CHAPTER EIGHT

The contribution of observation of mother-infant interaction and development to the equipment of a psychoanalyst or psychoanalytic psychotherapist[1]

(1976)

This paper develops the parallels indicated in Bick's 1964 paper between the infant observer and the psychoanalytic candidate, in terms of emotional turbulence and observational skills. Given that the analytic transference externalizes infantile relationships and desires, the earliest part-object relationships lie hidden in the patient's narratives; and being able to see the continuing internal infant provides the analyst with a metaphorical language for linking the patient with unconscious areas that are otherwise hard to verbalize. Infant observation teaches the analyst that the process of mother and baby "finding each other" cannot be artificially forced. The author considers problems of identifying with a thinking object, and its converse—the dangers of "societal debate" in producing two-dimensional analysts, and the potential constrictions in the analogous roles of supervisor and mother-in-law. Meltzer's "toilet-breast" is related to the decontaminatory function of the mother in thinking (Bion). The nature of transference and the "central truth" of waiting and tolerating pain without recourse to precipitate action is emphasized and the paper concludes with examples of fluctuating part- and whole-object orientation in an infant and an adult of equivalent "analytic age".

1 Published in *Collected Papers of Martha Harris and Esther Bick* (1987), pp. 225-239. Martha Harris took over Bick's infant observation seminars at the Tavistock in 1967.

Esther Bick's paper in the *International Journal of Psychoanalysis* (1964) described the history of infant observation as initiated by her at the Tavistock Clinic, and as adopted later at the British Institute of Psychoanalysis. It continues to be a valued part of the training of analysts at this Institute, and plays an even more central role in the training of psychoanalytical psychotherapists in the Department of Children and Parents at the Tavistock Clinic. Mrs Bick's paper described the method of observation and the aims in setting up this exercise. She gave indications and examples of what could be observed together with some discussion of the relevance of both the method and the observations made accessible by it, to the work of the psychoanalyst.

One must consider that weekly observation of an infant with his mother in a family throughout the first year or two years, the detailed recording of these observations and the necessary discussion in a small seminar group, take a great deal of time in the training of an analyst or of a therapist. The importance and relevance for a student who may not even be planning to work with children afterwards may be difficult to see, and yet in my experience those students who have undertaken this exercise while being able to discuss their observations in a seminar led by someone who has already undergone this rather rigorous and persevering study, have almost invariably felt it to be a central if not *the* central item in their analytic training. Many have followed it up later by making another series of observations or by participating in discussions of those made by others.

One may ask: is it not possible for a candidate to learn in the course of his personal analysis and from supervision of his cases, everything that he needs to know about the child within the adult, and about the infant within the child? In view of the distinguished analysts, theoreticians and imaginative practitioners who have made their contributions without the benefit of structured infant observation or even of child analysis, one can hardly say that experience of these is essential in the formation of the analyst who intends to work with adults.

However, one can make a case for the view that the development of psychoanalysis is in danger of being choked by too many

theories, and that too much time is spent in societies and in groups, debating these theories from a background of insufficient common experience founded on detailed observation. All too often adherence to theories is dictated by personal loyalty or adherence to analytic pedigrees. In no area are these theories debated more hotly than in that of child development and infant-rearing—in psychoanalysis, as in paediatrics and pedagogy. All the experts know about it and how it should be done; but few are willing to take the trouble to stay long enough with the infant to see how their advice and prescriptions work in practice.

If one approaches psychoanalysis as a science-art concerned with the study and description of phenomena, rather than as an explanatory science which seeks to find the *cause* of mental illness and to offer prescriptions which will teach people how to avoid it, one must regard the enlargement of the capacity for observation as essential to the development of an analyst. Lacking, as he does, a clear map charting the route and a definite goal to focus and funnel attention, the analyst is exposed to uncertainty, confusion, anxiety when bombarded at close quarters by the emotional experience of another person as a mother is bombarded by the emotional state of the infant.

The essential intimacy and nakedness of the analyst-patient, if an analytic process is taking place (the "whitehot experience of the consulting room" as Winnicott once called it), is probably more analogous to the mother-baby relationship than to any other. This can be more easily lost sight of in training analyses or in the debates of psychoanalytical societies, than in child analysis or in work with patients outside the analytic community who have come because they feel ill and are in need of help.

