it on purpose, and thoroughly enjoys aggressively getting rid of it, and is especially pleased when it makes a ringing sound on contact with the floor.

The end of this third phase comes when the baby either wishes to get down

on the floor with the spatula, where he starts mouthing it and playing with it again, or else when he is bored with it and reaches out to any other objects that lie at hand.

This is reliable as a description of the normal only between the ages of about five months and thirteen months. After the baby is thirteen months old, interest in objects has become so widened that if the spatula is ignored and the baby reaches out for the blotting-pad, I cannot be sure that there is a real inhibition in regard to the primary interest. In other words, the situation rapidly becomes complicated and approaches that of the ordinary analytic situation which develops in the analysis of a two-year-old child, with the disadvantage (relative to the analytic) that as the infant is too young to speak material presented is correspondingly difficult to understand. Before the age of thirteen months, however, in this 'set situation' the infant's lack of speech is no handicap.

After thirteen months the infant's *anxieties* are still liable to be reflected in the set situation. It is his *positive interest* that becomes too wide for the setting.

I find that therapeutic work can be done in this set situation although it is not my object in this paper to trace the therapeutic possibilities of this work. I give a case that I published in 1931, in which I committed myself to the belief that such work could be done. In the intervening years I have confirmed my opinion formed then.

> This was the case of a baby girl who had attended from six to eight months on account of feeding disturbance, presumably initiated by infective gastro-enteritis. The emotional development of the child was upset by this illness and the infant remained irritable, unsatisfied, and liable to be sick after food. All play ceased, and by nine months not only was the infant's relation to people entirely unsatisfactory, but also she began to have fits. At eleven months fits were frequent.
>
> At twelve months the baby was having major fits followed by sleepiness. At this stage I started seeing her every few days and giving her twenty minutes' personal attention, rather in the manner of what I now describe as the set situation, but with the infant on my own knee.
>
> At one consultation I had the child on my knee observing her. She made a furtive attempt to bite my knuckle. Three days later I had her again on my knee, and waited to see what she would do. She bit my knuckle three times so severely that the skin was nearly torn. She then played at throwing spatulas on the floor incessantly for fifteen minutes. All the time she cried as if really unhappy. Two days later I had her on my knee for half-an-hour. She had had four convulsions in the previous two days. At first she cried as usual. She again bit my knuckle very severely, this time without showing guilt feelings, and then she played the game of biting and throwing away spatulas. While on my knee she became able to enjoy play. After a time she began to finger her toes.

Later the mother came and said that since the last consultation the baby had been 'a different child'. She had not only had no fits, but had been sleeping well at night – happy all day, taking no bromide. Eleven days later the improvement had been maintained, without medicine; there had been no fits for fourteen days, and the mother asked to be discharged.

I visited the child one year later and found that since the last consultation she had had no symptom whatever. I found an entirely healthy, happy, intelligent and friendly child, fond of play, and free from the common anxieties.

The fluidity of the infant's personality and the fact that feelings and unconscious processes are so close to the early stages of babyhood make it possible for changes to be brought about in the course of a few interviews. This fluidity, however, must also mean that an infant who is normal at one year, or who at this age is favourably affected by treatment, is not by any means out of the wood. He is still liable to neurosis at a later stage and to becoming ill if exposed to bad environmental factors. However, it is a good prognostic sign if a child's first year goes well.

DEVIATIONS FROM THE NORMAL

I have said that any variation from that which I have come to regard as the norm of behaviour in the set situation is significant.

The chief and most interesting variation is in the initial hesitation, which may either be exaggerated or absent. One baby will apparently have no interest in the spatula, and will take a long time before becoming aware of his interest or before summoning courage to display it. On the other hand, another will grab it and put it to his mouth in the space of one second. In either case there is a departure from the normal. If inhibition is marked there will be more or less distress, and distress can be very acute indeed.

In another variation from the norm an infant grabs the spatula and immediately throws it on the floor, and repeats this as often as it is replaced by the observer.

There is almost certainly a correlation between these and other variations from the norm and the infant's relation to food and to people.

