

WATCH, WAIT, AND WONDER: An Infant-led Approach to Infant-parent Psychotherapy

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From birth, infants grow and develop in their capacity to show feelings, to communicate both verbally and through their gestures and facial expressions, to think, and to relate socially. We now know that early relationships affect how well infants develop, and that problems in an infant's early relationships are linked to later problems in social relationships, emotional health, thinking, and problem solving. Increasingly, parents seem to be recognizing the importance of their relationships with their infants, and when this is not going well, many seek help.

Infants brought to mental health clinics cannot use words to express their anxieties and distress. Their symptoms typically appear as functional problems such as in feeding or sleeping, or in extreme tantrums or difficulty being soothed. While not apparently relational, these problems commonly reflect difficulties in the relationship between parent and infant. For example, sleeping problems may reflect the infant's separation anxiety resulting from an anxious attachment.

Case

Mother: Joey has never slept through the night. He doesn't know the meaning of the word sleep. We haven't had a good night in the 11 months since he's been born. We can't get him to sleep during the day and we can't get him to sleep during the night. So during the day I was ready to call the orphanage and during the night my husband was dealing with him and ready to call the orphanage. I kind of reached a point where I said I can't go in there anymore because he's making me very angry. You give so much but he doesn't give anything back.

A particular challenge in mental health interventions for infants is that although the infant is the focus of concern, the focus of treatment is typically on the parents or other caregivers (Lojkasek, Cohen & Muir, 1994). Over the past 12 years, we have been refining an innovative, intervention called "Watch, Wait, and Wonder" that shifts the focus of therapy to the infant and requires

the parent to follow the infant's spontaneous and undirected activity (Muir, Lojkasek & Cohen, 1999). This article describes the theoretical underpinnings and techniques of Watch, Wait, and Wonder, as well as the findings from research comparing the outcome of this form of treatment with a more traditional psychotherapy with the mother when the infant is present.

Attachment Theory and its Association with Infant-Parent Therapy

John Bowlby (1988) suggested that attachment security develops through experiences that infants have with their mothers in relation to their mothers' emotional responsiveness and physical proximity. There is considerable evidence that for secure attachments to form, parents must perceive their infants' emotional signals accurately, respond to them sensitively, display affection, accept their infants' behaviour and feelings, and be physically and psychologically available when their infants are distressed. Development appears to proceed more optimally for infants who are securely attached. These infants are able to regulate their emotions and have a sense of inner confidence and efficacy (Goldberg, 2000). Feeling safe, securely attached infants can express their curiosity and are eager to explore their environment. Securely attached infants enjoy more pleasure and harmony in their relationship with parents and this fosters their openness to other relational experiences. In contrast, infants who are not securely attached have mothers who are unpredictable and either provide minimal or inconsistent care or may even be frightening to their infants. Mothers of insecurely attached infants negatively interpret their infant's normal bids to gain access to them and to explore and master the environment, thus promoting insecurity in the infant. It is important to keep in mind that in such situations the mothers themselves have had caregiving experiences that were not optimally responsive to their own emotional needs. The Watch, Wait, and Wonder psychotherapy helps the parent and infant discover for themselves a new way of relating, thus preventing a repetition of intergenerational transmission of insecure attachment patterns.

An intervention consistent with attachment theory would need to meet a number of criteria, including:

- providing the infant emotional and physical access to the parent
- focusing directly on the parent's sensitive responsiveness to the infant's behaviour and emotional signals
- placing the parent in a non-intrusive stance that allows for the development and expression of the infant's initiative, curiosity, self expression, and mastery of the environment
- providing a space in which the infant can work through relational struggles through play and interaction with the mother
- providing a therapist who can function as a secure base for the dyad working through their relational difficulties.

Watch, Wait, and Wonder meets all of these criteria.

Watch, Wait, and Wonder Technique

Watch, Wait, and Wonder involves the infant in therapy directly. It is best to start Watch, Wait, and Wonder no earlier than the age of 4 to 6 months when infants can regulate emotional and behavioural states to some extent and are mobile to explore.

