

## **PSYCHOLOGICAL INTERVENTION WITH PARENTS OF AUTISTIC CHILDREN**

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### **ABSTRACT**

*An important component of management of autism is the role played by parents as active collaborators in the process. The case histories of 5 children with autism are described in this report. Psychological intervention carried out with parents of these children is detailed. The treatment package included a mix of behavioural, supportive and educational techniques, delivered in 3-6 sessions of 45-60 minute each, in the setting of a child psychiatric clinic. Results showed that on the whole parents found this brief contact helpful. They rated emotional aspects of the support offered to be the most helpful. Child psychiatric clinics are often the first point of contact for parents with autistic children, and may have an important, primarily supportive role to play at this early stage of treatment.*

*Key words: autism, parents, psychological intervention, child psychiatric clinics*

In the absence of a recognized cure, management of autism to foster normal development, promote learning, reduce maladaptive behaviour and alleviate family distress (Lord and Rutter, 1994). It involves accurate diagnosis and proper assessment as the essential first step, before drawing up individually tailored treatment plans. Rehabilitation is usually multimodal, and includes educative, supportive, behavioural and other psychosocial strategies (Lord and Rutter, 1994; Campbell, 1996).

Particular attention needs to be paid to the role played by parents in management. They need to be educated and supported throughout the process of diagnosis, and need to be made active collaborators in subsequent treatment planning. Showing parents what to do is often more helpful than simply telling them what to do. Other useful forms of parental support include initiating contact with support groups and social services (Cohen & Volkmar, 1997).

These principles form the core of a

programme developed by the Department of Psychiatry, University of North Carolina, for comprehensive and multidisciplinary treatment of autism and other Pervasive Developmental Disorders. The treatment and Education of Autistic and related Communication handicapped Children (or TEACCH) is a programme which places major emphasis on parent-professional collaboration for the purpose of helping and understanding the child (Campbell et al., 1996). In addition to this, the programme also aims to improve adaptation, enhance skills and minimise deficits arising from autism using cognitive and behavioural principles. Modified versions of the TEACCH adapted for use among Indian children have been proposed (Dawson, 1999). These place a lot of emphasis on structuring the lives of autistic children in order to improve their communication and foster independence among them. Structuring of the physical environment, of time, and of activities form the three main components of such treatment regimens (Dawson, 1999).

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More specialized forms of management include behavioural techniques such as shaping, chaining etc., communication techniques such as facilitated communication, auditory integration training, social skills training etc. A number of drugs have also been tried but, currently their usefulness is limited to amelioration of associated problems such as hyperactivity, aggression, self-injurious behaviour, depression etc. (Campbell et al., 1996).

Despite this wealth of knowledge about the condition and its management, rehabilitation of children with autism in India suffers from a lack of coordinated efforts. Although such children are treated in several centres around the country, information about techniques used or their efficacy is scant and limited to a few case studies (e.g. by Narayanan, 1978).

The following is a description of 5 children with autism and psychological intervention carried out with their parents. A preliminary attempt to evaluate the usefulness of different strategies on the basis of feedback from parents is also described.

### CASE HISTORIES

#### Evaluation:

Subjects included 5 autistic children and their parents, attending the Child and Adolescent Psychiatric Clinic of the Department of Psychiatry, PGIMER, Chandigarh.

Assessments of the children included a detailed evaluation by a multidisciplinary team, IQ, other investigations, and playroom observation. Diagnosis was made according to ICD-10 (WHO, 1992), using a multi-axial framework.

#### Interventions used:

Psychological interventions were carried out principally with parents of each child by one or more therapist (s). Contact was brief and consisted of 3-6 sessions lasting 45-60 minutes each, conducted mainly in the playroom setting. A mix of behavioural, educational and supportive strategies was employed. A more detailed description of these techniques is given below

along with case histories.

#### Case Descriptions:

Case 1: AB a 3-year-old boy was referred to the clinic by paediatricians. His mother reported that he had gradually become withdrawn and could not seem to sit still for the past 18 months.

He had been born normally of a full-term vaginal delivery, with no antenatal/perinatal complications. He had been a little slow in attaining his motor milestones.

Since one and half years of age he had gradually become withdrawn and self absorbed. He appeared to be oblivious to his parents' efforts to communicate with him. He did not respond when called, neither did he call them on his own. He showed no affection towards them. His speech was limited to a few incomprehensible sounds. If he wanted anything he would drag his parents along and point towards to the object.

