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Helping toddlers to communicate: infant observation as an early intervention

Maria Rhode

My aim in this chapter is to describe the use of infant observation as an early intervention for children at risk of autistic-spectrum disorder, as well as some of the preliminary findings of a pilot study intended to investigate its effect.¹ Vignettes from observations are cited in order to illustrate some of the interactions taking place between toddlers, their family, and the observer, and some speculations are offered about how the observer may facilitate communication between the children and their families.

This intervention focuses on preverbal communication, even more perhaps than on the development of language. It is now well known (e.g., see Hobson, 2002; Trevarthen, 1979) that language arises out of the matrix of nonverbal communication between the infant and its caregivers. When all goes well, babies and their parents intuitively read each other's cues, share each other's feelings, and build up increasingly complex and sophisticated sequences of communication. These include the familiar games of infancy such as peek-a-boo and, during the course of the second year of life, culminate in speech.

However, babies can be unresponsive, for a wide variety of different reasons; their signals may also be difficult to read. It is hard to imagine any experience that could be more devastatingly undermining and invalidating for parents. In the case of babies who are later diagnosed as autistic, many parents report feeling from the beginning

that something was wrong without being able to pinpoint it. Indeed, as Muratori and Maestro have documented (see chapter 3), it is often not easy to distinguish, on the basis of home videos made in the first year of life, those babies who are later diagnosed with autism from those who are not. It is only gradually that distinguishing signs are beginning to emerge, as discussed in several chapters in this volume (see also Acquarone 2004). In these circumstances, it is little wonder that parents can often feel doubly invalidated: by their baby's lack of responsiveness, and by doubts—their own as well as those of professionals—about the accuracy of their own perceptions. These are circumstances that the presence of a sensitive, non-intrusive observer can do much to alleviate.

Infant observation as part of mental health training

Infant observation was originally developed in 1948 by the psychoanalyst Esther Bick, as a central component of the training for child psychotherapists that she founded at the Tavistock Clinic in London (Bick, 1964). It now forms part of the training of many mental health professionals (see Sternberg, 2005). It is also greatly valued by professionals, such as teachers, who wish to develop the insight and reflectiveness they bring to their work. Papers on various aspects of infant observation are published in the *International Journal of Infant Observation*, and a number of books and collections of papers have been devoted to the topic (e.g., A. Briggs, 2002; S. Briggs, 1997; Haag, 2002; Miller, Rustin, Rustin, & Shuttleworth, 1989; Reid, 1997a).

The observer visits a family once a week at a mutually convenient time, ideally from birth onwards, though this will, of course, depend on when a visit becomes manageable for the family. The observer's aim is to understand something of what it feels like, for the baby as well as for other family members, as relationships unfold within the ordinary events of everyday life. Of course, the beginnings of a life are never ordinary. Observers inevitably find that their emotions are deeply stirred by the miracle of birth, by the baby's vulnerability, by the parents' devotion and struggles that are part of the demanding task of child-rearing, and by the siblings' feelings of love and jealousy (M. E. Rustin, 1989). Learning to pay attention to these emotions, and to think about them instead of acting on them, is an important part of what makes infant observation such a valuable training experience.

Bick's injunction to observers was that they should always put the family's needs and feelings before their own, and that they should

interfere as little as humanly possible in the family's routine (Haag, 2002). This is not to say that it is possible or desirable to be a "fly on the wall": that in itself would be a kind of interference, since it is not natural human behaviour. But the observer must be reflective about her² own contribution to the observation and accommodate to the parents' practical and emotional needs. The observer makes notes as soon as possible after the observation; these should include as much detail as possible, as well as her own feeling responses. However, any attempt to conceptualize is deliberately left to the seminar group in which the observations are presented, so that observation and theory are purposely distanced from each other.

Helpful implicit messages

Infant observation conducted in this way conveys a number of important messages to the family. The first is that someone is consistently interested in everything the baby does, as well as in everything the parents say. Parents generally love talking about their babies, and they appreciate the observer's genuine interest, particularly since it is free of any claim to "know", let alone to "know better". Many mothers with new babies can feel cut off from their previous activities and relationships. Although they may form new friendships with other parents, they can sometimes feel that their baby's development, which to them is so absorbing, is of limited interest to friends from the past. The regular visit of an adult concerned with the minutiae of the baby's life can be welcome and reassuring. So, too, can the observer's openness to the full range of the parents' feelings about the baby: happiness and pride as well as exhaustion and resentment, frustration and fears for the future alongside fulfilment and love.

