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Autism Treatment Program

Promoting Inner Well-Being and Improved Functioning for Children Diagnosed with Autism Spectrum Disorders through Inner Humanism Psychotherapy: A Retrospective Evaluation of Outcomes

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Executive Summary

By Stephen Budde, Ph.D.

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Smart Love Family Services
Natalie & Ben Heineman Smart Love Center
2222 N. Kedzie Blvd., Chicago, IL 60647
contact@smartlovefamily.org

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Overview

The psychotherapy program at Smart Love Family Services (SLFS) opened in 2007. In weekly clinical consultation and supervision sessions, evidence began to accumulate that children who had been diagnosed with Autism Spectrum Disorders (ASD) were responding positively to the Inner Humanism psychotherapy (Pieper and Pieper, 1990) provided by therapists at the clinic. Inner Humanism (IH) is a unique approach to child psychotherapy that aims to identify and nurture the child's own powerful motives for constructive and enjoyable relationships. The promising observations at SLFS were consistent with previous evidence that IH had been an effective treatment for extremely violent children and adolescents who were deemed untreatable by multiple residential treatment and inpatient psychiatric hospital facilities (Pieper & Pieper, 1995). In response to the positive anecdotal findings and concerns about existing treatments, we decided to undertake a more systematic retrospective evaluation of the effectiveness of IH treatment for an inclusive sample of twelve children treated at the clinic who had prior ASD diagnoses.

The evaluation showed

- Children increasingly turned to IH therapists for care and support
- Demonstrated evidence that most children made substantial progress in feeling and functioning better
- Progress was evident across a range of outcome indicators
  - core ASD symptoms
  - serious internalizing symptoms
  - behaviors at school
  - relationships at home

Inner Humanism offers hope to parents and professionals who are searching for more positive and effective ways to help children who are experiencing the debilitating symptoms, isolation, and anxiety that characterize autism spectrum disorders.

Autism Spectrum Disorders: Symptoms and Treatment

Core features of ASD disorders include persistent deficits in social communication and interactions across multiple contexts (e.g., lack of social reciprocity— the capacity to have "give and take" interactions, poor social relationships), restricted or repetitive behaviors and interests, and difficulty coping with transitions (e.g., DSM V: American Psychiatric Association, 2013; Koenig and Levine, 2011). Children diagnosed with ASDs are also at increased risk of other mental health disorders and symptoms, including anxiety, depression, and difficulty regulating anger and attention (e.g., Bellini, 2004; Sofronoff et al, 2007; Reierson & Todd, 2008).

The IH theory of psychopathology provides a useful understanding of why this constellation of presenting problems is so challenging. Given the focus in IH theory and treatment on the child's subjective experience of relationships, the strong preference for isolation manifested by many children diagnosed with an ASD is of particular concern, since it indicates that the child has tuned out the world and turned away from relationships. The extent to which relational preferences for isolation are historically entrenched and constant across settings also provides an important indicator of the depth of the child's psychopathology (Pieper & Pieper, 1995). Accordingly, how much a child's preference for isolation noticeably changes, within or outside the therapy setting, is an important gauge of therapeutic change.

The concept in IH that symptoms are experienced subjectively by children as a pathological form of soothing helps explain the addictive and tenacious nature of ASD symptoms. Anyone who has interacted with a child who is extremely isolated, has obsessive interests, or displays repetitive behaviors can observe that these behaviors are compelling, soothing, and often explicitly enjoyable to the child. Not surprisingly, efforts to interfere directly with the child's (fixated) symptomatic motives and behaviors are, understandably, often met by the child with extreme distress. Further, the child does not empirically know or trust in alternative ways to pursue genuine forms of happiness.

Autism Rates Doubled but only Minimal Support for Commonly Used Approaches

The reported rates of ASDs have doubled in the past ten years and now stand at 1 in every 68 children (Center for Disease Control and Prevention, 2014). Parents and professionals are interested in finding more effective treatments for children. However, a systematic review of research on treatment interventions for children with ASDs by the Vanderbilt Evidence-Based Practice Center offered only minimal support for commonly used approaches.

Chicago Location: Natalie & Ben Heineman Smart Love Center, 2222 N. Kedzie Blvd., Chicago, IL 60647
Oak Park Location: Rush Medical Office Building, 610 S. Maple Street, Oak Park, IL 60304

773.665.8052, ext. 4 | www.smartlovefamily.org

Behavioral and educational interventions varied considerably in approach and outcomes, and researchers noted that available studies provide limited understanding of whether these treatments result in meaningful changes in child functioning. Psychotropic medications, including antipsychotic medications (e.g., risperidone and aripiprazole), reduced problem behaviors for some children but were accompanied by significant side effects, (Warren et al, 2011). Detrimental side effects of riseperidone on children, for example, include rapid weight loss, sedation, and increased production of milk hormones (see review by Sparks, Duncan, Cohen, & Antonuccio, 2010).

