

Therapeutic Group Composition for Disturbed Autistic Children and Adolescents

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The obvious but very basic principle pursued by all of us involved in education, training or therapy of the mentally handicapped is to equip them to become more normal, i.e. more like ourselves. This means developing self-help skills, the capacity to conform socially, to anticipate what will be required within a group and to communicate in a reliably comprehensible way. Our efforts to help the handicapped achieve this are usually based on the assumption that they are slow in learning such skills. A distinctive, and exasperating, feature of the autistic child is that he may well not be slow at all but every selective in his learning. A common dilemma within many a family with an autistic child is that although many months may be required to equip their disabled youngster to button up his coat, he can spontaneously and without apparent effort dismantle their television set. The peculiar selectivity, of awareness and motor acts in autistic children presents the parents, teachers or therapists with a problem not only of instructing, but of guiding and containing readily available skills all too readily used in inappropriate ways. To guide autistic children in this way when with their social impairment they do not see the point or purpose of your guidance means that confrontation is inevitable. Bringing up and teaching autistic children can very easily develop into recurrent battles. Unfortunately many parents feel, or even worse are led to believe, that such battles are the reason for not only slow progress but even for autism itself. In some schools for the autistic with which I am familiar a very sensitive shift in emphasis is developed by the staff so that they concentrate on helping the parents understand the peculiar nature of autistic disability and encourage the parents to seek their own solutions (with of course the help and advice of the staff) rather than issue instructions of the 'best' or 'correct' training methods to employ. Such a working relationship between teachers, therapists and parents requires a lot of time and patient dialogue as well as a great deal of mutual trust and respect. The parents have to be reassured to an extent that they have confidence in their own efforts and can cope with their own mistakes. Such mistakes leading perhaps to temper outbursts in public places can be very distressing to the whole family. It is one thing to cope with a furious outburst in a Down's syndrome or spastic child where everyone around you in the shop, street, or cinema can recognise that you are trying to help a retarded child, but it is quite another task when the child looks normal and is motor intact as would be the case with autism.

All these problems increase in severity as the child grows into an adolescent. Whereas the child in a temper can be picked up and removed from embarrassing situations, the adolescent is too big, too heavy, too stubborn or too wilful to be removed in the same way. Similarly efforts to help a child by demonstrating skills, i.e. by moving his hands through the required movements are quite feasible in a 5 year old, but can result in a physical struggle in a fifteen year old. The physical growth, aroused sexual interest and labile affect of the growing adolescent often make hither-to successful teaching and training programmes virtually unmanageable.

In the UK the crucial nature of these emerging problems is now exercising the major effort of responsible agencies and, in particular, the National Autistic Society representing the views of parents. This is inevitable as the population of autistic children who have benefitted from the excellent schools established for them in the UK emerge as school leavers and need to be helped as adolescents and young adults. There are two contrasting, but complementary ways of tackling this problem.

The first is to continue into adolescent and adult life with the schooling and training methods developed so successfully

for the younger school-age child. A splendid example of this will be shown in the next presentation this morning. This method continues with the aim of helping the growing autistic adult to fit into the opportunities and constraints of a normal society, that is to live with support among you and me. It needs ample resources, the recruitment and retention of committed, even dedicated staff who can be expected to cope with only comparatively small numbers of potentially difficult adolescents.

The second and alternative way is to accept the adolescent's level of disability and its improvement established within the school and aim not so much at continuing modification of the young adult, but at modifying the environment in which he lives, so that, given his level, of functioning he is able to cope with the demands of that environment. I think it is quite reasonable to assume that in many handicapped youngsters there are limits to the extent you can expect them to adjust to the norm so that it may be more fruitful and sympathetic to adjust the environment to them. From discussions with colleagues here even in the short period I have been with you has revealed to me that this process of environmental adjustment is widespread within your own urban, and in particular your village communities. A similar adjustment occurred in my experience in a hospital setting and one which I hope you will find instructive.

Some years ago when the Children's Department at Harperbury Hospital, near London, in the UK where I work, was under considerable pressure to admit a succession of very disturbed autistic adolescents, they were accommodated in a ward where the structure of the ward itself, its setting, but above all the nature of the handicapped adolescent population already living there, i.e., the peer group, very effectively helped these disturbed autistic youngsters. This very beneficial effect was not planned, nor indeed even anticipated, but I would like to outline briefly the reasons why such a therapeutic effect occurred.