Another important message is that the observer will fit in with the family, will put their needs first, and will not be put off by behaviour that might be problematic in other circumstances. The observer's consideration for the parents' needs conveys her respect for them and for the importance of their task in modulating their children's feelings, even when they are under pressure themselves and suffering from lack of sleep. If the mother misses an appointment, the observer will not react punitively: if the parents have not found time to get dressed, or if the older child's toys are all over the floor, the observer will not be critical. At a time when the encounter with a new, vulnerable baby reawakens the parents' own infantile anxieties, support from their own parents is particularly welcome. Often, however, grandparents

have other claims on them, and professionals, no matter how helpful, do not have the time simply to witness the baby's development but must, rather, focus on a specific problem. The observer's stance shows that she realizes the importance of ordinary events and the power of the feelings that can be associated with them.

The birth of a new family member unavoidably brings with it the disruption of previous family patterns and some degree of strain on relationships. Part of the observer's task is to learn to take in and respond to the actions, words, and feelings of all members of the family, even though she is primarily there to focus on the baby. Inevitably this is difficult, and she will not always succeed. However, the very fact that she continues to struggle, and that her behaviour expresses the conviction that there is room for many viewpoints, can be helpful to a family on its way to reconstituting itself to include an additional member.

These are some of the factors that contribute to the helpful effect of an observer's presence. Although infant observations were intended as a learning experience for the observer, writers from Bick (1964) onwards have noted that those parents who choose to have an observer—and, of course, not all families would—tend to feel supported by the experience. (In a way, this is not really surprising: most mothers find that it is easier to cope with their children when another adult is present, even if that person is not offering any practical assistance.) Out of this recognition has grown the applied use of infant observation with specifically therapeutic aims.

“Therapeutic” infant observation

In some infant observations, unforeseen difficulties mean that the observer deliberately takes on a more therapeutic role. For instance, the parents of a baby who was failing to thrive had difficulty in making use of the professional help offered, but they responded well when the observer took up the potential seriousness of the child's condition (Wedeles, Grimandi, & Cioeta, 2002; Williams, Grimandi, & Cioeta, 2002). The observer's role changed to that of participant observer: her observations and her feeling response now served as information on which she relied in order to respond directly to the baby and “interpret” the baby's cues for the parents. The child stopped refusing food, and family relationships were much improved. When the observer had to leave, the parents asked for another participant observer to take over.

Therapeutic infant observation has been applied in a number of different settings and for varying problems, largely in France and in South America. Its systematic use was pioneered by Didier Houzel, a French psychoanalyst and professor of child psychiatry who integrated it into the regional child psychiatry services in Brest and, later, in Caen (Houzel, 1989, 1999). He stresses the usefulness of the method on a number of counts. It is minimally intrusive, and the fact that it is based on home visits means that families can be reached as soon as a problem is detected. This includes those families who, for whatever reason, would not be able to make use of formal, clinic-based appointments, though the experience of improvement during the observation may encourage families to support such treatment later if it is still necessary. Houzel underlines the cost-effectiveness of therapeutic infant observation when compared to outpatient treatment: observations can be carried out by psychiatric nurses or generic mental health workers who have had the experience of doing a conventional infant observation, as long as they have adequate access to supervision seminars in which to discuss their observations and to process their own feeling responses. Even when observers visit a family twice weekly and attend two supervision seminars a week, the intervention package costs less than outpatient treatment by professionals with lengthier trainings. Once-monthly appointments are offered with the supervising psychiatrist for the parents to discuss their child's development and any concerns they may have.

This intervention is offered to babies with failure to thrive or who are thought to be at risk of communication disorders, both by Houzel's team and by that of Pierre Delion, a psychoanalyst and child psychiatrist who formerly worked in Angers and is now a professor of child psychiatry in Lille (Delion, 2000a). Good outcomes are reported, and the package remains part of district child-psychiatry provision.

Bianca Lechevalier, who has written widely on the psychoanalytic treatment of children with autism, has described a successful outcome to the observation of a baby with West's syndrome (Lechevalier, Fellose, & Bonnesoeur, 2000). This is a degenerative convulsive disorder in children that is associated with an abnormal EEG and, often, with autistic behaviours; it is generally treated with cortisone. The baby discussed by Lechevalier was observed from the age of 7 months; six months later, his EEG was normal, and his subsequent development proved satisfactory. Lechevalier is careful not to suggest that all cases of West's syndrome would respond like this. However, even one such

well-documented case has obvious far-reaching implications, both practically and theoretically.

Successes have also been reported for the use of therapeutic infant observation in cases where the family's capacity to care for a baby was compromised, whether because of a life-threatening illness of the child (Cardenal, 1998) or because of long-standing transgenerational difficulties that had led to previous children being taken into care (Delion, Libeau-Manceau, Péan, & Petit, 2000).