As in psychoanalytic debates with colleagues, so also in the consulting-room: all too often the child is talked *about*, maybe eventually trained to behave in the way that the adults—the psychoanalytic establishment—think is appropriate. This tends to produce the well-adjusted child, the "well-analysed" candidate; allowing unexperienced, uncomprehended and therefore unintegrated parts of the self to be split off and projected elsewhere (the other family, the other group), taking with them some of the potential strength and richness of the personality.

If we look at the role of the observer in infant observation, we can consider how learning to become an observer may help in learning to become a psychoanalyst (a process that continues long after qualification). Close observation of a mother and young baby is an emotional experience which requires mental work if it is to be thought about rather than reacted to. The tendency to project one's own unconscious infantile desires and dreads into the situation between the mother and baby is ubiquitous. If one does not come close enough for the relationship to have an impact, many details will be missed and the quality of the learning impaired. On the other hand, in order not to be drawn into action—into acting out the anxieties evoked instead of containing them by reflection—one must find a sufficiently distanced position to create a mental space for observing what is happening in oneself, as well as in the mother and baby. If one takes up the detached stance of an experimenter looking through a microscope in a laboratory one is likely to disquiet the mother and to impose an extra burden upon her, as of course many an observer fears to do when first beginning his visits.

One must find one's way to a position with the mother from which one can be friendly, receptive, and willing to forego judgemental attitudes, explicit or implicit; taking an uncritical interest in whatever she wants to confide about the baby or about her own feelings in dealing with him. This may involve learning to bear the projection of a good deal of anxiety, and to restrain the impulse to rush in and relieve with advice or support in action. One has in fact to restrain therapeutic zeal, while making a human response which indicates to the mother than one can appreciate her feelings without criticizing or colluding. The state of inward suspension of judgement, of "negative capability" (so aptly quoted by Bion from Keats), is indeed a precondition for learning from experience. It is also achieved more easily through experience which teaches one humility by revealing the fallibility of one's omniscient preconceptions.

By exchanging experiences in a seminar discussion group one learns that one has to respond to each mother as an individual, and also to notice the effect which one's own presence, conversation and acts may be having upon her; also to recognise the transference

of infantile expectations and fears from her to the observer. Those observers who are in analysis have the opportunity of sorting out their own countertransference feelings there; much as candidates, while learning to work with patients, may also get help in clarifying their states of mind in this way. Nevertheless each observer's particular problems in finding a useful stance that potentiates a friendly non-intrusive relationship is usefully discussed and shared in the seminar where the observations are being discussed. The private psychopathology of each individual observer is a matter for his analysis or self-analysis, but the problems of understanding the projections and provocations to action through countertransference reactions to the baby's or the mother's distress are to some extent common to all, and can be shared learning experiences.

Inevitably the observer discovers that he approaches the observation with certain preconceptions and implicit, if not explicit, theories of how babies should be treated, accompanied by a tendency to criticize the mother. These may be defended against by an idealization of the particular mother-baby relationship, especially as presented to the seminar group in an atmosphere of competition with other observers' couples: "How well my mother and baby are getting along." One has heard the same sounds frequently from analysands in a state of idealized projective identification with "their" analyst. Again these tendencies are discussed in a general way in the seminar as phenomena that are evoked by closeness to the most primitive infantile emotions. Attention to the details of the observation presented, and discussion of their possible implications, is also then likely to bring out hitherto unapprehended aspects of the situation which may assist the observer towards recalling further details which he did not realize he had noticed at the time.

Discussion of the observations in a seminar can have much the same function as a clinical discussion or supervision of a patient, if one is encouraging the candidate to recall all the details he did not understand. By trying to reconstruct the muddle he was in at different periods in the session he is reporting, the candidate or observer is helped to reconstruct with hindsight some possible meaningful patterns in this muddle. A candidate who is able to tolerate his muddle and to share it with the supervisor is much more

likely to derive benefit from the supervision than one who presents a polished performance that leaves no room for further questions. An observer who has really come to learn how a baby grows and who becomes increasingly interested in the complexity of its development, is likely to reinforce the mother's interest in her baby and to encourage her to value her capacity to understand him as well as to perform services for him. The presentation of observations in a seminar and the sharing of unique yet similar experiences of emotional involvement can greatly help each observer in his own weekly visits to the family of the infant of his particular study, to participate in a more unselfconscious way in its atmosphere and to learn from his own countertransference. In order to make the best of the situation he must allow himself to *feel*, but needs to *think* about his feelings in order to restrain himself from acting them.