For half of the session, the parent is asked to:

- get down on the floor with the infant
- follow the infant's lead
- not initiate any activities him or herself
- be sure to respond when the infant initiates but not to take over the activities in any way
- allow the infant freedom to explore; whatever the infant wants to do is okay as long as it is safe
- remember to watch, wait, and wonder

The Watch, Wait, and Wonder play space is marked with a heavy-duty plastic mat. The same toys are arranged in the same predictable order. Both construction and representational toys that the infant can manipulate are included. Some toys are chosen to promote emotional and relational themes central to the infant's symptoms. For instance, an infant with eating problems is often drawn to the feeding utensils such as bowls and spoons, and an infant with sleeping problems to the dolls and doll bed.

The therapist's role in Watch, Wait, and Wonder is less interactive than in other forms of psychotherapy. Just as the mother is asked to watch, wait, and wonder with her infant, the therapist sits slightly off to the side of the area defined by the mat and watches, waits, and wonders, reflecting on the interactions of parent and infant. The therapist shows interest and curiosity about the relationship and inner life of the parent-infant dyad, and supports and validates the parent's experience. This parallels the task of the parent who is placed in the position of being curious about and accepting of the infant.

During the second half of the session the parent is asked to talk about what he or she observed about the infant's activity and his or her experience during the session. The main idea of this is to put the parent in a position to become more knowledgeable about the infant and not to feel it is necessary to intervene or

rely on the therapist for advice or insight. Although some parents talk about their early relationships with their own parents, this is not necessary for therapy to work. The infant, too, can use play and activity to master difficulties in relation to the parent.

Case

Mother: We were really expecting the therapist to say we looked at all the evidence and test results and I know that Joey is like this and because he's like this we can do this. It turned out that I did all the work! Once a week, for 1 hour, Joey and I would play on the floor with toys that were provided. The therapist would sit quietly to the side without any involvement. I was not to initiate any play. I was to follow Joey's lead and watch, wait, and wonder. Then for the second half hour the therapist and I would talk about what had happened during the play time. What did I see in Joey's behaviour? What did I think he might be trying to do? How did I feel when he acted in this particular manner? She never told me to do things differently. Instead, she asked me questions and helped me figure out some of what mattered to Joey by helping me notice his actions and behaviour that I may have overlooked. She gently urged me to think more about particular things he had done. After some time, things he had done many times before began to take on a new meaning and I was better able to understand his needs. For example, every week he went over to a bean bag chair and jumped or fell into it laughing. First I thought he was saying "Look see what I can do. Aren't you jealous of me?" Then three weeks later it hit me. I understood he was repeating a game we play at home. We have a new duvet and I throw him on the soft bed and he just loves it. I realize that he was inviting me to play.

The most important thing I learned was how sensitive Joey was to my moods and emotions. If I was angry or stressed, then he would be also. It was as though he could feel stress in my arms and hear it in my voice even when I was trying not to show it. He would cry and whine and couldn't relax. No wonder he couldn't fall asleep because he was being held by someone who wasn't relaxed. Now we are much happier and I have more understanding not only of Joey but of myself. I try to really listen to Joey even though he doesn't talk yet. I get down on the floor with him and try to allow myself to be led into his world. I guess in a way it's like having a totally new baby or maybe it's finding him like I never found him to begin with. I can honestly say I went through a stage where I regretted that he ever came into my life. We finally got our baby. He was missing. It feels more like a family now.

Research on Watch, Wait, and Wonder

Recently, we completed a study comparing Watch, Wait, and Wonder to a more traditional psychodynamic parent-infant psychotherapy often used in clinic settings (Cohen, Muir, Lojkasek et al., 1999; Cohen, Lojkasek, Muir et al., 2002). In traditional psychodynamic parent-infant psychotherapy, it is assumed that the parent explores early relationships with his or her own parents and, through this process, gains insight into current relationships

with the infant and family. The work in this approach is between the parent and the therapist. The presence of the infant in the therapy sessions provides the motivation for change.

This study involved 67 mothers and their 10 to 30 month old infants who were randomly assigned to one of the two groups. The infants were primarily referred for problems manifested as functional symptoms in the infant or in behavioural or emotional regulation. In some other cases, referral was triggered by factors that got in the way of the mother's capacity for infant care such as feelings of failure in the attachment process, maternal depression, and in a few cases, risk or allegations of abuse. Problems had begun in the infant's earliest months of life. Assessments were done before treatment began (pre-treatment), at the end of treatment (post-treatment), and six months after treatment ended (follow-up).

