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LA PSYCHIATRIE DE L'ENFANT

DAVID & APPELL
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ÉTUDE DES FACTEURS DE CARENCE AFFECTIVE DANS UNE POUPONNIÈRE [1]

par Myriam DAVID et Geneviève APPELL

INTRODUCTION

Les effets des carences précoces de soins maternels sur le développement de la personnalité ont été décrits et ne sont plus guère contestés.

Ces carences ont été spécialement étudiées chez les enfants séparés de leur mère et placés en institution. De ce fait, des auteurs tels que John Bowlby et ses collaborateurs ont mis l'accent sur le facteur « séparation », alors que d'autres pensent que la séparation importe moins que la carence d'un milieu institutionnel qui n'offre pas à l'enfant des soins équivalents.

Des carences liées à l'absence de la mère, il y a lieu de rapprocher les troubles psychotoxiques décrits par R. Spitz, consécutifs à des relations précoces mère-enfant impropres. Dans le même ordre d'idées, Beata Rank et ses collaborateurs attirent l'attention sur les vicissitudes de la relation mère-enfant chez les enfants à développement atypique : tantôt existe une séparation psychique, la mère étant déprimée, et indifférente à son nourrisson pendant les premiers mois de son existence ; tantôt atteinte d'une psychose, camouflée par des

(1) Cette étude, amorcée pendant l'année 1955-1956 sous les auspices de l'Organisation Mondiale de la Santé, a repris en 1958 grâce à l'aide financière de la *Foundation's Fund for Research in Psychiatry*. Le Conseil d'Administration de l'Association pour le Développement de l'Assistance aux Malades a mis à notre disposition la Pouponnière Amyot et des locaux dans son École d'infirmières et d'assistantes sociales, devenue depuis l'Institut de Service Social.

possibilités d'intellectualisation, la mère offre à son entourage une image de compétence et d'efficacité, tandis que dans une relation symbiotique avec l'enfant essentiellement projective, elle modèle celui-ci à l'image de ses fantasmes psychotiques.

Si tous ces travaux concourent à montrer l'influence néfaste des carences précoces, une diversité d'opinions existe quant à la nature de la « carence » et ceci plus particulièrement en fonction de l'âge de l'enfant.

Pour les psychologues qui se rattachent aux théories pavloviennes, ou aux *learning theories*, ce n'est ni la séparation d'avec la mère, ni l'absence maternelle qui engendrent les troubles, mais l'absence de stimuli adéquats et d'un apprentissage des réponses à ces stimuli.

Les psychanalystes insistent au contraire sur l'importance de la relation précoce mère-enfant, mais ici encore les idées exprimées varient. Pour Anna Freud ce qui importe pendant les premiers mois, c'est plus la satisfaction des besoins que la personne qui y pourvoit, laquelle ne peut être discriminée en tant que telle.

Pour Spitz, la spécificité de la relation mère-enfant s'établit autour de l'âge de 8 mois, signée par l'apparition d'angoisse à la vue de l'étranger et à la séparation d'avec la mère. La relation objectale est précédée d'une relation pré-objectale, à partir de laquelle elle se construit, la mère jouant à ce stade un rôle important par sa façon de communiquer avec son nourrisson.

Winnicot, de son côté, insiste sur le caractère symbiotique irremplaçable de la relation première mère-enfant. La mère est douée d'une sensibilité particulière qui naît et se développe pendant la grossesse, lui permet ensuite de communiquer avec son enfant et de répondre de façon instinctive à ses besoins.

Bowlby met lui aussi l'accent sur la symbiose mère-enfant, mais, s'inspirant des études des ethologues, il se demande s'il n'existe pas des interactions instinctives entre mère et nouveau-né, nécessaires au développement de celui-ci, les conduites innées disparaissant en cas de séparation. L'étude de son collaborateur Antony Ambrose sur « la réponse par le sourire au visage humain » est une contribution à la vérification de cette théorie.

Pour clarifier cette question, il a paru intéressant d'étudier

ce qui se passe lorsque des nourrissons sont séparés de leur mère et élevés en pouponnière pendant les trois premiers mois de leur existence. Quelles sont les conditions de vie offertes à l'enfant, quelle est leur incidence sur la vie des enfants, comment et dans quelle mesure façonnent-elles leur développement, leur comportement ? Existe-t-il, ou peut-on faire naître un début de relation entre infirmière et enfant ? sinon qu'est-ce qui s'y oppose ? Si, au contraire, cela est possible, comment naît et se développe une telle relation, quelle est son incidence sur la vie de l'enfant, que se passe-t-il lorsqu'elle est interrompue et que l'enfant retourne avec sa mère ?

Présentation de l'étude

Pour répondre à ces questions, une étude longitudinale, à court terme, de nourrissons séparés de leur mère dès la naissance a été entreprise. Les enfants sont observés de façon intensive pendant les trois mois de séjour à la pouponnière et au moment de la réunion familiale. Ensuite, ils sont suivis dans leur famille, à un rythme hebdomadaire, puis bi-mensuel, jusqu'à l'apprentissage de la marche et du contrôle sphinctérien ; soit jusque 15 à 18 mois environ. Les enfants sont revus, ultérieurement, aux âges de 2 ans, 2 ans 1/2 et 4 ans. Ces âges ont été choisis, parce que critiques quant à l'acquisition de capacités et fonctions importantes ; et afin de voir comment elles sont intégrées dans le développement de la personnalité de ces enfants.

Une étude pilote a d'abord eu lieu en 1956, elle a porté sur 13 enfants ; 8 dossiers seulement ont été retenus comme valables. Cette étude a permis de décrire le milieu et les soins, puis de décider quels étaient les éléments significatifs du développement et du comportement des enfants qu'il était souhaitable d'observer, la méthode de travail pour y parvenir.

Une nouvelle étude longitudinale, à court terme, portant sur dix autres enfants élevés dans cette pouponnière et observés selon cette méthode, a été alors entreprise ainsi qu'une étude comparative de ces enfants avec dix nourrissons du même âge, recevant un autre type de soins.

L'idée de comparer les enfants de pouponnière avec des enfants élevés dans leur famille, bien que séduisante, n'a pas

été retenue en raison des difficultés auxquelles elle se heurte, entre autres, l'impossibilité d'obtenir un groupe de soins maternels homogènes. Il a paru préférable d'introduire un changement expérimental dans les soins de la pouponnière, changement qui peut être standardisé, mesuré et qui permet de comparer ces soins avec ceux dispensés habituellement dans la pouponnière.

Ayant constaté, au cours de l'étude pilote, trois caractéristiques dominantes des soins de routine : multiplicité et instabilité du personnel auprès d'un enfant, longues périodes de solitude de l'enfant, faible quantité et pauvre qualité de contact social, il a été décidé d'exposer dix enfants à des soins infirmiers intensifs et individualisés au cours desquels ces trois traits ont été modifiés (1).

Une infirmière prend alors en charge les soins de jour de un ou deux enfants à la fois, leur consacrant entièrement son temps de travail, leur donnant le bain le matin et quatre repas sur six. Les jours de congé, une autre infirmière, toujours la même, ayant le même emploi du temps, la remplace. Le premier et dernier biberons (4 heures-21 heures) sont donnés par les infirmières de nuit, dans les mêmes conditions que ceux des enfants recevant les soins de routine.

Ainsi, des conditions de travail ont été créées permettant à l'infirmière de jour et à sa remplaçante d'être stables auprès de l'enfant, de lui consacrer autant de temps qu'elle le juge nécessaire pour lui donner des soins attentifs et affectueux.

Deux catégories d'enfants peuvent donc être comparées : ceux élevés selon la routine de la pouponnière, ceux recevant des soins plus stables, plus individualisés et plus affectifs. En fait, à la suite de l'étude pilote, les soins de routine n'ont pas cessé d'évoluer ; si bien que trois groupes d'enfants sont étudiés dans les pages qui suivent : groupe pilote 1956, groupe routine (A) (1958-1960), groupe expérimental (B) des soins individualisés (1958-1960) comportant pour le moment 8 enfants chacun (2).

(1) Nous n'utilisons pas le terme « soins maternels substitutifs » ne sachant pas dans quelle mesure « les soins infirmiers individualisés » diffèrent des soins maternels. En introduisant de tels soins pour un groupe d'enfants, nous cherchons à faire varier le « milieu » auquel il est exposé dans le sens d'une individualisation des soins : soins donnés surtout par une personne qui répond au mieux aux besoins individuels de « son bébé » tels qu'elle les comprend.

(2) Les groupes A et B doivent être complétés à 10 chacun.

La recherche est en cours. L'état des travaux ne permet pas encore de rapporter les effets des soins sur le développement de la personnalité de l'enfant pendant et après son séjour à la pouponnière. Dans cet article, seule l'étude des facteurs de carence et leur incidence sur la vie de l'enfant sont envisagées. Certes, quelques hypothèses sur les effets possibles des divers facteurs de carence s'imposent, hypothèses qui seront indiquées au passage et qui seront testées ultérieurement en examinant les données relatives au comportement et au développement de l'enfant. Seront envisagées également ci-dessous les tentatives faites pour supprimer les causes de carence, les obstacles rencontrés et leur signification. Nous souhaitons aussi montrer comment la recherche a contribué au perfectionnement des soins infirmiers dans cette pouponnière.

La pouponnière et les familles (1)

Il s'agit d'une pouponnière-école de 20 lits, admettant, en vue de la vaccination par le B.C.G., des enfants âgés de moins d'un an, dont les parents ont (ou ont eu) une atteinte tuberculeuse. L'éloignement du milieu familial est indiqué pour éviter toute chance de contamination pendant la période où s'établit l'allergie. La grande majorité des enfants est séparée de leur mère à la naissance et vient directement de la maternité vers l'âge de 6 à 10 jours. C'est sur ce groupe d'âge que l'étude a été poursuivie. La durée du séjour est de 2 à 3 mois.

Les familles retenues pour l'étude répondent aux conditions suivantes : couple normalement constitué, père et mère au foyer, la mère demeurant au domicile pour prendre soin des enfants ; statut socio-économique et conditions de logement suffisantes pour assurer le bien-être matériel de l'enfant ; absence de perturbations manifestes, médicale, sociale ou psychologique, autres que la tuberculose, les parents étant

(1) Nous voudrions mentionner ici Mlle Klein, directrice de la pouponnière, qui collabore activement à l'étude. Seuls, son esprit de coopération et son intérêt pour l'étude ont rendu celle-ci possible, facilitant la sélection des cas et favorisant au maximum les conditions d'observation. Nous tenons ici à l'en remercier, ainsi que son personnel.

Nous voulons également remercier Mlle David, directrice de l'École d'Infirmières et d'Assistantes sociales ; Mlle Ginet, directrice de l'Institut de Service social ; le Dr Dolfus-Odier et le Dr Georges, pédiatres de la pouponnière, pour leur accueil sympathique.

d'ailleurs guéris au moment de l'étude et capables de s'occuper de l'enfant ; familles installées de façon stable dans la région parisienne.

La pouponnière est un établissement d'un excellent standing. La directrice est une infirmière puéricultrice diplômée. Elle est assistée par une adjointe, infirmière diplômée, et par sept auxiliaires de puériculture. Ce personnel est complété par quatre élèves infirmières : celles-ci font un stage de deux mois, au cours duquel elles travaillent six heures, six jours par semaine.

L'ambiance générale est agréable ; les locaux sont décorés avec goût et simplicité ; les relations interpersonnelles sont harmonieuses. Le personnel est remarquablement stable, ambitieux dans son désir de faire de la pouponnière un établissement modèle.

Il est au courant des problèmes concernant la carence de soins maternels et depuis l'ouverture de la pouponnière s'est assuré la collaboration d'une psychologue, pour la formation du personnel et des élèves ainsi que pour la surveillance du développement des enfants. Un médecin pédiatre surveille leur développement physique et assure la vaccination par le B.C.G. ; il vient régulièrement tous les deux jours et davantage en cas de besoin.

D'une façon générale, les enfants sont en bon état physique, la morbidité des plus réduites. Le développement psychomoteur des enfants est satisfaisant dans l'ensemble.

Dans les pages qui suivent, consacrées à l'étude des facteurs de carence affective, les soins de routine pendant l'étude pilote et pendant l'étude comparative, ainsi que les soins infirmiers individualisés, sont étudiés successivement sous leurs trois caractéristiques dominantes :

1) Nombre d'infirmières et leur stabilité auprès de l'enfant ;
2) Degré d'isolement de l'enfant ;
3) Quantité et qualité du contact social.

I. — NOMBRE D'INFIRMIÈRES ET LEUR STABILITÉ AUPRÈS D'UN ENFANT

L'étude du mouvement des infirmières auprès d'un enfant a été facilitée par l'existence, pour chaque enfant, d'un cahier sur lequel les infirmières notent, à côté de leur signature, l'heure et la nature de leurs interventions (change, température, tétée, etc.).

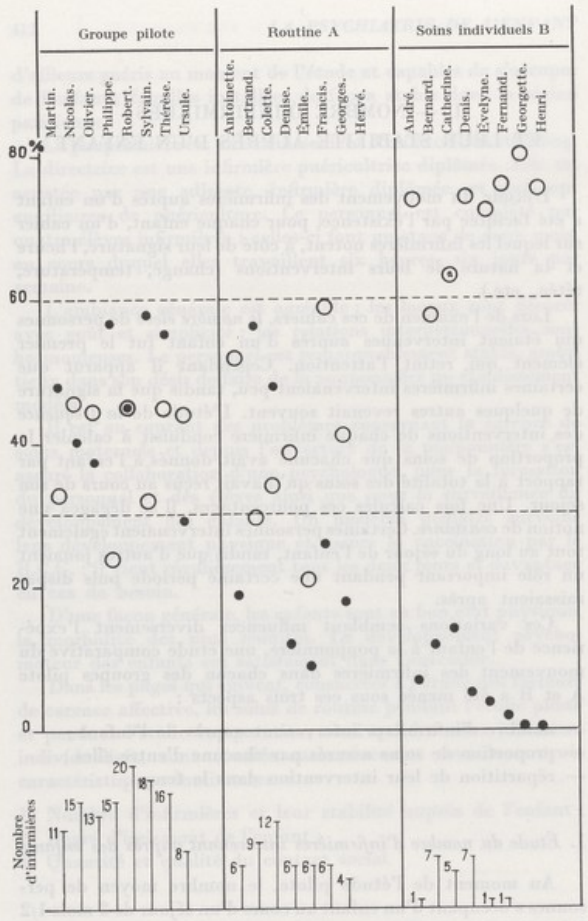
Lors de l'examen de ces cahiers, *le nombre élevé* de personnes qui étaient intervenues auprès d'un enfant fut le premier élément qui retint l'attention. Cependant il apparut que certaines infirmières intervenaient peu, tandis que la signature de quelques autres revenait souvent. L'étude de *la fréquence* des interventions de chaque infirmière conduisit à calculer la proportion de soins que chacune avait donnés à l'enfant par rapport à la totalité des soins qu'il avait reçus au cours de son séjour. Une fois calculés ces pourcentages, il se dégagea une notion de *constance*. Certaines personnes intervenaient également tout au long du séjour de l'enfant, tandis que d'autres jouaient un rôle important pendant une certaine période puis disparaissaient après.

Ces variations semblant influencer diversement l'expérience de l'enfant à la pouponnière, une étude comparative du mouvement des infirmières dans chacun des groupes pilote A et B a été menée sous ces trois aspects :

— nombre d'infirmières intervenant auprès de l'enfant ;
— proportion de soins assurés par chacune d'entre elles ;
— répartition de leur intervention dans le temps.

1. *Étude du nombre d'infirmières intervenant auprès des enfants*

Au moment de l'étude pilote, le nombre moyen de personnes s'occupant d'un enfant au cours d'un séjour de 2 mois 1/2 à 3 mois, était de 25. Ce nombre élevé était dû en partie au fait qu'il s'agissait d'une pouponnière-école, que les stages à cette époque ne duraient qu'un mois, et que pendant les périodes de



GRAPHIQUE I

● % soins par variété d'infirmières ; ○ % soins par D

congé, du personnel de remplacement était embauché. De plus, chaque infirmière et stagiaire prenait la garde de nuit à tour de rôle. Considérant exclusivement les soins de jour, ce nombre N restait assez élevé : 16 en moyenne (10 à 22 selon les cas).

La prise de conscience de ce fait fut une surprise pour tous, y compris les observateurs. L'organisation générale prévoyant qu'une infirmière s'occupait toujours des mêmes 4 enfants, personne n'avait réalisé que tant d'autres personnes soignaient ces enfants en son absence.

L'organisation des soins individualisés pour les enfants du groupe B devait réduire, en principe, à 2 le nombre de personnes assurant les soins de jour d'un enfant de ce groupe. En fait, le tableau I et la partie inférieure du graphique I font apparaître dans quelques cas des interventions de 1 à 7 personnes supplémentaires, dues à l'impossibilité d'instaurer le système à 2 dès l'arrivée de l'enfant à la pouponnière.

En ce qui concerne le groupe routine A, le tableau I et la partie inférieure du graphique I montrent que le nombre moyen N d'infirmières s'occupant des enfants de ce groupe a beaucoup baissé par rapport à celui constaté lors de l'étude pilote : 7 au lieu de 16.

TABLEAU I (1)

Groupe	N	D	*d*	*x*
Pilote (1956)	16 (10 à 22)	39 % (24 à 46 %)	15 %	46 % (24 à 57 %)
Routine A (1958-1960)	7 (4 à 12)	42 % (30 à 52 %)	31 %	27 % (12 à 57 %)
Soins individualisés B (1958-1960)	3 (0 à 7)	69 % (58 à 80 %)	27 % (36 à 17 %)	6 % (0 à 12 %)

(1) N = nombre de personnes s'occupant de l'enfant dans la journée.
D = proportion des soins de jour assurés par l'infirmière principale.
d = proportion des soins de jour assurés par un double.
x = proportion des soins de jour partagés entre une variété d'infirmières.
Les chiffres entre parenthèses indiquent le minima et maxima.

2. *Proportion de soins de jour assurés par chaque infirmière auprès de l'enfant*

Lors de l'étude pilote, chaque infirmière avait déjà des enfants attitrés, dont elle s'occupait en priorité. Cette infirmière dominante (D) assurait en moyenne pour un enfant 39 % des soins de jour, la partie supérieure du graphique I montrant que ce nombre varie de 26 à 46 %. Le plus souvent une autre infirmière (*d*) se dégageait comme ayant donné une proportion appréciable de soins (15 % en moyenne) tandis que les 46 % restants étaient divisés entre les 14 autres infirmières.

Pour les enfants du groupe B, l'organisation des soins individualisés devait permettre à l'infirmière principale D et à son double *d* d'assurer 100 % des soins de jour. Tableau I et graphique I montrent que D assure en moyenne 67 % des soins de jour, *d* : 27 % ; le résidu, soit 6 %, étant assuré dans 5 cas par une troisième infirmière et dans 3 cas par 5 à 7 infirmières.

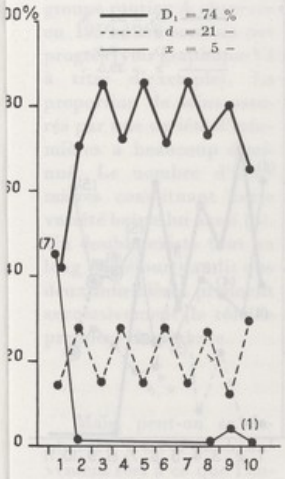
Enfin, pour le groupe A, tableau I et graphique I mettent encore en évidence l'évolution des soins de routine. Si la quantité moyenne de soins de jour assurés par l'infirmière principale ne paraît guère augmentée (42 % au lieu de 39 %), la quantité moyenne des soins donnés par une variété d'infirmières s'abaisse par contre de 46 % à 27 %. Le groupe A se rapproche davantage du groupe B que du groupe pilote sous cet angle ; ceci grâce à l'augmentation de la proportion et de la stabilité de soins assurés par la seconde dominante, *d*.

3. *Répartition des soins dans le temps*

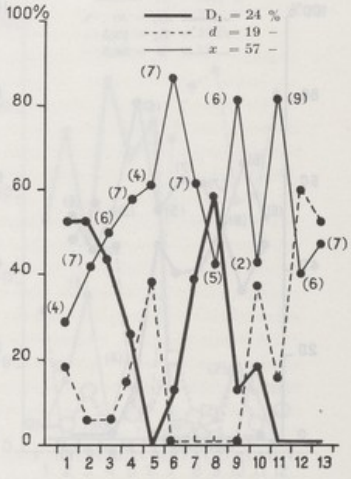
En ce qui concerne le groupe B recevant des soins individualisés, une représentation graphique des soins donnés par D et *d* de semaine en semaine à chaque enfant montre que la stabilité de ces deux infirmières auprès de leurs enfants est grande (voir graphique II à titre d'exemple). Elle montre aussi que c'est au début du séjour que plusieurs infirmières sont amenées à intervenir en plus des deux infirmières responsables, un petit délai ayant existé avant que ne soit établi, et cette fois de façon définitive, le régime à deux.

Pour les enfants du groupe pilote, les graphiques révèlent

une grande irrégularité dans la distribution des soins de semaine en semaine, irrégularité qui donne une allure anarchique à la courbe. Ceci est illustré par le graphique III, bien typique de ce groupe, montrant la disparition de l'infirmière principale ou de son double certaines semaines, alors que d'autres semaines



GRAPHIQUE II. — Denis



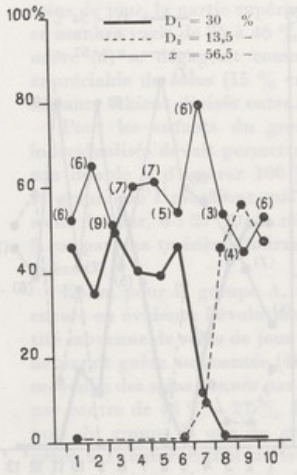
GRAPHIQUE III

elles assurent une proportion importante des soins. A ceci diverses causes : le fait que chaque infirmière à tour de rôle devenait à cette époque infirmière de nuit pour une durée de un mois ; les congés échelonnés tout au long de l'année sont eux aussi responsables de la chute brutale des courbes.

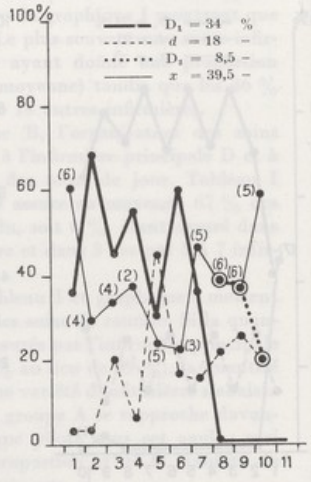
Le groupe routine A, en 1958-1959, sans différer beaucoup du groupe pilote, montre déjà quelque amélioration.

Par exemple, la quantité moyenne de soins de jour donnés à Bertrand par D pendant l'ensemble du séjour est assez faible. 29,5 % seulement (voir graphique I), *d* donnant, elle, 14 %. Cependant, le graphique IV, représentant la répartition des

soins de semaine en semaine, montre que, pendant les 6 premières semaines, D, en fait, assure environ 43 %. Mais elle part en congé au début de la 7e semaine, et c'est alors qu'apparaît *d*, qui, en réalité, n'est pas un double, mais une remplaçante (D′) qui assure elle aussi, pendant les trois dernières



GRAPHIQUE IV. — Bertrand



GRAPHIQUE V. — Colette

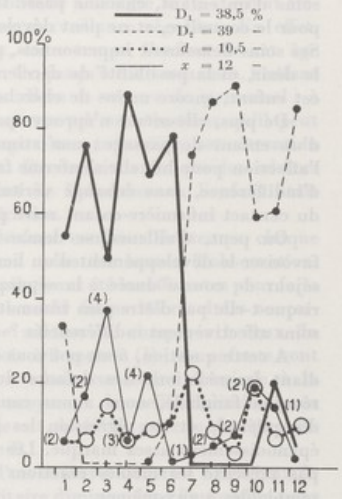
semaines, près de 50 % des soins de jour. En fait, Bertrand a bénéficié de deux dominantes D et D′ qui se sont succédé, assurant, lorsqu'elles étaient là, près de la moitié des soins de jour. Par contre, aucune des deux n'a de double, ce qui explique la proportion de soins, relativement importante, assurés par une variété d'infirmières tout au long du séjour (voir graphique I).

Le graphique V montre que Colette perd, elle aussi, sa première dominante D, à la huitième semaine de son séjour ; par contre il existe tout au long un double (*d*) et le pourcentage des soins donnés par une variété d'infirmières est assez réduit (23 % en moyenne) au début du séjour. Il s'élève

jusqu'à 60 % la dernière semaine, quand disparaît D, insuffisamment remplacée par D′ (voir graphique V).

Ces constatations montrèrent l'intérêt d'établir un système à trois ou quatre qui permet de réduire considérablement la quantité des soins donnés par une variété d'infirmières.

Les soins des enfants du groupe routine A observés en 1959-1960 sont en net progrès (voir graphique VI à titre d'exemple). La proportion de soins assurés par une variété d'infirmières a beaucoup diminué. Le nombre d'infirmières constituant cette variété baisse lui aussi (6). Un double existe tout au long du séjour, tandis que deux infirmières prennent successivement le rôle de première dominante.



GRAPHIQUE VI. — Denise

* * *

Mais, peut-on se demander, y a-t-il un inconvénient réel à ce que l'enfant passe en de multiples mains pendant les trois premiers mois de sa vie ? Peut-il distinguer l'une de l'autre des infirmières qui sont toutes habillées de la même façon et qui le manipulent avec une dextérité qui contribue à uniformiser les soins ?

Les observations faites, depuis l'établissement de soins individualisés, nous mènent à faire les deux remarques suivantes :

a) A partir de l'âge de 8 semaines, les enfants montrent des signes de joie et des réactions plus vives à l'égard d'une infirmière dont la dominance est notable et stable. Il semble donc que l'enfant commence à la connaître et à l'apprécier, alors

qu'il ne distingue pas encore entre elles les personnes qu'il connaît peu. Il y aura lieu de voir si, à cet âge, la disparition de la dominante vers la 8e semaine, comme par exemple pour Denise (graphique VI), affecte l'enfant.

b) Lorsqu'un grand nombre d'infirmières se partage les soins d'un enfant, chacune passe trop peu de temps avec lui pour le connaître, et ne peut développer d'intérêt à son égard. Ses soins demeurent impersonnels, passe-partout, et elle n'a ni le désir, ni la possibilité de déceler les besoins plus propres à cet enfant, encore moins de chercher à y répondre.

De plus, elle-même n'éprouve pas grand plaisir à s'occuper d'un enfant de passage ; non stimulée par de l'intérêt et de l'affection pour lui, elle s'enferme facilement dans une attitude d'indifférence, sans échange véritable avec lui, et la qualité du contact infirmière-enfant reste pauvre.

On peut, d'ailleurs, se demander s'il est souhaitable de favoriser le développement d'un lien infirmière-enfant dans un séjour de courte durée : la séparation d'avec l'infirmière ne risque-t-elle pas d'être plus traumatisante pour l'enfant que des soins affectivement indifférenciés ?

A cette question, nous pouvons seulement répondre qu'étudiant les réactions des enfants du groupe pilote lors de la réunion familiale, nous avons constaté l'existence de signes d'inquiétude et de régression les premiers jours suivis d'un épanouissement assez marqué. Les enfants du groupe B n'ont pas présenté les mêmes réactions de désarroi et sont restés semblables à eux-mêmes.

Ceci conduit à penser que la naissance d'un lien est déjà utile à l'enfant à cet âge. Même s'il ne discrimine pas pleinement la personne en tant que telle, il expérimente pourtant la joie d'un certain type de rapport humain. Ce rapport, il le transfère aisément sur quiconque lui offre des soins analogues et ceci semble lui apporter une sécurité qui supprime l'inquiétude lors du changement de milieu.

Toutefois un complément d'observations est indispensable pour vérifier les idées suggérées par un premier examen de ces données.

II. — LES PÉRIODES DE SOLITUDE

L'étude pilote indique que les enfants en 1956 étaient exposés à de longues périodes de « solitude », malgré le va-et-vient fréquent des infirmières et une surveillance régulière. En effet, les soins étaient rapides, et, entre-temps, l'enfant de cet âge était laissé dans son berceau. Or, jusqu'à 6 à 8 semaines, l'enfant ne semble pas percevoir les allées et venues du personnel ; à partir de 8 semaines, s'il montre par ses réactions qu'il peut entendre ou sentir le passage d'une infirmière, son attention n'est retenue qu'un instant. De ce fait, sans que les adultes aient eu jamais le sentiment de l'abandonner, l'enfant était seul pendant de longues périodes.

Il était intéressant d'évaluer combien de temps chaque enfant restait seul éveillé, au cours des heures d'observation. Les observations du groupe pilote ont été insuffisantes pour faire des calculs valables. Le tableau II donne les résultats concernant les enfants du groupe routine A, comparés à ceux du groupe B, aux âges de 2 mois à 2 mois 8 (1) ; les enfants sont classés dans chaque groupe selon leur ordre d'arrivée à la pouponnière. La quantité moyenne de veille solitaire pour 100 minutes de veille totale est de 67 % pour le groupe routine A, 47 % pour le groupe B.

On note des variations d'un enfant à l'autre à l'intérieur de chaque groupe. La veille solitaire diminue dans l'ensemble pour les enfants du groupe A à partir de 1959. En effet, à partir de 1959, prenant conscience de ces périodes de veille solitaire, les infirmières des soins individualisés, suivies assez rapidement par les infirmières du groupe A, inaugurent de se grouper pour donner les biberons et de garder à leur côté, dans une corbeille ou une petite chaise, l'enfant dont elles ont la charge.