First a few simple facts about the ward itself. It was a single storey building of conventional hospital design in which thirty lads live, the majority in their 'teens or twenties'. Unlike some of the more fortunate wards in the Children's Department at Harperbury, this one had not been upgraded so although brightly decorated it was sparsely furnished and not sub-divided into small bedrooms or living spaces. It had a large day-room which was 'T' shaped; the smaller arm of the 'T' being used as a dining room. There was a sitting room with a television and a separate play room beyond which were two dormitories and a small number of single bedrooms. There was a sizeable toilet annexes with washbasins, lavatories and bathrooms, a kitchen and the usual array of boxrooms and offices that one finds in a hospital ward. It had a quiet site on the edge of the hospital grounds together with the other five wards, then comprising the Children's Department set in a ring around a central grass play area with swings and roundabouts. The setting itself offered certain advantages. The ward units separate so that neighbour tolerance of noise is high. The ward, though not isolated, was in open surroundings well away from the main road so that youngsters bent on escape could run a fair way and be watched without too much staff anxiety and without too urgent a need for pursuit. It was quite remarkable how often these simple environmental advantages, by reducing anxiety in staff, quickly stopped such alarming behaviour as constant screaming or running away. We were surprised to find how many stop running away when no one evidently chased them! The highly disturbed autistic adolescent, finding himself in a much less tense setting than the one from which he had been removed, quickly overcame his own worries at the novelty and strangeness of his new home.

But it was in the mixing of retarded adolescents who lived together in the ward which most helped the disturbed autistic newcomer. There was a nucleus of about ten retarded lads, many of whom had lived in the ward together for several years. They formed the backbone of the ward economy in that they did a great deal of the domestic work and in their own way helped care for other residents. Most of them were healthy, and fairly hefty lads retarded to an extent that they had little speech and enjoyed very simple social pursuits. They were sociable, easygoing and comparatively dull compared with the autistic newcomer, but they set a code of expectations that all in the ward look after themselves and help the less able. A further ten lads were less capable and needed help or supervision in dressing or going to the lavatory, but most had a particular task which they regarded as their own, such as clearing the table or sweeping a part of the ward, or making a bed. About half of the lads had simple jobs outside the ward and most of the others for part of the day had a programme elsewhere in the hospital. With the ten or so autistic lads it was our aim to harness their odd manipulative skills, concern for tidiness, etc. to refine their self-help, equip them either domestically or in crafts to be a valuable member of an 'outside' community. There were regular evening activities which were part of the routine and which anyone could attend but no one needed to attend. Some of their leisure activities were quite sophisticated but bizarre pursuits were tolerated quite happily such as fiddling with thread or tearing paper. They had their own pets including a

dog or a rabbit which they all looked after, and made an attempt at their own gardening.

It was into this group in this setting that we introduced the highly disturbed autistic adolescent. As pointed out he quickly found himself in a situation in which there was far less anxiety generated by his behaviour than the normal home setting from which he came. With this group of lads he found himself among youngsters big enough to deter his aggression, who tended to be responsive only to welcome him in their simple way but too dull to be provoked. It was very gratifying to see how this combination reduced the aggressive outbursts that had hitherto made him so troublesome. He found that to divert his energies and to gain approval and attention he need not, nor could not, threaten others but would gain prestige and fulfill himself by taking on tasks they performed. These tasks requiring self help and simple domestic skills were typically those in which he may, at least in the past, have been very proficient and quickly revived them to become a valued member of the community. At the same time the routine carried him along with a minimum of social pressure to conform or join in though he was welcomed if he did.

Significantly he was not, as would be the case in a normal verbal setting, frequently confronted with his own language handicap but could see what was happening, learned the routine quickly and could join in as he wished. "Conversation" between the lads tended to be very simple, repetitive and often in the form of single words or short phrases but normally inflected with ample associated gesture - which is precisely the type of language which was easiest for him to understand; nor was it initially embellished by explanations or argument (as occurred at home) which tended to confuse or anger him.

This very supportive community, in a sub-normality hospital setting, managed to absorb and support a group of young people who present one of the most serious management problems of the handicapped. The majority of lads on the ward were on no drugs whatever, and medication was able to be kept at a minimum with the others. The ward of thirty residents was run by only two staff on each shift - and in no small way depended for its success on the personalities of the two Charge Nurses involved. Certainly theirs was a community which encouraged a disturbed autistic member re-establishing control over himself rather than their seeking and maintaining control over him.

The policy suggested by this experience depended to a large extent on the composition of the community within the ward or any other accommodating 'unit - dull, easy-going, relatively unresponsive lads, helping in their simple way very effectively in this setting to contain the impulses of the highly disturbed autistic group. What emerged was a coherent group of young people living amenable together, whose progress was the result of their mutual interaction, establishing on a simple but very effective level a real therapeutic community.