These points have an obvious immediate relevance to the student who is learning to become a psychoanalyst. In the consulting-room he will be in a sequestered observational situation where, if he can learn to bring this attitude of emotional receptivity, he will receive not only the confidences of the patients but also increasingly the projections of the more primitive infantile parts of the patient's personality. In work with adults one can so much more easily be misled by the *apparent* meaning of the words than in work with children. This applies particularly to the training analysis. And as an adult, especially as one aspiring to treat disorders in other people, one tends to become rather clever at learning *about* more vulnerable or nastier parts of one's personality: to develop a facility to talk about them in oneself as well as in others in a way that keeps them at arm's length.

The infant-observer attitude helps the aspiring analyst to take not only the words, but also the details of the patient's total demeanour and behaviour into account: to read between the words and to discern the nature of the experience which is being conveyed or avoided. It can help him to wait until he gathers from his own response to the patient some intuition of what may be happening. If he cannot bear this period of uncertainty and confusion he is likely to pre-empt the emergence of the emotional experience in the patient by explaining it first. As many an infant/mother observer has noted, books on child development can be a

comfort to an inexperienced mother, but one which can also come between her and a direct experience of pondering about the child. Maybe there are times when, as an analyst or a candidate, one does need the comfort and protection of well-tried theories and learned interpretations, or simply to rely upon the rules; but it is useful to be able to notice when one is doing this too mechanically.

The observer may learn from his own experience and from watching the mother's reactions to the first few weeks of the baby's life, how painful it is to stay with the recognition that something as helpless as a young infant—helpless in the way that a young animal is not—does experience intense anxiety and does have a mental life. Unlike small animals, babies can do little about their bodily needs and discomforts; they have to suffer the pain of waiting until help comes. Their pain is relieved not only by their bodily needs being met, but through understanding, social contact, love.

If we understand the analytic transference as a process of externalising infantile relationships and desires, then the opportunity of following historically from week to week the growth of the infant's relationships—the way in which he utilizes his developing capacities within the context of those relationships to make sense of his world, the phantasies he weaves about the stimuli which impinge upon him from within and from without—undoubtedly adds to the analyst's sensitivity to the quality and movement of that transference. Observation during the first six months for instance affords an opportunity to study how the infant's object relationships begin, by the baby relating unintegrated parts of himself to parts of the mother. It brings home what we all know and talk about fairly glibly: the reality that emotions at the most primitive level are rooted in bodily states and sensations located in particular parts of the body, sensations that are educated and achieve meaning through the mother's emotional responses.

This has an obvious relevance to the understanding of psychosomatic symptoms in patients. It may also help one to understand how, hidden in the presentation of narratives about people in patients' material, is concealed another layer of meaning concerned with the earliest part-object relationships, centrally the combination of nipple and breast: the giving-withholding-organizing, receptive-comforting-indulgent qualities of the primary object.

For although obviously it has been possible to help and for that matter "cure" many patients without reference explicitly to the first year of life, we are dealing with people whose psychopathology—whatever its alter intensification or crystallization—almost certainly has its origins to a greater or lesser extent in that early period. The richer the opportunities we have to observe and think about this period, the more likely are we to be able to talk to a patient about these unconscious areas in evocative metaphorical terms which help him to link with them in a meaningful way; the more likely are we to perceive the operation of infantile phantasies in patients as phenomena to be described, rather than to try to work from some abstract idea of their existence.

Let us, for instance, consider the education of one's capacity to utilise the countertransference to perceive the quality of the emotion or lack of emotion in a patient's verbal communications; the meaning or lack of meaning. The work of Esther Bick, influenced by following many infant observations, and of Donald Meltzer and others who have followed the development of autistic children, has alerted us to the phenomena of two-dimensional relationships and modes of learning: to imitation of behaviour and copying, as methods of avoiding mental pain which do not lead to the development of the personality. One can see that this two-dimensional way of clinging to external objects and of imitating more grown-up behaviour has its place in the growing up of every infant, and in the life of every adult. One can also see the impoverishment or stunting of development which occurs when this becomes a pervasive defence against emotional experience, more detectable in gross pathology than it is in personalities who behave in an apparently normal way. It is seen in the consulting-room as patients who are behaving as if they were having an analysis, but cleverly avoiding a really distressful experience. One may think of these patients as having a defective internal container or internal breast which would enable them to hold and make use of painful emotions, and therefore of all new experience.