(1) Au cours de la semaine de 2 mois à 2 mois 8, les enfants sont observés en moyenne six demi-journées pendant 3 heures, tantôt le matin, tantôt l'après-midi. Il y a donc en moyenne 1 080 minutes d'observation pour lesquelles nous calculons : temps de veille, temps de sommeil ou de demi-sommeil. A l'intérieur du temps de veille, nous recherchons le temps de veille solitaire, paisible ou agitée, le temps de veille avec contact. C'est à partir de ces données que sont calculés les pourcentages de veille solitaire sur 100 minutes de veille totale.

La semaine de 2 mois à 2 mois 8 a été choisie parce qu'elle correspond à des signes nets d'éveil. Mais, ultérieurement, ces calculs seront établis pour l'ensemble du séjour de chaque enfant.

TABLEAU II

Pourcentage de veille solitaire

	Routine A		Groupe B	
1958			André (Mme V.).....	46 %
			Bernard (Mlle X.)....	51 –
			Catherine (Mlle X.)...	52 –
	Antoinette	78 %		
	Bertrand	82 –		
1959	Colette.....	57 –	Denis (Mlle X.).....	37 –
	Denise	60 –		
	Émile.....	69 –		
	Francis	60 –		
1960			Evelyne (Mlle X.)....	36 –
			Fernand (Mlle X.)....	42 –
	Georges	56 –		
			Georgette (Mlle Z.)...	59 –
	Louis	72 –	Henri (Mlle Z.).....	52 –
	Moyenne	67 %	Moyenne	47 %

Certes, l'enfant dans ces conditions n'est pas en contact direct avec l'infirmière, mais il reçoit, de temps à autre, des marques d'attention, et il est atteint par un plus grand nombre de stimuli visuels et auditifs, qui maintiennent son intérêt éveillé.

De plus, au moment de l'étude pilote, la veille solitaire durait de longues périodes, et n'était interrompue que par le biberon et les soins.

Dans les soins individualisés, des contacts viennent couper les périodes de veille solitaire entre les soins. Ces contacts apparaissent peu dans le groupe A qui sous cet angle demeure semblable au groupe pilote, même pour les derniers enfants observés.

* * *

Quelles sont les conséquences de ces longues périodes de veille solitaire ?

a) Une connaissance insuffisante de l'enfant par l'infirmière. En effet, pendant ces temps de veille solitaire, quantité de choses échappent aux infirmières, telles par exemple : les difficultés de sommeil, les pleurs, les périodes de malaise : il en résulte une ignorance des besoins, qui s'oppose à une individualisation des soins. Ou encore, le bref coup d'œil que l'infirmière jette sur un enfant, en passant, lui donne facilement une idée fausse de l'état dans lequel il se trouve et entraîne des interventions à contre-temps.

De plus, l'enfant est capable de quantité de petits exploits, que l'infirmière ignore et dont elle ne provoque pas, de ce fait, la répétition.

b) Des longues périodes de malaise sans réconfort. Presque chaque enfant connaît au cours de son séjour de longues séquences d'agitation et de pleurs, pendant lesquelles, dans les soins de routine, il ne recevait pas de réconfort de la part de l'adulte. Ces moments de malaise ne surviennent pas tout au long du séjour de l'enfant, mais par périodes ; ils sont peut-être liés au développement, car ils semblent exister aussi bien chez les enfants du groupe B que chez ceux du groupe A. Si intenses et prolongés soient les pleurs pendant quelques jours, l'enfant finit toujours par s'assagir, « s'adapter », quel que soit le groupe auquel il appartienne.

Toutefois, l'observation attentive des enfants en soins de routine au moment de l'étude pilote indique que pour parvenir à cette sagesse, l'enfant, abandonné à lui-même, utilise des moyens dont nous nous demandons s'ils ne sont pas préjudiciables et s'ils n'entament pas en quelque sorte son capital de santé mentale.

Lorsque, en effet, en l'absence de réconfort, les cris atteignent un paroxysme, et que l'enfant paraît débordé par sa rage, de brèves pauses apparaissent, l'enfant étant épuisé. Il semble alors faire des efforts pour prolonger ces intermittences, retenir les pleurs, les « ravaler », utilisant à cet effet des moyens tels que fermer fort la bouche, s'immobiliser en fixant l'espace, s'arquer en arrière, sucer, tourner la tête rapidement de droite et de gauche, secouer le bassin, etc.

L'expérience clinique auprès d'enfants plus âgés suggère qu'il n'est pas bon pour un si jeune enfant de mettre en œuvre des mécanismes de lutte contre des besoins, qui, ainsi, non seulement ne sont pas exprimés, mais qui, de plus, sont supprimés ou réprimés. N'est-il pas nuisible, par exemple, pour l'enfant de renoncer à son désir de contact humain avant d'avoir appris à en profiter pleinement.

Lorsque surviennent ces périodes de détresse pour un enfant du groupe B, l'infirmière intervient plus souvent et plus longtemps pour le réconforter et il semble bien que, au contraire des enfants du groupe A, l'enfant du groupe B, en trouvant là son réconfort, découvre le plaisir du contact humain.

Nous nous proposons de rechercher et de comparer d'un groupe à l'autre l'apparition des périodes de détresse, leur durée, leurs modalités évolutives.

c) Stimulations insuffisantes : Un autre inconvénient possible des longues périodes de veille solitaire est le peu de stimulations que l'enfant reçoit du milieu.

Or, Harriet Rheingold montre que les enfants de 2 mois 1/2 en pouponnière développent une grande ingéniosité oculaire et manuelle et nos observations confirment ceci dans plusieurs cas. Seul dans son lit, peu sollicité par l'entourage où il ne se passe pas grand-chose, ayant peu d'objets à portée de vue auxquels il puisse s'intéresser, l'enfant de 2 à 3 mois exerce longuement sa vision sur sa main, son boulier, le barreau du lit, la lumière au plafond, l'espace. La réduction des stimulations a en quelque sorte un effet stimulant, celles qui existent étant utilisées davantage et de façon répétitive par l'enfant.

Mais là encore, à la lueur des observations d'enfants carencés plus âgés, nous nous demandons si l'enfant qui investit intérêt et plaisir sur des objets inanimés, ou sur son corps, ne le fait pas aux dépens d'un intérêt pour l'être humain, handicapant ainsi sa capacité à établir des relations humaines. De plus, en l'absence de contact social, cet intérêt pour les choses risque de s'appauvrir lui aussi vers 4 à 6 mois, et de devenir stéréotypé.

d) Absence de réponse aux signaux de l'enfant : Nous pensons aussi que l'absence de réponse aux « signaux » venant de l'enfant contribue à l'extinction de conduites innées : c'est ainsi que, normalement, quand un enfant émet un son, l'adulte, instinctivement, répond par des sons ; l'enfant s'arrête, écoute, puis il répète ces sons. De même les sourires de l'enfant provoquent des réactions de tendresse chez l'adulte, lesquelles réactivent les sourires de l'enfant et sa joie à le voir. Ainsi s'établissent des réactions en chaîne entre enfant et adulte qui valorisent les conduites innées, et les renforcent alors qu'en l'absence de réponses elles semblent s'éteindre.

III. — CONTACTS HUMAINS

Un autre trait saillant des soins pendant l'étude pilote était la pauvreté quantitative et qualitative des contacts sociaux et leur occurrence quasi exclusive à l'occasion des soins.

1. *Quantité et occasion de contact social*

Enregistrant la quantité de contact social offerte au nourrisson pendant les temps de veille, les périodes de veille solitaire sont bien plus longues que les périodes de contact.

A titre d'exemple le tableau ci-dessous montre comment, pour le groupe routine 1958, entre les âges de 2 mois et 2 mois 8, un cinquième de la veille à peine est consacré aux soins, les 4/5 du temps de veille, l'enfant est seul.

TABLEAU III

Pourcentage de contact social sur 100 minutes de veille totale

	Routine A		Soins individualisés B	
1958			André (Mme V.)	54 %
			Bernard (Mlle X.)	49 –
	Antoinette	22 %	Catherine (Mlle X.) ...	48 –
	Bertrand	18 –		
1959	Colette	43 –	Denis (Mlle X.)	63 –
	Denise	40 –		
	Émile	31 –		
	Francis	40 –		
1960			Evelyne (Mlle Y.)	64 –
	Georges	44 –	Fernand (Mlle Y.) ...	58 –
			Georgette (Mlle Z.) ..	41 –
	Louis	28 –	Henri (Mlle Z.)	48 –

A l'occasion des soins individualisés, il fut recommandé à l'infirmière de faire profiter l'enfant d'une plus grande quantité de contact social et le tableau indique qu'elle se conforme à cette recommandation. Les soins de routine se modifient aussi et s'allongent en 1959-1960.

De plus, les seules occasions de contact social, pour les

enfants du groupe routine, étaient le change-biberon, lequel au moment de l'étude pilote durait de 8 à 12 minutes, les enfants étant ensuite livrés à eux-mêmes.

Cette rapidité de contact échappait totalement au personnel : à cette époque, lorsqu'un biberon durait plus de 6 à 7 minutes, l'enfant était considéré comme buvant mal. Sans en avoir conscience, les infirmières stimulaient l'enfant à sucer vite à l'aide de divers petits trucs, tels que pression rythmique de la joue avec un doigt, ou de la tétine sur la langue, ou encore retirer la tétine dès que la succion se ralentissait et la redonner aussitôt, etc. Le change était toujours très rapide, du fait même de la dextérité de l'infirmière. Le temps passé sur les genoux entre le biberon et le change était réduit, dépendant exclusivement de la rapidité de l'éructation que les infirmières sont habiles à obtenir.

A l'occasion des soins individualisés, l'infirmière fut encouragée à ne pas hâter le biberon, à respecter le besoin de succion de l'enfant, à tenir compte de sa fatigabilité, à garder l'enfant avec elle et à jouer avec lui aussi longtemps qu'il semblait en profiter et y trouver plaisir.

En fait, la durée moyenne des soins pour les enfants du groupe B calculée entre 2 mois et 2 mois 8 est de 40 à 47 minutes. La durée moyenne des soins de routine a augmenté elle aussi, le plus souvent autour de 25 minutes, s'élevant parfois jusqu'à 35 minutes. Cette augmentation est due à l'allongement des temps de biberon, mais aussi et surtout à l'apparition de périodes d'échanges et de jeux sur les genoux de l'infirmière au cours et à la suite des soins.

Dans les deux groupes, c'est surtout à l'occasion des soins que le contact social s'établit. Entre les soins, comme il a déjà été dit, il y a peu de temps consacré aux contacts, même pour les enfants du groupe B : 0,5 à 6 % selon les cas. Mais la fréquence avec laquelle l'infirmière va vers l'enfant éveillé dans son lit entre les biberons, encore faible pour le groupe A, est nettement plus élevée pour les enfants du groupe B. Ces contacts ont pour conséquence non négligeable des coupures dans les périodes de veille solitaire ; bien que brefs, ils se révèlent souvent efficaces, pour calmer l'enfant s'il est en détresse, ranimer son intérêt quand il commence à s'ennuyer. Dans un groupe comme dans l'autre, quand l'infirmière va voir l'enfant, c'est

presque toujours lorsqu'il est en train de pleurer, exceptionnellement quand il est sage.

A titre d'exemple, le tableau ci-dessous compare la fréquence des interventions entre les soins pour 6 enfants des groupes A et B, tous six séjournant à la même époque à la pouponnière.

TABLEAU IV

Fréquence des interventions de l'infirmière entre les soins au cours de 100 minutes de veille

Groupe routine		Groupe B	
Antoinette	2,5	André	17,0
Bertrand	2,5	Bernard	14,2
Colette	8,1	Denis	13,3

Il est intéressant aussi de constater que dans les soins individualisés les interventions de l'infirmière ont lieu plus souvent à bon escient que dans les soins de routine. Plus souvent présente, elle est capable de donner une juste interprétation du comportement de l'enfant ; le rythme des biberons, le régime s'en trouvent assouplis.

2. *Qualité du contact social : les échanges infirmière-enfant*

Pour évaluer aussi objectivement que possible la qualité des échanges entre l'infirmière et l'enfant, ayant présent à l'esprit les divers moments du contact tels que prise de contact, alimentation proprement dite, sur les genoux après le repas, à l'occasion de la toilette, au moment où l'infirmière quitte l'enfant, à l'occasion de contacts occasionnels entre les soins, etc., une cote de 1 à 5 (1) est donnée aux quatres questions suivantes :

— l'infirmière est-elle réceptive et attentive aux réactions de l'enfant et *vice versa* ?
— cherche-t-elle à éveiller ses réactions, à provoquer quelques petits exploits ?
— y a-t-il des réactions en chaîne de l'un à l'autre ; quelles sont leur fréquence, leur durée. Par là, nous voulons dire, les

(1) Méthode inspirée d'une méthode d'évaluation utilisée et mise au point par John D. Benjamin M. D. du *Child Research Council*, Denver.

actes de l'un entraînent-ils des réponses chez l'autre, qui à leur tour suscitent de nouvelles réactions chez le premier ?
— enfin, quels sont les sentiments qu'ils expriment l'un à l'égard de l'autre : indifférence, plaisir, irritation, etc. ?

Au moment de l'étude pilote, la pauvreté du contact était frappante et les cotes étaient presque invariablement en 1, ou tout au plus 2.

En effet, les descriptions de cette époque montrent que l'infirmière ne regardait guère l'enfant, et réciproquement l'enfant ne centrait pas son attention sur l'infirmière. Son regard était souvent « ailleurs ».

Les échanges de sourires, de paroles et gazouillis étaient peu fréquents, limités en durée et intensité. Il était rare que l'enfant soit chatouillé, caressé, stimulé.

Certes, l'infirmière était heureuse que l'enfant lui sourît ou la regardât, mais bien souvent aussi, elle ne le remarquait pas, et de toute façon elle passait peu de temps à obtenir un sourire de l'enfant. Dès le sourire obtenu, l'enfant était rapidement couché et restait seul à nouveau jusqu'au biberon suivant. Beaucoup de manifestations spontanées de l'enfant n'étaient pas perçues et restaient sans réponse.

Tout ceci montre que, en fait, il y avait peu de communication entre l'infirmière et l'enfant. Dans l'ensemble, les sentiments des infirmières pour les enfants paraissaient peu intenses, elles ne semblaient pas fortement motivées pour avoir un échange émotionnel avec eux. Parfois un intérêt mutuel se développait, mais souvent passager, il pouvait disparaître au lieu de se développer. Dans bien des cas, cet intérêt s'éveillait peu de temps avant le départ de l'enfant alors que, du fait de son âge, il faisait davantage de choses par lui-même, et montrait une plus grande sensibilité à la présence de l'adulte.

Les soins individualisés, assurant à l'infirmière une grande stabilité auprès de l'enfant et lui permettant de passer de plus longs moments auprès de lui, étaient destinés à améliorer la qualité des échanges infirmière-enfant.

Or, malgré les différences accusées par l'étude quantitative, il apparut que l'infirmière avait du mal au début à changer sa manière d'être et à utiliser le temps qui lui était donné.

Les trois premières infirmières qui se sont succédées dans ce

rôle ont éprouvé les mêmes difficultés. Au début nous les avons attribuées à la personnalité de l'infirmière ou à des circonstances défavorables, mais l'observation et les entretiens avec chacune d'entre elles, en montrant la constance de ces difficultés, ont permis de mieux comprendre la nature du problème.

A vrai dire, l'instauration des soins individualisés, bien que faite avec l'accord de tous, souleva au début beaucoup d'émotions dans la pouponnière. Elle était vivement ressentie par le personnel inquiet des comparaisons qui seraient établies, et contrarié de penser que les soins présents n'étaient pas parfaits puisque l'on se proposait d'en donner d'autres.

La première expérience fut faite par une jeune femme, Mme V., embauchée à cet effet. Isolée dans son travail, elle ne réussit pas à établir des contacts fructueux avec ses collègues qui se montrèrent assez critiques. La tâche fut pour elle pesante jusqu'à ce que son bébé, André, ait atteint l'âge de 2 mois. Elle s'en occupa consciencieusement mais montra de réelles difficultés de contact avec lui. Si, sur le plan de la quantité de contact et de la stabilité des soins, elle réussit à changer vraiment l'expérience de cet enfant, par contre elle parut peu douée pour sentir ses besoins, et fut gênée parce qu'elle se sentait « exposée » aux critiques. Elle fut anxieuse tout au long, souleva pas mal d'hostilité, et il fut décidé d'interrompre l'expérience sous cette forme.

La directrice proposa alors une de ses infirmières, Mlle X., qui avait du mal à suivre le rythme rapide de la pouponnière, se montrait gentille avec les enfants, et intéressée par ce travail. Au début, Mlle X. se sentit désœuvrée avec les deux enfants qui lui furent confiés. Chargée de tenir un carnet de bord et un graphique représentant la journée de chacun d'eux, elle fut confrontée avec le fait qu'il lui était pénible de rester avec l'enfant au-delà d'un temps très court. Elle s'ennuyait, ne savait quoi faire de lui, et, de fait, si les observations indiquaient une certaine prolongation du temps de contact, elles ne montraient pas une élévation sensible de la qualité de contact. Mal à l'aise auprès de « ses » enfants, Mlle X. invoquait sa gêne à l'égard des collègues, en regard de qui elle se sentait oisive, et prenait de nombreuses autres tâches. Cependant, astreinte à poursuivre sa tâche auprès de ces deux enfants, elle commença à s'attacher à Bernard tandis qu'à l'opposé elle exprimait une

certaine aversion pour Catherine, tout en lui consacrant scrupuleusement autant de temps. A mesure que Bernard répondait à ses soins et commençait à s'éveiller, elle s'en occupait spontanément davantage et déclarait qu'elle n'avait plus le temps de s'occuper de deux enfants à la fois. Elle se sentait d'ailleurs retenue de donner autant de temps qu'elle aurait souhaité au garçon, par souci de justice et de peur d'être critiquée.

Lorsqu'elle commença une autre expérience avec un troisième enfant, Denis, elle retrouva le même problème, le même ennui à son égard, le même sentiment à l'égard des collègues. Elle n'était pas attirée par Denis, mais pour se conformer à l'engagement pris, elle s'astreignit à s'en occuper tout en prenant d'autres tâches. Dès que cela fut possible, elle s'arrangea pour mettre l'enfant auprès d'elle dans le couloir, dans une corbeille. Là, il était distrait par les allées et venues et elle pouvait être avec lui tout en faisant autre chose. Denis était agréable à porter et elle aimait le tenir longuement sur ses genoux, tous deux paraissaient alors confortables. Mais, bien que grandissant, Denis ne souriait guère et ne la regardait pas volontiers, elle avait le sentiment qu'il ne l'aimait pas, disait de lui qu'il était « ingrat ». Elle fut tout au long assez intolérante à l'égard des pleurs, pourtant rares, de cet enfant.

La quatrième expérience éclaira davantage la nature réelle des difficultés. Mlle Y. souhaitait vivement faire cette expérience. Elle reçut une fille, Évelyne, et quelques jours après un garçon, Fernand. Elle se mit au travail avec ardeur et montra un certain enthousiasme au début, mais celui-ci s'évanouit dès les premiers jours. Le nouvel horaire lui parut pesant ; elle se déclara très fatiguée, en même temps elle montra une vive irritation vis-à-vis d'Évelyne. Elle se plaignit elle aussi qu'Évelyne ne l'aimait pas. Elle ne supportait pas le regard d'acier de la petite qui ne souriait pas. En fait, Évelyne faisait des sourires quand elle était posée à plat dans son lit et qu'on se présentait à elle de face. Mais jamais elle ne souriait dans les bras ; Mlle Y. se sentait rejetée par l'enfant et en était très émue. Elle établit une meilleure relation avec Fernand, pourtant plus exigeant, parce qu'il pelotonnait longuement sa tête dans son épaule. Elle se sentait aimée par cet enfant. Finalement, elle explosa un jour en montrant son extrême désarroi face au sentiment qu'elle avait d'être « une mauvaise

mère ». Elle demanda avec inquiétude ce qui se passerait si elle éprouvait la même chose avec son propre enfant, montrant combien il est angoissant pour une jeune fille d'être mise en présence d'un bébé pour lequel elle n'éprouve rien.

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Créant une situation nouvelle et obligeant les infirmières à rompre avec leur mode de travail habituel l'expérience des soins individualisés a, dans tous les cas, soulevé un certain désarroi chez celles qui, pourtant, s'y soumettaient librement.

L'infirmière est, en quelque sorte, forcée à une relation plus étroite avec le bébé qui lui est confié, ce qui soulève en elle de vifs sentiments et la confronte avec ses attitudes professionnelles habituelles.

Les entretiens et discussions qui avaient lieu régulièrement avec chaque infirmière au cours de l'expérience ont permis l'expression des difficultés qu'elles rencontraient. A partir de là il fut possible d'une part de les aider à établir une relation là où spontanément il n'y en avait pas et d'autre part de comprendre certains processus psychologiques qui expliquent l'attitude des infirmières en général et le type d'organisation rencontrée dans la plupart des collectivités de nourrissons.

a) Chaque infirmière a du mal, au début, à se consacrer à l'enfant. Elle se heurte à une absence de contact entre elle et ce nouveau-né qui n'est rien pour elle, et qui ne répond pas encore par des manifestations de satisfaction à ses soins. Dans ces conditions, elle s'ennuie auprès de lui et elle doit faire un réel effort sur elle-même pour prolonger son contact. Elle trouve la situation artificielle, et tend à la fuir, se disperse dans d'autres tâches.

b) Pour établir un contact avec un si jeune bébé, l'infirmière a besoin de trouver en lui quelque chose qui attire sa sympathie et on note ici de grandes variations individuelles : pour l'une ce sera la petitesse et la fragilité du bébé, pour l'autre sa rondeur, ou encore sa vivacité, ou au contraire son hypotonie et sa passivité, l'expression de son regard, un sourire, le caractère de ses pleurs, etc.

Dans chaque cas, il a fallu un certain *délai* : le contact s'établit après deux ou trois semaines pour Bernard et Fernand, à la fin du séjour seulement pour André, demeure assez passager et peu intense pour Denis ; dans deux cas, Catherine et Évelyne, il ne s'établit pas.

c) Dès que l'infirmière éprouve une affinité pour l'enfant, elle devient absorbée par lui, trouve difficile de se partager entre plusieurs enfants. Elle doit se faire un peu violence pour le remettre au lit. On constate entre eux deux un réel échange avec plaisir réciproque et la qualité des soins s'améliore dans tous les domaines. Cependant même alors il semble que l'infirmière ne soit pas tout à fait à l'aise, craigne la critique des collègues, se sente coupable de consacrer autant de temps à l'enfant et lors de la dernière expérience la vraie mère est souvent évoquée à l'occasion des soins comme si ce qui se passe entre l'infirmière et l'enfant n'était pas tout à fait permis, « que va dire ta mère ? » est une phrase fréquemment entendue.

d) Nous avons vu que pendant la période de délai au cours de laquelle l'infirmière ne sent rien pour l'enfant, elle tend spontanément à fuir la situation en se réfugiant dans d'autres tâches qui l'éloignent de lui. Si cependant, comme dans l'expérience des soins individualisés, elle se trouve obligée à un contact régulier et fréquent avec l'enfant, et que, dans ces conditions, son intérêt pour l'enfant ne s'éveille pas, elle ne tarde pas à éprouver un profond malaise et à exprimer de l'aversion à l'égard de l'enfant, tour à tour le blâmant et se faisant des reproches ; à l'extrême, elle peut se sentir menacée dans sa capacité à être plus tard une bonne mère.

e) Il est intéressant de constater que, plus ou moins positive ou négative, chaque expérience a soulevé de violents sentiments, et a supprimé l'état d'indifférence. Même dans les expériences où l'infirmière s'est irritée contre un enfant et elle-même, elle a donné beaucoup, sinon autant d'attention à l'enfant moins aimé qu'à son préféré ; les échanges ont été moins satisfaisants pour elle, mais ils ont existé et, dans une ambiance où elle n'était pas condamnée pour ses sentiments, et où au contraire elle rencontrait le soutien de tous, elle n'a pas manqué d'avoir aussi de bons moments avec l'enfant.

L'infirmière des soins individualisés a toujours été intéressée par la découverte de quantité de détails qu'elle n'avait pas remarqués auparavant. Par exemple : les difficultés d'endormissement et la nécessité de protéger l'enfant du bruit pendant ce temps ; les périodes de veille entre les biberons ; c'est elle qui souvent a attiré l'attention des observateurs sur certains comportements nouvellement apparus ; elle se posait davantage de questions sur sa façon de soigner les enfants.

f) Quant au départ de la Pouponnière nous voyons qu'il survient au moment où l'enfant est en état de répondre et devient source de satisfaction pour son infirmière. Il est évident que l'infirmière a besoin de se protéger à l'égard de cette séparation, qu'un attachement profond à l'enfant rendrait douloureuse. Les rêves faits par chacune d'elles la nuit qui suit le départ de l'enfant montrent clairement le caractère angoissant et conflictuel de la situation. On y retrouve un mélange d'angoisse et de culpabilité lié à une situation où elles perdent le bébé, celui-ci est menacé du fait de leur négligence et elles se font réconforter par l'observateur.

g) Or, ces infirmières n'avaient pas éprouvé de tels sentiments à l'égard des nombreux enfants qu'elles avaient soignés antérieurement. En effet, la routine de la pouponnière protège habituellement l'infirmière contre l'établissement d'un lien en lui permettant d'aller rapidement d'un enfant à l'autre. Accomplissant les soins avec conscience et dextérité, habile à obtenir ici un sourire, là un regard, n'en ayant pas besoin à propos de tous les contacts, l'absence de contact réel avec l'enfant lui échappe tout à fait. Cette attitude s'oppose à la fois à la naissance d'un attachement, mais aussi à celle d'une aversion qui est pénible, puis d'une séparation qui l'est également.

On voit bien alors comment la routine de la pouponnière est utile au personnel infirmier et pourquoi il résiste à l'idée d'introduire des changements, même simples en apparence et d'une nécessité évidente. En effet ceux-ci exposent l'infirmière à une expérience frustrante, soit qu'elle ne puisse suffisamment se consacrer à l'enfant préféré et qu'il faille par surcroît s'en séparer, soit qu'elle soit confrontée avec une indifférence ou une hostilité dont elle se sent coupable et qui risquent de la menacer dans sa capacité à être mère.

Nous venons de terminer une nouvelle expérience de soins individualisés. Cette fois, nous avons discuté longuement avec la quatrième infirmière, Mlle Z., d'une technique de soins aux nouveau-nés. Nous l'avons préparée au sentiment de « manque de contact » qu'elle risquait de rencontrer. Nous avons discuté avec elle de la nécessité de tenir l'enfant dans les bras un certain temps, de stimuler certains progrès, de ne pas se décourager devant l'absence normale de réponse. Nous espérions ainsi réduire son angoisse, empêcher l'apparition de sentiments de rancœur contre l'enfant et la rendre au contraire plus réceptive à son égard.

Mlle Z. a réussi à avoir des échanges plus vivants et fructueux avec les deux enfants (Georgette, Henri) sans être aussi affectivement impliquée que ne l'avaient été ses collègues. Elle a eu besoin d'encouragement et de stimulation pour être et demeurer stimulante avec Georgette qui s'éveillait lentement et qui, elle non plus, ne la regardait pas. Le tableau III traduit cette difficulté en montrant un temps de contact social de 41 % seulement. Par la suite, lorsque l'observateur lui en a fait prendre conscience, ce temps s'est accru. Quoi qu'il en soit, elle a pris ces difficultés « sportivement », sans s'en émouvoir. Elle s'est « amusée » avec ses enfants, ayant davantage l'attitude d'une grande sœur que d'une mère.

h) Parallèlement à l'observation et à la discussion de tous ces problèmes concernant les soins individualisés, de nombreux changements apparurent dans les soins de routine comme en témoignent les résultats quantitatifs concernant les enfants du groupe routine A (1).

L'organisation des horaires de travail des infirmières a été modifiée, la directrice cherchant comment concilier les besoins

(1) Il est vrai qu'il s'agit là d'enfants « observés » et que l'observation tend à modifier les soins parce que, même sans interventions directes des observateurs, elle conduit à une prise de conscience d'attitudes passant autrement inaperçues ; de plus, du fait même de l'observation, l'enfant devient plus intéressant ; enfin il existe un désir bien naturel de prouver que les soins de routine sont aussi bons que les soins expérimentaux. Il est possible de ce fait que les résultats concernant les enfants du groupe A ne soient pas représentatifs de l'ensemble des enfants de la pouponnière, c'est un point qu'il sera intéressant de vérifier. Pour le moment, cependant, l'impression générale partagée par tous ceux qui connaissent bien la pouponnière est que, dans l'ensemble, bien qu'en proportion variable, tous les enfants sont atteints par ces changements dont certains peuvent être facilement vérifiés.

des enfants et ceux du personnel. Elle a attiré l'attention des infirmières sur la nécessité de constituer auprès de chaque enfant une petite équipe constante et restreinte pour remplacer l'infirmière principale lorsqu'elle est absente. La durée de stage des élèves a été accrue et leur programme d'activités a été réorganisé dans la même intention, cherchant à concilier, ici encore, les besoins de l'enseignement et ceux des enfants.