He would spend hours together doing the same thing over and over again e.g. rotating an object endlessly, or arranging and re-arranging blocks in strange patterns. He developed strong likes and dislikes for things, such as food items. He was particularly fond of certain songs on the television, and would leave whatever he was doing to watch them. He refused to play with other children or his sibs.

Along with these symptoms he was noticed to have become more active and restless. He could not sit still or persist with one activity for long. He left things midway to take up something else. His sleep was fitful and disturbed. He would throw frequent temper tantrums and would become very disruptive when his demands were not met. He urinated and defecated in his clothes and seemed unconcerned by this. He had been attending play school for a month and there had been a number of complaints from his teachers regarding his overactivity, disruptive behaviour and inability to engage in any activity. He had not suffered from any major physical illness. Temperamental characteristics were marked by overactivity, non-rhythmicity, distractibility and intense reactions.

His parents were well to do and literate,

father a businessman and mother a housewife. He had a 9-year old sister and a 5-year-old brother. Both were healthy. There was no family history of mental illness. On mental state examination he was noticed to be ill kempt, overactive, withdrawn, and indulging in repetitive stereotyped play. When stopped from repeatedly opening and closing the door he threw a tantrum. He made no effort to communicate. His speech was un-understandable.

His IQ (social quotient) was 60; audiometry, EEG and CT scan did not reveal any abnormality. Playroom observation revealed withdrawal, aimless roaming about, poor speech capacity and lack of goal-oriented play.

A diagnosis of childhood autism, attention deficit and hyper kinetic disorder, mild mental retardation and developmental speech delay was made.

#### Management

Pharmacotherapy: Buspirone (upto 10mg/day) was started for hyperactivity and other symptoms of ADHD.

Psychological intervention: Four sessions were held with the child and his parents in the playroom by two therapists. This was done to help the parents observe the specific techniques used, which they could continue to use at home. Each session lasted from 45-60 minutes. Some of the strategies used for specific target symptoms are listed below.

#### Behavioural strategies

a) Enchanting eye-to-eye contact- The child's face was held between the two hands by the therapist while she spoke to him trying to make eye-to-eye contact. Even when there was resistance on the part of the child to be left alone, the therapist still persisted with her activity, unless the child showed discomfort.

b) Communication enhancement/reduction of maladaptive behaviour- For this purpose parents were educated about certain principles of the TEACCH approach and encouraged to put them into practice. The following were involved.

i) Structuring of physical environment- Parents were told to demarcate specific areas for specific

tasks and not let the whole house to be a place for play e.g. the dining table should only be used for eating. Since the child had a problem in communication the specific intention of such measures was to create an environment that clearly communicated what was expected from him.

ii) Structuring time- Here the family members were told to organise the hours in a day in order to engage the child in a constructive and appropriate manner. They were asked to break up child's activities into various slots for example, waking up to go to school, reaching home to lunch time, lunch time to dinner time, dinner time to bed time etc. A specific list had to be made and the parents had to follow the same activity schedule daily. Use of various cues (object cues, object and picture cues, picture cues and word cues) was encouraged. Time structuring was used to cut down on maladaptive behaviour such as stereotypies and also to promote a degree of independence in the child.

iii) Structuring activities- Once the time and place for activities had been decided, parents were to also try and structure the activity itself. To do so activities had to be kept simple. All the objects needed were to be arranged in a particular order based on a top to bottom, or left to right principle of arrangement. Nature, aim and expected duration of the activity was to be clearly defined. Visual and verbal cues were to be used consistently to help the child understand, learn and gradually master the activity.

#### Supportive techniques

A 'supportive' mode of counselling was employed with the principal aims of dealing with the emotional fall-out of the diagnosis on parents. The two arms of this strategy included

a) Understanding- which consisted of encouraging parents to discuss their emotional reactions to the illness, listening patiently, summarising their complaints by restatement and then clarifying final symptoms in order to deal with denial.

b) Comforting- consisted of empathic listening, giving reassurance, helping parents identify their strength and weaknesses and suggesting

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alternative ways of coping e.g. interacting socially with people outside of home.

