CLOSE ENCOUNTERS WITH AUTISTIC CHILDREN
A Group Therapy Program

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A brief review of the current state of knowledge regarding infantile autism is presented. This is followed be a detailed presentation of the multi-interactional group therapy process as the main thrust of intervention programs. Insights gained by the therapists are also discussed.

Early infantile autism was a term originally coined by Dr. Leo Kanner, a psychiatrist, in 1943 to describe infants who were characterized by extreme social indifference and lack of responsivity. This included an absence of reaction to or interest in people to the extent that normal attachment behavior did not occur (Webster, 1980). The diagnosis of autism is usually accompanied by feelings of hopelessness and helplessness among parents, as well as professionals. Although this attitude has changed slightly in the past years, the apprehension is still very much present today.

In recent years, there have been many important advances in the understanding of childhood autism, or what is now termed Autistic Disorder—a severe form of Pervasive Developmental Disorder (DSM III-R, 1987). Much of the work has been focused on its possible etiology. A debate as to what causes autism is ongoing among professionals and researchers. Researches on the therapy of autism have dealt mainly in the modification of specific behaviors in the autistic child such as sitting and attending behavior or eliminating hand-flapping, and self-inflicted injurious behavior (Hermelin & O Connor, 1970). The other treatment direction is biological or biochemical in nature. The discovery that certain biochemical substances in the brain may be implicated in autism's etiology has started a possible breakthrough which is helpful and essential to the understanding of the disorder both for the teachers and professionals who are working with these children. Advances in the biochemical frontier are of extreme importance and the value of research efforts in this direction cannot be overstated. The most recent significant development in the area of cognitive delays has also led to the formulation of psycho-educational programs that can improve the autistic child's grossly impaired language and communication skills (Massie & Rosenthal, 1984). However, except for a few studies such as those by Rutter (1983), Wing (1985) and Liwag (1987), not much has been written in terms of a comprehensive treatment program that includes the family. Aside from experiments using behavior modification and the book *Son Rise* which was authored by a parent, virtually nothing has been written about the therapy process itself. To date, there is no published study that describes the therapeutic process in the context of a multi-dimensional framework.

This paper will focus on the actual multi-interactional group therapy experience as the core of the total therapy program. By looking at the therapy process itself, it hopes to help both parents and professionals to understand the autistic child more intimately and more thoroughly.

In this paper, the author will:

First, briefly review the literature and "state of the art" on autism.

Second, describe the multi-interactional group therapy process as the core of the total intervention program. That is, attempt to "bring the reader inside the therapy room" and examine the

process itself. How are the connections made in the therapy hour?

Third, briefly mention the connections outside the therapy room as part of the total program, e.g. parents and other family members, teachers, medical doctors, etc.

Finally, present some ISSUES and INSIGHTS gained from the experience of the therapists themselves.

Early Infantile Autism: The Puzzle

This literature review is taken largely from Liwag (1987). In 1943, Dr. Leo Kanner published a now classic paper entitled "Autistic Disturbances of Affective Contact" where he described a paradoxical and bewildering behavioral disturbance of childhood. Based on his clinical observations of a unique group of young patients who displayed an extreme detachment from all human relationships, he recognized this autism (literally "self- ism") or total self-centeredness as the fundamental pathogenic disorder in their illness. A year later, Kanner named the new syndrome *early infantile autism.* The autistic child, who was unusual "from the beginning of life" was distinguished from the schizophrenic child, who regressed or withdrew from previously formed relationships (Kanner, 1944).

The disorder was rare. Kanner, as Director of the Child Psychiatry Clinic at Johns Hopkins, saw hundreds of patients before he accumulated 11 case reports for his original paper. But once identified, it was soon reported on throughout the world. Now, four decades after Kanner's original description, the syndrome is no longer as rare, but neither is it less perplexing. Autism occurs as often as congenital blindness or deafness in children. Estimates range from five to as many as 20 per 10,000 births (NSAC, 1984b). Autism is ubiquitous; afflicted children are found in all parts of the world, in all races and colors (Freeman & Ritvo, 1984). And the raging controversy as to the syndrome's causes and origin has not abated in spite of 40 years of clinical research. Infantile autism continues to raise the most important and sensitive issues in psychopathology: the role of organic brain defect, biochemical and genetic factors, parent-child relationships and the development of the complexity we call the self. Indeed to some, the unravelling of the puzzling nature of the problem may well have fateful consequences for the entire field of child psychiatry and clinical psychology (Bettelheim, 1967).