USE OF TECHNIQUE ILLUSTRATED BY A CASE

The set situation which I have described is an instrument which can be adapted by any observer to the observation of any infant that attends his clinic. Before discussing the theory of the infant's normal behaviour in this setting,

I will give one case as an illustration, the case of a baby with asthma. The behaviour of the asthma, which came and went on two occasions while the baby was under observation, would perhaps have seemed haphazard were it not for the fact that the baby was being observed as a routine, and were it not for the fact that the details of her behaviour could be compared with that of other children in the same setting. The asthma, instead of having an uncertain relation to the baby's feelings, could be seen, because of the technique employed, to be related to a certain kind of feeling and to a certain clearly defined stage in a familiar sequence of events.

> Margaret, a seven-months-old girl, is brought to me by her mother because the night before the consultation she has been breathing wheezily all night. Otherwise she is a very happy child who sleeps well and takes food well. Her relations with both parents are good, especially with her father, a night worker, who sees a lot of her. She already says 'Dad-dad', but not 'Ma-ma'. When I ask: 'Whom does she go to when she is in trouble?' the mother says: 'She goes to her father; he can get her to sleep.' There is a sister sixteen months older who is healthy, and the two children play together and like each other, although the baby's birth did arouse some jealousy in the older child.
>
> The mother explains that she herself developed asthma when she became pregnant with this one, when the other was only seven months old. She was herself bad until a month before the consultation, since when she has had no asthma. Her own mother was subject to asthma, she also began to have asthma at the time when she started to have children. The relation between Margaret and her mother is good, and she is feeding at the breast satisfactorily.
>
> The symptom, asthma, does not come entirely unheralded. The mother reports that for three days Margaret has been stirring in her sleep, only sleeping ten minutes at a time, waking with screaming and trembling. For a month she has been putting her fists to her mouth and this has recently become somewhat compulsive and anxious. For three days she has had a slight cough, but the wheeziness only became definite the night before the consultation.
>
> It is interesting to note the behaviour of the child in the set situation. These are my detailed notes taken at the time. 'I stood up a right-angled spatula on the table and the child was immediately interested, looked at it, looked at me and gave me a long regard with big eyes and sighs. For five minutes this continued, the child being unable to make up her mind to take the spatula. When at length she took it, she was at first unable to make up her mind to put it to her mouth, although she quite clearly wanted to do so. After a time she found she was able to take it, as if gradually getting reassured from our staying as we were. On her taking it to herself I noted the usual flow of saliva, and then followed several minutes of enjoyment of

the mouth experience.' It will be noted that this behaviour corresponded to what I call the normal.

'In the second consultation Margaret reached out to take the spatula, but again hesitated, exactly as at the first visit, and again only gradually became able to mouth and to enjoy the spatula with confidence. She was more eager in her mouthing of it than she had been at the previous occasion, and made noises while chewing it. She soon dropped it deliberately and on its being returned played with it with excitement and noise, looking at mother and me, obviously pleased, and kicking out. She played about and then threw down the spatula, put it to her mouth again on its being restored to her, made wild movements with her hands, and then began to be interested in other objects that lay near at hand, which included a bowl. Eventually she dropped the bowl, and as she seemed to want to go down we put her on the floor with the bowl and the spatula, and she looked up at us very pleased with life, playing with her toes and with the spatula and the bowl, but not with the spatula and the bowl together. At the end she reached for the spatula and seemed as if she would bring them together, but she just pushed the spatula right away in the other direction from that of the bowl. When the spatula was brought back she eventually banged it on the bowl, making a lot of noise.'

(The main point in this case relevant to the present discussion is contained in the first part of the description, but I have given the whole case-note because of the great interest that each detail could have if the subject under discussion were extended. For instance, the child only gradually came to the placing of the two objects together. This is very interesting and is representative of her difficulty, as well as of her growing ability in regard to the management of two *people* at the same time. In order to make the present issue as clear as possible I am leaving discussion of these points for another occasion.)