Houzel (1999) has proposed that three main qualities of the observer contribute to the therapeutic effect of a participant infant observation. The first is her "perceptual" receptivity—that is, her capacity to pay attention to details and sequences of behaviour that are later made sense of in the seminar. The second is emotional receptivity: it hardly needs belabouring that children flourish through the provision of sympathetic attention. The observer can serve as a model to parents because of her receptivity both towards them and towards the baby: they can begin to feel, if they did not already, that they and their child are worth paying attention to, over and beyond the professional attention that others give to their child's problems. Parents soon begin to tell the observer things they have noticed about their child, even if they did not do so previously: they begin to realize how precious is their own gift of attention. Perhaps the most important factor, in Houzel's opinion, is what he calls unconscious receptivity—that is, the observer's openness to communications at the deepest level, beyond what can be achieved through an effort of will. It is because the observer will need an opportunity to process and formulate impressions and reactions that she is not consciously aware of that the provision of a seminar or of individual supervision is such an essential part of this intervention. Equally, the observer's conscious feeling response is often very painful, particularly if a child is ill or if the observer witnesses miscommunications between parents and children and does not cut herself off from the distress that each one suffers. Where this is the case, a time for discussion is essential if the observer is to be able to conceptualize the interactions she becomes part of and to consider how best to respond.

Design of the pilot study

In view of the encouraging reports I have cited, it seemed urgent to pilot a study of the facilitatory effects of infant observation on children at risk of autistic-spectrum disorder. One could expect that such

a study should provide two kinds of information. On the one hand, it would furnish much detail about the development of at-risk children, of the kind yielded by “ordinary” infant observations of babies who turn out by chance to have features characteristic of the autistic spectrum such as the avoidance of eye contact (Cowsill, 2000; Reid, 1997b; Somerville, 2000). The systematic observation of a number of children within the same diagnostic grouping (M. J. Rustin, 1997) should allow fresh understandings to emerge through the application of systematic methods of qualitative analysis. On the other hand, the use of commonly accepted instruments to frame such a study would permit one to say whether a *prima facie* case existed for a systematic study on a larger scale and with a comparison group.

At present, no commonly accepted measures exist for the diagnosis of autistic-spectrum disorder in children below the age of 15 months, though clinicians agree on danger signals, including muscular hypo- or hypertonicity and withdrawal from social contact (Acquarone 2004) (see also chapter 6). Systematic efforts to validate these are well advanced (see chapters 3 and 5). A new scale (Greenspan, 2005) discriminates between children with communication problems and those with other difficulties, though it has not as yet been validated against diagnostic tools used in the second year of life, such as the Autism Diagnostic Observation Schedule (ADOS: Lord et al., 1989) or the Checklist for Autism in Toddlers (CHAT: Baron-Cohen et al., 1996) (see also chapter 5). The ADOS is valid from the age of 15 months; the CHAT has a window of validity between 16 and 20 months. We decided to use the CHAT in this pilot study, since it is a simple screening measure designed to be used by primary-care workers; it takes some 20 minutes to administer and includes a brief parent questionnaire as well as direct observation of the child, centring on the capacity for gaze-monitoring, for proto-declarative pointing, and for representational play. Although the sensitivity of the CHAT is very low (it picks up only 27% of the children found to have autism at the age of 3½ years), it produces virtually no false positives. Of 12 children (in a sample of some 16,000: Baron-Cohen et al., 1996) who had developed none of the three capacities tested and thus fell in the high-risk category of the CHAT at age 16–20 months, 11 were diagnosed as autistic at the age of 3½ years; the only one who was not showed residual expressive-language delay. This absence of false positives makes the CHAT an excellent screening tool, though the age of 22 months or so seemed to us regrettably late to begin a therapeutic infant observation for children suffering from a condition that is so difficult to modify.

We decided also to observe the toddlers—first, before the start of the intervention and then a year later—during two minutes when the mother left the room, and then on her return. This separation–reunion task was inspired by the Strange Situation Test (Ainsworth & Wittig, 1969), a means of assessing a child’s attachment status, which is carried out in a laboratory and rated from a video-recording. We carried out the procedure in the child’s home and without a video, which made it less stressful for mother and child. The child’s attachment status was assessed from the research assistant’s notes made during the separation/reunion.

Several measures were used for the mother (and will in future be used for fathers, too, where possible). Mothers were asked to supply standard demographic information and to fill in the Goldberg General Health Questionnaire, which provides a measure of anxiety. In addition, they were given a semi-structured interview about their experience of pregnancy, birth, and the child’s early development. Finally, the short form (Slade, Aber, Berger, Bresgi, & Kaplan, 2003) of the Parent Development Interview (PDI) was administered before and after the intervention. This interview provides a measure of the parent’s capacity to think about their child’s feelings and motivation: it is scored for reflective functioning, but without those questions about the parent’s own past that form part of the Adult Attachment Interview. Such questions could upset a vulnerable group of parents and might be misunderstood as implying a causal connection between the parents’ past and their child’s difficulties.