The Nature of Early Infantile Autism

In his seminal 1943 article, Kanner listed 12 diagnostic features which he felt to be characteristic of early infantile autism. Summarized, these included extreme aloofness, avoidance of eye contact, lack of physical reaching out from infancy, absence of visual and auditory responses, failure to use speech for purposes of communication, an obsessive need to maintain sameness in the environment via stereotypic behavior, and a marked facility with objects, in contrast to responses to people and to language. In addition, autistic children look normal, alert and expressive; motor coordination is good; and psychometric performances indicated that cognitive potentialities may be masked by the basic disorder (Kanner, 1943). Since then however, there has been a wide spectrum of opinion as to the necessary criteria for the diagnosis of autism. Rimland (1964) and Ornitz & Ritvo (1976) have extensively reviewed from a historical viewpoint the diagnostic debates that clinicians in the past have locked themselves in with regards to this baffling syndrome.

Fortunately, clinicians and researchers at least in medical and psychiatric circles, have already reached a consensus concerning the nature and essential diagnostic criteria of autism. Autism is now a clinically and behaviorally defined specific syndrome. It is manifested at birth, diagnosed by the appearance of symptoms prior to 30 months of age, and remains throughout the lifetime of the patient. It is also carefully distinguished from childhood schizophrenia by the specification that the autistic child must not exhibit any psychotic features such as delusions or

hallucinations (NSAC, 1984a; DSM-III, 1980; DSM III-R, 1987).

Early Signs and Key Symptoms of Autism

The first essential symptomatic feature of autism is the autistic child's *pervasive lack of responsiveness to other people*. This can be manifested in the following ways—failure to cuddle, lack of eye contact, indifference or aversion to affection and physical contact and failure to develop normal attachment behavior, cooperative play and friendships (Rapoport & Ismond, 1984). The child behaves as if other human beings are just objects and did not exist at all (Roberts, 1971). For instance, the child may use an adult's hand as a pointer, seemingly unaware that the hand is attached to a person. There is a persistent tendency to turn away from people or look past them especially when the child is spoken to. Most of the time, the child is simply aloof and withdrawn, sitting for hours staring into space, motionless as if in deep thought. The child's attention cannot be attracted by calling his name or speaking (Rimland, 1964). In the DSM III-R, this is referred to as qualitative impairment in reciprocal social interaction (1987).

A second essential feature is the *gross impairment in communication skills*. Both verbal and non-verbal areas of communication may be affected and this is evidenced by a child's mutism, delayed speech, immature syntax and articulation (Rapoport & Ismond, 1984). Some never speak, others learn a few words, almost always later than usual.

One of the most striking characteristics of early infantile autism is the baffling use of language by those children who do speak. These *peculiar speech patterns* constitute the third essential symptomatic feature identified by DSM-III (Rapoport & Ismond, 1984). The DSM III-R refers to this symptom as a qualitative impairment in verbal and non-verbal communication (1987). Autistic speech is generally of a non-communicative kind, ordinarily produced in an empty, high-pitched, parrot-like monotone. Naming of objects is common, but asking or answering questions is rare. Desires are expressed by leading an adult by hand to what is wanted. The children have trouble with prepositions and pronouns, and the words "I" and "Yes" are strikingly and consistently absent. "You" is used for "I" (pronominal reversal) and "yes" is indicated by repeating the question (affirmation by repetition). For instance, the child who is asked "Do you want a cookie?" will reply "Do you want a cookie?" meaning, yes, she wants one (NSAC, 1984b). Delayed echolalia or repetitive speech is shown by many children. The child may repeat a phrase or a sentence, often out of context and with no apparent purpose. Some are able to repeat verbatim something heard in the past, while others have a great repertoire of television commercials. One child in the author's clinic reproduces complete TV titles with alphabet blocks (e.g. That's Entertainment), with perfect spelling at age four, but he can neither talk, nor spell his four-letter name (Conti et al., 1986).