In this description of the baby's behaviour in the set situation, I have not yet said when it was that she developed asthma. The baby sat on her mother's lap with the table between them and me. The mother held the child round the chest with her two hands, supporting her body. It was therefore very easy to see when at a certain point the child developed bronchial spasm. The mother's hands indicated the exaggerated movement of the chest, both the deep inspiration and the prolonged obstructed expiration were shown up, and the noisy expiration could be heard. The mother could see as well as I did when the baby had asthma. *The asthma occurred on both occasions over the period in which the child hesitated about taking the spatula*. She put her hand to the spatula and then, as she controlled her body, her hand and her environment, she developed asthma, which involves an involuntary control of expiration. At the moment when she came to feel confident about the spatula which was at her mouth, when saliva flowed, when stillness changed to the enjoyment of activity and

when watching changed into self-confidence, at this moment the asthma ceased.

A fortnight later the child had had no asthma, except the two attacks in the two consultations.[2] Recently (that is, twenty-one months after the episode I have described), the child had had no asthma, although of course she is liable to it.[3]

Because of the method of observation, it is possible for me to make certain deductions from this case about the asthma attacks and their relation to the infant's feelings. My main deduction is that in this case there was a close enough association between bronchial spasm and anxiety to warrant the postulation of a relationship between the two. It is possible to see, because of the fact that the baby was being watched under known conditions, that for this child asthma was associated with the moment at which there is normally hesitation, and hesitation implies mental conflict. An impulse has been aroused. This impulse is temporarily controlled, and asthma coincides on two occasions with the period of control of the impulse. This observation, especially if confirmed by similar observations, would form a good basis for discussion of the emotional aspect of asthma, especially if taken in conjunction with observations made during the psycho-analytic treatment of asthma subjects.

DISCUSSION OF THEORY

The hesitation in the first place is clearly a sign of anxiety, although it appears normally.

As Freud (1926) said, 'anxiety is *about* something'. There are two things, therefore, to discuss: the things that happen in the body and mind in a state of anxiety, and the something that there is anxiety about.

If we ask ourselves why it is that the infant hesitates after the first impulsive gesture, we must agree, I think, that this is a super-ego manifestation. With regard to the origin of this, I have come to the conclusion that, generally speaking, the baby's normal hesitation cannot be explained by a reference to the parental attitude. But this does not mean that I neglect the possibility that he does so because he has learned to expect the mother to disapprove or even to be angry whenever he handles or mouths something. The parent's attitude *does* make a lot of difference in certain cases.

I have learned to pick out fairly quickly the mothers who have a rooted objection to the child's mouthing and handling objects, but on the whole I can say that the mothers who come to my clinic do not stop what they tend to regard as an ordinary infantile interest. Among these mothers are even some who bring their babies because they have noticed that the infants have *ceased* to grab things and put them to their mouths, recognizing this to be a symptom.

Further, at this tender age before the baby is, say, fourteen months old, there is a fluidity of character which allows a certain amount of the mother's tendency to prohibit such indulgence to be over-ridden. I say to the mother: 'He can do that here if he wants to, but don't actually encourage him to.' I have found that in so far as the children are not driven by anxiety they are able to adjust themselves to this modified environment.

But whether it is or is not the mother's attitude that is determining the baby's behaviour, I suggest that the hesitation means that the infant *expects* to produce an angry and perhaps revengeful mother by his indulgence. In order that a baby shall feel threatened, even by a truly and obviously angry mother, he must have in his mind the notion of an angry mother. As Freud (1926) says: 'On the other hand, the external (objective) danger must have managed to become internalized if it is to be significant for the ego.'

If the mother has been really angry and if the child has real reason to expect her to be angry in the consultation when he grabs the spatula, we are led to the infant's apprehensive fantasies, just as in the ordinary case where the child hesitates in spite of the fact that the mother is quite tolerant of such behaviour and even expects it. The 'something' which the anxiety is about is in the infant's mind, an idea of potential evil or strictness, and into the novel situation anything that is in the infant's mind may be projected. When there has been no experience of prohibition, the hesitation implies conflict, or the existence in the baby's mind of a *fantasy* corresponding to the other baby's *memory* of his really strict mother. In either case, as a consequence, he has first to curb his interest and desire, and he only becomes able to find his desire again in so far as his testing of the environment affords satisfactory results. I supply the setting for such a test.