Une constance de soins de nuit qui n'est pas mentionnée dans le rapport, parce qu'elle n'a pas été l'objet d'étude systématique, a été mise sur pieds. Toutes ces mesures ont réussi, on l'a vu, à diminuer le nombre d'infirmières s'occupant d'un enfant, à augmenter la quantité et à améliorer la qualité des soins donnés par chacune d'entre elles. Les soins durent plus longtemps ; le besoin de succion est mieux respecté, les régimes sont davantage individualisés. La veille solitaire a diminué et la vie des enfants est bien moins monotone.

Mais surtout, l'expérience des soins individualisés, en entraînant des discussions sur la valeur d'une expérience affective pour le nourrisson et en clarifiant les similarités et différences entre mère et infirmière, semble avoir développé chez toutes les infirmières un désir de « pouponner » et une liberté toute nouvelle pour le faire. Certes il existe encore des « limitations », les soins individualisés rencontrent toujours pas mal de critiques et soulèvent de gentilles moqueries ; cependant de plus en plus les soins de routine s'en rapprochent et ces limites paraissent progressivement reculer.

CONCLUSION

I. — Un cadre accueillant comme celui de cette pouponnière, la présence d'un personnel compétent et dévoué aux enfants, l'existence d'une ambiance de gaieté et de gentillesse font facilement illusion quant à la vie offerte aux enfants dans une collectivité et permettent à chacun d'être persuadé qu'un tel milieu n'est certainement pas source de carence affective pour les enfants. Seule une étude systématique et de longue haleine a permis de connaître quelle est l'expérience individuelle, réelle, de quelques enfants choisis pour observation et de faire une analyse assez poussée des facteurs de carences. Trois d'entre eux ont retenu notre attention :

— la multiplicité des personnes s'occupant d'un enfant et le faible pourcentage des soins donnés par chacune d'entre elles ;
— les longues périodes de veille solitaire ;
— la pauvreté quantitative et qualitative des échanges entre infirmière et enfant.

Or, chacun de ces trois facteurs ayant une incidence semblable sur la vie de l'enfant, leurs effets se renforcent, entraînant, dans les cas extrêmes, une pauvreté de stimulation des fonctions sensori-motrices, l'absence de stimulation des premiers modes de communication, un investissement de l'intérêt sur les objets plutôt que sur les personnes, une connaissance limitée de l'enfant par les personnes qui le soignent et qui de ce fait ignorent ses besoins et interviennent plus ou moins à contre-temps ; une absence ou pauvreté de réponses humaines aux manifestations spontanées de l'enfant telles que sourires, vocalises, pleurs ; l'enfant est livré presque exclusivement à son « moi », bien rudimentaire, pour trouver les moyens de réconfort, d'intérêt et de plaisir ; il reçoit peu de soutien de l'adulte par qui ses réactions spontanées ne sont pas renforcées.

Par contre, l'expérience des soins individualisés a montré comment lorsqu'une infirmière établit une relation avec l'enfant, la vie de ce dernier se transforme ; et comment, à travers le « pouponnage » qu'elle lui offre alors, tous ces facteurs de

carence diminuent simultanément jusqu'à disparaître complètement dans certains cas.

Ceci montre l'importance d'une relation de l'adulte vers l'enfant, tant pour percevoir les manifestations de l'enfant et y répondre que pour stimuler des réactions en retour de l'enfant vers l'adulte et l'investissement sur ce dernier d'affects liés à des comportements innées qui, sans cela, disparaissent.

Dans le cadre de la pouponnière, l'existence d'une telle relation demeurait assez exceptionnelle et n'atteignait que quelques enfants privilégiés. Dans un premier temps, cet état de fait a été considéré comme la conséquence de facteurs externes tels que l'organisation qui répartissait les soins d'un enfant entre de multiples personnes, la pression du travail qui obligeait l'infirmière à passer d'un enfant à l'autre, celle-ci ne pouvant jamais s'occuper assez régulièrement et longuement de l'enfant pour le connaître et s'y intéresser réellement.

En fait, l'expérience des soins individualisés a permis de reconnaître que l'organisation de la pouponnière, et ceci est peut-être généralisable à toutes les collectivités d'enfants, est vraisemblablement une réaction de défense contre la menace affective inconsciente que le contact étroit avec un nourrisson, qui n'est pas sien, représente pour une jeune infirmière. Contre cette menace, elle réagit en s'absorbant dans des tâches multiples, en se réfugiant dans la mécanisation de son travail qui tend à se déshumaniser de plus en plus. Il y a déplacement de l'intérêt pour les enfants sur les tâches matérielles.

Ceci explique la force de la résistance rencontrée lors de tentatives faites pour modifier l'organisation du travail en vue d'une meilleure réponse aux besoins totaux des enfants.

Les structures semblent être l'obstacle aux contacts infirmière-enfants, alors qu'en fait elles sont inconsciemment élaborées pour s'en protéger ; si bien que toute tentative pour les modifier de front se heurte à une fin de non-recevoir, soutenue par un système de rationalisation qui démontre l'impossibilité, les inconvénients ou l'inefficacité de tout changement. A l'opposé, une fois des changements réalisés, non seulement ils paraissent tout naturels, mais il paraîtrait impossible de revenir aux habitudes antérieures.

L'étude a en effet permis de constater qu'il est possible, bien que difficile, pour le personnel infirmier d'augmenter

considérablement sa capacité à apporter des soins affectifs valables. L'enrichissement progressif des soins individualisés, et, bien plus encore, l'évolution parallèle des soins de routine en sont les témoins.

II. — L'étude, toutefois, a aussi mis en évidence que le système de soins expérimental était complexe et qu'il n'est pas sans inconvénients d'assimiler le rôle de l'infirmière à celui de la mère qu'elle est amenée à remplacer.

N'est-il pas difficile pour l'infirmière de se voir demander de répondre à des besoins affectifs, alors qu'elle n'y est pas poussée par ses propres sentiments à l'égard de l'enfant ? Peut-on et doit-on l'encourager à un attachement avec des enfants dont elle doit aussi apprendre à se séparer, tout en restant ouverte aux nouveaux venus. Il y a là un rôle presque contre nature, l'infirmière étant amenée à développer une aptitude « à donner » sans « se donner » puisqu'elle ne peut « recevoir » en retour la totalité des joies fondamentales qui alimentent l'amour de toute femme s'occupant d'un tout petit. Ceci doit inciter à mettre au point des méthodes éducatives permettant à l'infirmière de développer sa sensibilité aux enfants au lieu de s'en défendre, tout en gardant à leur égard un certain « détachement » à l'intérieur d'une relation qui peut cependant être chaleureuse.

III. — Tout en étant intéressantes pour le personnel et bienfaisantes pour les enfants, les observations ont été pénibles pour les infirmières et pour les observateurs, avant que d'être utiles.

Mettant en évidence des besoins auxquels il n'est pas pourvu, l'observation soulève de l'anxiété, les infirmières sentant comme une exigence pesante la découverte de nouveaux besoins qui s'ajoutent à tant d'autres ; il est de plus insupportable d'admettre l'insuffisance de soins donnés avec dévouement, compétence et conscience professionnelle. Enfin, et c'est bien là l'essentiel, introduire des changements, modifier l'équilibre acquis remettent en cause des positions affectives inconsciemment ressenties comme nécessaires.

Les observateurs sont, eux, dans une position inverse. L'observation aussi intime et continue de l'enfant, avec ce désir de comprendre ce qui se passe en lui, l'entraîne à être exagérément identifié avec « les besoins » de l'enfant et risque de l'amener à une attitude critique vis-à-vis de ceux qui le soignent, attitude intolérable et nuisible pour tous. Il y a là une source possible de tension entre chercheurs et praticiens, risquant de conduire à une intolérance mutuelle, à l'isolement sinon à l'exclusion des chercheurs et à l'exagération des « résistances » dont il a été question plus haut.

Dans le cas présent, cet écueil fut évité, en grande partie grâce à la possibilité d'associer étroitement la directrice de la pouponnière à l'étude, et de bénéficier de sa collaboration sous de multiples formes : étude du matériel et dépouillement, participation active aux discussions sur les résultats partiels et les hypothèses qui surgissaient en cours d'étude.

Par son intermédiaire, il fut possible de susciter la participation de son personnel : en ajoutant à nos données leurs propres observations faites au cours de leur travail, en participant à l'expérience des soins individualisés, en participant enfin à des réunions-discussions sur la nature des besoins des enfants et des soins qui sont donnés.

C'est ainsi que, se préoccupant des difficultés que sa présence soulevait pour les infirmières et cherchant à y pallier, l'équipe de recherche a contribué à la dissolution des résistances et a aidé le personnel à réaliser un perfectionnement assez spectaculaire de la qualité des soins.

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RÉSUMÉ

Au cours d'une étude auprès de nourrissons séparés de leur mère dès la naissance et élevés dans une pouponnière pendant les trois premiers mois de leur vie, l'observation des soins qui leur étaient donnés a permis de dégager divers facteurs de carence qui risquaient d'endommager le développement de l'enfant : multiplicité de personnes s'occupant d'un enfant, chacune d'entre elles lui offrant peu de contact et lui consacrant peu de temps, l'enfant restant de ce fait, seul et éveillé de longues périodes.

Il en résultait pour l'enfant une pauvreté des stimulations des fonctions sensori-motrices, l'absence de stimulation des premiers modes de communication, un investissement de l'intérêt de l'enfant sur les choses plutôt que sur les personnes, une connaissance limitée de l'enfant par les personnes qui le soignaient et qui, de ce fait, ignoraient ses besoins, intervenaient plus ou moins à contre-temps et répondaient peu ou pas aux manifestations spontanées telles que sourires, vocalises, lesquelles risquaient alors de s'éteindre et de n'être pas investies de signification.

Introduisant, pour un nombre limité d'enfants, des soins infirmiers intensifs et individualisés par deux infirmières stables, comparant les soins reçus par ces enfants à ceux reçus à la même époque par les autres enfants de la pouponnière, l'analyse quantitative et qualitative des observations montre comment ces facteurs de carence diminuent seulement lorsqu'une infirmière établit un lien affectif avec l'enfant.

Cependant, des obstacles à l'établissement de ce lien se révèlent puissants et quasi constants. Ils ne sont pas liés, comme on a pu le croire au premier abord, à un manque de temps ou à une surcharge de travail, mais à des obstacles affectifs

dont chaque infirmière mise dans cette situation a cherché à se défendre, montrant comment habituellement les infirmières se protègent inconsciemment de ces difficultés en se réfugiant dans un rythme accéléré de travail, en s'intéressant davantage à la perfection technique des tâches qu'à la connaissance des bébés.

Clarifiant la nature de ces difficultés, la recherche en a permis l'évolution favorable, modifiant non seulement les soins individualisés, mais aussi les soins de routine montrant ainsi la nécessité et l'efficacité d'une action psychologique auprès du personnel infirmier s'occupant des enfants.

LA PSYCHIATRIE DE L'ENFANT

VOLUME IV

Deuxième Fascicule

SOMMAIRE

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Dr. Bowlby

STUDY OF INFANTS DEPRIVED OF MATERNAL CARE

DURING THE FIRST THREE MONTHS (trans. A. Sanders)

Dr. Myriam David

PRELIMINARY REPORT Sept 1958.

INTRODUCTION

It seemed to us that a study on infants brought up in a nursery during the first three months of life, then being reunited with their families, would make a contribution to the understanding of the first stages in the structuration of the personality and of the establishment of object relations.

It is possible during their stay in the nursery to study with precision what the environment brings to the infant. It is an environment that is stable, relatively simple in its structure and modifiable experimentally. Observations can easily be made which allow for the study of the behaviour of the infants from three angles: his constitutional equipment, the maturation of the equipment, and the way he uses it in order to adapt himself to the conditions of life in which he finds himself. From the reunion with the family the following can be studied: the influence of an environmental change, the modes of adaptation to the family environment, and the establishment and development of a relationship between mother and infant.

Such observations should allow for better understanding of how disturbances to the personality are formed in children deprived of maternal care in early infancy. They might also provide answers to a series of interesting questions from the theoretical point of view and from the point of view of the prevention of mental ill health: such being the role of the mother-child relationship in early development. Is the importance of maternal care solely in the satisfaction of needs, thus removing the sources of tension and discomfort, and bringing stimulation, well-being and peace? Or is it that it is, even more, a primitive bond which already has a certain specificity and in itself plays a stimulating and structuring role? Can the satisfaction of needs be carried out by a multitude of persons or must it come from one person only? To what extent is it possible and important ~~or not~~ that a tie of a certain specificity be established at the end of the third month? Does the absence of a tie at this stage create a handicap for later capacity to develop object relations? Does the development or/ of a tie through the individualised care of nurses favour/ hinder the development of the mother-child relationship after reunion, or is that a matter of no importance?

This is the collection of questions we have in mind in undertaking, with the collaboration of Genovieve Appell, the study of infants in the Amyot Nursery.

We are presenting in this report the design of the study and reflections which have emerged from the first observations.

THE AMYOT NURSERY

The Amyot Nursery takes infants of less than one year for 2-3½ months before vaccination with B.C.G. ... The situation allows for the control of four of the factors which have bearing on the effects of deprivation of maternal care: the age at which it takes place, its length, its cause, and the quality of care during separation.

Coming from a tubercular environment and needing to be isolated during the vaccination period, the great majority of the infants are separated from their mothers at birth and come directly from the Maternity Hospital at about the age of 8-10 days. A small number of infants come later to the nursery from their families in the course of the first year. This allows

us to concentrate on the study of infants deprived of maternal care during the first three months, with the eventual possibility of comparing them with children separated at different ages.

Moreover, the Anyot Nursery provides favourable conditions for work: small size (20 cots), a generally attractive set-up, cleanliness, and a welcoming staff who are not only aware of the emotional problems involved in bringing up infants in a nursery, but want to see them examined objectively and for remedies to be found as much as possible.

The Families

The infants admitted to the nursery are under one year old, in good health, coming from TB families. They come from families of very varied circumstances, judged by economic as well as professional and social status.

Only families meeting the following conditions were used for the project:

(1) normal couples living together, the mother staying at home to look after the children.

(2) parents of adequate socio-economic standing to ensure the material well-being of the children.

(3) Absence of manifest disturbance, physical, social or psychological, apart from TB - the parents having recovered at the time of the study and capable of looking after the infant.

(4) families permanently settled in the Paris area.

When a family satisfies these requirements, the study is outlined to them and discussed with them. Only those families were used which appear both willing and able to cooperate. We thought it preferable to eliminate those who showed an excessive interest in psychological problems.

Object of the Project

In the course of the pilot study, 13 children were observed during their stay in the Nursery and at the point of their reunion with their families. Eight of them were followed up until the end of the first year. The project was essentially a dual one: (i) a longtitudinal study of infants during their stay in the nursery and their later reactions in the family setting; (ii) observation of the type of care received at the nursery.

From this first study emerged the wish to modify the care received at the nursery towards an individualisation of care, in order to study the differences between children cared for in different ways. We decided, therefore, to study two groups of children: Group 1 receiving the care normally given at the nursery; Group 2, individual care.

The project thus has three main aspects:

(i) a longtitudinal study of the infants of each of the groups during their stay in the nursery and their reactions in the family.

(ii) observation of the care received by each of the 2 groups in the nursery.

(iii) a comparative study of the infants in each group.

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* We have not used the term "care of mother substitute" as it is not known to what extent the care of the individual nurses differs from ~~that of the mother~~ maternal care. In introducing such care for a group of infants, we sought to vary the environment in the sense of an individualisation of care: care given primarily by one person who responds to the best of her ability to the individual needs of "her baby", such as she understands them.

I Longitudinal study of the infants of Groups 1 and 2

(1) Study of development during the stay in the nursery

This is a longitudinal study of individual cases which seeks to capture the continuity or the "dynamic" of development, i.e. how the child reacts to the environment in which he is placed in terms of his constitutional endowment and the degree of maturity, and how these reactions, through repetition, mould his behaviour and direct his development. In this part of the project each case is studied in relation to itself.

We endeavoured to organise the observations in a way which would enable the carrying out of a parallel study of the development of the infant's sensori-motor capacity, the use he makes of it daily, both during the care he receives and during the series of states he seems to pass through when left by himself. By "series of states" we mean: states of peace, agitation, wakefulness, sleep, well-being, discomfort. We describe not only the state in which the child is, but ~~the~~ also the impression that is conveyed to the observer. We think it interesting to keep a note of these impressions in order to carry out reliability checks on the objectivity of two observers; and also as a means of judging to what extent ~~it~~ the impression can be justified, at least in part, by a minute description of the elements from which the impression is drawn.

Three types of observation ~~have~~ have been used for this purpose:

(a) Continuous observation of the behaviour of the child for an average of 4 hours, taking in two feeds. These observations took place on average once a week, except at the time of arrival at and departure from the nursery when they were made daily for two or three days.

The observer recorded the succession of states through which the infant passed, the quality of the sleep, of the wakefulness, of the crying, the sensori-motor ability which the infant showed in the course of the observations, the way in which he used this ability, his successes, his failures, the general impression given to the observer, the reactions to contacts with adults who cared for him, to the presence, arrival, departure of nurses or others, and when his needs were being attended to.

(b) Intermittent observations by sampling at regular intervals on average three times a week, the child being observed for several minutes every 10 to 15 minutes during 4 consecutive hours. These observations completed the "continuous" weekly observation, giving opportunities for the assessment of the ~~rythm~~"rhythm" of the child and to follow the progress of his development.

(c) Observations of the reactions of the child in an experimental situation, once a week.

(i) reaction to different elements of the Gesell test.... The test was intended to ~~show~~ throw up in relief the possibilities and limitations of the infant's capacities which would pass unnoticed in direct observation.

(ii) reaction to the active contact offered by the observer herself. Here, rather than presenting a situation similar to each of the infants, we have described what the observer had to do to establish and develop the contact with the infant and the infant's reactions.

This collection of observations is completed by those given verbally by the nurses and by information contained in the infant's records, i.e. weight, temperature, diet, digestion, intervening events.

(2) Study of later reactions in the family setting

This is based on the direct observation of the infant at home and on interviews with the parents.

(a) Observation of the children. In principle this is identical with the observations in the nursery, but in practice was somewhat modified.

(i) The rhythm of the observations is a little different. For the purposes of studying the reactions at reunion the observations were intensified. They were made daily during the three days which precede and follow reunion, twice weekly for one or two weeks and then weekly. In addition, the observer accompanies mother and child to their home in order to see all the first reactions of the child.

Later, visits are made once a week to 6 months, then twice a month on average to the end of the first year. Only occasionally has it been possible to follow up further the children of the pilot study. We have it in mind to make an evaluation at 3 years old and just before going to school. As contact is maintained with the families, it is possible to study the child if it is exposed to a traumatic experience (hospitalization, illness, family disturbance, new separation).

(ii) The continuous observation of behaviour was modified. The duration is shortened to 2½ to 3 hours. Moreover, although we encourage the mother to get on with her own work and leave us alone with the infant, as she gets to know us better she likes to keep us company and to talk, with the result that we do not feel free to concentrate exclusively on observation. This makes it impossible to take continuous and minute notes as at the nursery. Because of this the observations are less precise.

Further, our visit tends to modify the situation as it appears to the infant. Most of the mothers wait for the test with interst and watch the child on their knees or on the divan beside us. Their attention, like ours, if on the infant and they tend to be occupied and with him, play with him, and show us what he can do. These observations are therefore different from those made in the nursery. They give us less accurate information on the behaviour of the infant during the day and when he is left by himself, but on the other hand this situation provides excellent opportunities for observing interaction between mother and child.

(iii) Intermittent observation by regular time sampling. It has not been possible to make these up till now. Information on the rhythm of life is obtained by interview with the mother. At the time of reunion, mothers willingly agree to fill up the questionnaire about hours of sleep, waking, times of crying, etc., but none of them keep it up after the first few days and it did not seem to us to be ~~desirable~~ appropriate to encourage them to do so.

(iv) Observations on reactions to the test situation and to contact with the observer are easily made and became for the next study the focus for observation on the child.

(b) Interviews with the parents were undertaken in order to obtain information about the child's reactions, his development, rhythm, and intruding events; also to provide an assessment of the mother-child relationship, the way in which it é is established and develops; to understand the feelings of the mother with regard to her baby and the ways in which those feelings are expressed in the course of contact with the infant. In effect, we need the close participation of the parents in the project, especially that of the mother. For this purpose, we find it advantageous to avoid systematic questioning and use "free" conversation. By this means we discover the preoccupations and spontaneous interests of the mother with regard to her baby and with regard to the circumstances which led to the separation.

The first interview takes place after the registration of the child at the nursery, sometimes at the end of the pregnancy, sometimes immediately after the confinement at the maternity hospital. The object is primarily to tell the parents about the project and ask them if they wish to participate. When they accept, they are seen three or four times during the child's stay in the nursery.

Experience shows that the parents use these interviews to express their worries and thoughts about TB, means of protection, and about the separation. There is intense emotion surrounding these subjects which we encourage the parents to express. The amount of understanding that we are able to show them

and the news we can give/ them about their children and the interest we show helps to create a sound relationship and leads them to regard us as a support, to welcome our presence at the time of reunion and to share with us later everything concerning the children.

REFLEXIONS ON THE LONGITUDINAL STUDY OF THE PILOT GROUPS (provisional)

~~(1)~~ From the pilot study on 13 children cared for under the customary routine of the nursery, there emerged several ideas and working hypotheses.

(1) In the course of development during the first three months, progressive changes are observable in the infants' attitude to the environment. (Details of the stages of development will be given in a later paper.)

(a) The first state which is seen is unorganised and undifferentiated. The impression is gained of an empty state of tranquillity in which nothing seems to attract ~~his~~ the infant. Rather, he appears submerged by sensations which suggest a state of tension to which he reacts with painful agitation, ending sometimes in crying; the reactions are anarchical and the infant passes through an unpredictable succession of states of peace, agitation, crying and sleep.

(b) The infant emerges progressively from this ~~initial~~ initial state (beginning at 6-20 days and ending at 1-2 months). The appearance of empty peace changes, the expression becomes more alive and vaguely smiling, conveying the impression of being in a "happy" state, which is more than the previous impression of emptiness did, while the corresponding crying takes on at times a new intonation of rage. The infant seems to emerge little by little from his nebulous state and to open out a little, and for an increasing length of time, to the world around. This 'emergence' sometimes is slow and progressive and sometimes is marked by an unhappy crisis. Whatever the form, it leads the infant to:

(c) a state of attentive receptivity (from 1-2 months to 2½-3½ months) in the course of which the infant is now able to fix his attention on different objects and react with interest, animation, open pleasure or obvious displeasure. The observer begins to see the linking of cause and effect in the reactions of the infant.

(d) Finally, the awakening of tendencies to be active towards the objects in which he is interested (from about 2½-3½ months); interest in touching, moving towards, fidgetting, grasping, making sounds, shaking a rattle, etc. Cries and babbling take on a variety of tones which seem to indicate a greater diversity of states of emotion.

~~The point~~ This development of the reactions of the infant with regard/ to the environment is dependent on the maturation of his sensori-motor system and his psycho-motor abilities. However, the development should not be lost sight of (or mistaken for) among the latter for great differences exist in the use which infants make of their capacities as they gradually appear.

For example, at an equivalent level of maturity, one child will show pleasure and aptitude in being active, whereas another will make hardly any use of the possibilities of hand-eye co-ordination and his interest in things around lacks intensity and continuity. In one there is an investment of interest and pleasure in well-defined objects, which does not exist in the other.

The development of this general attitude to the environment, without prejudging the causes, seemed well worth observation, as representing, at least in part, the infants first affective reactions. Such observations, at the same time, have bearing on the development of positive reactions to actual experience (interest, pleasure - diffused at first and then directed to an object), and of negative reactions (agitation - tension, rage diffused at first and then better organised), etc.,...

(2) It seems that most of the children in the course of their stay experienced periods of more or less prolonged dissatisfaction, which led to frequent and long moments of agitation with or without crying, and sleeping difficulties. This dissatisfaction is not permanent but comes in spasms; sometimes the cause is discernible: insufficient diet, which weight has not yet indicated; a rhythm imposed on the infant which conflicts with his own; insufficient time

and opportunities for sucking; lack of comfort during prolonged periods of discomfort; insufficient contact and stimulation, etc.

Observation shows that not all the infants are dissatisfied to the same degree nor for the same reasons. There are important individual variations in 'needs' and toleration of frustration.

(3) Be that as it may, in the absence of comfort brought about by a modification of care, the infants bring into play behaviour which seems to be aimed at easing the state of dissatisfaction; behaviour which in turn differs from one infant to another and leads, it seems, to a resolving of the crisis. These resolving mechanisms in particular caught our attention as they seemed to contribute to the direction of development.

For example, "Michel, on the point of emerging from the initial state at the age of 30 days, showed for five days long periods of intense crying. This is/ crying stopped as soon as he/~~was~~ picked up, but normally Michel is alone and nobody takes any notice of his crying. Quite early on, he finds his fist or thumb in the middle of his rage and sucks it strongly but not continuously and it does not calm him. Several days later, however, he was able to calm himself by sucking. Several days later still, it was found that Michel no longer cried but from the time he woke up he seemed ill at ease, twisted himself, sucked immediately and fell asleep again. For several days Michel is thus a prey to agitated sleep, constantly interrupted. However, because of his sensori-motor progress, he begins to look around him when he sucks and begins to take interest in his surroundings. His periods of waking become longer and the periods of waking and sleeping become more defined. But quite quickly (about 12 days) Michel's interest seems to become dissipated; ~~his~~ he is agitated when he is woken up, cries more, but he who used to cry so loudly does not seem able now to let out real cries - they remain feeble and short. Again Michel utilises sucking and in doing so falls asleep. At 2½ months Michel is an uninteresting child who seems to sleep all the time but who in fact, on close observation, is constantly waking up, lying vacantly sucking, and then dropping off to sleep for a short time. However, in the test situation Michel showed good sensori-motor development, all trace of sleepiness disappeared, and he seemed delighted with the contact and stimulation which it afforded; left alone, however, he utilises practically none of his sensori-motor capacities."

What is to be thought of this "repression of crying and rage" which leads to introversion rather than to extroversion? To going to sleep rather than to waking up?

"Jean-Paul at the same age went through a crisis of intense crying with paroxysms of rage which seemed most painful. He reacted very differently from Michel to these attacks of rage. He did not suck but became completely immobile, giving the impression that by doing this he could summon up sleep. Each time his eyes closed, a start would wake him up again abruptly and he cried again bitterly. As with Michel, and to an even greater extent, the same attempt to suppress crying was observed. From the 15th day his cries became feeble and plaintive. A fleeting strabism appeared.

By means of this immobility, so it seemed, his gaze became fixed and several days later he ~~gives~~ gave the appearance of seeing and watching. He was not slow to become interested and, when alone, to watch for a long time anything within his line of vision (hand, cot, rattle, observer) and the pleasure this gave him led to a certain animation which caused him to shake his rattle accidentally. With the repetition of this movement, he lost no time in controlling it, and so well that this infant rapidly became capable of quite remarkable exploits of hand-eye co-ordination. Being so delighted with his game, he very early became able to do without company."

What is to be thought of this investment of interest in an inanimate object which enabled him to do without human contact?

"Luc is a merry baby, attached to one of the nurses whom he seems able to differentiate clearly from the others. He is active and plays a great deal with his hands which he sucks, crosses, opens and closes, watching them all the time. His play is pleasing and "harmonieux". When his nurse was absent for several days, Luc became dejected, showed little activity and no longer smiled;

then he resumed his game with his hands but it had lost its harmonious and varied character, and the observer could not help but call to mind the stiff and stereotyped movements described in the syndromes of hospitalisation. On the return of the nurse, these symptoms disappeared, only to reappear several days later when Luc returned to his family."

The presentation of these three cases goes beyond the framework of a simple description of behaviour. In effect, out of purely descriptive detailed observations, "patterns" of behaviour emerge. As these patterns appeared every time the infant was subjected to a state of tension and helped him more often than not to regain a state of well-being, we have interpreted them as means of resisting tension or mechanisms for resolving tension. In this way we have been led to talk about: repression of crying; seeking a return to sleep; investing an object with affect; withdrawal into himself by means of a stereotyped game, etc.

The validity of such interpretations over and above purely descriptive observation is difficult to establish. It seems important to us, nevertheless, to carry on with this type of observation if we wish to arrive at an understanding of the continuity of development and the rules which govern it.

We believe it will be fruitful, as Dr. J. Benjamin has suggested, to distinguish and formulate separately and systematically the observed facts and our interpretations. This helps to refine the acuteness of observation. It is interesting also to pass on the observational data to others for them to make their own interpretations. Agreement and divergence of interpretation each have their own interest.

(4) Reactions on reunion with the family: no infant has shown open distress at leaving the nursery nor on arrival home. On the other hand, all have shown symptoms, varying from one child to another in their form, duration and intensity, but indicative of a certain state of "confusion". These symptoms can be ~~to~~ classified somewhat arbitrarily as follows:

(a) Signs of uneasiness and restlessness indicated (i) by a restless expression which is described, as appropriate, as mournful, ~~sad~~ sad, restless, anxious, which appears amongst other things when the infant is dressed in different clothes and put in his cot; (ii) by the agitation connected with difficulty in finding a comfortable position; (iii) by occasional crying (this is never prolonged or intense); [on the whole, parents find them well-behaved and easy to handle]. They are more susceptible to being disturbed by certain noises, faces, objects, unaccustomed positions, which is in contrast to their normal indifference to comings and goings and the variety of handling they were subject to in the nursery. In a general way, signs of happiness disappear or are rarely seen.

(b) Lack of acquisition of new skills and regression: disappearance of smiling and difficulty of provoking it; disappearance of babbling; diminished activity; return to tonic-reflex position; loss of balance/equilibrium when in their cots.