The study of ways in which the infant's experience on a sensual level, with objects in the external world, does or does not become internalized, can throw light on such patients, or upon such states

of mind that at times probably present in every patient. The questions about the conditions that favour or impede introjection in infancy, are applicable to the study of the analytic process—in the course of which one hopes that a patient will be able to internalize a more receptive and a stronger object which will enable him to enlarge his acquaintance with himself, to add to and to think better about the experiences he is having.

In order to be able to utilize meaningfully potential qualities and parts of oneself, these probably do need to be expressed and worked with at an infantile level with someone else. Observation of how the infant needs to be able to express his pain and aggression can help one when analysing both children and adults to take that aggression less personally. For instance, apparent aggression or hostility in words or in behaviour may express on the part of the patient a need to make the analyst *feel* something which he cannot as yet tolerate feeling himself, because he has not developed the equipment for thinking about it. It may be better understood as an evacuation of pain than as a negative act. The "toilet-breast" in analysis, as Meltzer has termed it, appears in the transference as a need for one of the primary functions of the mother, first apprehended by the infant at a part-object level.

Relieving the infant of intolerable discomfort—basically the fear of dying—decontaminating that fear and returning it to the infant in a more assimilable form, can be seen together with nourishing as recurrent primary functions of the mother in the infant's first weeks and months. One can study the outcome in situations where the mother cannot sufficiently tolerate the impact of the projection of primitive anxiety to allow herself to *feel* it, but instead quickly gives a part of herself (the breast), or a substitute—the bottle, a dummy, or later a sweet—to stop the protest. Interpretations, reassurances, can be given in analysis in much the same way: to stop the gradual unfolding or expressing of hitherto unapprehended emotions, which bring with them pain but also the possibility of greater strength and enrichment. Anxious over-activity is one way whereby dependence on external tangible objects is perpetuated, reinforcing the infantile belief that there should always be somewhere a good enough *external* object to take care of one.

The central truth one can learn through one's own experience as an observer, and through observing the development of a mother who is learning to be a mother, is directly applicable to the relationship of the analytic couple. It is more painful to wait, to remain receptive and not cut off, to bear the pain that is being projected, including the pain of one's own uncertainty, than it is to have recourse to precipitate action designed to evacuate that pain and to gain the relief of feeling that one is doing something.

The observer so often feels initially and maybe for a long time that to be present, attentive and interested in situations of distress is not enough; that he must justify his presence by doing something to help. He may be observing a mother who, overwhelmed by anxiety about the baby's helplessness, feels too in those early days that she must always be doing something: giving the breast, giving the dummy, lifting the baby in a way that is consciously designed to stop the pain he is feeling. But what is likely to be conveyed to the infant in this over-busy attention to his bodily needs, is a projection of unassimilated anxiety which confuses and does not help him to distinguish his own emotions from that of the mother. If the anxiety projected by the infant can be thought about by the mother she may not necessarily manage to respond with the degree of understanding required, just as an analyst who tries to understand a patient's communications may indeed manage to achieve but a limited comprehension; but the capacity to continue to try to understand is in itself an encouragement to develop and to identification with a thinking object.

The observer may often find that as the baby grows and thrives the mother's anxiety is lessened, so that she may be able to learn from the baby how to meet his requirements and may understand him better, as she can give herself more time and space for reflection. But the observer will see that it does take time, and that the process of finding each other cannot be hastened by active intervention or teaching by others. The same kind of process may also take place in the establishing of an analytic relationship. Supervisors of anxious candidates could sometimes learn from the persecutions of overactive mothers-in-law (frequent visitors in infant observations) how not to intrude too helpfully between the

untried pair, and how to find a stance that supports and does not undermine the budding analyst.

Through discussion of different mothers and babies one can see how greatly not only mothers, but also babies do differ in temperament; how much in fact certain babies are able to do for themselves in the way of containing anxiety; how well others may be able to convey their needs and to respond rewardingly when these are met, thereby bringing out the latent mothering qualities in the mother. On the other hand, there are those who seem to have a difficult temperament from birth and tend to be discontented, exacting and tyrannical in ways that require infinite thought and tolerance from a mother who may or may not learn to develop these qualities in herself.

These considerations also apply to the patient-analyst relationship. There are some patients whose desire to develop and to become more acquainted with the truth of themselves is so strong that they are able to do a good deal of the work from early on in the analysis; there are others who continually sabotage the work that is done for them and are infinitely more exacting in their requirements.