It can be deduced, then, that the 'something' that the anxiety is about is of tremendous importance to the infant. To understand more about the 'something' it will be necessary to draw on the knowledge gained from the analysis of children between two and four years old. I mention this age because it has been found by Melanie Klein, and I think by all who have analysed two year-olds, that there is something in the experience of such analyses which cannot be got from the analyses of even three-and-a-half- and four-year-old children, and certainly not from the analyses of children in the latency period. One of the characteristics of a child at the age of two is that the primary oral fantasies, and the anxieties and defences belonging to them, are clearly discernible alongside secondary and highly elaborated mental processes.

The idea that infants have fantasies is not acceptable to everyone, but probably all of us who have analysed children at two years have found it necessary to postulate that an infant, even an infant of seven months like the asthma baby whose case I have already quoted, has fantasies. These are not yet attached to word-presentations, but they are full of content and rich in emotion, and it can be said that they provide the foundation on which all later fantasy life is built.

These fantasies of the infant are concerned not only with external environment, but also with the fate and interrelationship of the people and bits of people that are being fantastically taken into him – at first along with his ingestion of food and subsequently as an independent procedure – and that build up the inner reality. A child feels that things inside are good or bad, just as outside things are good or bad. The qualities of good and bad depend on the relative acceptability of aim in the taking-in process. This in turn depends on the strength of the destructive impulses relative to the love impulses, and on the individual child's capacity to tolerate anxieties derived from destructive tendencies. Also, and connected with both of these, the nature of the child's defences has to be taken into account, including the degree of development of his capacity for making reparation. These things could be summed up by saying that the child's ability to keep alive what he loves and to retain his belief in his own love has an important bearing on how good or bad the things inside him and outside him feel to him to be; and this is to some extent true even of the infant of only a few months. Further, as Melanie Klein has shown, there is a constant interchange and testing between inner and outer reality; the inner reality is always being built up and enriched by instinctual experience in relation to external objects and by contributions from external objects (in so far as such contributions can be perceived); and the outer world is constantly being perceived and the individual's relationship to it being enriched because of the existence in him of a lively inner world.

The insight and conviction gained through the analysis of young children can be applied backwards to the first year of life, just as Freud applied what he found in adults to the understanding of children, and to the understanding not only of the particular patient as a child, but of children in general.

It is illuminating to observe infants directly, and it is necessary for us to do so. In many respects, however, the analysis of two-year-old children tells us much more about the infant than we can ever get from direct observation of infants. This is not surprising; the uniqueness of psycho-analysis as an instrument of research, as we know, lies in its capacity to discover the *unconscious* part of the mind and link it up with the conscious part and thus give us something like a full understanding of the individual who is in analysis. This is true even of the infant and the young child, though direct observation can tell us a great deal if we actually know how to look and what to look for. The proper procedure is obviously to get all we can both from observation and from analysis, and to let each help the other.

I now wish to say something about the physiology of anxiety. Is it not holding up the development of descriptive psychology that it is seldom, if ever, pointed out that the physiology of anxiety cannot be described in simple terms, for the reason that it is different in different cases and at different times? The teaching is that anxiety may be characterized by pallor and sweating and vomiting and diarrhoea and tachycardia. I was interested to find in my clinic, however, that there are really several alternative manifestations of anxiety,

whatever organ or function is under consideration. An anxious child during physical examination in a heart clinic may have a heart that is thumping, or at times almost standing still, or the heart may be racing away, or just ticking over. To understand what is happening when we watch these symptoms I think we have to know something about the child's feelings and fantasies, and therefore about the amount of excitement and rage that is admixed, as well as the defences against these.

Diarrhoea, as is well known, is not always just a matter of physiology. Analytic experience with children and adults shows that it is often a process accompanying an unconscious fear of definite things, things inside that will harm the individual if kept inside. The individual may know he fears impulses, but this, though true, is only part of the story, because it is also true that he unconsciously fears specific bad things which exist somewhere for him. 'Somewhere' means either outside himself or inside himself – ordinarily, both outside and inside himself. These fantasies may, of course, in certain cases and, to some extent, be conscious, and they give colour to the hypochondriac's descriptions of his pains and sensations.