(c) Slight disturbance of habits: sleeping and feeding difficulties; refusal of the teat; digestive troubles, i.e. returning milk, slight constipation; and in one case only, diarrhoea.

These symptoms, however, are never all found in one infant and are not dramatic. They could be missed altogether if the child were not observed closely from day to day.

Further, because of the loving care with which the infants are surrounded, signs of disorientation ~~do~~ tend to disappear. At the same time as affective exchanges are multiplying, signs of pleasure develop which become more and more frequent and give the child a new "opened-up" look which is very striking, not being accompanied however by an increase in liveliness from psycho-motor development, but showing itself by a transformation of expression and a much greater degree of animation which gives the child a more wide-awake look.

Reactions of a child to reunion vary very much from one infant to another. A number of factors seem to play a part in determining the intensity and form in each case.

(i) The maturity of the child. Infants who are less mature seem to show the least signs of disturbance. In particular, the infants who go home when they are only just entering the state of attentive receptivity seem very little discrientated and profit more rapidly than the others from the stimulations of the new environment.

(ii) Investment of objects in the environment, whether human or inanimate, with positive affect makes for greater reactions of disquiet at the change of environment. The two children who showed the greatest discrientation were in the first place the most "advanced" and in the second place, showed active signs of attachment to or pleasure in a person (in the case of one) and in the immediate environment, cot, rattle (in the case of the other). At the other extreme, a third infant at the same stage of development who had shown little investment of the environment showed the least discrientation and profited ~~more~~ very rapidly from exchanges with various members of the family.

(iii) The degree of avidity of contact: infants more sensitive to contact profited rapidly from maternal care.

(iv) The welcome and acceptance shown by the parents: this seemed to be one of the most important factors in "opening-out".

Obviously these are only hypotheses needing verification. In future observations we will try to test them by making predictions (method used by J. Benjamin and also by Ernst and Marianne Kris) based on an evaluation of the infant and the family environment.

II STUDY OF THE CARE RECEIVED BY THE INFANTS IN THE NURSERY

Observation of the children in the nursery has enabled us to get a clearer idea of the type of experience which they undergo; we were equally struck by the profound change of existence on return home. While trying to make the differences clear, it seemed to us interesting to compare the children brought up in the nursery with some of the same age brought up by their mothers. However, to do this, we came up against difficulties of variations in the type of maternal care and family settings. This made it impossible to constitute a homogeneous group to compare with the nursery group. To this was added the difficulty of observing at home.

On the other hand, it seemed possible to constitute a group of children in the nursery receiving individual nursing care. This gave a number of advantages - identical conditions for observation and control of modifications in care which we introduced. For this reason we are at the moment not only observing infants receiving ~~the~~ so-called "normal" care (Group I) but some receiving individualised nursing care (Group II).

(1) Analysis of the care received by the infants in Group I. Characteristics :

(a) External environment: welcoming, rooms with three cots and a corner for changing and bathing, leading on to a wide general corridor. Clean, airy, and gay because of its brightness and delicate colours; but ~~it~~ they also have a regular character, where nothing escapes from an orderliness fixed by precise rules - a feeling of immovableness. The cots are spotless, regular, with sheets arranged always in exactly the same way; the row of playthings stretched across the cot varies from one infant to another but is always the same for the same infant and set in the same position. Cot, chair, mirror, lamp in the ceiling are the only objects, except for the rattle, in sight. The staff themselves are ~~also~~ also identical to look at - white figures, expert hands, faces topped with white caps, etc

(b) The Many people handling the child. It is the practice in this nursery for each person doing anything for the infant to mark it in a notebook. This practice revealed at the time of the pilot study that 24-28 people were engaged in looking after any one child.

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However, one person*, the nurse attached to the child's room, emerges as the chief figure who gives from about 28 to 33% of the care, the rest being given more or less equally (1-10%) by 23-27 people.

(c) The general background is dominated by a general impression of monotony and solitude. Between feeds (3-4 hours) the infant is, in fact, alone. Strictly speaking, he is not isolated because he shares the room with two other babies, but he seems scarcely aware of this before the age of 2½ to 3 months. At certain times, cleaning is done; at others, care of his small neighbours ~~causes~~ leads to coming and going in the room. This activity, however, is not directed towards him and without really breaking his solitude, it only helps to create a certain background. In general, an atmosphere of calm reigns supreme; nothing happens except distant noises from the street, the banging of a door, the crying of another baby, the entrance and quick passing by of a white figure which moves about without stopping by the infant. At other times the atmosphere is disturbed by cleaning and care of various kinds; and at others again, the air is electric with the contagious crying of the babies, particularly at certain hours.

(d) The timing of care is set by a timetable which depends more on the organisation of the nursery than on the individual rhythm of each baby. So much so that care is given whether the child is awake or asleep, calm or frantic. The diet of each child is fixed according to age and increase of weight. The rhythmof feeding is constant and set beforehand, the total quantity of milk for the whole 24 hours being divided up equally between the 5, 6 or 7 bottles which are given at fixed hours.

(e) The quality of the care is characterised by rapidity and dexterity of movements. Thus it is given always in the same way and differs very little from one nurse to another. This stereotyped and automatic handling has a profound effect on the contact between the nurses and babies.

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* One nurse is nominally in charge of four babies, but in practice she always attends occasionally to others.

(f) The relationship between nurse and child is marked by the small number of contacts. They are in fact very infrequent and only occur when the child needs routine attention. Other comings and goings in the room at other times do not directly concern the baby and are not occasions for exchanges. Moreover, the dexterity and rapidity of care given shortens the duration of contact: 8-10 minutes for a bottle, 20 minutes for the morning bath. The low frequency of contact (made even less by the fact that care given by any one particular nurse is even more occasional) and their rapidity greatly influences the quality of them.

(g) Quality of contact. As mentioned above, the nurses are competent, well directed, love their work, are interested and devoted to it. All of them in a general way love babies. They are ambitious for the nursery and the development of the children entrusted to them. But because of their constitution, they associate good development of the babies with good conduct of the nursery, so much so that the greatest part of their energy goes towards perfecting the technique mentioned above. They are taught to rank in second place their feelings for the children which would inevitably lead them to devote more time to certain infants and hinder their overall work in the nursery. They must, for that reason, repress not only their feelings of interest for particular babies, but also those aroused by their crying. This is reinforced by their training which regards crying as a normal phenomenon to which no attention should be paid.

Thus the attitude imparted by their profession and the organisation of the work in the nursery results in relatively little active contact and an impoverished relationship with each child.

When the child is being attended to, there is little or no verbal exchange; little or no exchange of glances (during feeding the nurse is often "far away", similarly the infant); little stimulation to ~~provide~~ provoke new exploits. To sum up, there is really no communication. The joy ~~of~~ of looking at each other, normal between a mother and her baby, the wish to comfort, elicit smiles again and again, or a sound or new exploit, rarely exist. The less a nurse has occasion to care for a baby, the less she knows it and the poorer the exchange and the relationship.

It is true that most of the time each nurse has a chosen one which she knows better and to which she becomes more attached. She finds real pleasure in looking after him, is proud of him and at each feed tries to get a smile and some sounds from him. But few infants benefit from such an exchange, always brief and always followed abruptly by separation when the infant is put back in his cot, so that the beginning of a relationship remains dead and ~~is~~ has no consequences.

(2) Analysis of care received by Group II (3 cases only as yet)

(a) Background. The same as for Group I

(b) One nurse spends most of her time, but not all her time, on day-time care. She gives the child his bath and 4 bottles. The first and last bottle (5 a.m. and 6 p.m.) are given by one of the two night nurses. When the principal nurse is absent (on holiday or ill) she is replaced by one nurse, always the same one. Thus four people share the care of the child:

45% of care by the principal nurse
15% by the replacement
20% by each of the night nurses

It was soon found that the principal nurse could look after two children at once. Occasionally, when free and in case of need, she looks after the third infant in the room.

As for the other factors, they are being modified but it seems that this cannot be done all at once. Up to now (3 cases concerning 3 infants and 2 nurses) at the arrival of each infant there is a "dead" period before the nurse succeeds in applying herself to the new arrangement. For this there are several reasons: difficulty in changing habits, reluctance to act differently from the other nurses, feelings of being confined and idle; the fact that the baby is still so small and not yet interesting and that the motivation for centring attention on it is

weak while at the same time they feel pushed towards doing other tasks which seem more urgent and draw them away from the room. In spite of all this, little by little the nurse succeeds in entering into her role and each of the factors is modified as follows:

(c) General surroundings. The almost constant presence of the nurse in the room is a source of animation. Naturally she does not occupy herself all the time with the infant. Sometimes she works sitting next to the cot, sometimes moves about the room or is occupied with the other infants, but she plays with him and talks to him during her work. The infant, object of this experience, arouses lively interest among the staff and nurses come to see him to verify what their colleague has said about him. The room becomes a centre for discussion and the cot is surrounded with the noise of voices and bursts of laughter.

(d) Routine care of the child ~~became~~ tends to become more elastic and the physical care better adapted to the needs of the infant to the extent to which they are shown. Knowing her baby better and participating more in his emotions, the nurse can tell the Director of the nursery and the paediatrician what she thinks are the demands of her young protege. She asks for an increase in diet, for permission to treat him slightly differently, to advance or delay the time of bottles, to give him a little sugar water when he cries, to change a teat, etc.

(e) The quality of care. The dexterity of the nurse is not modified but the new arrangement tends to prolong the duration of it, to vary it, to foster the introduction of prattling and games.

(f) The quantity of ~~care~~ contact the nurse has with the infant increases as he grows. Though limited when the baby is very small, it can be seen to grow as the child becomes more interesting to the nurse.

(g) The quality of contacts: the creation and development of an emotional bond. As Kris, Provence and Coleman have remarked in connection with the mother-child relationship, the bond between the nurse and the child is not established all at once or by order. It is born, develops and is modified as a function of the care given and the reactions of the child to this care.

As has been said above, in each of the three cases, the nurse at the start was ill at ease in her role. However, being obliged to be close to the infant for a large part of her time, she begins to watch him, and from the observations and discussions which have been made part of the research project, her interest in the child is born - interest in ~~the~~ his crying or difficulties in sleeping which she seeks to understand, and in the acquisitions she seeks to encourage. Thus her interest is gradually focussed on the child and she begins on her part to show a variety of feelings. She is shocked at his misdeeds and admires his exploits; she attributes to him all sort s of qualities, faults, inventions, emotions. Her feelings are intensified, multiplied and show shades of difference as her care of him progresses and he develops.

From the first contacts, it is possible in this way to see the beginning and development of an emotional bond between her and the infant, which contributes in a more personal way to what she is doing. She consoles him, nurses him, smiles at him, etc. She who felt idle now considers herself "run off her feet", finding it difficult to care for two infants at once. It seems to us that it is only from this moment (and this we hope to be able to verify more objectively) that the factors (c) general background, (d) routine of care, (e) quality of care, (f) quantity of contact, are modified and this as a direct function of factor (g)(relation to the infant).

III COMPARATIVE STUDY OF THE TWO GROUPS (This part of the study has not yet begun; we are looking at the moment for ways of organising the observations in order to make a comparison possible and valid. What is indicated here is our first thoughts on the subject.)

The infants of groups I and II are thus submitted to two different types of experience. From this it is interesting to try to establish a precise comparison between the care they have received on the one hand and their development on the other.

(1) Comparison of care. The analysis of care, such as we have just made, lends itself readily to comparison. It is necessary, however, to make more precise the quantity and quality of the care received by each infant within each group.

In fact, the so-called normal care tended to become modified, so that the infants of Group 1 actually received care which was clearly different from those of the pilot study. The director of the nursery and her staff, feeling that individual care was better, are seeking to establish an organisation of work which allows an increased degree of constancy of staff concerned with the children and to reduce the number of nurses dealing with any one infant. On their side, the nurses are seeking to increase the proportion of care they give to the infant for whom they are specially responsible; they observe them more and bring to the notice of the paediatrician points which lead to an individualisation of diet. The duration of care is lengthened somewhat; the progress of the infant is watched more and encouraged. Thus the differences between the two groups tends to become less marked. It must be added, however, that these attempts at change do not affect all the infants to the same degree, so that it is proper to verify it in each case.

It is the same for the infants in Group II. We have seen that the quality of care received by the infant varies during the course of his stay. Moreover, it is a mistake to think that all infants necessarily "live" identical experiences. Against the background of individualisation, two different nurses act differently; it is also evident that one nurse caring for two infants does not do the same things for both of them.

All this serves to show that to whichever group they belong, it will be necessary for each individual infant to study the experience he has undergone. In order to do this, it is necessary to define the precise quality of each of the factors constituting the care in the nursery, not only over the whole stay, but also for different times during the stay.

We have seen that thanks to the system of "booking" of care given, the number of people dealing with the infant, the percentage of care given by each, are both easily quantifiable. Besides this, for infants in Group II we have information on the quantity of ~~early~~ daily/ contact offered to the infant, by means of a graph of individual care kept by the nurse. On this graph appears not only the successive states through which the infant passes but also the periods of ~~attention given~~ care, contact and play the nurse has with him during the day. We shall try to set up an equivalent system for the infants of Group I.

The other factors (environment, quality of care, quality of contact) could also be quantified tentatively. At each "continuous" observation and at the interview we shall have with the nurse responsible, we will try to rank these factors on a five-point scale.

This implies that we should disentangle and make precise for each one of them a certain number of components that we can evaluate. For example, to evaluate the quality of the nurse-infant relationship, the following points could be ranked: (method used and introduced by J.D. Benjamin, Child Research Council, Denver)

Relations of Nurse and Infant

1. Total impression
2. Kinesthetic union at times of care
3. Nurse: cold or warm in manner
4. Degree of affection shown
5. Degree of interest in the infant
6. Degree of receptivity
7. Satisfaction of infant's needs
8. Degree of aggression
9. The narcissistic-altruistic character of the relationship.

We shall attempt to define as exactly as possible the reasons for our ranking and to assure ourselves by joint observations of the degree of confidence that can be placed in our assessment, the two observers making separate rankings.

Having thus ranked each of the factors it will be possible to make a graph which will show a "profile" of the care received by each infant. Apart from this data, we hope to be able to rank the infants within the group and establish various types of comparison.

(2) Comparison of infants of Groups I and II

This comes up against numerous difficulties, in particular the individual differences existing between each infant: differences of constitution, speed of development, sensitivity, modes of reaction which make the infant react differently to relatively similar situations. This is suggested, for example, by the observations on Jean-Paul and Michel: 5 days of intense crying at the same age ending in both cases in a repression of crying, but by radically different mechanisms: wakefulness and activity for Jean-Paul; apathy and sleepiness for Michel. The fact that Michel is greedy for sucking, whereas Jean-Paul uses his eyes much more, could play a determining role. ~~Here~~ However that may be, it is an appropriate question whether the individual differences outweigh the effects of differences in care, or if, in spite of everything, there emerges between the infants of the two groups differences that are greater, more numerous or different from those observed between the infants of the same group.

Another difficulty is to determine the points on which it is fruitful to make a comparison. From the pilot study, the following comparisons seem to be worth making:

(a) comparison of certain elements in the longitudinal study: do the infants pass through the same stages of development with regard to the surrounding environment; are there marked differences between the content of each stage; how is the passage made from one to the other? Are the vicissitudes or deviations more frequent in one group or the other?

(b) comparison of infants of a given age (cross-sectional study). We would make the comparison at 2½-3 months, a little before their return home. We have chosen this age for various reasons: the study can be made on the basis of the intensive observations made in order to examine reactions to reunion; moreover, the differences between the type of care received will be at its height; finally, it concerns a point of development which is interesting to study, the passage from the state of attentive receptivity to the awakening of active tendencies.

The following will be studied amongst others: quality and quantity of wakefulness and sleep; reactions to frustration; quality of attention, interest, activity; capacity for social relations, capacity for recognising and differentiating the particular nurse.

(c) comparison of reactions at reunion: for example, comparison of the degree of disorientation and its ways of showing itself; comparison of the length of time needed for the establishment of a relationship between the mother and the infant and the quality of that relationship.

It remains to be determined how these comparisons can be made.

Comparisons from the longitudinal study will be essentially qualitative since they bear primarily on the differences between the "modes" of reaction. On the other hand, for comparisons in the cross-sectional study and on reactions to reunion, we will try to introduce a system of quantification comparable with that used in the study of care.

CONCLUSIONS

The project is still in progress and does not yet give any answers to the initial questions we are proposing to examine.

Up to the present, the project has above all allowed us to clarify and disentangle a medley of points for study in order to ~~arrest~~ arrive at a better knowledge of the way in which the environment acts on the development of the baby. It puts in relief the multiplicity and complexity of the factors which play a part in determining the effects of a stay in a nursery, and which are on the one hand a product of the care received, and on the other hand, of individual sensitivity and modes of reacting. In life, these factors play a role conjointly. It is not a matter of simple addition but rather a "play of forces" which we ought to be able to grasp, describe and, if possible, measure; we should then be able to reveal the result of their working.

This is thereason why, at the risk of a certain amount of ~~de~~ dispersion of data, it seems to us important that each of the points brought out in this project should be the object of individual study, although they should be studied simultaneously and not successively in order to retain the total picture of development and to ~~capture the~~ grasp the complex play of inter-relations.

This will be a long project but we think that gradually as it progresses partial results will emerge which can be communicated and discussed.

September, 1958

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We wish at this point to thank Dr. John Bowlby and his colleague Dr. Christoph Heinicke for the moral support and technical help they have given us in this work. ~~They~~ They have both devoted many hours to discussing the pilot study and have contributed largely to the organisation of the project in its final form.

Etude d'un Groupe d'Enfants ayant sejourne pendant un mois en Colonie Maternelle

by Dr. Myriam David, in collaboration with Mlle.
Jacqueline Ancelin and Mlle. Genevieve Appell

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Aims and Methods

The aim of the study was to observe the immediate reactions of the children to separation and the mechanisms they called upon in adapting themselves to communal life.

We have, in fact, been able to establish in the course of our work at the Pouponniere Amyot and the Foundation Parent de Rosan that the level of adaptation achieved during the separation and its later effects on personality depend on the psychological mechanisms which they use to combat the first pain of separation and the need to adapt to a new environment.

Two sorts of mechanisms habitually come into play during separation. On the one hand, the insecurity and anxiety caused by the loss of the mother bring into being a sort of collapse or annihilation which is the basis of the reaction sometimes of despair, sometimes of prostration, debility or regression; on the other, the child fights against this insecurity and distress with the aid of defence mechanisms which, while being his sole immediate weapon, can later limit his expansiveness in a way that is more or less lasting.

It is the combination of this double process of destruction and battle which determines the form and gravity of his difficulties.

This is our reason for undertaking a close study of the modes of adaptation of a small group of children in a 'colonie maternelle' (translated as 'Holiday Centre'). It seemed that an intimate knowledge of the reactions of a small number of children would give an indication of the meaning of the experience to the children in general, the nature of their difficulties, their ways of coping with them, and give better grounds than would a superficial observation of a larger number, for judging whether a stay in a holiday centre contributed towards or hindered favourable development.

Ten children were observed intensively and systematically while eight others were also observed intermittently. We are aware of the weaknesses of so small a sample. Moreover, the observations were made in one Centre alone. If this particular one seemed to show both the qualities and the limitations of the best of the Centres actually held in France, the study remains, nevertheless, an experiment with limitations, and hasty generalizations would be out of the question.

Its qualitative character, however, should lead, not to the taking up of definitive positions, but to a better general understanding of the emotional situations created for children by these stays, and lead to a greater capacity on the part of adults for an appreciation of the difficulties met with and the mechanisms of adaptation. From there it should be possible to develop means of helping individual children as well as a more differentiated organisation of social service.

In order to understand the children's reactions, it was necessary to observe them intensively during the separation and to have a good knowledge of their family background and the quality of their adaptation to it.

In order to accumulate data on each child, it was necessary to obtain the participation of the families as well as conditions within the holiday centre which allowed prolonged and detailed observations to be made on the children. To achieve this a good deal of team work was needed between the personnel of the family social service, the holiday centre and ourselves.

To this end, a visit to the centre during the year preceding the study, general meetings and individual discussions with the various people responsible, gave us the opportunity of explaining our aims, discussing objections, and eventually allaying anxieties. In this way we were able to arrange individual participation so that no extra work was created for anyone, and to determine exactly our own role and to see that it did not in anyway obstruct the normal running of the centre.

Selection criteria were discussed. The general tendency was to suggest the most difficult cases in order to gain some enlightenment about them. This implied a dangerous confusion about the aims of the study and care was needed not to fall in with this way of thinking. The following criteria alone were retained:

(1) Age: some from amongst the group for the smallest children (3-4½ years)
some from amongst the ~~group~~ middle group (4½-6 years)

(2) The fact that the child would return to his own home after his stay in the holiday centre.

(3) The fact that this would be his first separation.

In practice, it was difficult to find a sufficient number of children fulfilling all these criteria and, as will be seen, only the criterion of age was respected throughout.

After the selection had been made, the family social worker told the families of the existence of the study and, if they agreed to co-operate - prepared them for ~~the~~- a visit from the team's social worker. The purpose of the latter's visit was to explain the nature of the study and to arouse interest in the parents so that they would be motivated to give detailed information on their child's personality and to say how they felt about the child's departure and what had led them to decide to send him. In the course of ~~conversation---of~~ the interview, the social worker would ask whether the psychologist could come and see the child and to play for a considerable time with him both before and after his stay in the centre.

All the families approached agreed to participate. Their comprehension and interest in the aims of the study varied but their co-operation was constant and the welcome extended to the social worker and the psychologists alike was excellent. They all showed satisfaction in the interest that was being taken in both their children and themselves.

As stated above, the aim of the observations on the children was to gain a better insight into the nature of the child's immediate experience, his difficulties, how he copes with them and to what extent the mechanisms of his adaptation to life in the centre limited or otherwise his expansiveness and to what ~~the~~ extent the centre could or could not help him.

We shought, therefore, to determine the feelings of the child in the various situations in which he found himself and by what means he coped with them. We tried particularly to catch his reactions to events of importance to him, such as the moment of separation, arrival at the centre, parent's visits, leaving the centre and reunion with the family. Equally, we watched his reactions to the daily routine, the quality of his spontaneous activities, his relations with other children and with the adults who were engaged in his care, the use he made of them and the satisfaction he found in them. We sought constantly to comprehend his emotional state, his degree of ~~satisf~~ satisfaction or disatisfaction, his ability to seek again and find satisfaction, his capacity to defend himself against dissatisfaction or his tendency to sink

under it. We sought also to assess the effects of emotional state on character and adaptation at different moments at the centre, comparing at the same time the state of the child at the centre and at home.

At this age, of course, children are soon aware that they are being observed. This was even more so in this case becaue the observer, on her part, through the very function of observing a child's emotions, is drawn into showing interest in his feelings, whether of pleasure or pain, out-going or fearful, etc. Naturally quite a strong relationship tends to arise between observer and child. We decided not to withdraw or stand aloof from such relationships, but rather to let them develop and allow the children to make such use of them as they could. For this reason, it had been agreed that we should not have any active, directive or educational role like that of the nurses, but were, during the period of observation, completely at our own disposal to show any child sympathy for or understanding of the feelings which he struggled to express either directly or indirectly, verbally or not.

This approach naturally changed the experience of the child, affording him more often supplementary support. However, it seemed important to us not to refuse ~~the assistance~~ support to a child who showed his need of it. Besides, we thought that this method would provide as effective a demonstration of his feelings as pure observation of behaviour without involvement. We knew, in effect, that the very way in which the child used the presence of a receptive and understanding person would give a true picture of the state of his feelings and his emotional needs, seen through the type of relationship he establishes.

To observe a child, we followed the group he belonged to, noting rapidly on paper or memorizing a mass of actions and expressions. The observations were dictated or written-up the same day, all the remembered details being transcribed without any attempt at interpretation.

For six days at the beginning and at the end of the duration of the holiday centre, all three members of the team were present and observed three children each almost continuously or at least for many hours at a time during the morning and afternoon.

In the intermediate period, the psychologist (Mlle. A) remained as the sole observer. It was decided that she should observe two children at a time for half a day. Each child would thus be closely observed every third day. In fact, as the group for the smallest children gradually structured itself and the children joined in games together, it was possible to watch a greater number at the same time, which increased the frequency of the observations, each child becoming the object of a supplementary daily observation, albeit less closely carried out.

The same psychologist observed the children within their families both before and afterwards: 2 visits in the week prior to leaving home, 2 visits the week of the return home and then a further visit one month and three months later.

At the end of the first six days the observations on each child were reviewed and discussed by the three observers in order to arrive at a common understanding. Similarly, a common evaluation of the adaptation achieved by each child was made six days before the end of the period and the day of their departure from the centre.

The records on each child were studied later and the observations discussed with the director, some of the nurses at the centre and some of the social workers attached to the organisation.

Study children

Berthe B.	} sisters	5 years 6 months	
Paule B		4 years 2 months	
Michele D		4 years 6 months	
~~Pierrette~~			
Pierrette X	(sister)	6 years 6 months	
Didier X	(brother)	3 years 11 months	
Denise A	} sisters	5 years	Average 4:8
Maryse A.		3 years 10 months	
Emilie C.		3 years 9 months	
Pierre C.	} brothers	5 years 6 months	
Andre C.		3 years 11 months	

As the table shows, nine of these children were in the room for the smallest children, either at the beginning, the end or throughout their stay. This gave the observers the opportunity to spend most of their time with this group, so that they were able to note the reactions of eight other little ones, listed below, although to a lesser extent.

Collette A. (sister of Maryse and Denise)	6 years
Simon and Tobi (brothers)	6 years and 3½ years
Amelie (cousin of Simon and Tobi)	5 years 6 months
Jeanne and Chantal (sisters)	6 years and 4 years
Pierrot	5 years
Jackie	4 years 6 months

The ten study children reacted in very different ways, and it is convenient to classify them according to their initial reaction into three categories: (i) open distress; (ii) disorientation; and (iii) easy adaptation. It should be noted, however, that this concerns initial reactions only, the final pattern of adaptation being often of a very different nature from the initial one.

Open Distress

Out of the fourteen children in the group for young children, we noted six cases of open distress, of which two were amongst the study children. In each case the distress was characterized by crying, an obvious state of confusion, dejection, prostration, inertia, lasting several days. We give here the detailed observations on two children showing such a state: Maryse and Denise.

Maryse and Denise are sisters aged respectively 3:11 and 5. They both came to the centre with their sister Colette (6½), while three older children and a younger baby stayed at home. They belonged to a socially disturbed family. The family environment was difficult. The children seemed to be left to their own devices, taking care of one another without supervision. There was incessant quarreling. The home was unstable and the previous year the children had had to be put under the care of the "Assistance Publique de la Seine" for several months. Mlle. Y., who was their nurse at the centre, worked with this family.

Observation on Maryse (3:10)

... On the occasion of the psychologist's visit, Maryse was very shy. She refused to say good-morning, said absolutely nothing during the first half of the visit, and stayed completely passive and inert in front of the toys brought by the psychologist. On the other hand, a little while before the psychologist left, while the latter was talking to her mother, Maryse became quite animated, tried to keep the test toys to herself and openly expressed her opposition to Mlle. A., crying "No, no" from a distance to every word. She cried a little when the toys had to be given up. At the second visit, although still shy, Maryse leaned up against Mlle. A., and allowed herself to be coaxed by her. She played more actively with the toys. Once again she became difficult and verbally aggressive at the end of the visit, shouting at Mlle. A. "No, no naughty!" for no particular reason. Amongst her brothers and sisters, Maryse became rather inconspicuous. She seemed to make Denise her protector, staying willingly with her at difficult moments.

Detailed observations during stay at centre: only summary at end translated.

... In general, at the end of her stay Maryse was happy, well adapted to the routine, well-behaved, but all those who looked after her were struck by her 'inner poverty'. Her demand for contact was of quite an early, primitive, form and oscillated between 'kittenishness' and a form of aggression, brutal in nature and little controlled. She behaved in this way towards any adult without discrimination. She was more cheerful and assured but her activities remained poor in quality and just as they had been at home.

Maryse can be said to have succeeded in overcoming her distress and recovered her feeling of security. Undoubtedly the quality of her contacts and her games remained poor but this poverty was in keeping with her emotional immaturity and her previous psychological difficulties - probably bound up with the defective conditions of her upbringing, particularly the very narcissistic quality of the maternal tie.

Denise (5). During the psychologist's visit, Denise was the least shy of all the children. She quickly made advances to her, went to find the case and used the toys she found in it in a constructive way and with a good deal of pleasure. In her games she showed herself to be imaginative. She was gentle and protective towards Maryse and the younger child, and remarked to Mlle. A. "You see, Maryse is afraid of you"; "Maryse isn't happy". On the second visit, her interest in the observer had diminished, her games were less stable and she was quite dictatorial to her older brothers and sisters. In general, she showed a better capacity than Maryse for establishing relations with others and more resourcefulness, activity and imagination. It was possible to think that this child, readily sociable, little loved by her family, and showing pleasure in playing and being active, would adapt herself easily to life in the Centre. In fact, she did adapt but only after passing through an alarming state of depression.

(Observations).... Thus Denise, like Maryse, reacted with a deep distress which lasted four days, expressed mainly by a state of deep depression from which it was difficult to arouse her. Like Maryse, she could be seen to emerge from this distress little by little as she rediscovered a measure of security in Mlle. Y.