The following summarizes the sequence of stages in the project:

1. Participants are contacted through workers in primary care who may have concerns about the child’s capacity to communicate or who may have been alerted by the parents.
2. Families are visited by the project coordinator, who explains the intervention, answers any questions, and obtains informed consent.
3. A research assistant visits to administer the CHAT (twice), the separation–reunion task, the demographic questionnaire, the Goldberg General Health Questionnaire, and the semi-structured interview on the parents’ experience of the birth and early history.
4. The parent worker visits to administer the PDI, which can provide a good way of accessing themes likely to be important in parent work. [This work provides an opportunity for the parent(s) to

- discuss any issues arising out of the observation, as well as any concerns they may have in relation to their child.]
5. The intervention now begins, comprising weekly visits by a participant observer and fortnightly visits from the parent worker. We had originally expected to offer monthly parent support, but this proved too little and was increased to fortnightly.
 6. At the end of the year, the parent worker again gives the PDI, and the research assistant returns in order to readminister the Goldberg General Health Questionnaire and the separation–reunion task.
 7. When the child reaches the age of 3½ years, an independent psychiatric interview is arranged if one has not already been put in place by the statutory services.

Some preliminary findings

So far, only three children have been offered the programme, partly with the aim of piloting the measures and of discovering how best to deliver the intervention. (For example, we needed to establish whether monthly parent work was sufficient or whether the frequency needed to be increased to fortnightly.) Of these, only one child, Adam, of those assessed during the window of validity for the CHAT remained in London for the whole year of the intervention. This child was in the high-risk category of the CHAT and statistically had an 11-in-12 chance of receiving a diagnosis of autism at 3½ years. However, the psychiatrist found no signs of autistic-spectrum disorder when Adam was 3½, despite “a very worrying early history”. Instead, there remained some residual expressive-language delay, though emotional, nonverbal communication was excellent, including social referencing. According to the CHAT, the chances of such an outcome are only 1 in 12.

In addition, this child’s attachment category, as rated on the separation–reunion task, had changed over the year from Avoidant to Secure, and the mother’s anxiety level, as measured by the Goldberg General Health Questionnaire, had been reduced by half.

Another of the children was contacted at the age of only 12 months. He had avoided eye contact with his mother since birth and was showing some pronounced stereotypic movements, which is rare at such a young age. Though 12 months was too young for the CHAT, we proceeded with the intervention, as the mother was very anxious for this to start at once, and we felt that, from an ethical viewpoint,

we could not refuse. In this case, too, the child's attachment category changed from Avoidant to Secure, and maternal anxiety was reduced by half; no problems were found when the child was reassessed by the paediatrician at the end of the intervention. More particularly, normal eye contact with the mother had been established, and language development was age-appropriate.

In spite of the very small numbers in this pre-pilot, we therefore feel encouraged to proceed with the pilot project, particularly in view of the 1-in-12 chance, according to the CHAT, that the boy who completed the intervention would have been diagnosed as suffering only from expressive-language delay. Our intention is to recruit a further six children in the high-risk category of the CHAT, all of whom would have the intervention. The very high likelihood of a later diagnosis of autism for such children would make it possible to gauge from a small number whether a *prima facie* case had been made for a more extended study with random allocation and an untreated comparison group.

The process of the intervention

I would now like to offer some speculations as to what may be taking place in the course of the intervention, and what functions may be fulfilled by the observer and parent worker. In order to do this, I shall offer some illustrative vignettes drawn from all the observations.³

The vicious circle of discouragement

Babies and toddlers who have a particular vulnerability, whether neurological or emotional, require even more responsive handling than other children if they are to reach their full potential. Young children at risk of autism are no exception to this. However, their own lack of responsiveness and difficulty in tuning in to other people can sometimes make parents and professionals feel exhausted and discouraged. Their hopefulness can be undermined, and they can become less able to respond to what are often minimal cues. In this way, a vicious circle can be set up that adds to problems in communicating that may already be present, much as Sinason (1986) has proposed that the "primary handicap" of some learning disabilities may be aggravated by the "secondary handicap" arising from the child's way of coping with the condition.

I would like to give two examples of this. The first is from my preliminary visit to Mr and Mrs C and their son Andrew, who, in fact, did not complete the intervention because they moved away.

Andrew was sitting on his mother's lap while I explained what the project would entail, and he held out his arms in the direction of his father, who was watching the television while the other children played nearby. I commented that Andrew seemed to want to go to his father. Both Mr and Mrs C disagreed: they thought Andrew was gesturing to go out the door, though this was, in fact, at right angles to the direction of Andrew's outstretched arms. I said that obviously I had only just met them and Andrew, whereas they had known him all his life, but that I would not have hesitated to assume that Andrew was reaching out towards his father. His parents remained convinced that this was not so: Andrew would never reach out towards either of them.