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If we are examining the hesitation of an infant in my set situation, we may say that the mental processes underlying the hesitation are similar to the ones that underlie diarrhoea, though opposite in their effect. I have taken diarrhoea, but I might have taken any other physiological process which can be exaggerated or inhibited in accordance with the unconscious fantasy that happens to affect the particular function or organ. In the same way, in consideration of the hesitation of the infant in the set situation, it can be said that even if the baby's behaviour is a manifestation of fear, there is still room for the description of the same hesitation in terms of unconscious fantasy. What we see is the result of the fact that the infant's impulse to reach out and take is subjected to control even to the extent of temporary denial of the impulse. To go further and to describe what is in the infant's mind cannot be a matter of direct observation, but, as I have said, this does not mean that there is nothing in the infant's mind corresponding to the unconscious fantasy which through psycho-analysis we can prove to exist in the mind of an older child or of an adult who hesitates in a similar situation.

In my special case, given to illustrate the application of the technique, control includes that of the bronchial tubes. It would be interesting to discuss the relative importance of the control of the bronchus as an organ (the displacement of control, say, of the bladder) and control of expiration or of the breath that would have been expelled if not controlled. The breathing out might have been felt by the baby to be dangerous if linked to a dangerous idea – for instance, an idea of reaching *in* to take. To the infant, so closely in touch with his mother's body and the contents of the breast, which he actually takes, the idea of reaching in to the breast is by no means remote, and fear of reaching in

to the inside of mother's body could easily be associated in the baby's mind with not breathing.[4]

It will be seen that the notion of a dangerous breath or of a dangerous breathing or of a dangerous breathing organ leads us once more to the infant's fantasies.

I am claiming that it could not have been purely by chance that the infant gained and lost asthma so clearly in relation to the control of an impulse on two separate occasions, and that it is therefore very much to the point if I examine every detail of the observations.

Leaving the special case of the asthma infant and returning to the normal hesitation of a baby in taking the spatula, we see that the danger exists in the infant's mind and can only be explained on the supposition that he has fantasies or something corresponding to them.

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Now, what does the spatula stand for? The answer to this is complex because the spatula stands for different things.

That the spatula can stand for a breast is certain. It is easy to say that the spatula stands for a penis, but this is a very different thing from saying it stands for a breast, because the baby who is always familiar with either a breast or a bottle has very seldom indeed any real knowledge based on experience of an adult penis. In the vast majority of cases a penis must be the infant's fantasy of what a man might have. In other words, we have said no more by calling it a penis than that the infant may have a fantasy that there is something like a breast and yet different because it is associated more with father than with mother. The child is thought to draw on his or her own genital sensations and on the results of self-exploration in the construction of fantasy.

However, I think the truth is that what the baby later knows to be a penis, he earlier senses as a quality of mother, such as liveliness, punctuality at feed times, reliability and so on, or else as a thing in her breast equated with its sticking out or its filling up, or in her body equated with her erect posture, or a hundred other things about her that are not essentially herself. It is as if, when a baby goes for the breast and drinks milk, in fantasy he puts his hand in, or dives into, or tears his way into his mother's body, according to the strength of the impulse and its ferocity, and takes from her breast whatever is good there. In the unconscious this object of the reaching impulse is assimilated to what is later known as penis.

Besides standing for breast and penis, the spatula also stands for people, observation having clearly shown that the four-to-five-months infant may be able to take in persons as a whole, through the eyes, sensing the person's mood, approval or disapproval, or distinguishing between one person and another.[5]

I would point out that in the explanation of the period of hesitation by reference to actual experience of mother's disapproval, an assumption is being made that this infant is normal or developed enough to take in persons as a

whole. This is by no means always true, and some infants who seem to show an interest in and a fear of the spatula nevertheless are unable to form an idea of a whole person.

Everyday observation shows that babies from an age certainly less than the age-group we are discussing (five to thirteen months) ordinarily not only recognize people, but also behave differently towards different people.