### Educational/Informational measures

These were meant to educate parents about the nature of the disorder and its management. As a first step basis information about various aspects of autism and its rehabilitation was imparted. Other problems such as hyperkinesia, learning disability and speech delay were also discussed. Parents were then given addresses of special schools at Delhi and of the 'National Action for Autism Group'. This was done in order to put parents on the right track so that they do not run from pillar to post without any information or help.

### Outcome of the intervention

On a subsequent follow-up session some improvement in his hyperactivity was noticed after about three weeks. The parents reported that he had started making more eye-to-eye contact. They also reported that they found the use of 'comforting skills' to be most beneficial followed by the use of communication enhancement (holding the face between the hands), understanding by the therapist and the guidance about the school facilities. Other techniques were found to be less useful.

Case 2: A private psychiatrist referred 5-year-old AK to the clinic. His parents reported that he had poor interaction with others and tended to remain self-absorbed ever since he was one and half year old.

He was born normally at term with no perinatal complications. He attained his motor milestones in time, but social and speech development were delayed.

Gradually it was noticed that he remained aloof most of the time. He hardly ever made eye contact with anyone. He did not like to play with other children. Instead, he would spend hours fiddling with household articles, or watching television. He would become angry and tearful when attempts were made to engage him otherwise.

His speech was delayed and limited to a few words. He would not ask for or demand

anything. He would often repeat the same word over and over again.

These problems got worse as he grew older. In addition, since the age of 3 years he also became overactive, restless and often wandered about aimlessly.

He had never had any major physical illnesses. His parents were educated; his father a businessman and mother a housewife. There was no history of mental illness in the family.

During the interview he initially sat alone for a while. Subsequently he moved seemingly aimlessly around the room. At no point of time did he make any effort to communicate with his parents or the doctor.

No hearing impairment was detected on audiometry. IQ was 71. Playroom observation revealed lack of goal-directed activity, impaired speech, lack of communication and eye contact.

A diagnosis of childhood autism, developmental speech delay and borderline intelligence was made.

### Management

Psychological intervention: Basic principles of management were similar to the first case. Five sessions were held with the parents and the child by a single therapist. These sessions were mainly utilized to teach the parents some specific techniques, which they could use at home. The sessions lasted 45-60 minutes. Principle strategies used were-

Behavioural interventions: These were aimed to improve communication and cut down on aimless wandering that the patient demonstrated.

a) Parents were shown to communicate with the child using a technique used was holding the child's face between the two hands and speaking out the name of the item, which he was holding in his hand, for example, while he picked up a ball, the therapist spoke the word "ball" to him holding his face.

b) To orient the parents to the TEACCH approach. Here the parents were demonstrated how the list of daily activities were to be drawn up. Visual cues were to be used liberally; for example, while the therapist said the word "brush" she also had a

picture of "brush" pasted on the cardboard. Parents were asked to prepare a list of their child's activities and carry out each activity in the simple but consistent pattern. Area for play activity was also to be earmarked by the parents.

Supportive strategies

These strategies were aimed to deal with the emotional sequelae of diagnosis on parents.

The emotional turmoil of the parents on hearing about the nature of the condition was acknowledged and empathized with. Feelings of guilt and blame were addressed. Restatement and clarification of problems as and when needed was attempted. This helped the family to feel comforted and want to socialize and interact with people outside home as suggested.

Educational and informational techniques: Were used to improve parents' understanding of the condition and its management. Apart from a discussion on autism other problems such as speech delay and borderline intelligence were also discussed. The parents were guided about the schooling facilities, which were available at Delhi. They were also told about some of the schools that are providing parental observational guidance programmes, which they could visit along with their child.

Outcome: After the first few sessions the parents reported that individual attention and forceful eye contact were appearing to help the child. The mother felt more comfortable and relieved by being able to discuss her feelings about the child and appreciated the patient hearing she was given. Unfortunately, they dropped out of follow-up soon after.

Case 3: His parents brought 3-1/2 year old S to the clinic after having read a newspaper article on autism. They said he had difficulty in communicating with others since he was a year old. They were also concerned that he was not doing well at nursery school.

S had been born normally and had attained his motor milestones in time. His speech had also progressed to the level of 3-word sentences.