It is clear that this attitude would be likely to interfere with the way family members could relate to each other.

The other example concerns Adam, the little boy in the high-risk category of the CHAT who completed the intervention with the good results I have indicated.

During the research assistant's first visit, before the observation and parent work began, she was distressed to witness how difficult it was for mother and child to get together, though both were trying. Adam's mother, who had just returned to the room, went to lift Adam down from the window seat. Adam protested, wriggled out of his mother's grasp, and climbed down himself. He looked at his mother, who had gone to sit on the sofa, and then climbed onto her knee. The research assistant wrote:

"I was expecting him to cuddle, but instead of putting his arms around his mother's neck, Adam reached behind her and put his fingers behind the sofa. His mother's arms remained by her sides on the sofa. Adam pulled out a little soft toy, then used his mother's shoulders to lever himself onto the arm of the sofa. He tried to edge round the door, then gave a terrible scream, as though he were stuck. His mother told him to come back inside, and he did. . . . He came over to the sofa where his mother was still sitting, put his head into the sofa next to her, and fretted some more. His

mother sighed and tried to pick him up. Adam howled, struggled out of her arms, pushed his face into the sofa cushions, and really cried out. . . . He got down and pushed my papers onto the floor, then hurled himself onto the carpet and cried loudly. As his cries got more determined, his mother said, 'This is normally when he starts banging his head. I try and pick him up and he pushes me away.' She then said, 'Come on, Adam, are you coming up?' She sounded tender but exhausted. She sat Adam on her lap so that they were facing each other, and they had a brief, but very touching cuddle. I felt very moved and relieved. Almost immediately, Adam pulled back from his mother and climbed off the sofa, becoming absorbed in a toy."

This extract shows how hard it was for Adam's mother to persist in offering him comfort, in view of the many experiences of rejection she had suffered. Equally, Adam did not ask for the affection and comfort he so clearly yearned for. His mother had to persevere in the face of his discouraging behaviour. To the research assistant's huge relief, the "very touching cuddle" did happen—but almost immediately Adam interrupted it and distanced himself.

In contrast, this is what happened at the end of the separation–reunion task after a year's intervention:

While mother was out of the room, Adam pointed at an aeroplane outside the window. The research assistant agreed: "Yes! An aeroplane!" . . . Adam watched the plane and called out, "Bye!" as it moved across the sky. He looked back at the research assistant, then said "Bye!" "See!" and "Oh!", finally calling "Bye" more softly as he waved at the plane. . . . He went over to the table, handed the assistant a pen, and pointed to a letter that his mother had written on a piece of paper. He said, "Mu! Mu! Mum!" a bit anxiously, and the research assistant felt that his mother was very much on his mind. He drew a mark on the paper and said "Mu!" in a brighter tone; the research assistant said that that was where Mummy had done her writing. Adam said "Yeah" in a sing-song way. . . . At that moment, his mother and elder brother came back. Adam sat up immediately on hearing their voices, . . . looked round at his mother, pointed at the research assistant, and made some excited noises. Then he made an "all gone" gesture with his hands. He picked up a ruler with wild animals on it, made an exaggerated "Oooh" sound, and looked up at his mother, smiling. He took the ruler over

to her, and she acknowledged it in an affirming way. He then began pointing out the bricks, pen, and paper to his mother, chattering excitedly as he did so. The research assistant wrote:

“He seemed really pleased to be showing his mother the things he had been doing while she was out of the room. His mother nodded and said ‘Yes’ as Adam pointed the things out to her. It felt as though they were really coming together and communicating even though a physical distance remained between them. Adam suddenly made a loud roar at his mother, which was done playfully but which also felt a little precarious. She returned the roar. Adam looked at the ruler and roared again, smiling. His mother roared back, and it felt as though a game were taking place.”

After a somewhat edgy interlude with his elder brother, Adam crawled over to his mother and lay down at her feet. He looked up at his mother, who clapped her hands. Adam reached his hands up towards his mother, who bent down and lifted him up by his hands. They stood for a moment holding hands and looking at each other. Adam glanced round at his elder brother, then turned back to his mother, fell on his knees and buried his head in her tummy. The research assistant wrote:

“Mother’s body became concave, as though making room for Adam. I was very moved at the sight of their togetherness. Adam lifted up his head and reached up his arms and his mother gathered him up onto her lap for a cuddle. Their necks were locked together and their arms wrapped round each other in a strong embrace. Adam looked up at the fan behind him and made urgent ‘uh, uh’ noises, which suggested that he wanted to share his interest with his mother, who looked around at the fan with him. He slid off mother’s knee, looking round at me and his brother while keeping hold of her hand, then ran out of the room to chase the cat.”

