

## Parents as Cotherapists in the Treatment of Psychotic Children<sup>1</sup>

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A treatment program for psychotic and autistic children in which parents are helped to function as primary developmental agents is described and evaluated. Research and clinical experience is reviewed suggesting that parents react to their child's developmental disorder, rather than cause the disability. Demonstrations to parents observing through a one-way screen have been focused on corrective approaches to relatedness, competence motivation, cognitive, and perceptual motor functions. Parental participation has also included program sessions and research activities at home. The latter corroborated clinical observations that autistic children responded best to high external structures for acquiring new patterns and to relative freedom to practice those which have been mastered. Initial outcome trends are presented, indicating that parents have been developing effective skills as cotherapists. Objective recognition of their children's disabilities has helped to improve family equilibrium. Substantial improvements in participating children have been noted. Optimal or normal levels of development are prognosticated, depending on IQ, consistency of appropriate education and degree of impairment.

Severely disturbed children have been exposed to a remarkable array of therapies in the past three decades, including custodial isolation, electroconvulsive shock, drug therapies, psychoanalytic therapy, operant conditioning, electronic typewriters, and megadose vitamin therapy. This variety attests to a mounting experimental interest in helping those children and understanding

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their disorders, as well as to the lack of professional consensus. Developmental therapy, discussed in this report, is a method in which parents function as the primary developmental agents for their own severely disturbed child. The goals are to prevent the elaboration of psychosis, to increase adaptation between the child and his family, and to promote recovery where possible.

Since we do not yet have sufficient knowledge of specific causes for childhood psychosis, it may be helpful to explain the theoretical framework and the focal propositions that guide such a program. It is assumed that the directions of a child's development are based on the interactions with his parents. By and large, the normal child's behavior is shaped around parental expectations; the child in turn has an effect on the parent's behavior. The human infant is born with a biologically determined set of reflexes and responses that appear in regular sequence, relatively unaffected by learned experience. Some of these responses are basic to social development. Some infants, for example, smile a great deal, whereas others smile less. The infant's smile increases his mother's involvement. Infants who smile frequently tend to be fatter than infrequent smilers (Freedman, 1966). For an autistic infant with impaired social responses, the mother is negatively reinforced for her mothering efforts. The interaction cycle is directed more by the biological limitations than it is for the normal child.

The presence of such constitutional adaptational rigidities was alluded to in Kanner's original discovery of autism, which has subsequently been elaborated and clarified in the reviews of Eisenberg (1967) and Rutter (1970). From these reviews a consensus about the nature of childhood psychosis appears to be evolving. Several factors are important to developmental therapy: (1) the causes are multiply determined, (2) in individual cases the primary causes are usually unknown, and (3) it is most likely that the primary causes involve some form of brain abnormality resulting in language impairment and other symptoms, depending on the child's age, severity of disability, and time of onset.

Learned experience has had less effect on preschool children than on older children, increasing the likelihood that for the younger child, adaptational difficulties involve biological processes. Our own studies (Schopler, 1965, 1966; Schopler & Reichler, 1970) agree with those of others (Ornitz & Ritvo, 1968; Rutter, 1968) in suggesting that the primary defect in childhood psychosis involves impairment in communication and understanding with manifestations in both cognitive and perceptual processes.

New knowledge about the personalities of parents of psychotic children has been perhaps even more prominent in the evolution of developmental therapy than what is known of their children. Until very recently parents were generally

looked upon as the primary causative agents. However, little of the care lavished on classifying and describing the children was spent on understanding the parents. Based largely on psychogenic theories, they were bestowed with such homey epithets as "refrigerator parents," "smothering mothers," "cold," "intellectual," "rejecting," and "schizophrenogenic." Since the clinical history of childhood psychosis is relatively brief, it is possible that the psychogenic theory, placing the etiologic emphasis on parental feeling and thought, was an attempt at substituting theory for lack of information (Schopler, 1969). To date the psychogenic theory has generated virtually no specific research which may help explain the nature of childhood psychosis. Its persistent application has evoked scientific and parental indignation against such unsubstantiated bias. Besides inhibiting research, the theory may also be implicated in social-political processes that appear to go against the best interests of the children. Parents of retarded children, whose child-rearing practices have rarely been considered as a primary cause of retardation, have long been effectively organized toward promoting educational resources for their children. Parents of autistic children, on the other hand, did not form a national organization until Rimland spoke out in 1964 against the psychogenic emphasis and then became the founder of the now growing National Society for Autistic Children.

Clinical observations of parents have ascribed to them emotional and intellectual deviations far more frequently than these characteristics have been demonstrated through controlled research. Pitfield and Oppenheim (1964) found that some of the stereotyped characteristics did not apply to their sample of 100 mothers of psychotic children. Meyers and Goldfarb (1961), on the other hand, found mothers imposing their perplexities on their schizophrenic offspring. Parents' aberrant thinking has been repeatedly linked to the thought structure found in their schizophrenic offspring. Such "schizophrenogenic" thinking has been reliably measured in several studies (Singer & Wynne, 1965; Lovibond, 1954; Lidz, 1958; Wild, 1965; and Rosman, 1964) using the Goldstein Scherer Object Sorting Test. In each of these studies parents showed more disordered thinking than did control groups. (The primary interpretation of the findings placed the emphasis on parental thought disorder as generating similar impairment in their child.)

These studies have recently been extended (Schopler & Loftin, 1969a, b) with parents of psychotic children. The results showed that they were impaired in their thinking when tested in association with their psychotic child in the context of psychodynamic evaluation. When another group was tested in the context of an interview asking them how they were able to raise successfully their normal children with a problem child in the family, they showed no more impaired

thinking than a control group of parents of retarded children. It has become increasingly clear that parents of psychotic children are disorganized in reaction to their disorganized, psychotic child.

