

FINDING MISSING PIECES TO THE AUTISM PUZZLE

By Carrie Sheppard, M.Ed., LMHC

When I met eight- year- old Josh, a high-functioning third-grader on the autism spectrum, he greeted me with a barrage of questions. Where did I live? How old was I? Did I have pets? Without much apparent interest in my responses, Joshua launched into a lengthy monologue about animals. Ignoring social cues that indicated my impatience, he continued his litany of an encyclopedic knowledge of zoology.

Conversations with Josh's parents revealed that he managed fairly well academically, but his rigidity and anxiety caused difficulties at school. Attempts to teach self-regulation and social skills through special education services had provided only scripted solutions, not generalizable outside the therapy room. Joshua had no friends.

His parents, Karen and Jeff, felt that they served mainly an instrumental purpose in Joshua's life; their inner feelings and responses did not seem to matter--or even register--with him. His parents were saddened by his inability to engage in meaningful interactions. Most of their attempts to engage him in communication amounted to question and answer sessions. Karen and Jeff conducted a thorough search for treatment methods to address social deficits.

As a psychotherapist and the parent of an autism-spectrum child, I have spent many years exploring therapeutic approaches that address social and relational development. In particular, I have been fascinated by the connection between interpersonal engagement and development of the mind. The field of infant mental health has offered a significant contribution toward understanding how the infant's mind develops through attachment and intersubjectivity.

From the beginning, typically-developing infants and parents are highly attuned to each other's subjective states. Parents want to know how to soothe their infants and they enjoy getting a good smile or laugh. The infant learns to read parents' cues for security, and also enjoys responding for the purpose of shared laughter. The parent becomes the filter to help the infant make sense of the voluminous amount of information encountered daily. Understanding each other's states of mind--"intersubjectivity"—is the primary

gateway for the infant's development of complex cognitive, emotional, communicative and social functioning.

Intersubjectivity allows for depth and intimacy in interpersonal relationships, as one's innermost, subjective mental and emotional life is shared. Research shows that interpersonal engagement is integral to cognitive development. In non-autistic populations, attachment and intersubjectivity disruptions are associated with lower IQs, higher anxiety, poor socialization, cognitive impairments, and attentional problems. (Siegel, 1999; Hobson, 2004).

Autism interferes with the infant's ability to connect with the mental and emotional orientation of the parent. Without learning through social engagement, intellectual development is thwarted and cognition impoverished. Infants also become highly anxious and avoidant of novelty. Rigid patterns develop as reliance on predictability becomes the infant's strategy for managing anxiety.

Relationship Development Intervention (RDI), an approach I have found useful for expanding a child's engagement with others socially, emotionally and mentally, is based on years of developmental research. RDI is a relationship- focused treatment model that targets the core deficits of autism. Often RDI treatment begins by assisting the child to discover the joys of interaction and satisfactions of gaining competence through developing intersubjective thinking with his/her parents. This process in turn motivates development of other important functions, such as social referencing, coordination of emotional states and collaboration.

RDI, founded by Drs. Steven Gutstein and Rachelle Sheely of Houston, Texas, is a multidisciplinary, cognitive model that provides individualized consultation to families. Parents typically attend a workshop with Dr. Gutstein to learn RDI principles, and then work individually with a consultant to design a home program addressing cognitive and relational issues specific to their child.

Gutstein (2000) stated, "We know from years of rehabilitation research that previously damaged and underused parts of the brain can be strengthened. What if there

were exercises that created traffic to strengthen those pathways? That is what I set out to do in developing the RDI Program.”

Professionals become RDI-certified through a rigorous training program that typically takes at least 18 months to complete, along with annual re-certification. Since my certification, I have had a waiting list of parents requesting RDI for their children. I personally gain tremendous satisfaction from watching families make progress in areas not previously influenced by other treatment methods.

An RDI Treatment Plan in Action

In Joshua’s case, one of my first goals centered on altering his ineffective communication patterns, so that he could begin to truly engage with his parents. We worked on helping Josh learn to focus on nonverbal signals, and to perceive underlying intentions, attitudes and feelings. I designed activities to practice interactions without words. I instructed the parents to discontinue their questions and prompts and instead to share more of their inner experiences both with each other and Josh. Within two weeks, they noticed a significant shift in his communication style.

Next, we worked on activities that forced Josh to take note of his parents’ emotional reactions. Up to this point, Joshua’s conversations had been virtual monologues centering on his own interests, with utter disregard for whether anyone else was interested. For Karen and Jeff, his developing skills in noticing and caring about their feelings was one of the most rewarding and motivating steps in the process. A third goal involved helping Josh take note of his parents’ point of view— “mind-connecting”-- and Josh soon discovered that connecting with his parents’ minds was a path to solving problems and developing competence. This discovery motivated him to engage more fully and regularly with his parents, thus increasing his level of trust and decreasing his anxiety.

The first six months of RDI focused on cultivating mutual experiences. I encouraged Jeff and Josh to do yard work together, with Jeff using gestures and facial expressions to convey directions rather than words.

Karen made up silly games that fostered collaborative thinking and cognitive flexibility, and Josh enjoyed interacting and laughing with his mother. If Josh began

focusing on his own preoccupations, Karen said, “This isn’t fun for me anymore,” and she then either gave him a chance to re-connect, or simply walked away. By this time, Josh was motivated to stay connected to his mother, and he learned it was his responsibility to make a repair.

Josh -- like so many other children with whom I have worked -- became noticeably more engaging, both with parents and peers during this six-month period. He began to feel moved emotionally by the feelings of others, demonstrated more flexibility and showed considerably less anxiety. Jeff and Karen are highly motivated to continue with RDI because they now feel more valued by Josh.

As a therapist, I find an RDI approach enormously gratifying, because I have discovered a model that works well across nearly all age groups, language levels, and intellectual levels. RDI provides a piece long-missing from the autism puzzle by empowering parents, opening a new channel for lifelong learning and promoting genuine reciprocity in relationships.

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