At the end of the relatively brief treatment (averaging 14 sessions over approximately 5 months), we found that both psychotherapeutic interventions had positive effects on infants and their mothers. Specifically, at the end of treatment both forms of psychotherapy had reduced infants' presenting problems, increased mothers' confidence that they could manage these problems, and decreased stress associated with parenting. As well, at the end of treatment mothers were observed to be less intrusive and to engage in less conflict with their infants during infant-mother play interactions. This suggests that there are some common beneficial effects of treatment regardless of technique. At the same time, we found some differences in outcome between the two treatments. In particular, infants in the Watch, Wait, and Wonder group were more likely to shift toward a more organized or secure attachment relationship than infants in the group whose mothers had psychodynamic psychotherapy. The infants in the Watch, Wait, and Wonder group also showed greater improvements in cognitive development on the Bowlby Scales of Infant Development and increased capacity to become engaged in the cognitive tasks. Although we do not know whether improvement in cognitive functioning resulted from positive changes in attachment security or organization, attachment theory does suggest that improved cognitive developmental functioning should be an outcome of increased attachment security. Moreover, at the end of treatment, mothers of children in the Watch, Wait, and Wonder group were significantly less depressed and reported more satisfaction and effectiveness in their parenting than mothers in the group receiving psychodynamic psychotherapy.

When followed six months later, effects of both psychotherapeutic interventions on presenting complaints and maternal and child functioning were maintained (Cohen et al., 2002). Moreover, in some respects, further gains were observed after treatment ended in that, at follow-up, there was continued improvement in infant symptoms and observational measures of maternal intrusiveness and dyadic reciprocity observed during mother-infant play. Although this general conclusion applied to both treatment groups, the pathway for change for the two treatments had a different timeline. As reported above, greater gains were made from the beginning to the end of treatment in the Watch, Wait, and Wonder than in the psychodynamic psychotherapy group

on some measures. In the parent-infant dyads receiving psychodynamic psychotherapy, these gains were also observed but not until six months after treatment ended. At the same time, an advantage persisted in the Watch, Wait, and Wonder group from the end of treatment to six-month follow-up. Mothers in this group reported a further increase in comfort in dealing with the infant problems that brought them to treatment and a further decrease in their ratings of parenting stress.

What might account for the different timeline for changes in the two treatments? In trying to understand this, we return to attachment theory. We believe that Watch, Wait, and Wonder maximizes the requirements for forming a secure attachment relationship. The instructions to the mother to allow her infant to take the lead increase maternal sensitive responsiveness and make the mother uniquely physically accessible to her infant, creating the potential for a secure connection. To find a way to establish a more secure relationship with the mother, when left to his own devices the infant will inevitably approach her. We have observed that at this point the infant will quickly bring the core issues in his relationship with his mother into the play, for example, the infant's desire for closeness when physical accessibility was previously restricted. Watch, Wait, and Wonder involves enhancing the mother's capacity to respond to her infant's activity with a reciprocal gesture, by placing her in a non-intrusive stance that allows for the evolution of the infant's potentialities or "true self" (Winnicott, 1976). We speculate that when the mother observes her child without being able to intrude, her assumptions about herself, her infant, and her relationship with the infant are challenged. More importantly, the interaction feels different and more pleasurable. Since as part of the process the mother begins to feel more competent in reading her infant's cues, she gains confidence to work things out with her infant on their own, resulting in enhanced confidence as a caregiver. Thus, involving the infant directly and the mother's non-intrusiveness might account for the difference between Watch, Wait, and Wonder and more traditional psychodynamic psychotherapy. Although the infant is involved in psychodynamic psychotherapy, the primary focus is on feelings and thoughts about relationships. This focus may delay changes as the mother needs to work through her earlier relationships before her new insights can influence the relationship with her own infant.

The therapist in Watch, Wait, and Wonder engages in a parallel process of watching, waiting, and wondering. That is, the therapist does not intervene through modeling or directing the mother or interpreting the infant's activity. Due to this, as well as to the expectation that the mother observe her infant's activity, the mother is enabled to become more knowledgeable about her own infant and not to feel the same need to rely on the knowledge of the therapeutic "expert." In addition, the therapist provides space for the mother to reflect on and deal with anxieties that are inevitably aroused while trying to follow her infant's lead and that compromise her capacity to be sensitive and responsive to her infant's emotional cues.

Both treatments we studied aim to improve maternal sensitive responsiveness. Each approached this in a different way and both were successful. However, although "all roads lead to Rome," some roads are shorter than others.

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