Seeing the difficulty she had in establishing relationships with anyone except Mlle. Y., it could be asked whether she had in fact succeeded in overcoming her depression in the absence of Mlle Y. and her sisters. On the other hand, the presence of Mlle. Y. and the experience she had lived through with her had been for Denise a source of an unusual affective growth which revealed her capacity to love as well as the development of her tendencies towards activity and imagination. It seemed that by means of this relationship Denise became capable of a certain degree of independence and to take pleasure in it, which should be helpful to her later at home and at school.

Other Observations. We will only give a summary of the observations on other children showing violent distress. Amongst them, Tobi ($3\frac{1}{2}$) went unnoticed and only at the end of the first day dissolved into floods of tears. He was inconsolable, insensible to the observer who held him for a long time on her lap. Tobi's outbursts of crying were as painful as they were violent and as he refused all ~~help~~ comfort, theywere followed by a state of dejection, prostration and inertia which grew worse during the first six days. Tobi, however, finally emerged from this state and by the end of his stay became one of the most well-balanced children in the Centre, independent and boisterous, without being aggressive.

His older brother Simon (6) ~~showed~~ shared his distress but did not abandon himself to it. He tried hard to be brave and to suppress his tears. He managed to find consolation in the observer, but he did not establish an elective relationship with anyone and the quality of his adaptation to life in the Centre remained unstable, although better than in the previous year. One felt him to be often dissatisfied, and he was argumentative with the other boys.

Amelie ($4\frac{1}{2}$) went through a long phase of deep distress. To emerge from it, she attached herself to one of the observers who, being concerned also with other children, could not respond to the totality of her demands. Amelie overcame her distress but, like Simon, did not expand completely and remained ambivalent and demanding in her relations with adults and children.

As for Colette (6), the older sister of Denise and Maryse, her reactions followed the same pattern as the two younger children. She profited a good deal from her relationship with Mlle. Y. and later enjoyed being protective ~~twe~~ towards the smallest children, like Emilie. She did not become as expansive as Denise but was better able to assert and amuse herself than Maryse.

Reflections on the cases of open distress

Out of the fourteen children in the youngest group, six showed an initial reaction of violent distress characterized by a veritable 'collapse' of the personality, an inability to defend themselves against complete disorganisation. These children seemed lost, utterly engulfed by their distress and destroyed by it.

Notice the difficulty these children had in gaining comfort from an unknown adult, the sight of whom only served to reinforce their insecurity. None of them, except Simon, accepted at the beginning any form of comfort from, for example, the observers; quite the contrary. The presence of a family worker known to them seemed to have been of considerable support to these children, particularly Colette, Denise and Maryse. Even so, several hours passed before they were able to approach her; several days in the case of Tobi. Equally, we were completely surprised to discover that the approach of the little A. girls to Mlle. Y., as a person known to them, was partially unconscious. In fact, Colette, who was the first to seek consolation from Mlle Y., only discovered after ten days that Mlle. Y. was the same 'jeune fille' who came to her home. After she had become secure in her relationship with Mlle. Y. she suddenly declared in astonishment, "Oh! Are you the girl who comes?"

It should be noticed as well that all these children succeeded in emerging from their distress and that in all cases, their adaptation involved an improvement and broadening of personality. For two of them (Denise and Tobi) it can be said that the experience was of positive value in allowing them to experience a very satisfying type of relationship which helped them towards a considerably greater maturity. The progress recorded at the Centre was lasting and was noticed and confirmed by the family and Mlle Y. later. Two children (Maryse and Colette) found satisfaction in the Centre by the end of their stay and had lost their insecurity. Amelie and Simon, too, lost their insecurity but showed signs of dissatisfaction right up to the end. It is notable that they were the only ones who did not establish an elective relationship, satisfying to themselves, no one being available to respond to their "thirst" for exclusive attention.

Reactions of Disorientation

Among five of the study children, there was no open distress but a slow and difficult adaptation. They seem, in fact, to have been disoriented, frightened, anxious, but their reactions brought into play psychological mechanisms more complex than those we are going to study.

In general, adults regard these reactions rather as more or less unpleasant character traits in the face of which they show varying degrees of tolerance and patience; traits which they either wish to try to correct or to which they attach no importance.

Michele D. (4½) Michele was a fine, well-built child with blond hair in long, thick plaits, perfectly combed, and blue eyes that were not very expressive. She was the eldest of a family of four: Chantal (3½), Denise (2½) and a baby of six months. Her mother, barely 22 years old, was a lively young woman who seemed to have simple and warm relationships with her children. Worn out by successive pregnancies, she had become very thin and Michele's departure was motivated by the mother's need for rest. Mme. D. would willingly have let Michele go with Chantal, who although younger was more independent and lively. However as Chantal has asthma on the day of the medical examination, she was not accepted. Mme. D. was more reluctant to let Michele go alone but resigned herself to it. If the paternal grandmother had been in better health she would have taken the two children to help her daughter-in-law but was not able to do this because she herself was just recovering from the effects of an operation. There seemed to be ~~though~~ throughout the family a certain degree of ambivalence about letting Michele go, but no one being able

to make the effort to take her, there was tacit agreement to let her go. While with her mother, Michele wanted to go to the Centre very much and asked every morning if it was time to go. Everyone seems to have described the pleasures of the Centre, the farm, the animals, etc., in glowing colours. Michele had been to school but only for a few days, her attendance being broken off because of whooping-cough. At school, Michele, who had been quite clean during the day, soiled regularly.

Michele was described by her mother and those about her as an easy, well-behaved child, very talkative, who amused her family very much by her incessant prattling and comments in advance of her years. She was a bit shy with people she did not know but readily got used to them, though not as quickly as Chantal who would go immediately to anyone. During the psychologist's visits she showed herself to be shy but able to overcome her shyness and become very talkative, curious and interested in everything going on around her.

Observations ..... Towards the end of her stay (from the 18th-25th day) while remaining on the whole well-adapted, she began from time to time to be a little more peevish. This may have been due to the fact that she was developing measles. Indeed on the 26th day Michele began to cough and was feverish and two days later the rash broke out which led to her return to her maternal grandmother. Thus, Michele at first tried to cope with the situation without help. She defended herself from the pain of separation by pushing it back, by repressing any feelings whatsoever. In doing this she froze into a dejected state of passiveness in which she was ~~empty~~ completely inexpressive. There were no evident signs of distress; she simply gave the appearance of a plump little girl, a little bit slow to respond and sluggish, not very attractive or resourceful. This apathy and the protracted nature of all her actions was somewhat irritating for the nurse who was surprised and impatient at Michele's lack of response to the activities she suggested. This apathy was in fact at one and the same time a passive resistance, inhibition and a depressive state which became evident after the third day, although systematic observation had revealed signs of it from the first day. During the first day, she fought her distress; she tried to attach herself to Pierette and made use of the advances of the observer, emerging from her passive state to ask questions, but this show of interest was fleeting and intermittent and in the end her depression increased.

Her father's visit, in spite of the cold welcome she gave him, gave Michele the opportunity to express her feelings about the loss of her mother. She was reassured and at once changed completely, becoming active, lively, cheerful and talkative. She did not, however, succeed in establishing a ~~real~~ relationship with her nurse and seemed again to sink into depression. However, she had recovered sufficient security to enable her to express her distress and dissatisfaction and to oppose her nurse more openly and to seek actively a relationship with Mlle. Z. This relationship allowed her to recover some of her independence and to adapt herself to ~~communial~~ communal life among the little ones. Then, as she gradually took her place among them, she had less and less need to seek the support of Mlle Z and became completely integrated ~~with~~ into the group. This attachment showed itself again towards the end of her stay, possibly because she began to feel her loss again, but more probably because the onset of measles made her feel unwell and in need of comfort from an adult who would give her individual attention.

Emilie O. (3:9) Emilie was the only child of Mlle. O., an unmarried mother. Mlle O. lived with her mother and went out to work. She had put her daughter in a day nursery from the age of three months. The relationship between Emilie's mother and grandmother seemed somewhat poor. Mlle. O. complained about her mother and represented herself as the only one who looked after the child, not being able to rely on her mother, whereas it seemed that the grandmother did in fact devote a lot of attention to Emilie and was very fond of her. There was it seemed not a little rivalry over Emilie between the two women and Mlle O. seemed to be sending Emilie to the Centre so as not to have to depend on her mother. She seemed also a little jealous of her mother's affection for Emilie. Both women were rather on the defensive during the preliminary visits by the observers but later became more confiding, though always critical of the social services.

During the psychologist's visits Emilie went to her and explored the box of test material with a certain amount of interest, though without playing very constructively with it. She hardly spoke, but cried when Mlle A. left

with the toys, but welcomed her with a happy smile at the second visit. Mlle A. gained the impression that Emilie was a little withdrawn and already not a little unstable. Probably Emilie felt somewhat inhibited during this visit, as both mother and grandmother said she was usually talkative and sharp. Later observation confirmed this. We were not able to gather any more precise information from the day nursery, but understood that she was easy to deal with and had no problems.

Observations ..... 5th-8th day. During the three or four days after the observer had left, Emilie maintained her successful adaptation. She tended to attach herself to the director Mlle Z. on whom she became quite dependent. In Mlle Z's absence, she was ~~un~~ able to benefit from group activities such as dancing or 'skylarking' in the dormitory. Then almost imperceptibly her adaptation deteriorated. She cried more often. She still asserted herself but mostly by opposing an imperative 'No' to whatever the others wanted. She became increasingly self-centred with a certain amount of aggression. She lost her pleasant expression, became intolerant, cried the moment anyone touched her. She was often to be seen standing idle by someone's side; not always the same person. If anyone or anything frustrated her, she screamed, looked overwhelmed and took a long time to recover. At mealtimes, Emilie began again to "freeze", took on a stupid look and lost appetite. It was noticed that she dreamed and cried often in her sleep. She even wet her bed. None of these changes were however dramatic; they happened progressively and almost imperceptibly. Thye were very striking when the observations were read through.

On her mother's visit (18th day) she was overjoyed to see her and was very affectionate but at the end of the visit she was sorry to have to return to the Centre. In the days which followed she became worse. Finally, she developed a feverish chill which necessitated her staying two days in the sick-room. There she made use of the two nurses who were present and from whom she demanded a good deal of attention and with whom she became considerably more expansive. On her return to the group she adapted quite easily but continued to be stubborn and possessive. No one, for example, could make her give up her place on the swings.

Emilie spent two days at home (23rd and 24th day) for a family celebration. On her return, her face was dead and expressionless, refusing to look at anyone until Mlle Y., her nurse, took her for a walk on her own. Under these conditions she quickly made an excellent link with Mlle Y., through which she attained the same expansiveness as she had with the observer at the beginning of her stay. At this point the observer returned. At first, Emilie pretended not to recognize her. Mlle Y. had become for her the important person. On the second day she was equally friendly to both and showed what she was doing tirelessly to both alike.

.... Emilie reacted strongly to the separation. Like Michele she defended herself from distress by "dying". She ignored the games, watched surreptitiously all that went on, was ~~unresist~~ unresisting and docile, cutting herself off from all feeling. This very absence of affect, this docility, easily fostered the notion that Emilie, like Michele, had adapted herself easily, while her lack of expression, the poverty of her activities, her indifference would be regarded as normal to her. However, as Emilie began to take notice of the adults around her and to respond to any attention paid to her, she became much less withdrawn and thanks to a satisfactory relationship with an adult, succeeded in establishing herself happily in the group. She could not maintain this state without the ~~su~~ support of this relationship. After the observer had left, her success in this first attempt to form a relationship enabled her to approach another adult, the director, Mlle Z., but with the lack of opportunity to establish with her a completely elective relationship, her adaptation deteriorated gradually, until at moments it resembled that of her first days. When once more she was able to establish a real and elective relationship with her nurse, Mlle Y., the excellent quality of her adaptation was restored. The elective relationship she had created a second time with Mlle Y., derived from the fact that the latter had understood her distress and was able to give her exclusive attention, which had not been possible during the first days of her stay, for at this time Mlle Y. was absorbed in the acute distress of four children, while in comparison Emilie appeared to have no problems. Moreover, Emilie did not make any spontaneous appeal to Mlle Y. or, if she did, it was in an indirect and tenuous fashion so that it passed unnoticed. Besides, once the observer had responded to her need for attention, Emilie no longer sought to turn to Mlle Y.

Didier X (3:11) Didier was the youngest of a family of three, Jacques (9), Pierrette (6½). All three had been to the Centre the previous year and remembered well the director, the buildings and the group organisation. Pierrette and Didier dreamed of being put in the group for the biggest children. Pierrette was also a subject for observation.

They came from an economically better background than most of the children but small and unsuitable accommodation made daily life difficult and interviews with the mother revealed profound psychological difficulties which had had obvious effects on the children's personalities. All three presented difficulties in one form or another: Jacques was backward at school; Pierrette suffered from obsessional neurosis. As for Didier, he was a whimsical little fellow, very dependent on his mother who tended to treat him still as a baby and who at the same time found it difficult to bear his reactions of dependence, in which he was querulous, unsatisfied and demanding.

On the observer's visit, Didier gave the impression of a friendly little boy, liking to show of his energy, to explore, taking pleasure in his achievements, and doing things to attract admiration. However, at the slightest frustration he became stubborn and grizzly, clinging to his mother, full of demands and contradictions.

Observations.... To summarize, Didier was a child who, in spite of his previous stays at the Centre and in spite of the presence of his brother and sister, had great difficulty in adapting. He reacted first with passive resistance and isolationism, passing through an alternation of depression and moments of excitability during which he tried to prove his strength and to identify himself with the bid boys. This method of adaptation was abandoned at any set-back; in effect, after these moments of excitability and attempts at a show of strength, Didier reverted to dissatisfaction and depression. Didier was only able really to make an adaptation after he succeeded in establishing a relationship of dependence upon a mother-substitute. After that, Didier opened out progressively within the group which was well adapted to his needs. He found his place amongst the other children and succeeded in adopting his nurse, recognizing her as the person on whom he depended and who was important to him.

Pierrette X and Andre, C. We will only summarize briefly two other cases: that of Pierrette, sister of Didier and Jacques, and that of Andre C, who showed no more open distress than the others, but many signs of difficulty in adaptation. These two children, however, were both quite deeply disturbed. Pierrette showed all the symptoms of an obsessional neurosis, involving a certain amount of feeble-mindedness; and Andre was an unstable, border-line defective.

Pierrette (6:6) Pierrette was a thin child of six and a half, tall for her age and pale. She had adapted so badly the previous year that the director had asked if she were defective and advised the mother to consult a neuro-psychiatrist. She was timid, worked badly, was backward at school and had great difficult in verbal expression.

Although Pierrette seemed to have serious difficulties in adaptation, she didn't give the impression of being deeply disoriented. Hemmed in with already-existing obsessional mechanisms, she easily found a modus vivendi. She undoubtedly was distressed at the beginning of her stay and responded to her distress with an exaggeration of her symptoms, but within the liberal atmosphere of the Centre, she was able to make a place for herself that gave her a certain amount of happiness. We will return later to the importance for Pierrette that her neurosis was accepted and that no one in the Centre sought to check her behaviour or force her to give up her protective rituals. This attitude clearly allowed Pierrette to obtain the full benefit of this experience.

Andre C. (3:11) Andre, the last but one of a large family, five of whom were at the Centre, was a slightly defective and very unstable child. His behaviour during the first few days at the Centre seemed to be the same as at home - moments of excitability during which he devoted himself to stereotyped games of an aggressive nature in which he shouted, threatned and bit, and phases of inactivity when he had a dejected and stupid look. This child was very protected at home; mother and older brothers and sisters all

responding freely to his need to be petted and coaxed. At the Centre he rarely sought out his brothers and sisters, although they often came to see him, and he enjoyed their attentions. Quite often he tried to make an approach to an adult but the primitive and quite aggressive form of his approach, his way of rubbing up against and licking one were was not attractive, any more than the poor quality of his interaction and his games. As a result no one in the first fortnight really responded to his demands for affection.

The alternation of depression and excitability grew more exaggerated, so that although he accepted the routine of the Centre at first without fuss, it weighed increasingly heavily upon him as time went on, and he experienced greater occasions for frustration and wretchedness. Towards the end of the first fortnight, Andre's difficulties became more noticeable to the nurse and observer and he then began to receive greater attention from one or other of them in various ways, so that he became very dependent on his nurse, and managed to become interested in various manual activities. These he did very badly but at least he was able to concentrate on them and found pleasure in them.

Easy initial adaptation

Among the children observed, three showed neither reactions of distress nor of disorientation at the beginning of their stay at the Centre. They were Paule and Berthe B. and Pierre C. Amongst the other children in the youngest group, there were two little girls, Jeanne (5) and her sister Chantal (4).

Paule B (4:2) Paule was the fourth child in a family of six. The three older ~~ejeydren~~ children, Berthe (6), Gerald (8) and Bill (10) were also at the Centre. The two younger children (2years and a few months) remained at home. A seventh child was expected. This was the first time the children had been sent to a holiday Centre, and it was because of the fatigue of the mother who was a tall, pale young woman, who appeared to be very tired. The loss of a baby several months previously had affected her deeply and absorbed by memories, the liveliness of the other children had become too much for her. While wanting very much to be free of the children for a while, she was uneasy and fearful of accident to them. However she made the decision because the family worker who helped her regularly would be at the Centre. In spite of the drain the children made on her energy and resources, one felt that she loved them well and was anxious to protect them from her fatigue, depression and bitterness. She was sensitive to the difficulties of each child and showed by the way she spoke that she was aware of them, but in her interaction with the children, she had difficulty in not allowing her ambivalence to show through.

She and her husband were a united couple, completely in agreement about the way of life they led. Mr. B., once an artisan, had chosen to become a skilled salaried worker, in order to ensure greater comfort and security for his family. He loved his children and had a distinct preference for Paule. He was not interested in Berthe and found her a little wearing.

Paule was described as a little girl who was cheerful, friendly and charming and who made herself immediately likeable but who was not very good-natured and could be quite peevish. Berthe passed unnoticed beside her sister. She was much less attractive, a fact which her mother considered an injustice, but was more sensitive and alert. Her mother always seemed to regard her as a victim of circumstances. Paule was a pretty, chubby little girl, with thick short hair, her face suntanned and with dark shining eyes. There was no trace of shyness and she showed herself at home to be high-spirited, demanding and self-centred, ~~intolerant~~ intolerant towards the others, angry when crossed, able to get her own way and tyrannical towards her mother.

Observations..... Paule adapted without any difficulty to the Centre at first. She immediately arranged to be 'adopted' by the observer and established a close relationship which seemed to satisfy her. It is interesting to note that she had at once sought out the observer when the latter had taken an interest in Berthe. During the time that this relationship was maintained and developed, Paule was perfectly friendly and well-behaved. In contrast, the departure of the observer seemed to be the origin of her difficulties. At the time, Paule ignored her departure but became extremely aggressive. On the first day this was directed mainly towards three people: Emilie and Simon, the two children with whom she had had to share the observer; and the second observer. (Paule had established an identity between the three observers. When one was not present, she would ask of the other, "Where is your sister?").

In fact Paule felt furious with the first observer who had abandoned her. She did not however talk about it, but directed her aggression against those whom she mentally associated with her. Unfortunately Paule's aggression was not understood as a reaction of disorientation, and in her violence she was so intolerable that instead of arousing pity, she brought down the indignation of the adults upon her.

In the six days that followed, Paule made do with an ambivalent and very dependent relationship with the second observer. Paule would constantly seek her out but was at the same time aggressive and provoking, seeming possessed with the desire to arouse in the adult opposition, limitations, prohibitions and punishment. This behaviour reached a peak during the absence of the nurse, and soon after the nurse's return, a visit from her mother and the return of the observer, Paule improved and became better-behaved, but never recaptured the ~~eclat~~ eclat nor the quality of her initial adaptation.

Pierre C (5:6) Pierre was the eighth in a family of ten children. His father, a factory worker, was in regular employment and seemed a very good father, affectionate and good-tempered. His mother did not work but remained at home looking after the children, the home and the shopping. She had on occasion kept the children away from school so as not to be alone and to have them at hand to help her.

Mme. C. was very proud of her large family and seemed happy to have the children around her. She played considerably on their emotions and sought demonstrations of affection from them. They responded willingly and there existed an atmosphere of happiness and understanding in the family. It seemed that sometimes she smacked them hard but that did not seem to worry them. The older children were particularly gentle with the little ones. None of the children had been away from home except during mother's stays in hospital, when they were put in a nursery but saw her nearly every day. Their mother had great difficulty in balancing her budget and had perhaps a tendency to drink.

The eleventh child was expected. Mme. C. had no complaint; she considered it normal and was proud of it. She was however very tired and her legs were in a bad state, and for this reason she and her husband decided to send the children to the Centre. They accepted this solution because the family worker, Mlle X. who had been coming to them for a long time and whom they liked very much, would also be there. Nevertheless, Mme C. said it did something to her to see them go. She said that the two little ones, Pierre and Andre were a nuisance because they were demanding all the time, but she didn't express any anxiety about the children "because they will have Sophie" (the family worker).

Pierre left for the Centre with four of his brothers and sisters and was with Andre in the youngest group and was cared for by Sophie (the family worker). He was a bonny child, well-set-up and with a prepossessing face and sparkling expression. At home he was very interested in the observer's visits and sat on the table so as to be able to see her better and 'drink' in her words. However, whenever she spoke directly to him, he turned shy and would not respond. In contrast, when one or the other of them suggested doing something, he was 'off like a shot' and was never last. In the end, he even asked for a drive in the car. Once in the car, where he took the best place, he began to sing infectiously so that the others joined in. In much the same way he submitted without protest to the authority of his elders. On the other hand, if he wanted something he could not have, he would whine, lolling his head in a miserable way. Pierre seemed to understand that he was going to the Centre, but did not express any feelings on the subject.

Observations.... Pierre's history (in the Centre) ressembled closely that of Paule. At the outset he 'adopted' Mlle X. and obtained sufficient satisfaction from that to enable him to maintain his usual lively good-humour. It seemed as though everything would turn out favourably for Pierre, but gradually he too began to show numerous symptoms which are characteristic of children suffering from a loss of some sort - peevishness, unreliability, irritable and irritating.

Other observations. Three other children, Berthe (Paule's sister), Jeanne and her sister Chantal adapted initially to life in the Centre without difficulty. The observation on Berthe was a repetition of Paule and Pierre. The only difference was that at first Berthe seemed to do without a mother substitute. She was manageable, obedient, found many things to do that she liked and

was happy with the routine. She did not take particular interest in the adults around her but had occasional friendly contact with them. But in the same way as Paule and Pierre, her adaptation deteriorated progressively to a point where, near the end of her stay, she became extremely sensitive and cried frequently for no reason at all.

Comments on the cases of easy adaptation .

These cases were characterised not only by the fact that the children showed neither rage, fear, nor anxiety, but that they were capable of varied activities, both constructive and imaginative, and were sociable with the adults, both wanting and able to establish a relationship with them. Undountedly these children could display character traits that were more of less unpleasant, Pierre's boisterousness, Paule's selfish egoism, Berthe's extreme sensitivity, but these did not succeed in preventing them from benefiting from play and contact with adults. This was the normal character of the child who was already sufficiently mature to be capable of a certain amount of independence, and to profit from anything fresh and new without being afraid of it. As far as Berthe, Pierre and Paule were concerned, these three children were interested in everything that went on in the Centre, and each one immediately found there something he or she liked - for Paule, the sand, the toys and the company of the observer; for Pierre, the swings, the opportunity to run and jump about, the pleasure of being with Sophie whom he adored; for Berthe, less evident to be sure but existing all the same, pleasure in the play materials.

However, it seemed to us that these three children did not maintain their level of adaptation, and that gradually they became more difficult as if they were suffering from a loss, of which they were not fully aware but which made itself felt through an undefined state of disatisfaction which caused an exaggeration of all the unpleasant traits in their personality to a point where they became unbearable.

Paule seemed to maintain her level of adaptation as long as her relationship with the observer lasted. Pierre did not lose his Sophie but he too became more and more difficult, often managing to discourage her and tire her out. In Berthe too there was a slow deterioration and she ended up in a chronic state of semi-satisfaction.

We felt that if they had to endure a protracted stay at the Centre, these three would become typical of children so often found in nurseries - aggressive, unstable, dissatisfied, attaching themselves compulsively and without discrimination to any adult, but at the same time unable to be satisfied by the attention of these very people to whom they attach themselves.

Assessment and analysis of the effects of their stay in the holiday centre

The striking fact revealed by a review of the observations on the ten children studied closely was the intensity of each child's reaction. Not one escapted. Did the other children have the same experience? We can only hazard an answer for the youngest group where eight children, though not studied systematically, were observed fairly closely. Amongst them were four cases of open distress, the fourth, Jackie, about five years old, rejoining the little ones on the sixth day because he showed increasingly signs of being unable to adapt to the middle group in which he had been placed. There remained therefore only three children out of 18 who did not show apparent signs of difficulty. One of them, Pierrot, was slightly defective, somewhat like Andre C., and went completely unnoticed, as Andre would have done if he had not been the object of special study. We can say nothing about him. Jeanne and Chantal were remarkably well adapted to the youngest group during the six days they lived in it. These two little girls were very attached to each other, very mischievous, constantly played together, fitting into the routine without difficulty. They were completely occupied with their pranks and games and nothing else seemed to preoccupy them. They did not seem to form any special friendships with other children but amalgamated with the group and its activities with ease, allowing others to join in their games. After the sixth day they were placed in the middle group and we were not able to see them so often but their level of adaptation seemed less good at the end of their stay than at the beginning, especailly in Chantal, the younger.

Altogether, we have to ask ourselves whether or not the children benefited from such a stay. An answer can be attempted as a result of studying first the degree of adaptation to life in the Centre and secondly, to effects observed after return home.

(a) Adaptation at the Centre . Our criteria for judging difficulties in adaptation were:

(i) if they showed open distress (Maryse and Denise)

(ii) if they put into action defence mechanisms which absorbed all or most of their energy abd became the main components of their behaviour (Didier, Michele, Emilie)

(iii) if certain character traits become exaggerated and become a source of disturbance (Andre, Pierrette, Paule and Pierre).

When the child arrives at the Centre it brings with it a personality already partly formed, distinguishable by individual tendencies, and a personality structured by the ties he has developed with his parents. Thus every child arrives with his own level of maturity, his own particular areas of unresolved difficulty, his own character traits and complex of habits. Obviously Pierre's boisterousness, Paule's egoism, Berthe's sensitivity, Andre's defectiveness, Pierrette's obsessional rituals, Michele's timidity, etc., existed before they came to the Centre. Clearly also these were the traits, already very well defined, which would be shown at the Centre as at home.

In effect, we did not expect Andre to become intelligent or that his games would become constructive and stable, nor that Paule would become modest and altruistic, nor that Didier would stop flaring up into a temper for nothing. However, within certain limits, depending on the environment in which they found themselves, these children were capable of a degree of expansion of personality. In other words, their activities could become more or less constructive and varied, they could establish varying degrees of good relationships with those around them, both children and adults; there were occasions when they would experience inevitable frustrations and would cope with them either better or worse; and they would have opportunities to be either more or less cheerful, animated, good or bad-tempered.

Paule, for example, at the beginning of her stay was undoubtedly already self-centred and as good at getting her own way. This was the type and level of relationship she was capable of establishing and which she needed to feel secure. If she can have this type of relationship, she flourishes, that is, she puts all her energy into her activities, her play, her relationship with the observer; she can accept the routine without difficulty and even tolerate the fact that the observer is interested and concerned with other children. But when, for one reason or another, Paule regresses and begins to live at a lower level of maturity, where her needs grow stronger and her tolerance of frustration diminishes, so that she cannot overcome her difficulties of rivalry and jealousy, we speak of her as having a diminished level of adaptation.

Thus our judgements on the level of adaptation of a child are not static and absolute but relative with regard to the evolution of behaviour, in which we sought to capture and understand the fluctuations in it. We have tried to represent on graphs the evolution of the children's adaptation. This is not stringently scientific and has no absolute numerical basis but is a visual representation of the successive states undergone by each child. Time forms the abscissa, the ordinate being level of adaptation in which we differentiate out three areas: distress (lowest), difficulty in adaptation (middle), expansion (top). Into these three grades we place somewhat arbitrarily the child's degree of emotional maturity. In the top grade we placed the child in good physical condition, with the intelligence level for his age, able to interest himself in play with a certain degree of stability, to assert himself amongst the other children but at the same time showing tolerance towards them, and to establish a relationship with adults other than parents, without becoming totally dependent. Examples are Paule, during her first days at the Centre, Michele at home, and Denise at the end of her stay.

graphs at end.

We gave a middle grade to the child who, having an average level of maturity for his aged, showed many difficulties (Didier, for example) or to the child which remained a little younger than his age (Emilie and Pierre). The third grade was reserved for children with serious difficulties, such as Andre and Pierrette.

Examination of the curves showed that all the children had moments of distress and inadaptation. For the former, taking the form of open distress at

the beginning of their stay, soon reaching a maximum intensity and then decreasing slowly, the child adapts progressively until it reaches a ~~plateau which is~~ ceiling which is more or less high according to the particular child. In others the distress was masked but grew steadily, then they seemed again to gain the upper hand and progress towards a better adaptation.

Finally, in others distress was delayed but progressive and did not begin until the end of the first week but grew considerably, the curve only rising again at the end of their stay and then not reaching the initial level (Pierre and Paule).

It is noticeable that most of the children (7 out of 10), with the exception of those with delayed distress, moved towards an improved adaptation but most did not achieve a satisfactory level until the second half of their stay and sometimes not till the last week (Didier, Andre).