At this stage, Adam is able to communicate with the research assistant about the plane that goes away like his mother (“Bye”) and to refer to his absent mother by means of the paper on which she had been writing. When mother comes back, Adam “tells” her what he had been doing. He can now deal with a mishap (the fallen ruler) by exaggeration, which suggests that he now understands the pretend mode. It is also as though he were remembering and reproducing a helpful adult reaction: this comforting internalized voice supports him, and he smiles up at her as though sharing the reference. The sudden, slightly

precarious roaring communicates something about a sudden irruption of anger, but it remains appropriately contained within a game, quite unlike the painful interaction between him and mother the year before. It is striking how closely Adam's mother follows his communications. Later, when they find each other for a cuddle, it is not suddenly broken off as it was in the previous instance. Then, Adam's attention was immediately distracted by a toy; this time, he shares with his mother his interest in the fan. He then looks at his brother and the research assistant while keeping hold of mother's hand, before running off to pursue his own interests. It is as though he had begun to feel that there was room to include everybody.

Interestingly, Adam showed many instances of social referencing very early during the observation: he looked round in the direction of the observer, as though to make sure she was paying attention or to check her reaction. This is particularly striking because, according to the CHAT (which he had been given twice, at intervals of a week) he was not capable of following someone else's gaze. It is not unduly surprising that he should have shown more of his capacities when he was receiving someone's undivided, empathetic attention. However, we must remember that the prognostic validity of the CHAT is linked not to what a child *can* do in optimal circumstances, but to what he or she *does* do when tested. The implication must be that at least some children in the high-risk category of the CHAT have capacities they do not show. One of the questions for the pilot study will be how many of the children this applies to.

A related important point is that both Adam's mother and the observer had difficulty in noticing, remembering, and believing in Adam's capacities. His mother often described him as being unable to do something that the observer witnessed him doing. However, she could sympathize with the mother, since she had the same difficulty, though she often needed the supervision sessions to realize this. For example, very early in the observation Adam produced a word: he imitated the observer, who had just said "Ta" when he handed her a toy. But it was difficult fully to take the implications on board: months later, the observer, just like Adam's mother, was asking herself why he didn't speak. It was as though Adam powerfully put over a picture of himself as someone incapable, so that it was difficult even for the observer to trust the evidence of her own ears. This again would lead to a vicious circle. A number of authors (e.g., Brazelton, Koslowski, & Main, 1974; Papousek, 1992) have documented the importance of parental expectations for early language development. The parents'

assumption that early vocalizations are intended as words, as are their responses to them, plays a vital role in the normal process by which words develop out of sounds. Any factors—physical or emotional—that undermine the parents' confident expectations will be likely to have far-reaching effects.

Observation and parent work

How might Adam's striking transformation have come about? I shall offer only a few suggestive vignettes, together with some speculations. I do not go into any detail here about the parent work, except to say that it was an essential component of the intervention and that monthly visits proved to be insufficient. The parent worker provided support of any kind that seemed necessary or appropriate, including, at times, liaison with nurseries or with social services.

The optimal degree of communication between observer and parent worker touches on difficult boundary issues. On the one hand, teamwork could be a source of strength: the families rightly assumed that both workers knew each other, and this seemed to be experienced as a helpful example of two people cooperating to support the parents and children. Some information—such as the child's first word or first day at nursery school—obviously had to be shared in the interests of common sense. On the other hand, the parent worker had access to factual and biographical information that sometimes seemed unhelpful for the observer to know. Some kinds of knowledge could have provided an adult understanding of the parents' behaviour that was not available to the child and, in that way, could have interfered with the observer's emotional sharing of the child's experience. For example, the father in one of the families often suddenly left the room in the middle of an interaction in a way that made the observer—and, quite possibly, the child—feel abruptly cut off for no understandable reason. She could not have responded to this as fully as she did if she had known the cause of this behaviour, which was related to a recurrent urinary infection. (Later, the father began to tell his daughter when he was going to leave the room.)

Functions of the observer

The following is a discussion of some of the functions of the observer in a therapeutic observation, as distinct from the less active role in an observation carried out for training purposes.

- *Receiving, containing, and validating/verbalizing communications from both parents and children*

Firstly, and perhaps most importantly, the observers were witnesses. This applied to all of Houzel's levels of receptivity—perceptual, emotional, and unconscious. Many of the functions that I suggest the observers fulfilled were variations on this fundamental role of witness. While this may seem quite a modest function, it has profound implications on an existential level. The presence of a witness who is empathetic and non-judgemental provides validation of a person's point of view; of his or her emotional experience; and, ultimately, of his or her existence. As Winnicott (1967) described in his paper on the mirror role of mother and family, it is himself that the child sees reflected when he looks into his mother's face. This experience, Winnicott argues, is the foundation of the child's sense of self. It can then be built on through the internalization of experience in ways that have been described by psychoanalysts from Freud, Abraham, and Klein onwards.

