French Psychotherapy Practice Research Network

High emotional modulation insufficiency and ajustment of the therapist's attitude for children suffering from autistic disorder

BACKGROUND: Outcomes of psychotherapeutic approaches for autistic children and potential mediators of change were subject to very little research. A Practice-based Research Network was opened in France to develop studies in this area.

OBJECTIVE: In the semiology of autism, inability to modulate emotions involves child's suffering and has both behavioral and cognitive consequences. The present study focuses on evolution of this dimension during one year of psychotherapy for 41 autistic children and how the adjustment of the therapist' attitude can contribute to improve this insufficiency when it is particularly high.

METHOD: Psychotherapies of 41 children were observed intensively during one year (process-outcome studies) and then aggregated for group and sub group analyses. Emotional modulation insufficiency (EMI) was studied with the Behavioral Summarized Scale (BSE, Barthelemy et al., 1997). Process was rated with Child Psychotherapy Process Q-sort (CPQ, Schneider and Jones, 2007) that describes the main features of psychotherapy: child and his/her problems, therapist, his approach and technique, and their interaction. Cases whose EMI / General Score (GS) ratios were ≥ 1.5 at baseline were selected. The most characteristic items describing the psychotherapeutic process in the group EMI / GS ≥ 1.5 were compared to those of all other cases and the EMI evolution of these cases observed.

CARS (Childhood Autism Rating Scale of Barthelemy)

ECAR-T — **ÉVALUATION DES COMPORTEMENTS AUTISTIQUES** (version révisée)

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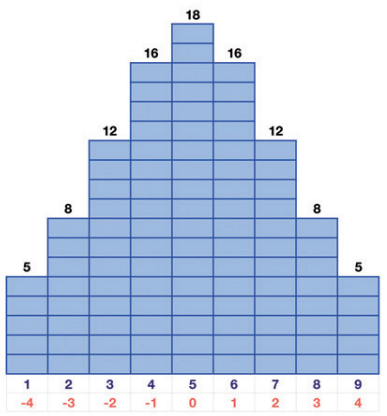
Nom :
Date :
Traitement :

Mettre une croix dans la colonne correspondant à la note jugée la plus exacte	0 Jamais	1 Parfois	2 Souvent	3 Très souvent	4 Toujours
1 Recherche l'isolement (ISO)					
2 Ignore les autres (IGN)					
3 Interaction sociale insuffisante (SOC)					
4 Regard inadéquat (REG)					
5 Ne s'efforce pas de communiquer par la voix et la parole (VOI)					
6 Difficulté à communiquer par les gestes et par la mimique (GES)					
7 Émissions vocales, verbales stéréotypées ; écholalie (ECH)					
8 Manque d'initiative, activité spontané réduite (ACT)					

BSE was validated in the hospital department of pedopsychiatry of Tours. BSE has 29 items, rated from 0 to 4 according to the frequency or severity of symptoms. It allows to explore the various domains of the autistic child's behavior: social withdrawal, verbal and non verbal communication, adaptation to environmental situations, tonus, motivity, affect, shady reactions of the main instinctive functions, attention disorders, perceptions and intellectual functions. Symptomatic profiles are obtained that can be followed over several months. It is possible to analyze the evolution of this profile, symptom by symptom, or by taking into account various factors. It lists, for the different behaviors observed, spontaneous variations over time and improvements induced by treatment and rehabilitations.

Quantitative data collected from the scale are also used as clinical variables to explore possible relationships with other variables. It is thus possible to follow the evolution of «relational disability» and «emotional modulation insufficiency» intolerance to change, frustration, agitation, turbulence, hetero-aggressiveness.

CPQ (Child Psychotherapy Process Q-set of Schneider and Jones



CPQ is a common language to describe, classify and quantify the process of therapy from 100 items. Each item is designed to be observable, avoid references to a specific theory. It is intended to be largely neutral and can be used for any therapy. The CPQ is used to represent a range of therapeutic interactions including systematic characterization of therapist-patient interaction.

Items are sorted into one of nine categories ranging from most characteristic (+4) to the most uncharacteristic (-4), through a neutral box (0) with a forced distribution (see diagram).

This methodology obliges the rater to assess the relative significance of each item to this particular therapeutic hour and avoids the well-known halo effect, by which raters tend to avoid using the two extremes of a rating scale.

RESULTS/DISCUSSION: Nine of the 41 children had EMI / GS ≥ 1.5. After one year, their EMI score reduced by 46%. The analysis shows several differences between the ten most characteristic items of the EMI subgroup and the whole group. Six most characteristic process items are common with those of all cases, but have a different ranking. The most important differences are: 1)Therapist is more confident and self-assured, his/her remarks are aimed at encouraging child's speech, h/she tolerates child's strong affect or impulses and refrains from overt or subtle negative judgments against him or her 2) Child is active, His/her is imaginative, lively, and generates new ideas.