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In the set situation the infant who is under observation gives me important clues to the state of his emotional development. He may only see in the spatula a thing that he takes or leaves, and which he does not connect with a human being. This means that he has not developed the capacity, or he has lost it, for building up the whole person behind the part object. Or he may show that he sees me or mother behind the spatula, and behave as if this were part of me (or of mother). In this case, if he takes the spatula, it is as if he took his mother's breast. Or, finally, he may see mother and me and think of the spatula as something to do with the relation between mother and myself. In so far as this is the case, in taking or leaving the spatula he makes a difference to the relationship of two people standing for father and mother.

There are intermediate stages. For instance, some infants obviously prefer to think of the spatula as related to the bowl, and they repeatedly take it out of the bowl and replace it with evident interest and pleasure and perhaps excitement. They seem to find an interest in two objects simultaneously more natural than an interest in the spatula as a thing that can be taken from me, fed to mother, or banged on to the table.

Only the actual observations can do justice to the richness of variation that a number of infants introduce into the simple setting which can so easily be provided.

The infant, if he has the capacity to do so, finds himself dealing with two persons at once, mother and myself. This requires a degree of emotional development higher than the recognition of one whole person, and it is true indeed that many neurotics never succeed in managing a relation to two people at once. It has been pointed out that the neurotic adult is often capable of a good relation with one parent at a time, but gets into difficulties in his relationship with both together. This step in the infant's development, by which he becomes able to manage his relationship to two people who are important to him (which fundamentally means to both his parents), at one and the same time, is a very important one, and until it is negotiated he cannot proceed to take his place satisfactorily in the family or in a social group. According to my observations this important step is first taken within the first year of life.

Before he is one year old the infant may feel that he is depriving others of things that are good or even essential because of the greed roused by his love. This feeling corresponds to his fear, which may easily be confirmed by

experience, that when he is deprived of the breast or bottle and of his mother's love and attention, someone else enjoys more of her company. Actually this may be father, or a new baby. Jealousy and envy, essentially oral in their first associations, increase greed but also stimulate genital desires and fantasies, thus contributing to an extension of libidinal desires and of love, as well as of hatred. All these feelings accompany the infant's first steps in establishing a relation to both parents – steps which are also the initial stages of his Oedipus situation, the direct and the inverted one. The conflict between love and hatred and the ensuing guilt and fear of losing what is loved, first experienced in relation to the mother only, is carried further into the infant's relation to both parents and very soon to brothers and sisters as well. Fear and guilt stirred by the infant's destructive impulses and fantasies (to which experiences of frustration and unhappiness contribute) are responsible for the idea that if he desires his mother's breast too much he deprives father and other children of it, and if he desires some part of his father's body which corresponds to mother's breast, he deprives mother and others of it. Here lies one of the difficulties in the establishment of a happy relation between a child and both parents. I cannot deal with the complicated matter of the interplay of the child's greed and the different ways he has of controlling this greed or of counteracting its results by restoring and reconstructing, but it can readily be seen that these things become complicated where the child's relationship is to two persons instead of to mother alone.

It will be remembered that in my case-note of the infant with asthma, I referred to the relation between the child's growing ability to bring the spatula and the bowl together at the end of her game, and the mixtures of wishes and fears in regard to the management of a relation to two people at once.

Now this situation, in which the infant hesitates as to whether he can or cannot satisfy his greed without rousing anger and dissatisfaction in at least one of the two parents, is illustrated in the set situation of my observations in a way that is plain for all to see. In so far as the baby is normal, one of the main problems before him is the management of two people at once. In this set situation I seem sometimes to be the witness of the first success in this direction. At other times I see reflected in the infant's behaviour the successes and failures he is having in his attempts to become able to have a relation to two people at once at home. Sometimes I witness the onset of a phase of difficulties over this, as well as a spontaneous recovery.[6]

It is as if the two parents allow the infant gratification of desires about which he has conflicting feelings, tolerating his expression of his feelings about themselves. In my presence he cannot always make use of my consideration of his interests, or he can only gradually become able to do so.