However, his parents had gradually come to notice that he tended to remain aloof and often actively avoided others. This behaviour became

marked by the time he was 2 years of age. He would not respond when called by his parents. He would make no eye contact. His parents were often unable to make out whether he was happy, sad or angry. He would be content doing one thing for hours, such as wrapping himself up in a particular quilt, or wearing his father's helmet, or staring at a page in a magazine. At times he would run around the house aimlessly, or go around in circles on his tricycle. He had been sent to nursery school but was not adjusting well because of his withdrawn, and occasionally disruptive behaviour. He had not suffered from any major physical illnesses. Temperamentally he was overactive and distractible with poor adaptability. His parents were educated and from middle class backgrounds. His father, an executive, had been alcohol dependent and had received treatment from our de-addiction services in the past. He tended to be liberal and overindulgent with S, in contrast to his wife who was fairly strict. His four and half year- old brother was normal. There was no family history of mental illness.

During the interview S sat on his father's lap and made no effort to communicate with his parents or the doctor. He started crying loudly whenever the doctor tried to interact with him.

Investigations revealed a mean IQ of 67 and no hearing deficit. Playroom observation showed solitary, self-absorbed behaviour with no meaningful effort at communication.

A diagnosis of childhood autism, mild mental retardation and developmental delay of speech was made.

Management

Psychological intervention: Six sessions were held with the patient and his parents in the playroom setting by two therapists.

Behavioural strategies: Target symptoms were lack of communication, self-absorbed and other inappropriate behaviour.

a) Parents were advised to make frequent eye contact with the child, forcefully if necessary. They were encouraged to gradually introduce the child to situations where he would have to interact with other children. They were told that individual attention would be of great help. The therapists

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also tried to establish a rapport with the child and interact with him, as a means of demonstrating to parents what needed to be done. The need for consistent handling was emphasized.

b) Parents were introduced to the TEACCH approach. The use of activities the child enjoyed was suggested to engage him in various activities. Parents were told that such activities were to follow a set schedule, would have to be simple, accompanied by clear instructions and visual cues. Demarcating areas for specific activities was also suggested.

Supportive techniques: These were used to help parents cope with the emotional impact of diagnosis. Their disappointment and frustration on learning about the diagnosis and its implications was acknowledged. Ways of handling the stress without resorting to maladaptive coping (especially in the father's case) were discussed. Positive methods such as discussing problems and their solutions among themselves, or with others, seeking help from professionals etc. were suggested.

Educational and informational strategies: Were used to improve parent's understanding of the nature of the disorder and its treatment. Parents were educated about various aspects of autism, possible prognosis, and treatment/rehabilitation. Other aspects such as speech delay and learning disability were also discussed. Information about facilities for special schooling was also provided.

Outcome: At the end of the fifth session parents perceived a slight improvement in his interaction. They were amazed when, on one occasion, he shook hands with the therapist, something he had never done before. Supportive intervention was found to be most useful followed by an attempt to initiate eye-to-eye contact. Rest of the techniques were found to be relatively less useful.

Case 4: SB a 2-1/2-year-old girl was brought by her parents with complaints of not speaking and not understanding what other said, which was noticed 6 months prior to presentation to the clinic. She had been born by caesarean section performed because of foetal distress. Developmental milestones, apart from speech,

were generally normal, or only mildly delayed. Nothing unusual had been noted about her temperamental characteristics. There was no suggestion of any major physical illnesses.

From the age of 2 years it was noticed that the child seemed to be unaware of anyone's presence. Her eye contact was poor. She only said 'ba-ba' or 'ma-ma' occasionally, that too to no one in particular. She did not respond when called, and did not seem to understand what was being said. However, she did indicate her needs by tugging her parents and pointing to the object.

She preferred to play alone, rather than with other children. She had particularly strong likings for certain things e.g. a song that she wanted to hear over and over again. She would frequently rub her fingers repeatedly over her own hands or feet or those of others. Her self-care was poor, she would urinate or defecate inappropriately. She did not seem to chew properly, but swallow all at once.

Both her parents were busy doctors who could not afford to spend much time with her. Thus, her paternal grandmother mostly looked after her. She had a 6-year-old sister who was healthy. There was no family history of mental illness.

Throughout the interview the child sat in a corner of the room and played with a spoon. She shrieked loudly when anyone approached her and stopped only when left alone.

Assessment of intellectual functioning revealed a Social Quotient of 63. An ENT surgeon had previously ruled out hearing deficit by audiometry. Playroom observation revealed a solitary, stereotyped style of play and self absorbed behaviour, with no effort at communication. Diagnoses of childhood autism, mild mental retardation and developmental speech delay were entertained.