I shall now give two examples: the first from observation of a baby over a period of fourteen months, the second from the material of a young man who has been in analysis for almost fifteen months. These excerpts are given in the hope of conveying how a background of infant observation can be of assistance in helping one to form a picture of the infantile configuration in the transference.

Baby William

William is a first baby aged fourteen months, born to a young couple who have taken a great interest in his development. He has been breastfed, sucking eagerly from the start. There was a brief disturbance when he was three to four weeks old, when his mother's milk supply dwindled owing to antibiotics she was given for some delayed postnatal infection. At that time William wanted to feed continually, waking up frequently and searching frantically

for the breast. This persisted when the milk supply was evidently quite restored, until the parents decided they must have some sleep and that constant feeding didn't help. His father just held him soothingly and let him continue to cry until he went to sleep. Thereafter he began to sleep again through the night. For some weeks after this crisis, however, following his feed he would push his tongue forward between his lips as if to fill up the hole that had been occupied by the nipple.

His relationship to the breast, and to his mother as she came to be perceived as a more whole object, was characterized by a passionate intensity and involvement, evident also with his father to a lesser extent. Towards other people he tended to show a friendly but cooler interest. From about four months of age he began from time to time to have periods of intense distress during his breastfeeding, usually towards the end when he seemed to be overwhelmed by the realization that it would finish. Also occasionally after the start of a feed he would pull away and seem to scold the breast as if he resented its having been away. Despite these periods the breastfeeding continued for another four months, very enjoyably in the main both for him and for his mother.

During these second four months William began to extend greatly his range of other food, sampling almost everything he saw his parents eating. To begin with, these other foods were tackled with great and indiscriminate avidity, shovelled in with his thumb as if he were too ambitious for their possession to really enjoy them. He approached solid foods as if he were determined to master a task. "He thinks it all comes from his thumb", said his mother.

By the time he was finally weaned from the breast he seemed less avid and more discriminating, able to enjoy the taste of different foods. The importance of his thumb had receded, and instead came a great spurt in his mobility and increased impetus to explore his surroundings. Thumb-sucking began to be replaced by efforts at talking sounds. As a comforter in moments of distress and before going to bed he turned to a small eiderdown which he had had in his cot since birth. He would bury his mouth and his face in this in much the same way that he used to bury his face in the breast. After a period of being intensely addicted to this, he then

gradually seemed to be giving it up in favour of expanding relationships with people, but also intense explorations of objects around him, most especially of handles and light switches. From the early months he had been fascinated by lights going on and off. Now he became obsessed with trying to work them.

Shortly after his first birthday there was a period of minor illnesses in the family, colds and 'flu. At the same time his mother was more deeply occupied than usual in trying to finish a piece of writing she had started before his birth. William resented this, regarded the typewriter as an enemy, and suffered from a prolonged cold himself. He became increasingly re-addicted to his eiderdown, demanding it at all times, even in the bath. He became dilatory and fussy about his food for the first time in his life, unusually fitful in his sleeping and noticeably less friendly and responsive to people. He tended to cling to his mother but was less affectionate and appreciative. He would cling to her clothing in much the same way that he buried his face in the eiderdown, but often he would prefer the eiderdown to either mummy or daddy. The important things about it seemed to be its softness and the fact that it could be picked up, put down, stood on, lain upon, or thrown away, but was always there to hand in the explorations he was making of his environment. He also began to resent at times his nappy being changed and his bottom cleaned, "yelled as if he were being robbed", his mother said.

His parents began to worry that the eiderdown (a real "transitional object") was taking something away from his relationship with people and decided to confine it to its proper place, the cot. The first day that it was removed William became most upset, threw tantrums, behaved piteously, throwing himself on the floor and kissing the carpet and the velvet chair-cover. After a couple of days, with extra attention from his mother, he did not seem to expect it any more and was quite happy to have it only in his cot. His sleeping improved and he became noticeably more friendly to people again, treating them less like mere articles of furniture among the other things in the world which he was so intent upon exploring. In short, what was quite a marked regression to a part-object relationship, centred round the expendable controllable eiderdown, was arrested.