The experience of daring to want and to take the spatula and to make it his own without in fact altering the stability of the immediate environment acts as a kind of object-lesson which has therapeutic value for the infant. At the age which we are considering and all through childhood such an experience is

not merely temporarily reassuring: the cumulative effect of happy experiences and of a stable and friendly atmosphere round a child is to build up his confidence in people in the external world, and his general feeling of security. The child's belief in the good things and relationships inside himself is also strengthened. Such little steps in the solution of the central problems come in the everyday life of the infant and young child, and every time the problem is solved something is added to the child's general stability, and the foundation of emotional development is strengthened. It will not be surprising, then, if I claim that in the course of making my observations I also bring about some changes in the direction of health.

Whole Experiences

What there is of therapeutics in this work lies, I think, in the fact that the *full course of an experience is allowed*. From this one can draw some conclusions about one of the things that go to make a good environment for the infant. In the intuitive management of an infant a mother naturally allows the full course of the various experiences, keeping this up until the infant is old enough to understand her point of view. She hates to break into such experiences as feeding or sleeping or defaecating. In my observations I artificially give the baby the right to complete an experience which is of particular value to him as an object-lesson.

In psycho-analysis proper there is something similar to this. The analyst lets the patient set the pace and he does the next best thing to letting the patient decide when to come and go, in that he fixes the time and the length of the session, and sticks to the time that he has fixed. Psycho-analysis differs from this work with infants in that the analyst is always groping, seeking his way among the mass of material offered and trying to find out what, at the moment, is the shape and form of the thing which he has to offer to the patient, that which he calls the interpretation. Sometimes the analyst will find it of value to look behind all the multitude of details and to see how far the analysis he is conducting could be thought of in the same terms as those in which one can think of the relatively simple set situation which I have described. Each interpretation is a glittering object which excites the patient's greed.

NOTE ON THE THIRD STAGE

I have rather artificially divided the observations into three stages. Most of my discussion has concerned the first stage and the hesitation in it which denotes conflict. The second stage also presents much that is of interest. Here the infant feels that he has the spatula in his possession and that he can now bend it to his will or use it as an extension of his personality.[7] In this paper I am not

developing this theme. In the third phase the infant practises ridding himself of the spatula, and I wish to make a comment on the meaning of this.

In this the third phase he becomes brave enough to throw the spatula down and to enjoy ridding himself of it, and I wish to show how this seems to me to relate to the game which Freud (1920) described, in which the boy mastered his feelings about his mother's departure. For many years I watched infants in this setting without seeing, or without recognizing, the importance of the third stage. There was a practical value for me in my discovery of the importance of this stage, because whereas the infant who is dismissed in the second stage is upset at the loss of the spatula, once the third stage has been reached the infant can be taken away and can leave the spatula behind him without being made to cry.

Although I have always known Freud's description of the game with the cotton-reel and have always been stimulated by it to make detailed observations on infant play, it is only in more recent years that I have seen the intimate connection between my third phase and Freud's remarks.

It now seems to me that my observations could be looked at as an extension backwards of this particular observation of Freud's. I think the cotton-reel, standing for the child's mother, is thrown away to indicate a getting rid of the mother because the reel in his possession had represented the mother *in his possession*. Having become familiar with the full sequence of incorporation, retention, and riddance, I now see the throwing-away of the cotton-reel as a part of a game, the rest being implied, or played at an earlier stage. In other words, when the mother goes away, this is not only a loss for him of the externally real mother but also a test of the child's relation to his *inside* mother. This inside mother to a large extent reflects his own feelings, and may be loving or terrifying, or changing rapidly from one attitude to the other. When he finds he can master his relation to his inside mother, including his aggressive riddance of her (Freud brings this out clearly), he can allow the disappearance of his *external* mother, and not too greatly fear her return.