Sometimes, so as not to intrude, the observers remained silent witnesses. At other times, however, they might put into words what they had seen or experienced, particularly when parents and child seemed to need "interpreting" to each other. Observers might use words to reflect the experience of parents and child ("It can feel really difficult sometimes"; or, "That's right, Mummy's gone into the kitchen"; or "You want Mummy to see that you like the music from that toy"). At other times, they might engage the child by means of actions, particularly imitation. Children with communication disorders readily respond to being imitated—something that many different programmes of intervention make use of—but they do not themselves imitate spontaneously in the way that other children do. In the course of these observations, the children began to imitate the actions of the observer, who had imitated them: it is as though, once they had felt their own actions had been witnessed and reflected, they could begin to take the adult as a model.

Sometimes the observer had to validate an experience, not by naming it in parents or child, but by tolerating it emotionally herself (Bion, 1962). For example:

Six months into the observation, Adam was watching television. He put his drink down on the table, making a noise. The observer imitated the noise, tapping the table with her hand. Adam looked at her with surprise and delight, and they enjoyed a brief "rhythm game". The observer put words to the game, saying that she and

Adam were playing together: “Adam is banging with the cup”; “Mrs Y is tapping the table with her hand”; “Now we are doing it together”. Adam made lively bubbling sounds and stared at the observer. Then he went back to watching the television. The observer felt very lonely. She tried to attract his attention by moving her head into his line of sight, but it felt mechanical and she stopped. Suddenly Adam pointed to the screen, as though he wanted to share something with her. She said, “Adam wants Mrs Y to share something with him, something on the screen.” Adam looked at the observer, then back at the screen, still pointing. She said, “How exciting, Adam and Mrs Y can both watch something at the same time”, and Adam laughed delightedly.

In this example, a game developed when the observer imitated Adam; however, he then broke off the contact, just as he had with his mother in the first separation–reunion sequence. The observer had to tolerate feeling lonely and unable to do anything about it, just as one might assume both Adam and his mother had felt. This seems a good example of the process of emotional containment, in which, as Bion (1962) described, the mother’s or therapist’s capacity to tolerate an emotion communicated by the infant or patient makes the emotion less overwhelming. It also provides an example of someone who can sustain and think about a feeling and thereby make it meaningful. In this vignette, the observer’s function of containment is immediately followed by Adam’s pointing out something on the screen: an instance of the capacity for joint attention, which the observer validates to Adam’s delight.

- *Making links between parents and child*

The observers would often “interpret” parents and children to each other: “You want Mummy to see you hold the dolly”; “He likes being close to you”; “Mummy will be pleased with what you’ve done”. This applied largely to positive situations that might otherwise have been overlooked. It links with the next function.

- *Embodying a third-party/regulatory function*

Describing and fostering an interaction between parent and child sends the message that the observer welcomes it, even though she is not directly involved. This is an essential aspect of what Britton (1989) has termed the “third position”, that of someone who observes a

relationship. He suggested that this position was the foundation of self-reflectiveness, of the capacity to “observe oneself while being oneself”. Equally, the observer might act to set boundaries, in this way embodying a paternal function that regulates the distance between mother and child. Some of the parents would set limits verbally, but they might give up in exhaustion when it was necessary to actively enforce them. If the mother, for instance, asked the child to stay inside the room and the child did not respond, the observer might support the mother by closing the door. She would make a point of verbalizing the reasons: “I’m closing the door because Mummy wants you to stay inside.”

- *Facilitating the inclusion of all people present*

This function, in turn, follows on from the previous one: the underlying message is that there is room for more than one person, and that it is possible to tolerate waiting one’s turn. Alvarez (1997) has described mothers who have the capacity to keep their children in mind even when they are temporarily concentrating on something else—for example, turning the page of the book the child is looking at, in-between cooking the dinner or talking to their husband. These mothers can also allow their children to follow their own interests: they do not feel invalidated by not always being in the forefront of the child’s concerns. Alvarez has suggested that these maternal qualities can support the child’s own capacity for turn-taking and for trusting that thoughts, as well as people, can wait their turn without disappearing and can therefore be organized in meaningful patterns. Besides attending to more than one person, observers actively drew parents or siblings into a game or other interaction that had begun between themselves and the child.