On the whole, the final level of adaptation seemed to correspond in these cases more or less to the quality of their adaptation at home, except for two children in whom it was clearly superior (Denise and Tobi) and perhaps for a third (Didier).

(b) After-effects. A far more minutely conducted study than we have been able to do would be needed to judge later effects. Home visits were too few and too infrequent. Moreover, the conditions for observing the child at home were inadequate. The results given here are therefore tentative and do not allow predictions of the ultimate effect on the child's personality.

It should be noted only

No dramatic reaction was observed in any case. ~~We noticed only~~ that it took Pierre several months to regain his former balance and to become again the jolly amiable little fellow he had been. This was reported by his nurse, who continued to go to the home as family worker.

When the observer visited, Paule had settled once again into her usual place in the family; her difficulties did not seem to have become any greater and she had regained her friendly, shining expression. However, although the had been quite well adapted to school life the previous year, it seemed that this year she had serious difficulties. Her teacher who had been fond of her previously did not seem to have any success with her. Paule seemed to be as disagreeable at school as she had been on her worst days at the Centre. We wondered whether the communal life at school aroused in Paule reactions of aggression and jealousy which could not be understood by the teacher and which served to stir up a reaction of contraryness ~~with~~ towards the teacher ~~from~~ which they were not successful in overcoming, just as Paule had reacted to the second observer at the Centre.

Two children seemed to have gained real benefit from the Centre. These were Denise and Tobi. Tobi had acquired an independence that surprised and delighted his mother and which persisted after his return home. Denise maintained her happy expression in spite of innumerable difficulties in the family. She liked school and worked well there and continued to benefit from a very warm relationship with her nurse who was family worker to them.

As for the other six children, they did not seem to have any new difficulties but at the same time no perceptible progress could be seen. Michele was overwhelmed by both the visits made by the observer and did not ~~wish~~ want to go back to the Centre. Next time, she said, it would be her little sister's turn to go. Emilie went to the Centre a second time and according to the director, the time passed without incident, but after returning, her grandmother said, 'There must have been something' because Emilie spent her time reassuring herself 'that the car is not coming to take me to the Centre'.

Didier gave a cold welcome to the observer on whom he had been so dependent. He played aggressively with her, tied her up, hit her and finally sang at the top of his voice "Au revoir colo, aurevoir". He also spoke of not wanting to go back and Pierrette thought the same because she said "The same ladies won't be there" and "They wouldn't be so kind". How much importance should be attached to what a child says? It does at least reflect the fact that except for two of them the memory of the holiday at the Centre was not very pleasant.

~~Various factors affecting adaptation~~

Various factors affecting adaptation

The observations make clear that difficulties in adaptation were almost universal. However, except for cases of open distress, it was only systematic observation that revealed these differences. In spite of their importance they went unnoticed and their existence was denied by many of the people looking after the children. There were many reasons for that. The children's reactions are easily forgotten - the present easily effacing the past. When Emilie was open and friendly, no one remembered Emilie inert and "frozen" who, for this very reason went unnoted. When Paule became insupportable, no one remembered the happy Paule who was easy to manage and friendly at the beginning of her stay. Moreover disorientation and progressive disadaptation are not dramatic but signs/ appear almost imperceptibly, so that they/are almost always misinterpreted. They are not felt to be a form of disorganisation by the adults concerned as much as a sign of bad character, naughtiness or bad upbringing that must be corrected.

It is interesting to establish, for example, the reactions of all the adults in the Centre after the observer had left. When Paule became insupportable, her aggression was interpreted almost unanimously, not as confusion, but as the result of spoiling by the observer. "She gave way to her on everything". In fact, the observer, when she was there, had never given way to Paule who had always been ready to give way provided she had the attention of the observer. It should be remembered that at this time the observer was able to give similar attention continuously to two other children (Simon and Emilie) and occasionally to one or another of the children (Didier, Tobi, Denise, Berthe) without Paule being affected. When the children's reactions are misinterpreted, not only do they not receive the help they need but they become objects of disapproval which only increases their feelings of dissatisfaction, anxiety and internal confusion (Paule, Michele Pierre).

It is striking to note that the children who adapted best were those who showed open distress. Such a reaction evokes pity and brings the child into contact with an adult who is concerned to give him compensating satisfactions, which gradually he learns to profit from and which allow him to open out.

As for the children who showed reactions of disorientation, they were seen at first to be mal-adapted or at least lacking satisfaction ~~which~~ while they remained by themselves, then slowly re-adapting as they found an adult who, understanding the nature of their difficulties, gave them help. On the other hand, the child who adapted well straight away gradually experienced a "loss". But the loss was felt without being differentiated and was manifested in a form which did not permit an unsuspecting adult to recognize the underlying distress.

Altogether, it seemed that one factor was essential for favourable adaptation amongst children of this age - the establishment of an emotional tie with an adult, and the fact that this adult should perceive the disorganisation of the child as soon as it begins to show itself, and give him the help he needs.

(Importance of a supporting relationship with an adult: 5 pages not translated)

Other factors. Brothers and sisters.

In general we found that parents prefer to send brothers and sisters together to the Centre. They think that the presence of an older child will reassure the younger. They often express the wish that the children shall be in the same dormitory and charge the eldest with a certain amount of responsibility for the little ones. The director of the Centre is for the most part also anxious to put brothers and sisters in the same group unless there are considerable differences in their ages.

In some cases, brothers and sisters spontaneously sought each other, especially at the beginning of their stay. We saw how Denise, Maryse and Colette stayed close to one another in their distress, and how each one would be overwhelmed if by change she became separated from the other two. In the same way, we saw how the sisters Jeanne and Chantal constantly played together, so close in their friendship and their play that it seemed it would not matter to them where they were. Didier constantly sought out his big brother Jacques who deferred very patiently to his wishes and took care of him.

But however much these children sought each other, it seems important to us to insist on the limited nature of the support they can give to each other. The presence of a brother or sister can perhaps in certain cases prevent them from being totally overwhelmed (i.e. Didier with Jacques) but does not help them to gain the upper hand on themselves again. Thus Didier in tears took his distress many times to Jacques who comforted him, but his distress was renewed over and over again and the comfort Jacques could give him was no more than a palliative which gave Didier momentary relief without increasing his capacity to adapt. In the same way, Denise, Maryse and Colette sought each other and cried as soon as they were separated but it seemed more that they were uniting their distress rather than being able to console one another.

In many cases, it was more often the older children who sought out the younger ones, coming to see them, trying to attract their attention, hugging them and showing proof of their affection. The youngest ones responded with a certain amount of indifference to these advances. This was the case with Paule and her brother, and with Andre and Pierre and their brothers and sisters.

Quite often, brothers and sisters seemed to have little in the way of bonds between them. Berthe and Paule never asked for their brother, any more than did Andre and Pierre. Tobi, even though he was in the same room as his brother, never looked to him for any support, and they did not play together. Though Paule and Berthe were in the same group, they had few activities in common, and when they did do something together, they quarrelled incessantly. It is true that when they were separated, Berthe joining the middle group, they did look for each other in the evening.

In some cases the children seemed often to restrict rather than help each other. This was the case with Simon whose presence gave no comfort to Tobi, but whose own distress was re-awakened and strengthened by the sight of his little brother's distress. And although Didier did benefit a little from the presence of Jacques, that of Pierrette only upset him, in the same ways that the presence of Didier increased Pierrette's distress because she felt unable to assume the responsibility towards him with which she had been charged. These observations have led us to conclude that it is better to be flexible over the question of keeping brothers and sisters together in a group and that action cannot be decided upon any general principle but only from on-the-spot observations. It would surely be desirable to have a very flexible organisation so as to allow brothers and sisters to come together according to whether they are of the same age group and whether they show the need to be together; for example, if the fact of being separated increases their distress or if they show real harmony in play. However, we do believe it is important to insist that the presence of older children cannot be a real factor in adaptation but only a temporary palliative. It seems to us far more important for the child to be in a group where the routine, activities and type of attention he receives are suited to his needs. An organisation which allows brothers and sisters to look for each other at times, even though belonging to different groups, seems to offer certain advantages.

(Routine of the Centre and Development of play activity: neither translated)

Visits. Visits took place every Sunday, parents being allowed to take the children out of the Centre if they wished. Our observations with regard to visits were somewhat inadequate. Most of the time, the parents took the children out and conditions for observation at the time of return were not very favourable. Generally speaking, we thought the children were momentarily disturbed by the arrival and departure of their parents. Some showed sulkiness and inhibition when they came; nearly all cried when they left - distress that differed in the amount of time and difficulty taken to calm it. With the exception of Didier, however, whose behaviour regressed during the following half day, they all recovered their equilibrium the next day and some clearly made progress after a visit from the parents, while others just carried on at their usual level of adaptation. Before concluding however we feel it necessary to make the observation that most parents tended to visit towards the end of the children's stay whereas it would be more in the interest of the child to give it the reassurance of an early visit.

Sick-bay and illnesses. The sick-bay proved a diversion for all the children and a haven of safety for some children in distress. It seemed that apart from the pleasure of coming out with a beautiful bandage,

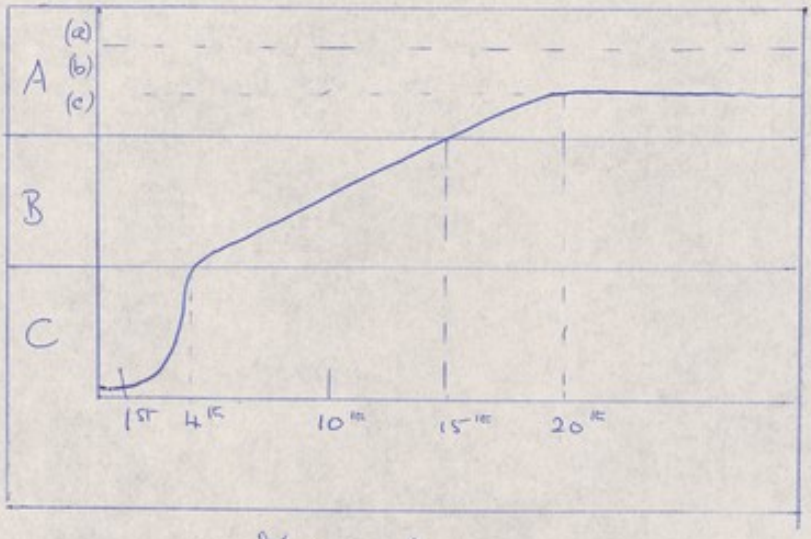
the sick room served as a refuge from the nursery. The slightest bump served as an excuse to go there; the children certainly got from the two nurses a little bit of peace and comfort which they greatly appreciated. For many of the bigger children tooth-ache, stomach-ache, an unexpected fall, are the means of gaining individual attention which they feel they are lacking; it is the only means they know. Eliane, for instance, throughout the first week pestered every adult with complaints about her teeth, her ears or her tummy.

From the point of view of mental health we think it undesirable for a child to adopt the habit of pretending to be ill in order to attract attention. Another time we would like to verify more systematically the cause of these visits to the sick-room. If, on our hypothesis, the older children use this as a way of gaining attention rather than because of real need, could it not perhaps be concluded that a number of these children (6-7years) need to be treated as little ones in this respect?

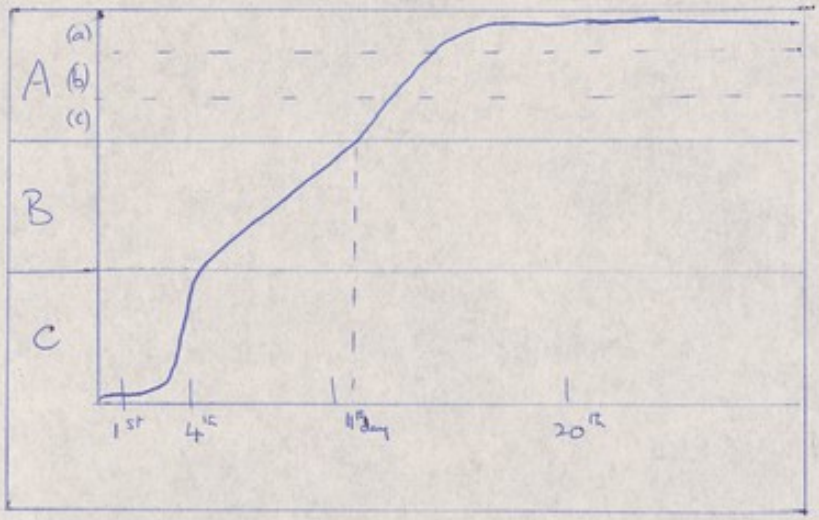
The outbreak of measles at the end of the duration of the Centre brought to mind the absolute necessity for isolation cubicles to avoid emergency hospitalisation by keeping the children on the premises while waiting for them to be returned to their families, without incurring the spread of infection which, as is well known, is a grave risk at this age in a nursery.

Family background. Although we realize that there would be interesting relations to establish between the reactions of the children// and the quality of their relationships to their parents, we do not feel empowered to discuss them at length here, as the need to respect anonymity prevents us from revealing in detail the family situation.

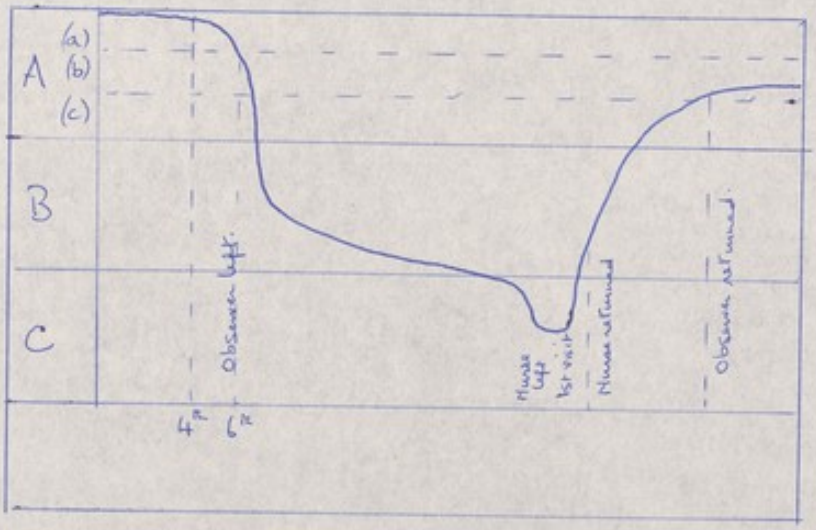
It was clear that the most violent distress was shown by children coming from the poorest backgrounds and who had experienced previous separations under dramatic ~~conditions~~ circumstances such as being placed in the care of the Assistance Board because of the sudden departure of the mother, or father leaving with another woman. The fresh separation seemed to arouse in the children all their previous insecurity, and even in the most favourable conditions they seemed unable to cope with the situation again (Maryse, Denise, Amelie, Colette). Equally, well-loved children such as Paule and Pierre showed initially a better capacity to adapt while at the same time the change of environment allowed them to form relationships with other adults, known and unknown. Finally, Tobi's reaction, of an 'anaclitic' type depression, seemed completely in accord with the positive but very dependent quality of his attachment to his mother.



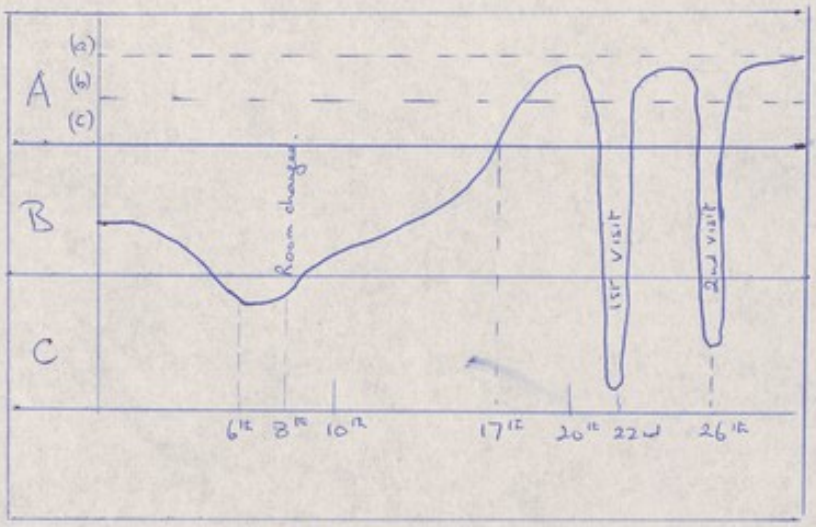
MARYSE A.



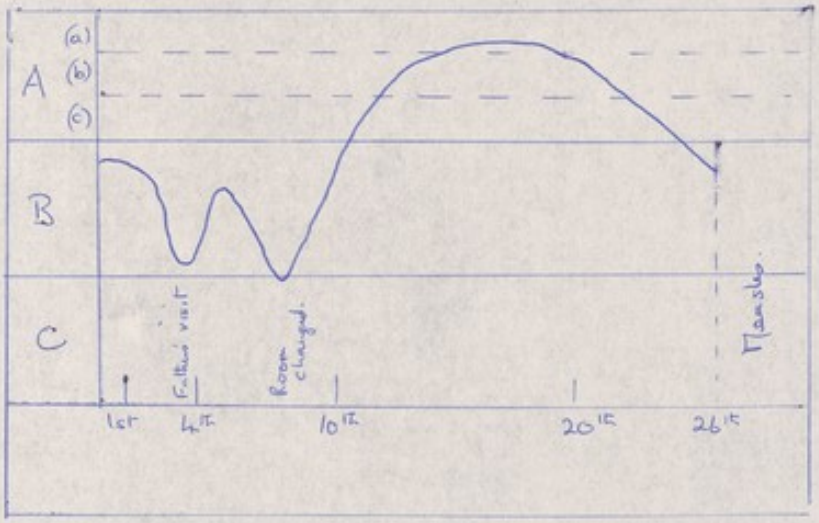
DENISE A



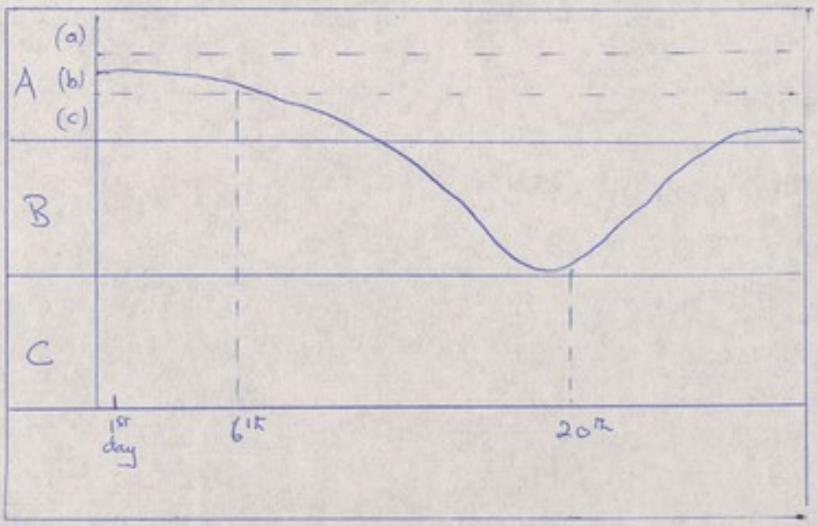
PAULE B.



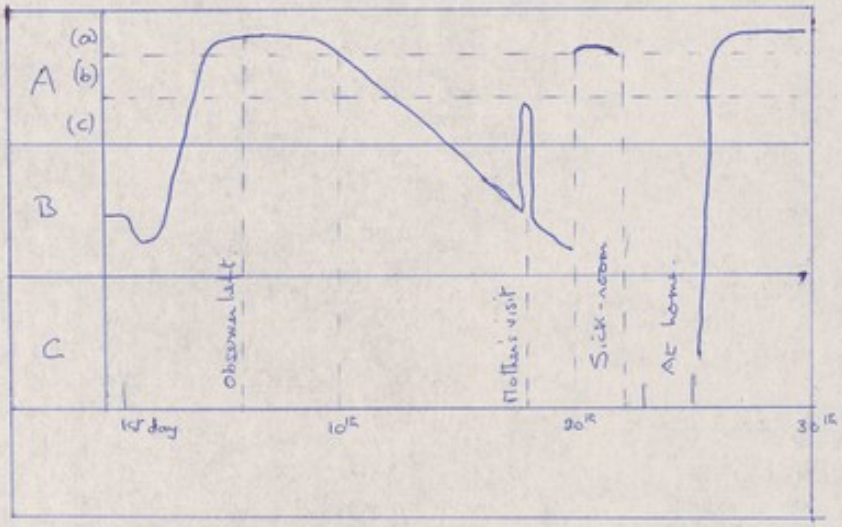
DIDIER X.



MICHELE D.



PIERRE C.



EMILIE.

A = Adaptation : (a) excellent ; (b) medium ; (c) mediocre level.

B = Recuperation or disadaptation
(difficulties in adaptation)

C = Distress.

A RESEARCH PROGRAMME INTO THE EFFECTS OF MATERNAL DEPRIVATION DURING INFANCY

by

Dr. Myriam David and Melle
G. Appell

This research project planned by Dr. Myriam David in collaboration with Miss Geneviève Appell, was presented for an aid in grant to the Foundation's Fund for Research in Psychiatry by l'Association pour le Développement de l'Assistance aux Malades, 1, rue du Onze Novembre, MONTROUGE (Seine).

The Foundation's Fund at its meeting of January 30th. 31st and February 1st, has decided to give financial support for two years.

A RESEARCH PROGRAMME INTO THE EFFECTS OF MATERNAL DEPRIVATION DURING INFANCY

by

Myriam David and

Genevieve Appell

I N D E X

Techniques for studying the children in their homes : the follow-up

The reliability of the data collected on the children

Study of the mother-child relationship :

Aim

Interviewing procedure

Preparatory stage : the first interview

During the child's stay at the nursery

The parents are seen a few days before the child is due home

After arriaval of the child at home

The reliability of the data collected on the mother-child relationship

Personnel

Bibliography

Finances

A RESEARCH PROGRAMME INTO THE EFFECTS OF MATERNAL DEPRIVATION DURING INFANCY

BACKGROUND AND GENERAL ORIENTATION OF THE STUDY

Many writers have emphasized the importance of a stable early mother-child relationship as a primordial factor in the normal development of the child. The lack of such a relationship either because of emotional disturbance in the mother, or because of the loss of the mother, has been emphasized by many writers as being of crucial importance in the development of emotional disturbances in children. We are thinking here of such people as Beata Rank, Marian Putnam, Rene Spitz, John Bowlby and Jenny Aubry.

The project for which we are applying to your Foundation for support has grown out of the work we have been carrying on in this field for the last six years. This work was carried out from 1950 to 1954 at the Fondation Parent de Rosan in collaboration with Mme Jenny Aubry and others; it aimed at describing and understanding the effects of long and short term maternal deprivation between the ages of 0 and 6 years. It was mainly oriented towards an elucidation of the psychological mechanisms which these children used in order to cope with their deprivation and how the use of these mechanisms in turn affected their further development. Thus while some children avoided the possibility of a disappointing human relationship by complete withdrawal, others achieved similar ends by a series of fleeting though active approaches. It can be imagined that these forms of making relationships tended to isolate the children and to have profound effects on their further development.

Although all the children we studied had lived in institutions from the first month of life, they did not come into our care until they were anywhere from one to three years old. In an effort both to help and understand these children many of them were taken into therapy. This work indicated that they had in most cases either regressed or become fixated at an earlier stage of development. It also aroused our interest in making direct observations of infants separated from their mothers in these first months of life. We hoped in this way to throw further light on the immediate effects of deprivation an how they may lead to personality distortions in later years.

A grant from WHO enabled us to pursue these interests in the form of a small pilot study on the effects of maternal deprivation in the first three months of life. This work has been done in a residential nursery (Pouponniere Amyot, where children under I year old whose parents have tubercular infection are given B.C.G. vaccination.)

and has been going on since February 1955. Miss G. Appell and I are now completing the write up of this pilot work. We feel it has been of great help in clarifying our thoughts in relation to the possibility of carrying out a larger programme. It is for this programme that we are applying to you for financial aid.

THE AIMS OF THE STUDY

More specifically the present project is designed to throw further light on the following questions :

1. Does lack of maternal care during the first three or four months of life have a damaging effect on the development of the child ? What are the immediate and later effects of such deprivation on the infant"s development ? How does such deprivation affect its adaptation to the external world and to internal pressures ?

2. How does a 2 - 4 months separation of infant and mother immediately after birth affect the further development of the mother-child relationship ? Does it affect the child's capacity to establish an adequate relationship once it is reunited with the mother and or does it affect the mother"s ability to make a satisfactory relationship with her child ?

The answers to such questions ought to be relevant in any attempt to clarify certain major theoritical positions. Thus, Anna Freud maintains that the first three months of the child's life can best be characterised as a " phase of need satisfaction", although others, for example Melanie Klein, would claim that the infant already shows signs of considerable differentiation in these early months. Since both of these points of view are mainly derived from the retrospective work of analysis, direct observation, especially of the separation situation, ought to be highly relevant.

SUBSIDIARY AIMS

We feel it is impossible to work on such a problem without keeping in mind the necessity of clarifying related questions in the field of preventive mental health. Therefore we wish to include in our research programme consideration of the three following problems :

1. If separation has to take place, how and when can it be dealt with so as to minimize its eventual ill effects : here we are thinking for instance of exploring better methods of caring for infants in institutions and ways of helping the nursing staff to understand and deal with the emotional needs of the infants under their care.

2. Since we assume from previous experience that the ability of the mother to cope with the child's stress and needs is an important factor in the child's ability to recover from the effects of deprivation and to build a profitable mother-child relationship, we would want to study the feelings and related behaviour of the mother towards her own illness (that is T.B.), contagion, separation and reunion, how they interfere with the mother's feelings for the child, and how they may or may not disrupt the mother's ability to relate to her child and if the ability is impaired how the mother can be helped to deal with these feelings.

3. Finally, we feel that the knowledge we would acquire about the above points could be used directly for educational purposes for the personnel of agencies taking care of separated children and their mothers, e.g.T.B. physicians, social workers belonging to agencies having to deal with similar problems and administrative personnel.

RELATIONSHIP OF PRESENT PROJECT TO OTHER RESEARCH

Since our work covers only a relatively small segment of the general problem of the effects of emotional deprivation in infancy and since there are many other research workers in related areas, we feel it is important to maintain a close liaison with these people. Such liaison will permit us to compare results, to integrate the planning of studies, and to become acquainted with the methods and points of view of other workers.

In the past we have worked in close liaison with the research team under the direction of Dr.John Bowlby, London, and have had many beneficial discussions with Dr. Gerald Caplan, Harvard University, School of Public Health. These contacts have proved of great value to our research. We hope to maintain these particular contacts and eventually to develop a liaison with other projects as well

THE RESEARCH SETTING

Our work will be carried out in a small Residential Nursery, the Pouponniere Amyot, for children under one year old whose parents have had or are having T.B. infections. The reason for admission of the children is always to isolate them from their parents in order to receive safely B.C.G. vaccination which will permit them to return home once they are immunized; that is, if the parents are no longer contagious.

We would like to stress the many advantages that this research setting offers. The physical care of the children in this Nursery is of a very high standard. The reason for separation, the age of separation, and the length of separation are all fairly constant. Moreover, the fact that the arrival of the child is predictable and known well beforehand, enables us to plan the research more efficiently and also makes it possible to become acquainted with the family and to get their participation in the research. Finally, the cooperation and interest of the Nursery Staff already established during the pilot study is invaluable in making observations and introducing slight experimental modifications.

THE DESIGN OF THE STUDY

Introduction. The experience of the past year has led us to emphasize certain aspects of the general questions posed under the aims above.

1. In the previous study we were struck by the long periods during which the infant in the nursery was left by himself. No-one paid any attention to him, and even the feeding was done very quickly. During these periods of isolation the child showed frequent and intense signs of distress and gradually developed a variety of defensive patterns in order to cope with this stress.

2. A second factor observed during the pilot study was the striking difference between the behaviour of the infant in the nursery when alone compared with when someone was in contact with him.

3. We were also impressed by the fact that when the child returned to his mother the behaviour patterns developed in nursery were no longer appropriate because his environment and care taking had changed to such a marked extent. New ways of reacting had to be developed to cope with this change.

4. The initial work also indicated that the mother's capacity to respond to the infant's needs at the time of reunion is of crucial importance in bringing this experience to a satisfactory conclusion. When the mother is able to respond to the needs of the child, the effects of the nursery experience seem at a minimum.

The above considerations indicate that an intensive clinical study of the infants inthe nursery and at home ought to clarify further how different emotional experiences influence the child to adopt different behavioural patterns. It is felt that in the existing setting two types of analysis are likely to be fruitful - individual case studies and comparisons between groups of children with different experiences during their stay in the nursery.

Intensive clinical case studies - For the individual studies each child entering the nursery will be observed intensively throughout its stay there and for some long period after its return home. This will enable us to obtain an integrated clinical study of each individual child and to determine the particular behaviour patterns which each child develops in order to cope with its tensions, to restore peace and to find pleasure. We hope also to study the sequence of these behaviour patterns, how they are related to maturation and how their growth is influenced by the emotional experience undergone by the child.

Group comparisons. Three major factors likely to influence the behaviour of the children who come to the Pouponniere Amyot are (i) the presence of T.B.in the family; (ii) the separation of the child from the family; and (iii) the type of substitute care offered to the infant when it is in the nursery. Ideally, for the purpose of group comparisons, we would have liked to have been able to isolate each of these three factors. However, such a programme raises practical difficulties which it may be unwise to tackle at present. Since factors (i) and (ii) are common to almost all the children in the nursery, the only factor which it is at present possible to vary is the nature of the substitute care in the nursery. The major group comparison in this initial study will, therefore be between :

A - a group of children who are receiving the ordinary routine institutional care,

B - a group of children who would receive intensive child centered care of a carefully selected nurse.