IM/ EG is ≥ 1.5

9 children have a ratio IM/ EG ≥ 1.5.

- *Strong EMI variation:* 2 children (Y1 and Y2) show an EMI variation of 41.7 points, respectively 83.3% and 71.4%, corresponding to a variation of EMI / EG of 3.2 and 1.7.
- *Medium EMI variation:* 4 children (Y3, Y4, Y5, Y6), show a variation of 25 points, corresponding to a variation of EMI/EG of 2.2, 2.9, 1.8 and 1.7.
- *Low EMI variation:* 1 child (Y7) shows an EMI variation of 16.7 points, corresponding to a variation of IM/EG = 1.3.
- *No EMI variation:* 2 children (Y8 and X9), have a variation of EMI = 0. cases are very different.

Question 1

Does therapist has implemented with EMI children a special technique (different from that of 32 other children)?

In addition to the elements similar to all patients, Therapist has particularly encouraged child's speech. He tolerated his/her strong affects or impulses, without judgment or emphasizing his/her emotional experiences. Children were particularly active and their play imaginative,lively (see attached table).

Question 2

EMI of 2 children (Y8 and X9) did not evolve while their EMI/EG was identical to that of 7 other children. Why?

X9. Therapist is particularly sensitive to the childs feelings. Therapy session has a specific focus and its material is relevant to child's conflicts. T avoids explicit instruction or education. The child draws the T into play and engages in make-believe play...

Y8. T is highly affectively engaged, tolerates his strong affects or impulses of the child, restrains from responding personally to provocations, adjusts to him. Child rejects therapist's advice or information. His communications are affect-laden.

Question 3

What can reveal the specific situation of these two children?

X9 is 5 years old. She is in psychotherapy for 2 years and goes to school. Moderators' Index is favorable 8/10. Much improvement during the year: 8/14 acquisitions at T0, 14/14 at 12 months. Birth of a little sister between times 2 and 3 of study, problematic in the organization of the family ....

Y8 is 11 years old. Developmental disabilities from infancy, is hospitalized. Moderators' Index favorable 6/10. Decreased in his acquisitions (T0 6/14, T12 4/14). General improvement during the year but developmental age between 2 and 3 years. Stressors: the little brother came into the language and the older sister left home ....

n°	items characteristic	32 P	9 P	X9	Y8
9	R. Therapist is affectively engaged.	3.20	3.00	3.33	3.67
6	Therapist is sensitive to the child's feelings.	3.05	3.11	3,33	3.00
77	Therapist's interaction with child is sensitive to the child's level of development.	2.90	2.56		
47	When the interaction with the child is difficult, the therapist adjusts to the child.	2.48	2.00		3.67
24	R. Therapist restrains from responding personally to provocation and disturbing material.	2.47	2.44		3.67
88	Material of the hour is meaningful and relevant to child's conflicts.	2.28	2.22	4.00	
65	Therapist clarifies, restates, or rephrases child's communication.	2.13	2.00		
86	Therapist is confident, self-assured.	2.08	2.67		
81	Therapist emphasizes feelings to help child experience them more deeply.	1.94	1.11		
3	Therapist's remarks are aimed at encouraging child's speech.	1.93	2.78		
18	R. Therapist refrains from overt or subtle negative judgments of the child		2.56	3,33	
45	Therapist tolerates child's strong affect or impulses.		2,56		3.67
95	R. Child's play is imaginative, lively.		2.56		
72	Child is active.		2.33		
23	Therapy session has a specific focus or theme.			4.00	
64	Child draws therapist into play.			4.00	
21	R. Therapist refrains from self-disclosure even when child exerts pressure for therapist to do so.			4,00	
71	Child engages in make-believe play.			3.67	
37	R. Therapist avoids explicit instruction or education.			3.33	
55	R. Therapist does not attempt to shape or reward behavioral changes.			3.33	
54	R. Child rambles, frequently digresses, or is vague.				3.67
20	Child is provocative; tests limits of the therapy relationship.				3.67
19	R. Child refuses or rejects therapist's advice or information.				3.33
61	R. Child appears un-self-conscious and assured.				3.33
40	R. Child's communications are affect-laden.				3.00

Table : Scores items PQS very characteristic — 32 children — 9 children — Child X9 — Child Y8

CONCLUSION:

Therapists of children with high EMI scores adjusted their approach in a tolerant, non-judgmental, and expressive way, allowing the child to have an imaginative and lively therapeutic playing and helping him to contain his affects when they appear overwhelming him.

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