In particular I have come to understand in recent years (applying Melanie Klein's work) the part played in the mind even of the infant by the fear of the loss of the mother or of both parents as valuable internal possessions. When the mother leaves the child he feels that he has lost not only an actual person, but also her counterpart in his mind, for the mother in the external world and the one in the internal world are still very closely bound up with each other in the infant's mind, and are more or less interdependent. The loss of the internal mother, who has acquired for the infant the significance of an inner source of love and protection and of life itself, greatly strengthens the threat of loss of the actual mother. Furthermore, the infant who throws away the spatula (and I think the same applies to the boy with the cotton-reel) does not only get rid of an external and internal mother who has stirred his aggression and who is being expelled, and yet can be brought back; in my opinion he also externalizes an internal mother whose loss is feared, so as to demonstrate to himself that

this internal mother, now represented through the toy on the floor, has not vanished from his inner world, has not been destroyed by the act of incorporation, is still friendly and willing to be played with. And by all this the child revises his relations with things and people both inside and outside himself.

Thus one of the deepest meanings of the third phase in the set situation is that in it the child gains reassurance about the fate of his internal mother and about her attitude; a depressed mood which accompanies anxiety about the internal mother is relieved, and happiness is regained. These conclusions could, of course, never be arrived at through observation only, but neither could Freud's profound explanation of the game with the cotton-reel have been arrived at without knowledge gained through analysis proper. In the play-analyses of young children we can see that the destructive tendencies, which endanger the people that the child loves in external reality, and in his inner world, lead to fear, guilt, and sorrow. Something is missing until the child feels that by his activities in play he has made reparation and revived the people whose loss he fears.

SUMMARY

In this paper I have tried to describe a way by which infants can be observed objectively, a way based on the objective observation of patients in analysis and at the same time related closely to an ordinary home situation. I have described a set situation, and have given what I consider to be a normal (by which I mean healthy) sequence of events in this set situation. In this sequence there are many points at which anxiety may become manifest or implied, and to one of these, which I have called the moment of hesitation, I have drawn special attention by giving a case of a seven-months-old baby girl who developed asthma twice at this stage. I have shown that the hesitation indicates anxiety, and the existence of a super-ego in the infant's mind, and I have suggested that infant behaviour cannot be accounted for except on the assumption that there are infant fantasies.

Other set situations could easily be devised which would bring out other infantile interests and illustrate other infantile anxieties. The setting which I describe seems to me to have the special value that any physician can use it, so that my observations can be confirmed or modified, and it also provides a practical method by which some of the principles of psychology can be demonstrated clinically, and without causing harm to patients.

Notes

1. Based on a paper read before the British Psycho-Analytical Society, 23 April 1941, and published the same year in the *International Journal of Psychoanalysis* 22 (1941).
2. But the mother had re-developed it.

3. The mother again rather made a point that she, however, had been having asthma, as if she felt she had to have it unless the baby had it.
4. At the sight of something particularly wonderful we sometimes say, 'It takes my breath away'. This and similar sayings, which include the idea of modification of the physiology of breathing, have to be explained in any theory of asthma that is to command respect.
5. As Freud showed, the cotton-reel stood for the mother of the eighteen-months-old boy.
6. I have watched from start to finish a fortnight's illness in a nine-months-old infant girl. Accompanying earache, and secondary to it, was a psychological disturbance characterized not only by a lack of appetite but also by a complete cessation of handling and mouthing of objects at home. In the set situation the child had only to see the spatula to develop acute distress. She pushed it away as if frightened of it. For some days in the set situation there seemed to be acute pain as if indicating acute colic instead of what is normally hesitation, and it would have been unkind to have kept the child for long at a time in this painful situation. The earache soon cleared up, but it was a fortnight before the infant's interest in objects became normal again. The last stage of the recovery came dramatically when the child was with me. She had become able to catch hold of the spatula and to make furtive attempts to mouth it. Suddenly she braved it, fully accepted it with her mouth and dribbled saliva. Her secondary psychological illness was over and it was reported to me that on getting home she was found to be handling and mouthing objects as she had done before her illness started.
7. See Chapter 5. [*In Through Paediatrics to Psycho-Analysis*.]

Developing ideas: inner reality different from external reality and fantasy; manic defence to deal with mother's inner reality; observation of consistent elements; period of hesitation, riddance (throwing away stage); spatula game; play