- *Modulating separations*

Modulating separations was a particularly important function of the observer: Adam’s response to the first separation–reunion task gives the flavour of his early response to separations. Some of the components of the observer’s modulating function included:

Registering and witnessing the child’s feelings: this might be a matter of noticing that, after the mother had gone out of the door, the child went to it and stood there looking forlorn. At the beginning of the observations, the child often gave no sign of this once the mother came back. Because the observer did not herself leave the room, she provided an

ongoing background of continuity. Sometimes simply speaking to the child's distress could have a dramatic effect:

Adam always went rigid and screamed when he was put in the car seat, so much so that the family went out much less than they wanted to. The observer found herself talking emphatically about how much he hated it. To her amazement as well as his mother's, Adam calmed down and allowed himself to be strapped in, and this was consolidated over the following weeks. An important factor was that Adam's mother had appealed to the observer to witness his behaviour and that he would have felt they were supporting each other.

Referring verbally to the absent mother: this is a way of supporting a mental and emotional link to her. The children began to follow the observers' example and to refer to people who had left the room, as Adam did in the second separation–reunion vignette.

Tolerating the reasons for mother's absence: this conveys the message that things happen according to a coherent, meaningful pattern—for instance, saying “Mummy's gone to unload the washing machine”.

Experiencing aloneness and rejection: this could be seen, for example, in the vignette of Adam in front of the television. Later in the observation, when Adam and his mother were linking up more, the observer was often in the position of the one who was left out or left behind in the room. In other observations, observers sometimes felt left out of what was being discussed with the parent worker, who often had similar feelings themselves. It is not surprising that the experience of being excluded should be so important in relation to children who do not readily respond in understandable ways.

Conclusions

Observation plus parent work seems a promising early intervention for children at risk of communication disorder, even when they have reached the relatively late age of 22 months. It may be particularly appropriate for those cases where the “vicious circle of discouragement” has gone so far that simply encouraging the parents to follow the child's lead, as in the “Watch, Wait and Wonder” approach⁴ (DeGangi

& Greenspan, 1997; Muir, 1992; Muir, Lojkasec, & Cohen, 1999) may be not be practical. The feature that distinguishes therapeutic infant observation is the central importance of the observer's emotional and unconscious receptivity (Houzel): her function of being available to receive and process experiences, like loneliness, that are often painful. An additional advantage is the fact that parents do not need to change their routine or attend a clinic.

Notes

1. Partners in this study are Maria Rhode (lead investigator), David Simpson, Judith Trowell, Margaret Rustin, Martin Bellman, and Elizabeth Nevrkla. We gratefully acknowledge the financial support of the Winnicott Trust and the Tavistock Institute of Medical Psychology.

2. Although most observers are female, there are some male observers. For ease of exposition, feminine pronouns are used in this chapter.

3. I would like to express my thanks to the observers and the research assistant (Agathe Gretton, Liz Stevenson, Jenifer Wakelyn, and Rebecca Hall) for permission to cite illustrative examples from their work.

4. I wish to thank Victoria Blincow for information on Watch, Wait and Wonder.

Early Intervention with Children Who Have a Hearing Loss: Role of the Professional and Parent Participation. Zerrin Turan Anadolu University. Early intervention is defined as "a set of services for children six years of age or younger who are at risk of or who currently have developmental delays or social emotional problems" (Guralnick, 2005, as cited in Mahoney & Wiggers, 2007). The underlying premise for early intervention is that children's developmental or social-emotional problems can be either prevented or remediated through specialized services and activities designed to maximize their developmental learning (Bailey, et. al., 1998; Baguley, et al., 2000; Bluebanning, et. al., 2004). This positive response from the parent increases the chances the infant will repeat these sounds. Early intervention is a federal- and state-funded program that helps children and their families. You may also contact the early intervention program yourself (see Resources to find a contact in your state). If your child qualifies for services, a team of specialists will work with you to develop an Individual Family Service Plan (IFSP). This plan becomes a guide for the services your child will receive until 3 years of age. It may include parent training and support, direct therapy, and special equipment. As a parent, follow your instincts. If you continue to have concerns about your child's development, ask for a reevaluation or referral for additional formal testing. Listing of resources does not imply an endorsement by the American Academy of Pediatrics (AAP). The Early Intervention Program for Infants and Toddlers With Disabilities, or Part C of the Individuals With Disabilities Education Act (IDEA), is a federal grant program that assists states in operating a comprehensive statewide program of services and supports for children birth through 2 years old with developmental delays, including (at state option) children who are "at risk" of developing a delay or special need that may affect their development or impede their education. Congress established the Early Intervention program (generally referred to as "Part C") in 1986, and most recently r Do you know what early intervention (EI) is? I hope so, but I know that many of you don't. I want to rectify that because if you are living in the United States and have a child under the age of 5 you may qualify for these free services. I think this comes as a surprise to most people and I wish I could send a letter to every parent across the US and let them know that YES if your child is having difficulty eating your state probably considers this a delay and will provide EI therapy in your home. Most states provide help for feeding and sensory processing difficulties.