The fourth symptomatic feature is the autistic child's *bizarre responses to the environment* (Rapoport & Ismond, 1984). There are several aspects to the child's unusual behavioral repertoire. One is his or her *fetish-like preoccupation with objects, without regard to their accepted functions*. There may be a great attachment to one special object, such as a box, with anger and distress manifested if it is lost. There can also be a tendency to examine objects in peculiar ways—the child may turn things over and over, hold them close to her eyes and then far away, bite, scratch, tap or twist them. Odd play with these objects also takes place, as in spinning, flicking, rattling and tearing (Roberts, 1971). *Ritualistic, compulsive behavior* is displayed; the child uses objects in idiosyncratic, stereotypic and perseverative ways (NSAC, 1984a). Light switches and faucets are repeatedly turned on and off, and any attempt to divert the child from this pursuit is met by an intense and violent reaction. *Resistance to change* is also highly evident in the child's rigid routines. He is often

disturbed when the slightest disarrangement in furniture is made. He may refuse to deviate from the usual route of a daily walk, insist on one type of food only, and refuse to wear any but familiar clothes (Roberts, 1971). One child reportedly went for several days without taking liquids until it was discovered that she would drink only from a transparent container. Other children have been reported to refuse to drink liquids which were not at a precise temperature (Rimland, 1964). Fourth, autistic children have *many unusual body motilities;* walking on tiptoe, flapping hands and arms, rocking back and forth in a chair, darting and lunging movements. They enjoy games that seem to provide vestibular stimulation, such as whirling and spinning without dizziness, or being tossed in the air by adults (NSAC, 1984 a & b). Finally, *disturbances of responses to sensory stimuli* may be present. Children may alternate from generalized hyper-reactivity or hyporeactivity states in periods ranging from hours to months. For instance, there may be close visual scrutiny of details, prolonged self- examination of body parts, close attention to self-induced sounds, repetitive sniffing or licking of inedible objects. On the other hand, some never pay attention to sounds, are seemingly insensitive to touch, pain and temperature, and underreact to gravity stimuli (hanging upside down, whirling without getting dizzy). These reactions tend to diminish with age, though at times, they may even become more complex and organized (Rapoport & Ismond, 1984). The revised manual (DSM III-R, 1987) refers to the above symptoms as: 1) qualitative impairment in reciprocal social interactions; 2) qualitative impairment in verbal and non-verbal communication; and 3)marked restricted repertoire of activities.

While all these symptoms fluctuate, abate and even disappear, if they were present when the patient was less than 30 months of age, the diagnosis remains. Long-term prognosis is guarded.

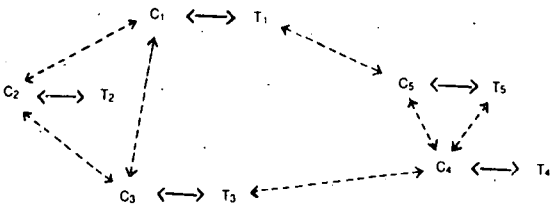
Until medical science discovers the biochemical cause, we professionals are tasked with making use of interventions that help the children and their families cope with the disorder.

This brings us to the main focus of this paper.

The Multi-Interactional Group Therapy Process

A. *Inside the Therapy Room*

1. *The Unique Group Structure.*



The above diagram attempts to describe visually the ongoing levels of interaction. It is impossible to describe the interactions in linear terms because they are all happening simultaneously. The diagram shows the one-to-one Therapist (T)–Child (C) dyads, e.g. (T1<—>C1), (T2<—>C2), etc. that are interacting in a group context. The T1 attempts to connect with C1 *at all times,* but the opportunity to connect with other children, e.g. (C1<—>C2) and other therapists, e.g. (T1<—>C2) is always there. When the child is ready, "the moment is not lost."

2. *The Child Enters the Room—We Enter the Child's World.*

There is an outright attempt to set the tone of group togetherness as the child (C) enters the room. He or she is introduced to his/her therapist (T) in an intimate manner by addressing the therapists as *tito* or *tita* as in "Tito Tom." Since this manner of addressing extended family members is used in the home, it is familiar to the child and invites an instant connectedness. The message is clear: "We are a group. We are together."

The goal is clear: connect with the child at all times.