### Management

Psychological intervention: Six sessions were carried out with parents and the child. Similar strategies as in the other cases were attempted with minor modifications. For example, being doctors, the parents already had some idea about autism and were more interested in knowing how

her behavioural problems. Particularly socially inappropriate behaviour, could be controlled. Thus more emphasis was placed on these problems initially.

Behavioural strategies: Main targets of these strategies were lack of communication and maladaptive behaviour.

a) For the former problem the therapist demonstrated how the child was to be spoken to while holding her face between the hands, in order to make and maintain eye contact. Parents were advised that they needed to take time off from their busy schedule to give individual attention to the child. To deal with the latter problem parents were explained basic behavioural principles such as rewarding adaptive and ignoring maladaptive behaviour, maintaining consistency etc.

b) Introduction to the TEACCH approach- Basic principles underlying this approach such as structuring of activities, time and space were also discussed.

Supportive techniques: Although they knew about autism the parents had a lot of difficulty in accepting the consequences of this problem in their child for them. Their attendance was irregular and both parents did not attend together. Their difficulties were acknowledged and these issues were discussed in detail, especially their belief that nothing could be done.

Educational and informational strategies: Misconceptions about autism were discussed. Parents were told about facilities for schooling autistic children at Delhi. It was suggested that they visit the facility to see for themselves how such measures could help.

Outcome: Initial compliance with therapy was poor, and no change was seen in the child's behaviour. However, two months after termination of therapy the mother rang up to convey that counselling in the form of understanding seemed to have given a lot of comfort to her. Also demonstration and guidance regarding schools had been of great help since the family travelled all the way to Delhi to learn the techniques. They also spoke of starting a school and a support group of all family members of autistic children at Chandigarh.

#### Case 5:

His mother, who had noticed that he had not been communicating properly for the past year or so, brought two and a half year-old H to the clinic.

She had two previous abortions and history of toxoplasmosis during previous pregnancies. She had developed pregnancy induced hypertension and gestational diabetes while pregnant with H. He was born prematurely (birth weight 2 kgs), but his APGAR scores had been normal. He developed jaundice soon after birth and had to undergo phototherapy. His parents did not notice any delay in his motor milestones. He also started saying 'mama' at 9 months of age. However, in the next 6 months or so it became apparent that he was not interacting appropriately with others. He did not respond when spoken to, did not seem to listen or understand, or make any effort to communicate with others. He did not even indicate his demands such as food, and would go hungry if not fed regularly. He spent the entire day wandering around the house, picking up things and banging them on the floor or the walls. He would go into a rage if prevented from doing this. He was very reluctant to play with other children. His mother gave up trying to force him to do so when he started to become aggressive with them.

He had not had any major physical illnesses. Exploration of temperamental characteristics revealed a pattern of overactivity, distractibility, short attention span, low threshold of responsiveness, and intense reactions. He was the only child of his shopkeeper father and teacher mother. Both were quite affectionate but had brought him up rather strictly. His paternal grandmother was also involved in his care. There was no family history of any mental illness.

During the interview he kept moving around the room, handling various objects and banging them on the floor. He made un-understandable noises from time to time, but did not attempt to communicate with the doctor or his mother.

Psychometry revealed an IQ of 79, and delayed speech development. Playroom observation showed stereotyped behaviour, lack of goal oriented play, minimal speech, deviant

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social interaction, and little emotional responsiveness. Audiometry did not show any hearing impairment.

A diagnosis of childhood autism with borderline intelligence and developmental delay in speech was made.

TABLE  
USEFULNESS OF INTERVENTIONS: FEEDBACK  
FROM PARENTS

Case no./s		1	2	3	4	5
Behavioural Interventions	Communication enhancement	+	+	+	0	0
	Use of TEACCH approach	0	0	0	0	0
Supportive interventions	Understanding	+	+	+	++	+
	Comforting	++	+	++	+	+
Educational Interventions	Information about autism	0	0	0	+	0
	Guidance about other facilities	+	0	0	++	0

0-little/not useful

+ - useful

++ - very useful

### Management

Psychological intervention: Contact with this family was relatively brief and lasted only three sessions. Target behaviours were similar, i.e. improving communication, cutting down on maladaptive behaviour such as aggression etc. An attempt was also made to inform them about the condition and listen to the difficulties they were facing.