Doctor P

Dr P is a young registrar in his late twenties who began analysis some fifteen months ago, initially rather cautiously to see whether it would help him with his patients. He has become increasingly involved and appreciative of the analytic method. He is a particularly intelligent, conscientious young man of a basically open and friendly personality, but with marked obsessional traits. He has had a privileged but very moral upbringing, admires his very successful father and consciously wishes to work well and honestly himself, but is suspicious of his tendency to be over-clever and pretentious, to rely on his connections rather than his work for advancement. This goes with feelings of regret at never quite making the top grade at sports at which he is very good but not outstanding.

The material of his session at present centres around the impending Christmas holiday which is hitting him quite hard this year. He fluctuates between fear of being depressed, apathetic or disabused of his faith in analysis, and fears that something might happen to the analyst—she has a cold, might have a road accident.

He has five sessions a week. On the Thursday he came with a dream about three international rugger players, one of whom he knows personally, the others more distantly. They are all good scorers and he is not in their class. He becomes annoyed on realizing that his car is due to have an M.O.T. in the Christmas holidays before it can be re-licensed. He is also rather depressed about the condition of his room in the hospital which is used as a dumping-ground for his belongings because he spends most of his spare time in a flat which his girlfriend shares with another girl. This material seemed to have the transference significance of rueful comparison between the infant's incontinent penis and bottom and daddy's potent (goal-scoring) baby-making, mummy-servicing one. Interpretations on these lines seemed acceptable to him.

The next day, Friday, he arrived saying that he could describe a dream he had just had but that it seemed rather foolish to do this without introducing it and going thoroughly into his present state of mind. In the past he has always been pleased and eager to bring dreams and has tended to feel that those sessions to which he brought them have been the most fruitful, those in which he came

closest to having illuminating experiences about himself, so this approach was an unusual one. He managed to spend most of the session talking about this dream as if he were about to give it but could hardly bear to let it go, talking continually yet managing to say practically nothing—pseudo-analysing his motivation for not mentioning it at once.

The withholding of the dream seemed to be connected with the material of the day before: little-boy humiliation at not having daddy's first-class status (the penis and testicles that could keep mummy going), trying to avoid this experience again by evoking curiosity in the analyst in order to convince himself that he has something of value that is not just faeces.

As he continued talking in a desultory frustrating fashion the picture formed in my mind of an infant threatened with weaning from the breast, still struggling and unreconciled to the recognition that he is not it and has not exclusive possession of it; an infant who has recently learned to walk but who is ruefully and recurrently meeting with evidence of his limitations in skill; not yet a walker like daddy, or a talker like his daddy who can entertain and renew mummy, give her babies and perform services that he cannot. This is an infant who is so preoccupied with trying to possess and control his object that he is unable to accept what it has to offer: seated as it were in his high chair playing with his food, while innerly preoccupied with sitting upon the stool in his bottom; provoking his mother to say, "Let's change your nappy and get rid of your stool and then maybe you can get down to eating your dinner."

Description of his behaviour in metaphorical terms something like this brought an amused reaction and finally the withheld dream. The dream was as follows: *There was a sick child with some unspecified illness. After a conference the doctors decided she needed special treatment and sent for a consultant from Melbourne. When he arrived this consultant seemed to have become the analysand himself. But before he could prescribe treatment for the child, it seemed that he had to go into another room, a seminar room in which a group of doctors and nurses were seated round a table presided over by an American woman who was addressing the conference.*

The sick child was associated with a child about whom the analysand had been asked to send a long overdue report which was needed for the next step in her treatment. He had delayed writing the report to a consultant whom he resented for his arrogant ways. The American woman seemed to be the analyst, whom he knows is married to an American [Donald Meltzer]. Presiding over the table she seemed to represent a combined figure of nipple and breast. The *Melbourne* is probably also similar in significance—*born of Meltzer*, whose books he is currently reading—a combination of parents from whom he has to learn how to consult about the child in him that is in need of treatment.

So, like baby William in the face of his anxiety about being unable to switch on the light (the analysis, the breast), to cure both himself and his primary object (the motor car mummy), in the face of his competitiveness with daddy's penis and greater powers, Dr P was retreating to a part-object relationship and substituting a ruminating control over what was essentially a meaningless faecal object for an experience at the breast.

The experience of listening to observations of baby William—almost as old as Dr P's analytic age—was helpful in approaching this analytic material. As already stated these two examples have been chosen, almost randomly, to suggest how one may find that infant observation can aid one to discern and form a vivid picture of infantile behaviour in the consulting-room.