3. *The Therapist Uses Self as Instrument—The Child's Awareness of Body and Sense of Self.* The key factor—is the attitude and the philosophical belief of the therapist—the willingness to use the self as the agent or instrument of therapy, e.g. saying "Roland" while touching the child, as if saying "You have a self." The attitude is consistent: "insist on your human presence in a totally present manner." Even the reinforcers used are human reinforcers, e.g. the T's smile, hug, touch, etc.

4. *A Sense of Hope—Trickles of Change:* Group Members Sustain Each Other.

A warning is made in the beginning. If you think that the child is hopeless, do not even attempt or begin to do therapy with the child. One has to experience a genuine sense of hope from the very beginning and all throughout the therapy process. This means being able to recognize and celebrate small steps towards improvement as a group. The therapists share the small successes and the frustrations and are therefore able to support each other along the way.

The Process

1. *How Connections Begin: Personal Entry Points to Therapy:* How do you start connecting with the autistic child? The therapists share their own "entry points" or how they begin to enter the child's world:

a. verbalizing—the T provides the auditory stimuli that corresponds to what the C is actually focused on at the moment; or the T articulates what the child is actually doing at the moment. In so doing, the T connects with the C and at the same time provides the words for the child's action. This is similar to mirroring, for example, "Rene is jumping", etc.

b. teaching—some children may not do anything and may be very rigid but will perform tasks such as arranging letters, numbers, etc. The T starts "teaching" the C through these tasks with the goal of "connecting" with the C. This is effective with children who perform cognitive tasks but do this "as if they were in their own world."

c. "doing with"—if the child is spinning an object, the T spins with the C while trying to increase eye contact; if the C is jumping, the T jumps with the C at the same time maintaining eye contact. The message is "I am with you." This basic principle is that it is more important to connect first with the autistic child than to correct the "autistic" behavior (e.g. spinning). The T can modify this behavior later on, after the T has entered the C's world.

d. use of music—music is used to signal the beginning of the session to help hyperactive children to calm down. It also helps to sing with the autistic child as a way of connecting and a way of starting to communicate verbally. Music is also used to signal the end of the session.

e. structuring—comes in the form of limit-setting and greeting each child by name as he/she enters the therapy room. Structuring also comes in the form of protecting the child from being hurt by another child, thus providing the needed sense of security during the hour. This also helps to teach the children to respect each other.

f. observing—one T starts by just observing the child keenly and just being there. Is the child's attention free-floating? without direction?

g. sensory stimulation—For the autistic C, the Ts find that touching, massaging, shaking the body and tickling certain parts of the body is very effective in getting the child's attention because this kind of kinaesthetic stimulation is difficult to ignore. Some children are observed to utter sounds and syllables when stimulated in this manner. This is espe-

cially useful with "non-verbal" or "pre-verbal" children. This is also used in locating tension spots and "liberating" physical tensions.

h. use of behavioral modification—This basic technique is used in most therapy interventions with children but the main difference is that the reinforcers used are all *human relational reinforcers*, such as a touch, smile, clapping of hands, a delighted facial expression, a hug, etc., instead of candies, or any material reinforcers. This has been found to be very much in tune with and unique to our Filipino culture where there is a lot of physical (vs. verbal) interaction. It has also been observed that Filipino autistic children initiate showing affection in a physical manner, and they can hug and cuddle even in the early stages of therapy.

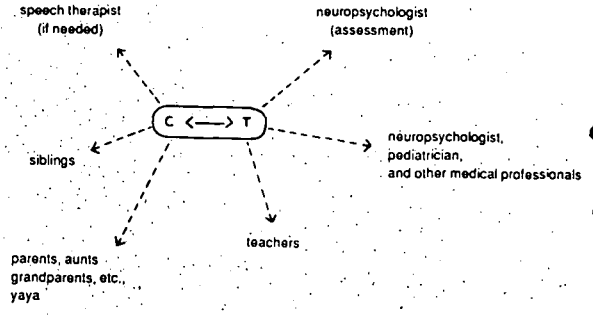
2. *Metaphors for the Group*

One way of "capturing" the atmosphere and interactions going on in the group is to see it as a "symphony," where the Primary Therapist (in this case, the author), is the symphony conductor who sees to it that no one T is "out of tune" and "no child is disconnected." The conductor has to make sure that the symphony is playing in harmony.