Once both groups of children have returned to their mothers we could continue the comparison in terms of such phases as initial adjustment and later adjustment. This would involve the follow-up work. At the same time we would want to study the mother's responsiveness and how this interacts with the child's behaviour to determine the eventual adjustment. Adjustment is here used to designate not only the presence or absence of pathology, but also includes the notion of varying character developments.

For convenience we have given a rough diagram of the study below.

Groups	Time				
	Birth	Ist month	2nd month	3rd month	Follow-up
A. Children separated from their mothers receiving ordinary care					
B. Children separated from their mothers receiving intensive mother-centered care.					

Certain advantages of this design should be pointed out. First of all, it provides for a variety of meaningful comparisons. One can compare groups A and B at various points in time (between group comparison). Or one can contrast the development of a group at one particular point of time with that at another point of time (intra group comparisons). Secondly, it would be possible to assess whether the two groups differ say at three months and not at birth or shortly after. If this were the case one would be in a better position to conclude that the later differences are mainly due to the different styles of nursing. Another advantage arises from the fact that the observations of both groups would be made in the same setting. Finally, by using certain selected individuals to do the intensive care we can both control and study this situation more effectively.

The study of single cases to aid in the general orientation. In order to have as wide an experience as possible, we felt it would be wise to study one or two cases undergoing another type of experience. Thus, some babies are sometimes admitted to the nursery after being with their mothers for one or two months. Have these children developed different means of adjustment ?

Although we will postpone the extensive study of children in the home, we thought that a study of a few cases as they became available through friends of the families being studied would be very useful. The cases have and will be studied mainly to provide a general orientation rather than to establish anything definitively.

Selection of cases. Children will be included in the sample if they meet the following requirements : I. The child will return to its home and will be cared for by his mother, 2. the child comes from a complete family - both mother and father live at home, 3. the economic status of the family is sufficient to provide for the physical well being of the child, 4. there are no obvious physical, social, or mental disturbances in the family, 5. the family is willing to cooperate, but excluding those families whose psychological interest is excessive.

The children will be assigned to the two groups (A and B) on a random basis. In order to check whether the resulting groups do differ we will give special attention to an adequate description of their development in the neonatal phase. We may reach a point where we will be able to assign and match the children in the two groups according to certain relevant characteristics. The nursery routine allows for such a procedure but we feel that at present we do not know enough about the relevant characteristics of the child and his family to follow it.

CRITERIA FOR COMPARING TWO GROUPS AND RELATED HYPOTHESES

A descriptive framework. Since the design calls for a comparison of two groups of infants it is important to indicate in greater detail what we intend to use as basis for this comparison.

The study of infants in the nursery during the pilot study has permitted us to follow the child through what has seemed to us four steps of development which we have called.

I. neonatal (up to 1 month about)

2. outgrowth of neonatal (about 1 to 2 months)

3. passive perceptive (about I.5 to 3 months)

4. organised activity (after 3 months)

We have been able to distinguish certain behavioural trends which we consider as characteristic of each phase, for instance during the neonatal stage the infant is in one or the other of two extreme states: either quiet peacefulness, or showing signs of extreme tension. During periods of peace, the baby is relaxed, calm, immobile; he may be either awake, gazing at emptiness or in deep sleep. Whether asleep or awake, he shows then no sign of any awareness of the surroundings or of his own body. This picture of peace is more or less abruptly interrupted by uncoordinated agitation and contortion of the body which conveys an impression of unease. This agitation may stop as abruptly as it started when peace is restored; however, peace may not last, and may be followed by new tensions. This alternation of tension and peace may lead to briefer periods of peace, and may after quite a long struggle lead to a culmination in crying. Crying at this stage has a monotonous, mechanical intonation; it seems to be the ultimate outcome of tension, being both a release and an expression of tension, though not leading to permanent relief.

This general state of agitation seems to be the infant's only answer to inner tension. If stimulated at this age, the infant either does not respond and remains at peace; or reacts by this general unorganized total motor behaviour.

To the observer standing by the child's crib, the tension periods are totally unpredictible; the infant seems to pass through successive states of peace and tension which follow each other in very quick succession. For instance, behavioural diagram N°I shows how the observer could in 20 minutes register that Jean-Paul had gone in succession 38 times from one state to another. (See section on the collection of data for further details of the behavioural diagram).

As the child emerges from this neonatal stage, when he is awake and comfortable the previous "empty gazing" is replaced by an "attentive", "interested" expression, while at the same time crying is less monotonous and is tuned with a rage intonation. The infant seems to start to find ways of restoring peace such as :

- assuming certain postures such as turning its head violently sideways and maintaining it in this position.
- lapsing into a more general catatonic immobility of the whole body.
- or using active tense thumb sucking.

With the increasing use of these patterns of defensive behaviour against stress, for instance, the child develops, a rhythm of life with more clear-cut sequences of tension and peace during his waking time. Diagrams 2, -3, and - 4 illustrate this, showing also how the child Michel was able to use sucking in order to eliminate tension and restore peace, and how this led to suppression of crying : tension sucking sleep.

We have tried in our pilot study to describe some of the main characteristics of each phase. We wish to stress however that we do not consider these phases as rigid entities but rather as a convenient way of describing the growth process, and the main steps which the infant passes in order to fight against tension, restore peace and find pleasure.

Our initial study has been carried out on a small number of cases (8), the results of which will be reported to the WHO. We feel however that this initial study needs to be complemented and made more precise. Whereas we have only occasionally drawn behavioural diagrams, we believe they could be done in a more sytematic way and be used as a good tool of work, in order not only to compare infants of different groups, but also to understand the development of each individual case.

Comparison criteria. Keeping in mind the general descriptive framework indicated in the previous section, criteria for comparison could be :

a) comparing phases of development : are the same main steps of development to be observed in both groups ? is there any meaningful difference in the length of each of the phases ?

b) comparing the two groups in terms of quantitative differences between the content of one specific phase. For instance : comparing in the neonatal phase the relative quantity of sleep - calm - awaken - tension; comparing in the perceptive phase the length of time and frequency the infant can remain interested in perceptive behaviour.

c) a qualitative comparison of the specific ways in which the child copes with tension, the duration of these tension periods and how these specific means of coping with unpleasure affect his general behaviour. For example, Michel's tendency to cope with tension by thumbsucking leading to sleep resulted in a general pattern of excessive though never deep sleep (see diagram 2.3.4.)
Since these patterns may be influenced by how and at what point the nurses or other people respond to the child's tension, any valid comparison of the child's behaviour will have to include careful observation of these external influences. Although the design of the study calls for a major difference in the amount and nature of the nursing care between two groups of infants, we feel it is important to observe the way in which these differences make an impact on the child.

d) similarly we will want to compare the children's differential response to social contact. Some infants seem eager for social contact in all phases. Others respond to contact in a certain phase but in other phases seem more interested in their inanimate surroundings. In some cases the child's behaviour definitely alters following social contact, while in others the social contact only has a temporary effect. All this will of course also be a function of the nature and timing of the social contact available to the child.

Statistical comparisons to be made. Since we will wish to study each case intensively, the numbers will most likely not be very large. We intend therefore to rely mainly on non-parametric techniques of analysis.

In so far as we will be able to rank order the data, we can compare the two groups using the Mann-Whitney Test. In relation to this test we would set a minimum N of 10 for each of the two groups. Where rank orders are not possible, the data could be arranged in contingency tables and could then be analysed using either Fisher's Exact Test or various kinds of Chi Square. It may of course also be possible to determine the association between various factors using a measure like the rank order correlation coefficient, but we think that this kind of analysis will probably be limited in scope.

Dr. Christoph Heinicke has offered to assist us with the statistical aspects of our work.

COLLECTING THE DATA

Techniques for Studying the children in the Nursery. In order to be able to study the various aspects listed above, and carry on both the intensive clinical study of each individual case, and the group comparison study, we plan to observe the child both in a free situation where he is on his own and the child's reactions to certain specific stimuli. We feel that especially with such young infants, interpretation of a specific piece of behaviour must always be done in the context of the infant's total behaviour. While our experience has lead us increasingly to use certain descriptive categories we feel it important to stress that these must continue to be used in the context of other categories of observations. To meet these considerations we have designed four types of observation.

I. Observing the natural sequence of behaviour of the infant when left on his own. The observer sits by the infant's crib and records everything he sees and the time at which it occurs. In order to try to get as complete an observation of the infant as possible, the following data is recorded :

- the succession of sleep, tension, and awakeness;

- the quality of these three categories of behaviour (for instance deep sleep, agitated sleep, weak crying, rage,etc.)
- the perceptive and motor ability shown by the child;
- the purpose for which it is used (for instance, sucking for comfort) and the degree of success or failure.
- the general impression the child conveys to the observer (content, uneasy, angry, indifferent, etc.) trying ultimately to precise from where one gets such an impression : for instance, facial expression, body movements, body tension, etc..

This method of observation, which has already been used in our pilot study, has led us to a tentative formulation which can perhaps best be exemplified by the use of the so-called behavioural diagram. It can be seen that the child's behaviour is recorded in terms of two coordinates. Along the vertical side of the sheet the reader will find a record of the number of minutes during which a given activity was observed. These activities are designated by a series of categories along the top of the page. These, in turn are grouped under three main headings (sleep; tension; wakeful state, peace) and two transitory states : the process of awakening and the process of eliminating stress. Although many relationships between these various aspects are possible the construction of the diagrams implies the tentative conclusion that the most frequent sequence is from sleep to awakening, to tension to attempts to eliminate tension, etc. The diagram helps to visualize the specific sequences seen in a child and how these patterned sequences change with age.

2. As indicated above, we also observe the child's reaction to social contact. This is done in relation to three different situations.

a) How does the child react to the presence, entrance and exit of the observer ?

b) How does the child react to being handled by the nurses ?

c) How does the child react to the active social contact given by the observer ? Contact is made by such means as looking, speaking, smiling, stroking, playing, etc.

We are mainly interested here in finding out the particular kind of contact the child answers to, likes, or dislikes, and how it affects his behaviour during and after the contact. Thus our approach is not strictly standardized but rather adapted to the individual characteristics of the infant.

3. We also observe the infant's reaction to the standard set of stimuli included in the Gesell Infant Test; this is done for controle purpose and also to give the child a greater variety of situations in which to express itself.

In order to collect the above three kinds of data we observe each child once a week for a minimum of four consecutive hours including at least two feedings. At the time of arrival and departure from the nursery the observations are made every day for, about 4 or 6 days. During the first part of the observation session we concentrate on the spontaneous behaviour. The Gesell Test and social contact are introduced later at a point which will be meaningful to the child. Thus, we do not introduce these things during periods of stress or just as the child is falling asleep but rather wait until the child has been awake for a while and we know something about its general state.

4. Finally we observe each child on a time sample basis. While observing a particular child intensively, we go and look at another child, also part of the study, every quarter of an hour for a brief moment. Each child is observed on this basis about three to five times a week. Since we know the child from the more intensive observations, this time sample record makes it possible to get more information on the rythm of the child and also to detect new trends of behaviour at their beginning.

Techniques for studying the children in their homes : the follow-up. The techniques outlined above will also be used to study the child in its home. During the first week of reunion the child has to be observed each day since the immediate responses to reunion may disappear quickly. After the first week we find it desirable to follow the child twice a week until the end of the first month, once a week for the three following months, and once every other week until one year old. We would find it desirable to continue the follow-up on a monthly basis during the whole pre-school period.

During our pilot study we have studied the immediate responses of the child as he goes home. We have noticed that each child goes through :

- a transitory state of disorientation
- a stage during which he shows signs of adaptation
- a stage of new organisation

The state of disorientation can be very short (a few hours) or last 2 to 3 days : one can observe, for instance, regressive behaviour (loss of smile, sounds, activity, regressive postures), signs of uneasiness (agitation, anxious expression, miserable crying), difficulties in sleeping and feeding.

The first signs of adaptation may appear after a few hours or a few days. As the previous signs of disorientation tend to disappear, the child starts showing signs of enjoying the new environment (increase of smiling, fretting if left alone, babbling in response to human contact). During this stage (1 to 5 days) one can see the child alternating from showing signs of enjoyment to showing now and then a few remaining signs of disorientation.

During the phase of new organization the child shows few signs of uneasiness. He has acquired a new rhythm of life, new habits, new behavioural patterns. These cannot be compared to previous ones since they are totally new modes of responding to a totally different situation. The handling of the child by mother is indeed very different from the nursery routine.

Here again it is interesting to study each individual case per se and to make group comparisons.

One can try to understand the development of each case in relation to its previous experience, to its own previous development and to the new emotional experiences offered by the mother. For instance Michel, who was eager for contact ever since the neo-natal period, had adopted in the nursery a behavioural pattern of lengthy periods of sleep frequently interrupted, as described before. During the" so-called" perceptive phase, periods of passive perceptive interest were short and unfrequent and crying had almost disappeared. Only when picked up, which seldom happened, did he show that he was not really sleepy and became quite wakeful and responsive to stimulation.

When back home Michel showed signs of uneasiness for a very short time (a few hours). His father and mother were very warm people and brought him both comfort and stimulation. Within a few days Michel acquired quite a new rhythm of life : he slept only a short time in the morning and in the afternoon; during the rest of the day time he lay on the couch in the living room, vividly interested in his mother and siblings who were moving around and often turning to him; he expressed a lot of overt enjoyment. At the same time, violent crying reappeared; it used to last until someone picked him up. He still called upon sucking as an immediate response to discomfort, but he no longer found permanent relief through it unless he was really sleepy. He would then sink into deep and quiet continuous sleep.

Different children have shown different immediate responses to their going home. In our pilot study we are attempting to analyse the factors which seem to have influenced their reactions.

We believe it would also be fruitful to compare both groups of children, in terms of the qualitative and quantitative differences in their modes of immediate response to reunion. Do they go through the same stages of reactive behaviour ? Are those stages identical or different quantitatively and/or qualitatively ? For instance, we would wonder whether the group receiving intensive care from one nurse shows greater or lesser signs of feelings of loss then the other group, and whether or not it shows a quicker ability to respond positively to maternal contact. In order to answer these questions one could compare the duration, intensity and modes of expression of the stage of disorientation in both groups. One could also compare the speed of final adjustment, and the modes of adjustment.

As the follow-up continues and as the child gets older, it will be necessary to devise new criteria for comparing the groups. This in the pilot study has not yet been worked up. We believe we could get considerable help by consulting other research workers who have already dealt with similar problems.

The reliability of the data collected on the children. While a check on the reliability of subjective judgments of the kind made here is certainly always important, we feel it is of special importance when such judgments are made on very young infants. We have tried to cope with this problem in a variety of ways though our efforts are so far necessarily of a pilot nature. First of all we would like to stress that the intensive and sequential nature of our observations provides an important check on the reliability of our hunches.

In this sense we are operating very much like the therapist who is constantly revising his hypotheses about a given patient. We are not observing the child once but for a great number of hours. To ensure that the material of the two workers would be comparable certain further precautions were taken. Although extensive previous collaboration had provided a common set of concepts and assumptions, we found it useful explicitly to discuss the vocabulary to be used in this study. Furthermore, though we found it expedient to allocate each child to one research worker, both workers observed each child during some of the time sampling periods and during portions of the intensive four-hour observation periods. This provided a basis for comparing and discussing various points relating to the same child. In no instances were the observations of the child's behaviour found to be contradictory; where difference occured the data tended to be complementary rather than dissimilar.

One would expect that differences would occur more readily in relation to the more general interpretation of the specific observation. To check on this possibility, the recorded material was analyzed separately by both workers. For example, after agreeing on the criteria for each phase of development, each of us determined the starting and ending dates of each period for each child studied. The agreement was very close, Similar agreement was found when data which had already been analyzed was worked over again three months later. Where differences did occur we usually found that discussion could clarify the point and lead to an agreed interpretation.

A lack of time and personnel has prevented us from doing simultaneous observations of the same child, and in general making more formal reliability studies. We have tried to indicate in the above paragraphs the framework in which such studies could be carried out.

STUDY OF THE MOTHER-CHILD RELATIONSHIP

Aim. Our primary aim in studying the mother and child is to assess the emotional experience the child undergoes in the home in order to be able to compare it with the emotional experience he has undergone in the nursery. The emotional experience of the child in the home depends not only on the way in which the mother handles the child, but on the conscious and unconscious fantasies and feelings which motivate her behaviour. Because the situation is not a therapeutic one, it is often difficult to assess the mother's deeper motivations. However, we have found that the research relationship may produce transference phenomena which in turn produce relevant associative material such as feelings towards past and present events, parents, and the husband, all of which can be related to the mother's feelings towards the child. We hope that this sort of material plus our direct observations will enable us to assess the following.

I. What is the impact of the mother on the child ? What is the quality of her handling ? How does she understand his behaviour ? How sensitive is she to his needs ? Does she tend to be primarily permissive or controlling ? Does she tend to protect herself ?

2. What does the child signify to the mother ? What significant persons or images in the present or past does he recall ?

3. How does the mother relate her feelings about the separation and illness to her feelings about the child ?

Though the mother will be the focus of our work in the home, it is also important to note the way in which the child relates to the father, his siblings, and other people who are present in the child's environment.

Interviewing procedure

a) Preparatory stage : The first interview with one or both parents takes place either at the nursery, at home or in some instances in the lying-in hospital.

We consider this first visit as crucial not only in terms of assessing the eligibility of the case, but also in order to create a solid foundation for a future good working relationship with the families. Throughout our contacts the primary aim is to develop a relationship which will enable the parents to discuss the child freely.

A detailed description of the nursery and personnel is given to the parents, as well as procedures for admission of the child, visiting and departure.

In introducing the research to the parents, emphasis is put on our attempt to find out how one can minimise stress for the child and parents during and after separation. This usually leads us into a discussion of the events which have led parents to put their child in the nursery. We show the parents that we are interested in understanding their problem and in helping them with this experience.

The parents are encouraged from the start to question us and to express their thinking and feeling about nursery policies, about problems under research, and about the principle of doing research in such a field. They are invited to express their doubts about the validity of such work and they are given time to think it over and opportunity to discuss it again in order to decide whether they can and wish to participate in it.

It is then possible to assess to a great extent the degree of co-operation we may expect from the family and it is usually possible at the same time to decide on the eligibility of case.

B. During the child's stay at the nursery parents are seen at home in order to bring to them news of the baby, in order to explore reactions of parents to the separation, and to keep on building up a working relationship.

By doing so we are aware that we are introducing a modifying factor; our visits indeed keep the child alive in the minds of parents and may be therapeutic. However, the reactions of parents to our visiting and to news are very revealing of their spontaneous attitude and feelings towards the separated child.

c. The parents are seen a few days before the child is due home. During this interview parents are encouraged to express their feelings about the arrival of the child and to discuss whatever seems problematic to them.

The detailed follow-up plan is discussed again. Precise hours and dates of visiting are arranged and the aim of the follow-up re-explained. Opportunity is given to the parents to withdraw if they wish.

d. After arrival of the child at home. As already indicated, visiting takes place on the evening of arrival, and the two or three following days. Progressively the visiting is scaled down to fortnightly interviews.

Since we are interested in observing the children and interviewing the parents, it is important not to pursue one to the exclusion of the other. We find that this is most easily accomplished when the parents go on with their usual activities, take responsability for the care of their child, are able to comment informally about it, and yet feel free to sit down with us and discuss a problem or observation.

Although we avoid direct questioning, we do try to get adequate information about the rhythm of the child and his behaviour. One can ask some families to fill out a simple questionnaire indicating the approximate time of feeding and nursing, and whether the child has cried, played or slept in the intermediate periods. We found that several parents liked to co-operate in this way. Most of the information, however, is obtained from the interviews which are conducted without a preconceived plan. The worker does, however, make an attempt to focus discussion on points important to research and to help parents to bring up meaningful material.

The reliability of the data collected on the mother-child relationship. Although much greater stress shall be placed on the isolation of relevant variables, the problem of the reliability of the material on the mother-child relationship will be approached in the same way as indicated in relation to the data collected on the child in the nursery. We hope to have enough staff so that some families can be seen by more than one person. We certainly anticipate that the extensive and detailed recording of the material will enable us to do indpendent analyses so that the reliability of any conclusions derived therefrom can be adequately checked.

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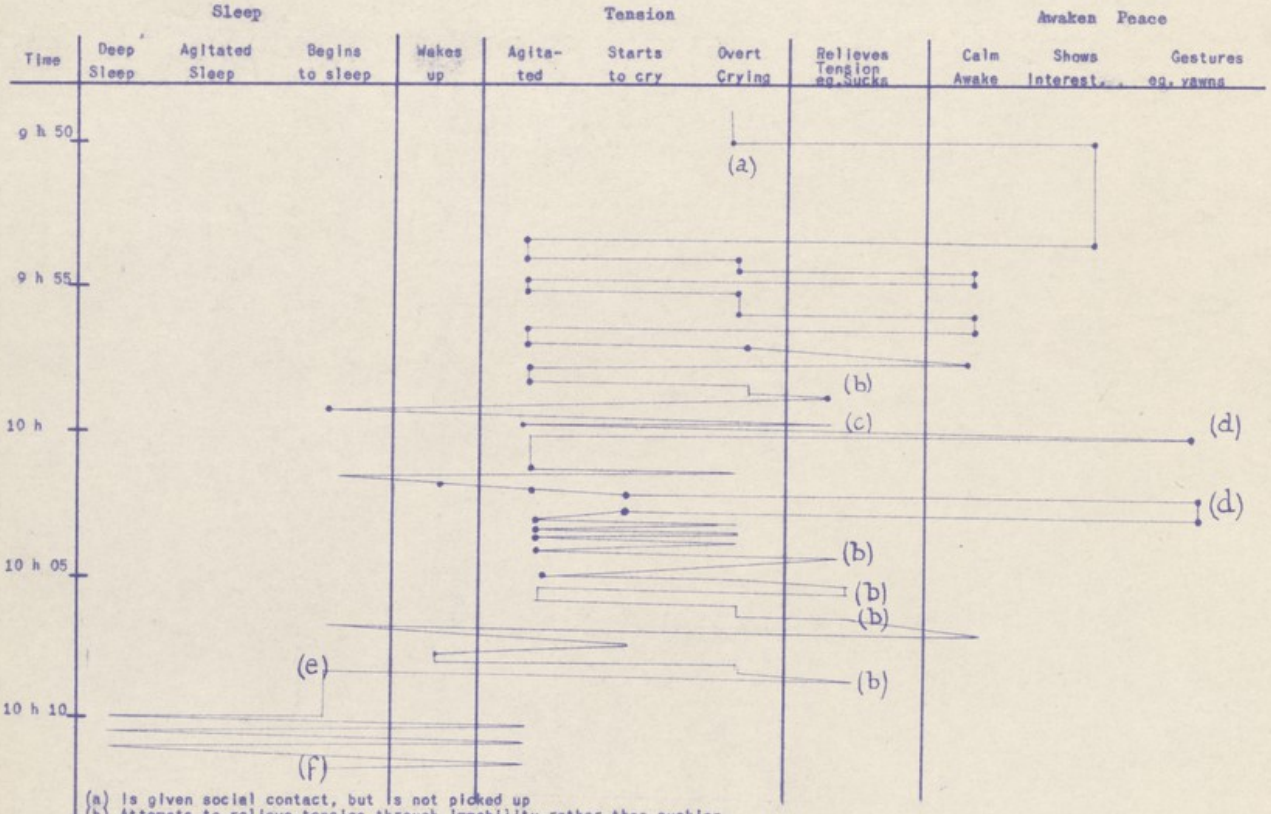
BEHAVIOURAL DIAGRAM N° 1

Jean-Paul
20 days

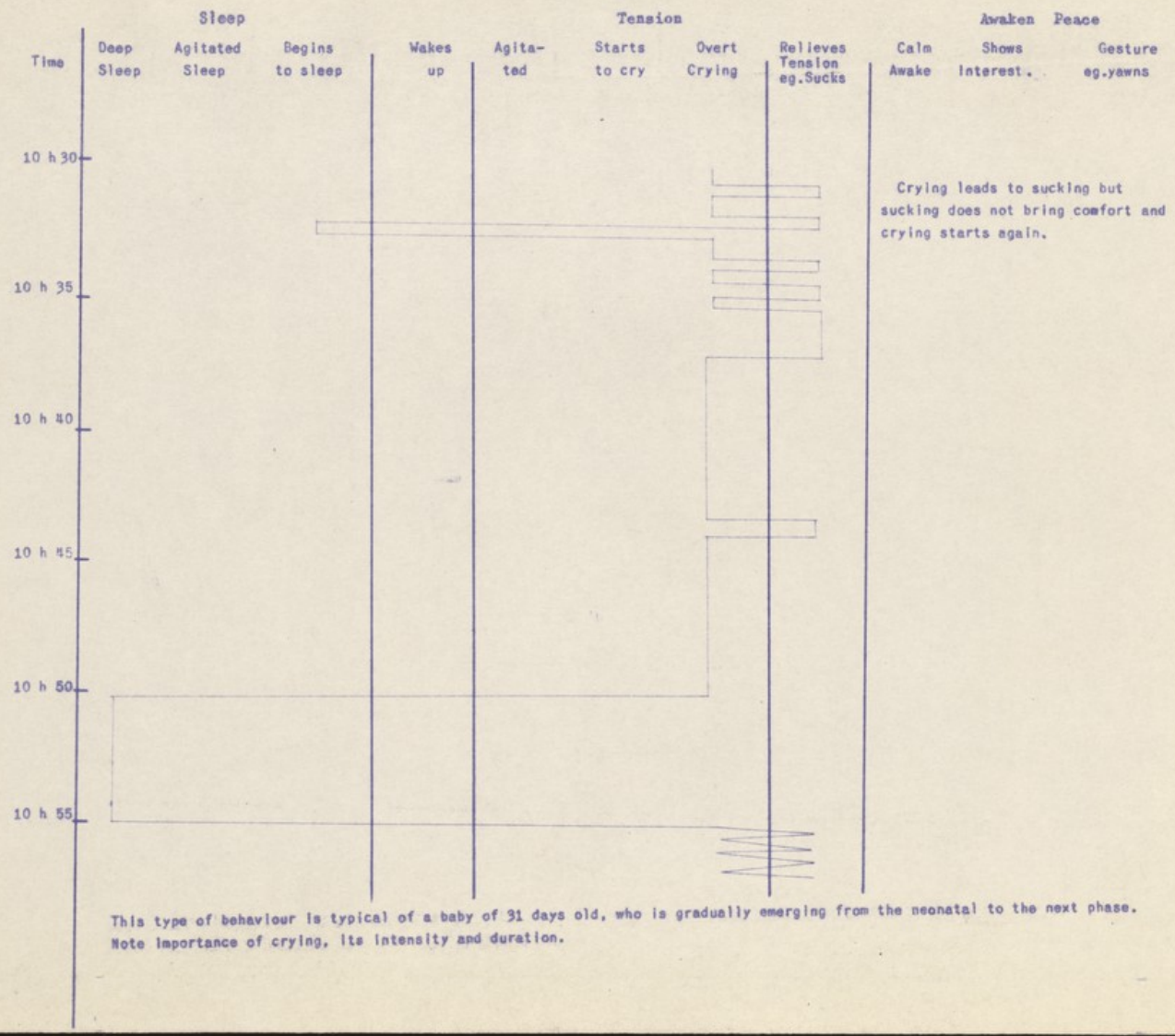


(a) Is given social contact, but is not picked up
(b) Attempts to relieve tension through immobility rather than sucking
(c) Sucks
(d) Yawns
(e) Eyes mostly shut but frequently opened for an instant
(f) From 10 h 11 to 10 h 25 in state of interrupted sleep; after that deep sleep.

Special note should be made of the frequency with which Jean Paul changed from one state to another in a short interval of time.