### Behavioural strategies

a) Enhancement of communication by attempting eye-to-eye contact forcefully or otherwise was demonstrated.

b) Principles of TEACCH approach were discussed briefly with emphasis on structuring time and activities.

### Supportive measures

Parents were allowed to discuss their reactions to the diagnosis and their apprehensions about future.

### Imparting information

Parents were explained about the need for special schooling, given the relevant addresses and encouraged to make contact.

Outcome: Parents appreciated the support offered. They made contact with one of the schools suggested. However, no great change in the patient's behaviour was reported at the end of 3 sessions.

Usefulness of techniques used: Usefulness of techniques was rated on the basis of feedback from parents on a three point scale viz. 'little or not useful', 'useful', and 'very useful'. This information is depicted in the table.

## DISCUSSION

All five children received a diagnosis of autism based on characteristic disturbances of social interaction, patterns of communication and restricted, stereotyped, repetitive repertoire of interests and activities (WHO, 1992). Comorbid diagnoses of speech delay and hyperkinesia were also common. IQ/SQ varied from 60 to 79, which is higher than usually expected. Parents were middle-aged, literate, professionals, businessmen or housewives, from well to do urban background.

The focus of management was parents rather than children. The contact with parents was relatively brief, since most of them dropped out after a few sessions. This, and the fact that the treatment was carried out in a busy outpatient clinic meant that only the most immediate problems could be addressed. Apart from a general discussion on how to handle maladaptive behaviour, behavioural interventions also focused on enhancing eye-to-eye contact. A modified version of the TEACCH approach was used with principal emphasis on providing a structured environment at home, clear communication and liberal use of visual cues (Dawson, 1999). Since most parents had little idea about autism and were considerably distressed upon hearing the diagnosis, it became imperative to include information and support as a part of overall management. These basic principles of treatment were similar for all, although the emphasis varied



depending on the needs of parents. The playroom was a particularly convenient site for these sessions. Both children and parents seemed more relaxed and comfortable here, than in the somewhat 'clinical' atmosphere of outpatient consulting rooms. It also proved useful when modelling of behavioural strategies was attempted.

Any observations made from such data are bound to be limited by the fact that they would be based on impressionistic assessments of a handful of cases. Despite this failing, it appears that it was possible to carry out such brief and focused interventions with parents of autistic children, in outpatient settings, using an eclectic mix of treatment strategies. Moreover, parents found such interventions to be generally helpful and seemed to appreciate the support being offered. Gaining the cooperation of parents is important, since they play a vital role in the treatment of autism, and their active involvement is essential for the success of any intervention (Lord and Rutter, 1994). However, it is difficult to comment on whether the interventions done led to any significant change in the children's behaviour, mainly because of the brief contact and short period of follow-up. In some cases minimal gains were noticed and even acknowledged by the parents. It is not known how long these persisted. Autistic children with high IQs, reasonable speech, coming from middle-class backgrounds and receiving special education, usually do better than their counterparts (Whore, 1993). Thus these children would be expected to have better outcome, but whether they actually did so would remain uncertain, without proper (long-term) follow-up.

It was easier to get some sort of a feedback from parents. This revealed that parents found the support, reassurance and empathy (understanding and comforting techniques) to be the most useful ingredients of the treatment package. The behavioural strategy of communication enhancement was also rated as useful, perhaps because the principles were easy to understand and apply, in contrast to the TEACCH approach, which the parents did not find of much use. Further, gains if any, were usually first noted in this area

of the child's behaviour. Surprisingly, parents found information about autism and guidance regarding other facilities to be of little use. Whether this was because they had already some knowledge of the condition, or because they were not ready to digest such information at this early stage, is difficult to say.

Treatment of autism requires that both short-term and long-term needs of the child and parents be met (Cohen and Volkmar, 1997; Fuentes, 1999). Child psychiatric clinics such as the one in which this study was conducted, may have an important role to play in this process. Most parents of autistic children will come into contact with these clinics much before any other facility. At such an early stage of contact, parents are often likely to be struggling to cope with the emotional aspects of support being offered by professionals at such facilities. Therefore, mental health professionals at child psychiatric clinics may need to place more emphasis on understanding, empathy and reassurance while beginning to work with parents of autistic children. In addition they may also play a 'bridging' role by introducing parents to behavioural strategies and making them aware of long-term treatment facilities.

However, properly designed studies that investigate this neglected area of management of autism in India are needed before any of these suppositions are deemed to be true.

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