Another metaphor that can be used is that of a "therapeutic dance" wherein the Primary Therapist sees to it that all are dancing to the same tune and are in step with the rhythm.

Connections Outside the Therapy Room

The Interdisciplinary Improvised Team



T – Primary Therapist, Clinical Psychologist, or Psychiatrist, etc.

The diagram pictures the other members of the *interdisciplinary team*. This team approach is very effective in working with autistic children. In one case, the mother played a central role in convening the improvised team which met quarterly to monitor development, look into persistent delays, suggest an educational program, etc.

Quarterly Group Sessions with Parents

Connecting with the home is an indispensable link in the multi-interactional group therapy program. Parents of autistic children participate in a periodic dialogue with the Primary Therapist in a session called for the purpose of giving and getting feedback on the child's development. The progress of each child is discussed in detail. The C differ in their severity and manifestations of their autistic disorder as well as the pace and direction of their development. Their parents express and discuss specific concerns ranging from communicative language, discipline, eating problems, hyperactivity, time management, sibling problems, and school problems, etc.

Another important purpose of the parent group is to provide support for each other—share anx-

ieties, tips and different techniques that each one discovers along the way.

Issues and Insights

From this rich experience, some interesting insights and issues have been brought out:

1. In order to work effectively and continuously with autistic children, the therapist needs to develop certain characteristics and attitudes such as:
   a. a sense of hope and adventure
   b. a strong sense of self
   c. a capacity to watch development inslow motion
   d. acceptance of the need for a support system to prevent burn-out

2. The diagnostic label of *early infantile autism* or *early childhood autism* does not automatically enable the therapist or the parent to understand the autistic child.

It is only through the actual repeated *connected-and-totally-present-interaction* with the child that one realizes how unique the individual autistic child really is and how different he is from any other autistic child.

3. Autism seems to come in varying degrees such that one autistic child may seem "more autistic" than another. This points to the need to further refine the diagnostic category and include the notion of the degrees of autism. When does one say that a child is actually autistic as compared to just having "autistic features"?

In knowing the child as a person, this uniqueness has to be respected and valued and used in the therapeutic program as seen in the different entry points and therapeutic techniques.

4. Therapists have their own entry points and personal styles that have to be respected, valued, shared and used in connecting with the autistic child (e.g. tactile, kinaesthetic, visual, auditory-multi-sensorial).

5. At this point in knowing them, it makes more sense to say that autistic children are extremely sensitive to external stimuli rather than that they are completely unaware of what's going on. This *extreme sensitivity* makes the impact of stimuli *so intense* that they have to tune it out and appear "deaf" at times.

6. It is very important to *connect* with the autistic child and to enter his world before any technique can be used effectively.

7. *Human relational reinforcers* are effective in connecting with the child and in modifying undesirable behavior and establishing desirable ones.

8. Multiple connections both inside and outside the therapy sessions are important. This includes ongoing connections with the child's family and extended family, special or regular school, special education teacher, and the medical doctors. Monitoring the child's progress requires dialogues among all concerned.

These multiple connections come from a basic philosophical and theoretical orientation of viewing the autistic child multi-dimensionally and considering all dimensions in the total intervention program (Carandang, 1981) as follows:

a. as a *total* person with specific cognitive, emotional, physical, social, and moral aspects.
b. developmentally—as functioning at a certain stage of development along the different aspects mentioned above such that one aspect may be developing faster or slower than the others.
c. contextually—as a member of a family with its own dynamics—interacting with his parents, siblings, grandparents, *yaya*, etc.; as a student in a special or regular school within a certain community and culture. It is important to harness these resources to help the child develop in all aspects.
d. phenomenologically—to enter the child's world and try to experience it as a fellow human being with his own view of the world and of himself.

The autistic child can and does lead the way if one is tuned in and connected to him.

9. Therapists function better and longer when they belong to an ongoing group support system.

10. The therapeutic group atmosphere can provide a sense of security both for the autistic children as well as for the therapists. And this enables the ongoing connections and therapeutic process to continue with very minimal incidence of burn-out.

11. Finally, using the multi-interactional group therapy as the core of the total therapy program, the therapeutic process for autistic children can be less tedious, less frustrating, and even enjoyable.

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