The narrow focus of most ASD researchers and practitioners on genetic and neurological explanations of ASD symptoms appears to have contributed to a bias against relationally oriented forms of treatment (Bromfield, 2010). From the perspective of IH, medical, behavioral, and cognitive interventions are overly pessimistic about the potential of many children diagnosed with ASDs to become involved in relationships and to engage in meaningful therapeutic change processes. These directive and sometimes highly intrusive and harsh interventions tend to assume that children with ASDs need to be forced or taught how to communicate with others and improve their behavior. The accompanying focus of these interventions is either on behavioral compliance or skill development.

Aims of IH help Children become more interested in Communicating and having Positive Relationships

In contrast, IH aims to address the more fundamental and meaningful task of helping children become more interested in communicating with and having positive relationships with others. The guiding belief that nearly all children retain an innate motive for pleasurable relationships provides IH therapists with an optimistic view of the child and his potential. Inner Humanism's unique relationship-based approach identifies and nurtures even the smallest constructive motives for involvement with the therapist as well as the child's motives to feel and function better across home, school, and social settings. In IH therapy, children are never pushed or taught to behave in a certain way. IH therapists respect and welcome all of the child's feelings and symptoms while being firm, (and not angry or harsh), in regulating any unsafe behaviors. Repeated empirical experiences with IH therapists can awaken the child's motives for constructive relationship experiences, promote self-worth and self-confidence, and decrease the power and appeal of a wide range of chronic symptoms.

Evaluation Methods

This evaluation addressed three research questions that reflect basic assumptions of IH about the nature and process of therapeutic change. The questions focus on a range of potentially observable results of the intervention within and outside the treatment setting, with particular attention to symptoms associated with ASDs. Relative to the start of treatment did children with ASDs:

1. Increasingly turn to the therapist for help, support, and pleasurable relationship experiences?
2. Experience positive changes in core ASD symptoms (such as increased communication and decreases in repetitive behaviors) during sessions?
3. Improve their interpersonal and behavioral functioning at home, at school, and in social relationships with peers?

Through detailed surveys and follow-up interviews researchers collected qualitative and quantitative (i.e., on 27 emotional and behavioral symptoms) data on child functioning at the beginning of treatment and change over time from the 8 therapists that provided once or twice a week treatment in the 12 cases. The evidence available to therapists was solely that which had accrued through their clinical work with children, periodic conversations and guidance sessions with parents, and direct discussions with teachers in several cases. No attempt was made to gather additional information from children, parents, or others purely for non-clinical (i.e., research) purposes in order to avoid affecting the quality of the treatment (Heineman Pieper, 1989). Interviews focused on gathering specific and concrete evidence and examples of positive and negative changes observed by or reported to therapists, as well as ongoing concerns that they identified. To respond to some of the limitations of the data and the possibility of therapists being overly positive in their judgments, follow-up interviews explicitly collected data on:

1. negative changes and ongoing concerns about child functioning;
2. specific examples and evidence for positive or negative ratings of change over time;
3. clarification, in behavioral terms, of what therapists meant by various terms (e.g., repetitive behaviors, interest in peer relationships);
4. the sources of information for specific evidence (e.g., therapist's observations of child behavior, child statements in treatment, parent reports to the therapist, or teacher reports);
5. the context in which symptoms or changes occurred (e.g., in session, at home, school, or in multiple contexts)

The lead researcher conducted extensive secondary analyses to compile qualitative and quantitative data into 11 indicators of child progress. These indicators assessed the extent to which children made documentable gains in turning to the therapeutic relationship, child functioning in treatment, core ASD symptoms, and functioning in home, school, and peer contexts.

Findings and Conclusions

Overall, the evaluation yielded positive and promising results on the three primary research questions.

- First, there was considerable evidence that all children increasingly turned to IH therapists for help, support, and pleasurable relationship experiences.
- Second, most children experienced positive changes (within treatment sessions) in core ASD symptoms including lack of pleasure in relationships, concrete indicators of communication symptoms (e.g., initiating communications, eye contact, using language), and repetitive behaviors.
- Third, and perhaps most compelling from an evaluative perspective, all twelve children in the sample made substantial progress on at least 2 of 4 key indicators of child functioning outside of the treatment setting—severe internalizing symptoms (e.g., suicidal ideation and self-harming behaviors), negative school behaviors, family interactions, and peer relationships. Outside of the treatment setting, the strongest improvements related to self-regulatory capacity, including elimination of, or substantial reductions in, chronic hand flapping for a subset of children, and substantial declines in negative school behaviors and severe internalizing symptoms.

Children showed somewhat larger gains in school than at home, and child progress in developing peer relationships was observable but less positive than gains in other settings. Parents (reporting to therapists), as well as the therapists themselves, reported that child functioning at school, and developing age-appropriate peer relationships and social skills, remained ongoing concerns and objectives. These promising findings are particularly noteworthy given the lack of sufficient evidence about whether commonly studied interventions for children with ASD are "linked to specific clinically meaningful changes in functioning" (Warren et al, 2011, p. vi).