BEHAVIOURAL DIAGRAM N° 1

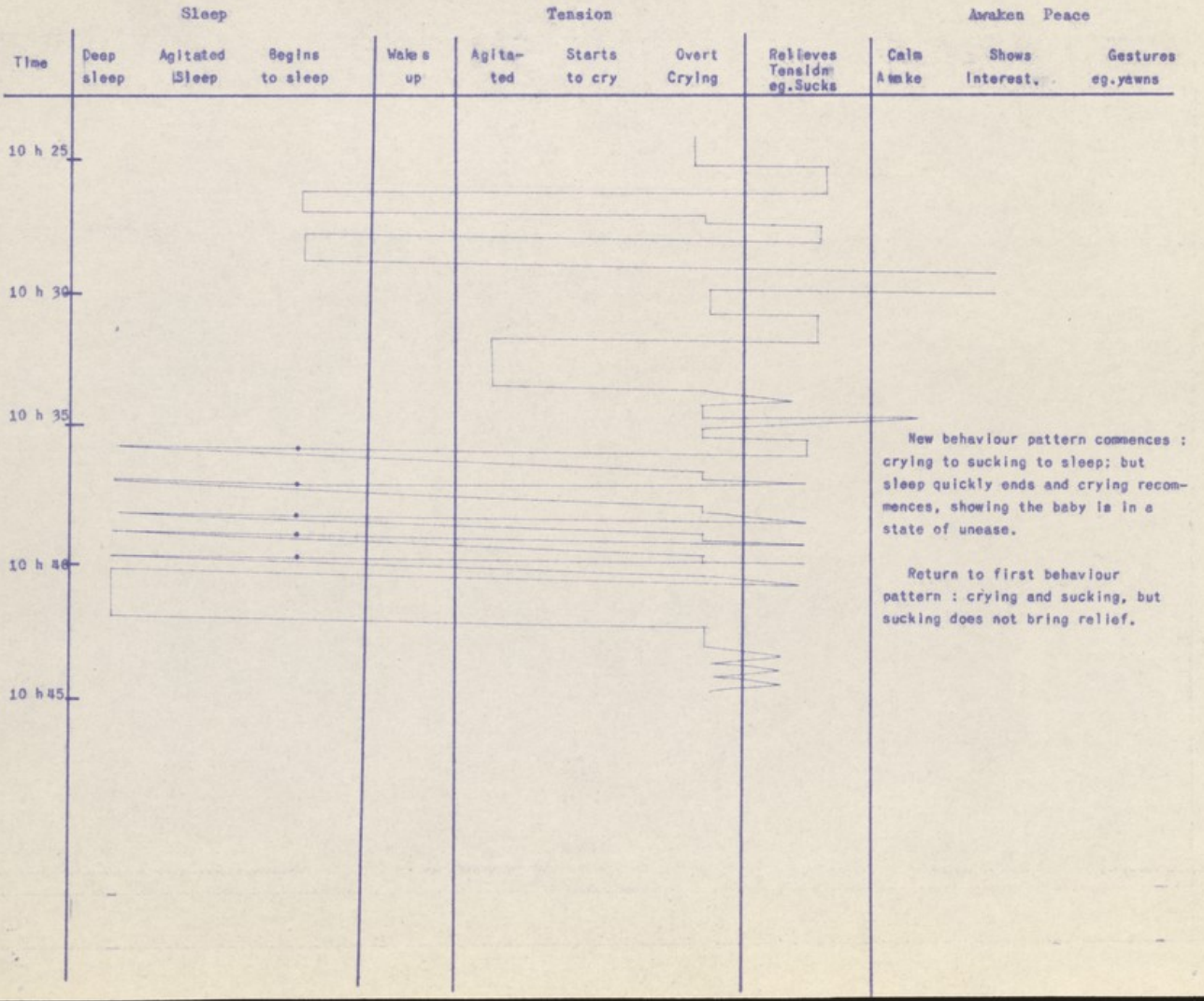
Michel 31 days



This type of behaviour is typical of a baby of 31 days old, who is gradually emerging from the neonatal to the next phase.
Note importance of crying, its intensity and duration.

Michel 1 month
1 week

BEHAVIOURAL DIAGRAM N° III

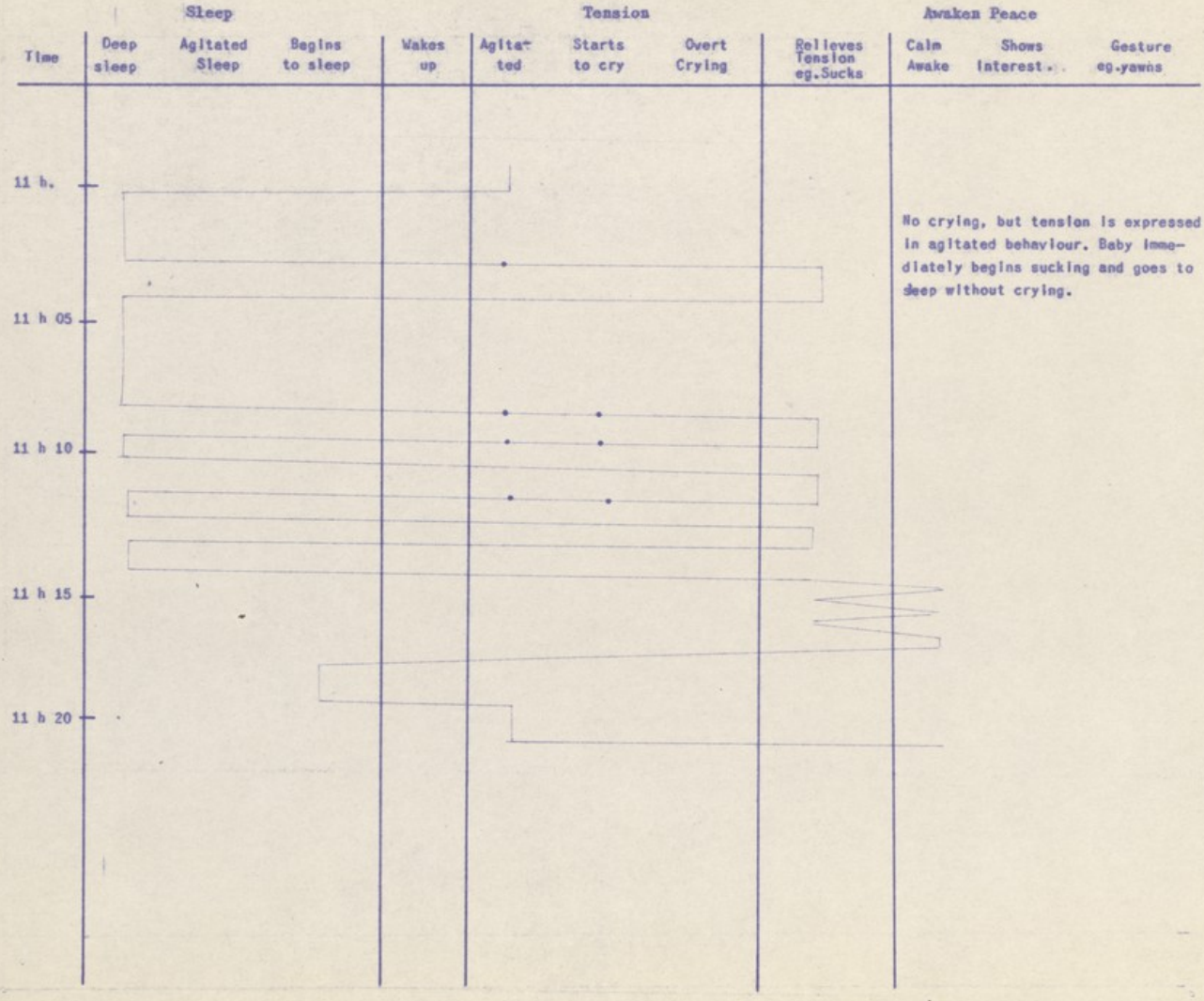


New behaviour pattern commences : crying to sucking to sleep; but sleep quickly ends and crying recommences, showing the baby is in a state of unease.

Return to first behaviour pattern : crying and sucking, but sucking does not bring relief.

BEHAVIOURAL DIAGRAM N° IV

Michel 1 month
3 weeks



No crying, but tension is expressed in agitated behaviour. Baby immediately begins sucking and goes to sleep without crying.

APPELL '63

CIBA FOUNDATION MEETING

September 1963

A STUDY OF MOTHER - CHILD INTERACTION AT 13 MONTHS

Geneviève APPELL and

Myriam DAVID

I INTRODUCTION

We have observed the development of interaction in seven mother-infant pairs, followed from birth to two and a half year of age. To day we will present a cross-section of our data for two mothers and their children - Molly and Bob - when they were one year old.

Our raw data were collected by naturalistic observation and recorded in the form of a detailed descriptive, chronological account of everything that happened during our visits to the home.

In order to retain a total picture of interaction and yet be able to compare different couples, we found it fruitful to analyse it according to :

1 - Quantity of interaction : its duration and frequency, and the space it occupies during the total period of observation of M and child.

2 - Its nature : Interaction can be :

a) a direct and simple interaction when partner A does something to which B reacts ;

b) a chain of interaction, when B's response to A, causes A to respond so that both partners are caught up in a series of responses to one another ;

c) interdependency without direct interchange as seen for instance during diapering, when M and child are in touch with each other, but involved in different interests for example the child with a toy, M with the diaper without active communication ;

d) indirect interaction, when one partner acts upon an environment common to both, the other one reacting in turn to the environmental change, the environment thus serving to mediate between them.

3- Initiation of interaction : who starts it and what is the releasing factor.

4- Termination of interaction : which partner ends it, how, what are the responses of other partner to such ending.

5- Modes through which interaction is expressed : looking, touching, holding, etc...

6- Immediate purpose of interaction : Physical care, relief from pain or fear, stimulating or stopping activity of partner, etc....

7 - Underlying feelings and ways they are expressed.

Analysis of interaction under these seven headings is carried out systematically in all different circumstances under which interaction happens, as for instance sleeping, feeding, toilet training, play etc.....

It shows that each mother-infant pair has a definite pattern of interaction which is quite specific to it : that is to say, the pattern of interaction remains consistent and characteristic throughout the whole span of the study and differs in many ways from the patterns of other pairs.

Analysis of content of patterns of interaction permits to get at the interplay of attitudes which both mother and child display in their interaction. Attitudes such as : closeness versus distance, reaction to separation, response to strangers and relatives, attitude towards food and cleanliness, attitude towards activity, objects and environment, mutual attitude towards protection and daring, zones of mutual satisfaction and frustration, attitude towards dependency versus autonomy, etc... This list not being exhaustive.

Two cases will illustrate these points.

Each child was observed three times between II I/2 and I3 months of age. Two, three hours, sessions took place at home according to our usual routine, the third session was arranged at the office. In the third session both the setting and a second observer were new to mother and child. There was a free play session and a Gesell test ; when child seemed adjusted and at ease, the mother was asked to leave the room for a short while, the child remaining with the unknown observer.

II INTERACTION IN MOLLY'S CASE.

Molly is the second daughter of a working class couple. Her sister, aged five, has recently started school. The family lives very much on its own, Molly does not go out very often and plays in a somewhat crowed two-room flat.

Direct interaction between M and child is extremely frequent even apart from physical care and consists of long and complex chains.

Both mother and child equally initiates and if one stops, the other takes the lead.

In regard to the immediate purpose of interaction, all serves as an occasion for Molly and Mother to interact, with however, three significant predominant, though non-exclusive, purposes on the mother's part : in response to Molly's direct or indirect request to be picked up or to walk around ; each time Molly gets out of sight ; preventing Molly from touching or doing this or that.

Interaction is boisterous and noisy on the part of both.

All modes of interacting are intensively used, while feelings of cheerfulness, eagerness, content, discontent, irritation alternate with one another at a quick tempo although enjoyment of interaction is the predominant mood.

Progressive and mutual termination is usual but pseudo-endings are quite frequent, mother being often responsible for this, by immediatly re-instating interaction, even if she had been the one to end it. She is the only M in our sample who does not accept ending of interacting by the child.

The following excerpt from our records is a good example of what happens :

"Molly, under a table, is playing a peek-a-boo game with observer, and smiles at her. Mother says to the observer : "You see she copies Susan", and addressing Molly "Come, let's go and fetch Susan". Molly, forgetting her play with the observer, comes out of her hiding place immediately, responds to mother with happy sounds, takes mother's hand and they both go towards the door. The mother asks Molly to say "bye-bye" to observer, Molly ignores this but tries to open the door. The Mother, wanting to stop her from doing so, picks her up. Molly protests strongly. Mother says "Come along, it is not time yet" and to distract her, gives her Susan's doll. Molly takes hold of the doll and speaks to it. Mother puts Molly down, but Molly goes bock to mother and wants to be picked up. Mother says cheerfully "always Mummy" and gives her another doll. Molly smiles broadly at mother and mother announces reluctantly "I won't look at you any more". Molly seems content and retires to play under the table, but mother looks down at her and says "what are you doing there ? " Molly comes out and stands up, helping herself by holding mother's legs ; she takes hold of mother's hand and pulls at it. Mother says "what do you want ?" Molly pulls her towards Susan's doll (though the doll was at hand) and Mother seems happy to be pulled by Molly and to comply. She gives her the doll, and Molly takes hold of it and cuddles it, saying "Te-te-te", so mother leaves her and goes to stir the fire in the kitchen next door. Molly, however follows Mother towards the kitchen and sits in the doorway. Mother says "I don't like you to be there" and comes back ; Molly rises to her feet and calls "Mum, Mum, Mun", she holds doll against her heart, then holds it out to mother, going towards her with sweet mimics ; while doing this she falls, mother says "Boum", Molly gets up and wants to be picked up ; mother does not respond, and Molly proceeds to play with the closet door ; Mother rushes to stop her and says "At her age Susan was less demanding" while Molly says "pa, papa" to which mother answers "Papa will come, so take care of your bottom" and mother remarks joyfully that she is scared of Daddy. Molly goes back to fiddle with the closet door, this time mother pays no attention and there the interaction stops for a moment ; Molly leaves the closet and quietly goes into the parents ' bedroom, while mother speaks of Sue ; however, a few instants later, Molly being out of sight, Mother goes to see what Molly is doing in other room and a new chain of interaction is set off".

Analysing now the attitudes which mother and child display in their interaction : we find :

I - Physical closeness between Molly and Mother is a predominant feature.

Mother manages to always have Molly around. She never lets her out of sight ; she constantly keeps contact with her by speaking to her, by using any of the child's interests to bring her back to her, and answering all Molly's demands and cries She seems unable to resist interacting with Molly, takes tremendous pleasure in cuddling, kissing, keeping the child on her lap, and takes advantage of all opportunities which occur.

Molly turns no less frequently towards mother, calling her for witness, asking to be picked up, bringing a toy, pulling her hand to get somewhere, and having cute and inviting ways to obtain what she wants.

The behaviours of the two fit in very well and create those long chains of close and warm interchange in which Molly and her mother seem to find endless pleasure.

2 - Avoidance of separation. This eagerness for "togetherness" leads M and child to avoid separation or to maintain it at a minimum. Thus, in every day life, separation is no source of frustration. The thresh-hold of tolerance for separation is low however, and when at the office a separation was experimentally arranged, for a few minutes, it left Molly absolutely helpless, more so than most children of her age.

3 - Mother's interference with child's autonomous activity. Need for closeness, leads mother to interfere quite often in what Molly is enjoying on her own, either toys, objects or motor activity, and people as well, as will be seen further. She makes out of it, mostly if not exclusively, an occasion of interchange and in this way brings back Molly's attention towards her.

a) In locomotor activities, M interferes to share interest, admire and stimulate by verbal comments Molly's achievments, letting her strive on her own, while indeed Molly enjoys movments and daring acrobaties.

b) Whereas with toys, interaction is mostly one of "give and take" in which quite often M is found teasing Molly by withholding, while Molly struggles for holding on. M is not seen encouraging or promoting constructive or symbolical use of toys, and Molly's interest remains at level of manupulation and possessiveness as is confirmed during testing where Molly

struggles to obtain objects from the tester, and to keep them, but makes no use of them nor shows great curiosity.

c) Molly is more interested in adult possessions than in toys, and is found struggling hard to reach out for them in opposition to M who will not let her, have them. This is one of the rare areas of tension between them.

4 - Mother's interference with child's relations with others. With people, interference takes a different quality, whether it concerns strangers who create acute anxiety in Molly, or a betterknown person with whom she is enjoying herself.

a) When Molly faces a stranger, she is the most panicky child of the sample, and rushes helpless to M, crying, clinging to her for a long while. M responding quietly and warmly, neither pushing nor keeping back, rather encouraging.

It takes long for Molly to overcome her anxiety and let interest and curiosity in stranger take the lead. Even with the observer whom she sees often, she is fearful at first, moving back and forth between the observer and M. After a while however, she becomes friendly and even quite provocative, and forgets about M. ; this is when M interferes in subtle ways, as it appears in the chain we have just described, diverting Molly's attention from the observer to herself. Usually Molly does not mind, since M offers her something even more attractive.

Data show that it is a consistant characteristic of the mother to maintain distance between Molly and other people in such way. The father is always presented as a threat and she rather enjoys Molly's fear of him. An aunt living one floor up is permitted no right to share in Molly's care.

5 - Mutual satisfaction and frustration. Extreme closeness, though a great joy to both Molly and M is also a source of mutual frustration in interaction, the child's demands on the mother being endless and the Mother's interference not always being appreciated by the child.

Episode of mutual frustration are quite short but intense. Notes of Molly's whining, grunting, and crying are scattered through the account in the midst of these long happy chains of interaction.

To frustration, Molly reacts with a stubborn fight to get what she wants, and, if she has to give in, she screams, turns helplessly towards M who comforts her, bringing then a prompt ending to Molly's misery ; as to mother when frustrated by Molly's behaviour she responds by inconsistent attitudes

letting go half way for a while, then impatient, putting the child down abruptly, but giving in the next moment.

This angry putting down of the child, is the only occurence of sharp ending of interaction by mother to which Molly reacts sometimes by yelling : more often she accepts it, and goes playing about. M then calls Molly back and starts a new chain of interaction.

Same contradictory attitude is seen in toilet training and feeding when on the one hand M allows Molly complete freedom to be messy, even laughing about it and not helping her in any ways to become clean, while on the other hand she is happy to comment on how naughty this is, and how Father disaproves of it and punishes Molly for it.

Closer analysis shows also that M at times provokes frustration, through teasing or otherwise, as a mean of maintaining interaction and of obtaining gratification through the child's happiness when she removes the source of frustration. This is well seen in frequent instances of inconsistent forbiddings.

6 - Mutual dependency. Thus examined in all aspects, interaction shows Molly and Mother in a relationship of total dependency. Though M recalls how much attached she was to her own mother and declares that she restrains herself so that she will not make her daughters too attached to her, she is seen using every means to keep Molly dependant upon her. Even when she stimulates locomotor activities, she maintains high emotional dependency. She loves it and on each visit she looks tenderly at the little girl, and comments on how sweet she is and on how much one would like to keep them small. While Molly relies on M, both for enjoying herself and even more completely so, for relief from pain, frustration and anxiety.

Molly shows ability to enjoy a certain autonomy in her whereabouts and dealings with others but M, does not give her credit for this, and in her subtle way of preventing Molly's investment in people and objects, she rather diverts Molly's normal trends towards autonomy while responding warmly to all Molly's spontaneous movements of dependency.

At age one Molly is a happy early walker, quite enterprising in her space conquest, she is active, but her level of activity remains at the stage of manipulation and possessiveness with no constructive, nor symbolical use of objects. She

is also an early talker and interested in social games. She has great ability in making understood her wants and desires. She is always ready to turn to M to share interest, rather demanding, easily frustrated, and then helpless, but easily comforted also.

III INTERACTION IN BOB'S CASE.

Now let us turn briefly to Bob, first child of a middle-class couple, living also in a two-room flat. Mother though not working, has been trained as a kindergarden teacher ; Father is an engineer and both are actively interested in community and social life. They remain in close relationship with relatives and friends, the children being often kept in common by each mother in turn while the others mothers are b-usy elsewhere.

Interaction between Bob and his mother, is in sharp contrast with what was observed for Molly.

Indeed, outside physical care, direct interaction seldom happens. Chains of interaction are short with long interludes in between ; physical care is of brief duration and goes on without interchange, but with a quality of mutual tolerance, and empaty in ways of behaving towards food, cleanliness and handling of the situation.

The factors which release direct interaction are few : on Bob's part, reaction to separation, and reaction to hurt or fear ; on mother's part to prevent him from touching or doing something dangerous and to comfort him when hurt. But even then interaction is rare, and sober in modes and content : for instance : "Bob hurts himself and starts crying : mother who was sewing, watches without a word, Bob comes up to her on all fours whining ; he leans on her lap, mother gently and silently puts her hand on his head for less than a minute, Bob is contented and starts off...".

It is striking to see that during three visits, only one longer and richer chain of interaction is to be observed.

Between Bob and his mother interaction is mostly indirect and carried on almost exclusively through the mode of watching.

This pattern of interaction is revealing of mutual attitudes contrasting also with Molly's case.

1) Physical distance. Physical contact is reduced to minimum with no unnecessary picking up, no long stay on the lap, no mutual game of contact, no direct stimulations little cuddling, and little if any verbal interchange. However, when contact is asked for by Bob it is willingly given to him. But Bob rarely asks for physical contact or attention. He does not seek for mother's approval nor participation in his play.

There is indeed mutual agreement between Bob and his M in remaining distant. However though physically distant, Bob and M are far from being remote towards one another as is shown by M's sensitive and warm comments about Bob's progress and achievements, and by Bob's acute interest in M's activities, his warm greeting when she comes in, and his despair when she leaves.

Wondering at this we found that constant mutual watching was a subtle but very active way of interacting.

This watching is very gratifying for M and provides her with a fine knowledge of Bob's abilities, likes and dislikes and permits her to arrange an environment in which Bob finds many thrilling interests in which he gets deeply involved, leaving M pleased to see him busy and clever, while she is able at the same time to carry on her work.

Bob himself watches M a lot and in this way shares her activities. He needs to be looked at and cannot bear it, when mother gets too absorbed in her work and becomes remote. He then becomes whiny and frustrated, very much as he does when his mother goes away, as will be seen later.

Mutual watching appears to be an implicit pact "we enjoy being here together, but we don't interfere in each other's business".

And indeed, in Bob's case physical distance and non interfering are as striking as closeness and interfering was in Molly's case.

2) Mutual non interference in social relations.

M likes Bob to have friends of his age and offers many such opportunities. She enjoys watching the children play, rarely interferes in their games. She also enjoys Bob and Observer interchanges, and often leaves him alone with observer.

Bob is delighted to have people around. Play with children is source of activity and excitement. He both provokes and follows : he defends himself, hardly ever crying. He is quick and clever at keeping or obtaining toys he wants, but also quite tolerant when he fails.

During visit at the office he was a little afraid but also fascinated by the unknown observer. He did not turn to M but made cautious and progressive moves towards stranger, until he was able to enjoy her company. Mother made no comments, let Bob go at his own pace and in his own way but enjoyed his being friendly at the end.

3) Mother's non interference in child's activity.

Bob is seen playing for long periods with variety of toys and objects which Mother generously provides. The room is organized so that Bob may enjoy a lot of freedom.

And Bob enjoys himself on his own, looking, listening, exploring and making endless experiments with objects. High investment in toys exists specially in a Teddy bear with which he plays out his emotional life in the most cunning and imaginative way.

4) Mother's non interference in child's emotional displays.

Mother comments very little on Bob's emotionnal displays, though she takes them into account. She lets her son deal with them as well as he can, and comes in only when help is needed. She then tends to bring changes in environmental conditions, and, only when Bob clearly asks for it, offers direct support with very few words. As to Bob he has his own personal means of dealing with anxiety and frustration, and does not rest much on his mother for help.

For instance when faced with stranger anxiety at the office he did not turn once towards M but watched the observer not losing sight of her, stopping what he was doing when he caught her eyes. He slowly came nearer and nearer though as ignoring her. He did not take the pencil she was holding and he was wanting. He touched it when it was put on the table but quickly withdrew his hands, finally he took it. He sent his t oys in direction of new observer and then dared to play directly with her. Later on one saw him able to vigorously fight with her when she teasingly tickled his neck, not fearful, nor crying. He was not even resentful for he included her in his games few minutes later.

5) Attitude towards autonomy. Thus, there again mutual adjustment seems very good, Mother favouring in all possible ways Bob's trends towards autonomy while Bob shows great capacity in this respect, and mother often comments joyfully : "he is not a baby anymore. He looks like a little school boy, does not he ?"

It is worth noticing that in one area Bob remains totaly dependent and passive while Mother is definitely imposing herself in a completely domineering way, thouroughly accepted by Bob : this is in physical care either feeding or cleaning. Bob is pleased with M's manipulations. He accepts the food that she spoons into him at a quick tempo without making any attempt either to interfere in what she does to him, or to do it on his own.

He complies to her demands about toilet, training towards which she herself is very matter of fact and not much emotionnally involved.

6) Mutual pleasure and frustration.

Pleasure in one another and happiness strike as dominant all through interaction, while very few frustrating instances are observed. No whining and seldom crying on Bob's part, and no irritation on mother's part. This is partly due to the reduced number of prohibitions, which are clearly stated and consistent. So much so that at one year old Bob has registered them and forbiddings remain active even in mother's absence.

Separation is the only but strong area of conflict.

7) Attitude towards separation.

Bob's separation anxiety though within the average range for his age, is quite marked. His mother's comings and goings are a source of concern, and long since he has been able to differentiate when M goes out of room from when she goes out of the flat. He then cries bitterly. Mother is greatly annoyed by Bob's demandingness of her presence, feels it as cumbersome and does not permit Bob to intrude in her work and in her social and cultural activities. Though she does not scold nor show overtly her annoyance to Bob, she does not give in and does not spare him.

It is interesting to notice that Bob is the only child of the sample who plays hide and seek with his Teddy bear and a few other objects. He is also the only one to present some difficulties going to sleep crying and rocking himself on all fours when put to bed.

At one year old, Bob is a happy, contented bright little boy, engaged in many constructive and exploratory activities, making already symbolical use of toys. He is able to develop good social relationships, is independent in many ways and shows an early ego development as is shown by the complex means which he invents in order to master his fears and anxieties, and to master the outside world.

Thus those two patterns of interaction which are both rich and enjoyable for both partners, are contrasting sharply under many respects and lead ineluctably at one year old in dependency for Molly, in autonomy and early ego development for Bob. What will this end in during the following years is an open question ?

SUMMARY AND DISCUSSION.

I- Starting from naturalistic observations in the everyday setting we have tried to define a methodology for the analysis of mother infant interaction valid in every case.

Such methodology has led us to a description of interaction along seven main features throwing light on its characteristics in each case and permitting to define the specific and complex pattern under which both partners are inter-connected.

From such description emerged each partner's own emotionnal attitudes towards the other which can be organised along variables which we have also sorted out as a methodological tool. It is likely that other variables might be used. Our choice was guided by those which were always present, imposing themselves on us, and useful for comparative studies.

This type of study does not answer to the question as to what are the forces which lead each partner to have this, rather than that, mode of interaction. May be psychoanalytical investigations of Mother's motivations, study of individual differences in infants and sociocultural and anthropological investigations will answer one day those challenging questions.

However direct observation of interaction between mother and child seems to us to enlighten the understanding of mother child relationship and of its impact on child's development as will be shown now.

2- The two cases we have presented to day illustrate a fact which is true of all other cases observed : reciprocal attitudes of partners towards one another and towards environment are constantly acted out in interaction and gives it its specific pattern.

It is fascinating to see how each piece of interaction reveals several different attitudes at the same time this leading to their constant interplay between each partner.

Thus one sees clearly that interaction is the result and a complex mode of expression of these mutual attitudes, interaction bringing them to realisation, giving them shape and consistency.

3- These two cases illustrate also the fact that the emotional attitude of one partner in regard to one variable entails a definite attitude from its part in regard to other variables, so that exists in fact a close interdepency between them.

This interdepency between variables, gives to each partner's total attitude in interaction a well built in gestalt, having a character of ineluctable sameness all throughout interaction, which each partner meets from the other, imposes on the other and expresses through its own pattern of behaviour in interaction.

4- It is obvious then that, in interaction there is a constant adaptation to each other which ends in one or the other of the three following ways :

a) in mutual pleasure in each other's spontaneous attitude ;

b) in acceptation and easy compliance from one partner towards the other the latter being a leader readily followed by the former.

c) in open conflict.

In both cases presented to day, mutual pleasure in interaction is predominant with obvious reinforcement of mutual attitudes. Many instances of easy compliance and giving in exist and it seems that in both cases M under such instances is more often the leader than the child.

In Bob's case, separation is an area of open conflict and causes frustration and anxiety in both partners. In Molly's case there is not as yet such open conflict though one would be inclined to predict that the frequent occurences of mutual frustration due to extreme closeness should lead sooner or later to open conflict.

In other cases, compliance is predominant with low mutual pleasure with however no area of open conflict.

Whereas in other cases, conflicting attitudes are predominant, conflicts being both intense and wide spread - while mutual pleasure is scant - and compliance is attempted but fails.

We believe that such attempt to define modes of adaptation to one another should throw some light on the widely used concept of so called good or bad mother child relationship.

5- This closely knit mother-child interaction has obviously a strong impact on the orientation and development of maternal attitudes as well as on orientation of child's development and shapint of personality, through the reinforcement of some behaviours while others are completely ignored or antagonised. We will be interested, as a next step, to examine zones of correspondances between patterns of interaction, maternal attitudes, and personality features of the child at one year old. With our small sample only hypothesis can be made, at least it may be useful to state them in a way which could be controled in a further study.

6 - On the other hand, we hope that longitudinal study of our case will permit, to follow the evolution of interacting attitudes, and the changes brought about by conflict solving process whenever open conflict occurs. We are in this respect most interested to hear the next contribution which will be made by Joyce Robertson.

DAVID — POSTVERLE.

Nursery chn entering at $\frac{4-5}{12}$ show no adverse devt <u>macroscopically</u> in later months if given good environ.

If chn stay longer eg. 9/12 on:
some diffs in problem solving
but are good with Ests & Gestures.

Those staying $\frac{15}{12}$ + all show some degree of indiscriminate & shallow relationships
Mother acts as 'organiser' of 'action-units'.
<u>Functions which are most vulnerable</u>
Language (Tests chn are given)

HAND $\frac{2-3}{12}$ grasping - can't relax.

PROVENCE.

Contrast existg & home chrs

Justify chrs (a) tend to cry abruptly instead of a slow build-up with some frustration Elements.

(b) have a much more limited repertoire of tension relief

(c) utilise smoking at first but gradually lose interest & satisfn in comparison to ~~home~~ home chrs who make themselves an Object

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Chrs who go to foster-home after 12/12 are readily picked up by strangers who visit home provided he does not see her. Will respond readily to being (a) fed (b) being picked up. Most one anxious if they see stranger. Later may become indiscriminately friendly & clingy.

Pattern in Instns