We argue that genuine improvements in self-regulatory capacity are best achieved by nurturing the child's own constructive motives to address perceived or real losses that trigger unhappiness and behavior problems. In the current study, behavioral improvements in school and at home were often, though not always, associated with children demonstrating new or markedly increased capacity to:

- talk about and cope with losses within the treatment relationship (e.g., missing sessions, having to stop the treatment session, limit setting for safety reasons);
- discuss concerns about life at school or at home with therapists, teachers, and parents rather than simply reacting; and/or
- reflect on better ways to take care of themselves and pursue constructive motives.

The evaluation findings provide support for (and *proof of principle* that) fundamental tenets of Inner Humanism's theory of therapeutic change are applicable to children diagnosed with ASDs:

1. Virtually all children have an innate motive to have pleasurable relationship experiences with caregivers;
2. IH therapists can identify, nurture, and grow a child's motives for enjoyable and constructive relationships by maintaining a hopeful view of the child's potential, welcoming all of the child's communications (including symptoms), and by actively supporting the child's *constructive motives* to turn to the therapist;
3. The child increasingly, though not without conflict or predictable backsliding, prefers *constructive motives* (*e.g., turning* to the therapist for help and support) over the child's *non-constructive motives* to turn to his symptoms, relational conflict, and isolation as familiar forms of soothing and coping with stress, loss, and anxiety;
4. The child develops an increased sense of inner well-being from his experiences in the therapeutic relationship, and [1]increasingly prefers and pursues his own motives to feel and function better outside of the treatment setting.

Other important lessons learned from the evaluation had implications for improving the quality of services for children diagnosed with an ASD, including:

1. *Ongoing concerns remain and long-term treatment is needed*: The fact that most children made substantial progress did not mean they were symptom free. As noted above, concerns remained for most children with regard to educational and social functioning. Since children with ASD diagnoses, including those in the study sample, tend to have severe and chronic pre-treatment symptoms and deficits, long-term treatment is optimal. The relationship-oriented psychotherapy should be a primary long-term service for children with ASD diagnoses in order to address underlying emotional and relational needs that regulate a wide range of symptoms rather than short or long-term interventions that focus only on symptom reduction.

[1] IH therapy recognizes that children with behavioral or emotional problems have both constructive motives and non-constructive (or fixated) motives that compete for hegemony in the child's mind. Therapeutic change initially involves a shift in the balance of these motives in favor of constructive motives.

2. *Children made less progress in relationships with peers (compared with progress with therapists and parents)*: While children often showed increased interest in relationships with peers over the course of treatment, (an important first step from our perspective), actual improvements in these relationships were modest or not evident for most children. One straightforward explanation of this finding is that peers are much less likely than adults to be supportive of children they view as odd because of ASD related symptoms. Information on social functioning from some cases led us to conclude that children needed more opportunities to develop peer relationships in supportive contexts that involve activities of interest to the children.
3. *Support from other caregivers mattered:* Behavioral gains and improved relationships with adults in school and at home were sometimes associated with teachers and parents who responded positively to the child's increasing motivation to turn to caregivers for support, such as when the child more actively and directly expressed feelings, needs and interests. While not surprising, these examples illustrate the importance of having other caregivers welcome the child's communications, even (or especially) when the child is upset. Therapists and researchers noted that, especially given the focus on the child-therapist relationship in IH, the clinical staff members need to intensify outreach to parents and provide more options for getting support. To that end, SLFS created Parent Support Coordinator and Parent Advocate positions, and initiated a wider range of supportive and therapeutic strategies for parents that start at the beginning of the child's treatment.

In conclusion, Inner Humanism child psychotherapy offers children, parents, and professionals an optimistic and realistic new approach for helping children with the persistent and debilitating symptoms associated with ASDs. Smart Love Family Services is pursuing strategies to provide more IH treatment to children diagnosed with ASDs and to increase the support we provide to parents and other professionals. Evaluation strategies have been improved so that we will examine parent ratings of child behavioral outcomes using an existing standardized measure, as well as an instrument developed internally that more directly measures dimensions of happiness and effective agency (e.g., expressing feelings and motives).

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The Smart Love Approach was developed by Martha Heineman Pieper, Ph.D., and William J. Pieper, M.D., and is described in their book *Smart Love*. The Natalie G. Heineman Smart Love Preschool offers classes for three to six year olds, and parent and child programs for children six weeks to 36 months. Smart Love Family Services provides counseling for children and families based on the Piepers' therapeutic approach, Inner Humanism®. Parenting programs include private parent coaching, educational seminars (co-sponsored by the Intrapsychic Humanism Society), parent training and support programs, and publications.