Some of the current trends concerning the nature of the psychotic child and his parents are discussed in greater detail elsewhere (Schopler & Reichler, 1971). The following propositions were derived as the framework for developmental therapy: (1) the causes of autism are as yet unknown, (2) the classification must therefore, for the time being, remain broad but descriptively explicit, (3) the most likely causes are those involving biochemical and neurological brain abnormalities, (4) these result in perceptual inconstancies involving speech and communication impairment, and (5) parents' personalities fall within the "normal range," differing from the general population only in that they react with perplexity and confusion to their unresponsive children.

Some theories of autism are locked tightly to the prescribed therapy for their verification. Thus, Bettelheim's therapy involves separating the child indefinitely from his parents, replacing them with warm, accepting parent surrogates. This parentectomy therapy and the psychogenic theory are often presented as evidence of one for the other. A similar relationship exists between the position taken by many learning theorists and their operant conditioning procedures. The therapy assumes that behavior can be shaped if the right reinforcement contingencies can be found. Ferster (1961) proposed that autistic behavior is caused by parental inability to provide a proper reinforcement history for the child. Such circular reasoning is not the link between developmental therapy and the propositions formulated above.

#### PROGRAM STRUCTURE

Following a pilot study in 1966, using parents of psychotic children as coterhapiists, a 5-year project was begun. Since it is only in its second year, some of the outcome data reported here are incomplete and based on clinical observations. The structure for the program, however, has been established. Three main admissions criteria are used:

1. The child must have a diagnosis of autism or psychosis based on the Creak (1961, 1964) criteria.
2. He must live at home in an intact family, with parents who are willing and able to participate in the Child Research Project.
3. He must be functioning on a pre-school level.

Families are referred from all parts of the state within commuting distance from the Project. Decisions for admission are made after a 2-hour diagnostic

evaluation which, like all subsequent sessions with the child, is conducted in a one-way observation room. Prior to this, all previous work-ups have been reviewed. Both parents accompany the child for this session.

#### Diagnosis of Psychosis or Autism

An objective rating system has been developed for measuring the degree of psychosis found in each child referred with a suspicion of autism or childhood psychosis. The child is rated on observations made during a semistandardized interaction. The ratings are based on the criteria worked out by Creak's (1961) working party and elaborated by Rutter (1970). These criteria, offering only a broad descriptive classification, have the advantage of avoiding premature closure and impediments for the subsequent identification of more discreet subgroups as more specific knowledge becomes available. Rutter has suggested that the term childhood psychosis be used to designate the broad range of severe disorders in which autistic characteristics are prominent. It is in this sense that the term childhood psychosis is used to select children for the Project. Ratings of the young psychotic child may be grouped in two levels of importance for differentiation from other conditions.

#### *Specific Response Patterns*

*Relatedness.* The absence of age-appropriate relatedness can often be distinguished between a lack of attachment to people or a lack of attachment to objects or places. Perhaps because people are themselves more complex and changing from day to day, lack of social responsiveness is more frequent. The child is aloof, or excessively clinging, avoids eye-contact and does not imitate verbal or non-verbal signals. He is impaired in communication and understanding, both of which are basic to age-appropriate human relatedness.

*Speech impairment.* Equally important, though developmentally subsequent to the relatedness impairment, is the absence, delay, or peculiarity of speech development. The child may speak slowly, late, and with poor ability to communicate. Sometimes he plays with sounds, words and phrases unintelligibly. He echoes certain words repeatedly, often the one heard most recently. This also results in pronoun reversal.

*Sensory peculiarities.* These children show various expressions of unusual sensory processes. Nearly all appear deaf or have been suspected of deafness. The child tends to be inattentive especially to auditory and visual stimuli. He may also show special sensitivity to selective sounds or have panicky reactions to certain visual stimuli. He may persist in excessive examination of things around

him by touch and taste. He may feel textures and tap on surfaces like a child who is born blind. He may appear indifferent to pain, unable to sense, locate, or respond to pain-producing stimuli.

#### *Other Characteristics*

The second level of psychotic signs includes peculiar motility patterns, such as rocking, spinning, toe walking, and hand flapping. The child manifests abnormal activity levels, appearing either hyperactive or hypoactive. He may have a preoccupation with the repetitive use of the same toy or object. Intellectual functioning is on a retarded level, but hints of normal or superior potential in some areas are common. Excessive and often unpredictable mood changes occur with severe temper tantrums and self-destructive behavior. The assessments of these behavior items during the diagnostic session can be made with satisfactory reliability between different raters.

#### Parent-Child Interaction

Both parents are also observed in an interaction with their child. They are asked to bring along some of the toys or objects he is currently most interested in and then to get him as involved with them in organized activity as they can, and to get him to help them return the materials to their container. This enables the staff to get an initial measure of the kinds of difficulties parents are having in interacting with their child. It also gives the parents an idea of how they will be expected to work with their child should they be admitted to the Project.<sup>3</sup>

#### Staff Background

All staff members function both as therapists and parent consultants, though not usually with the same family. This dual role enables them best to maintain a balanced perspective on parent-child interaction. Their past training and experience may have been in the discipline of education, psychiatry, psychology, or social work. They are selected for their interest and skill in teaching autistic children and their parents rather than for their professional identity. Experience with such children, enthusiasm, and willingness to learn have so far proven to be the best qualifications.

<sup>3</sup> When a family is admitted, an agreement of collaboration between them and the staff is made for a specific period of time.

#### PARENT PARTICIPATION

Parents attend twice weekly for 45-minute sessions, with mothers and fathers usually alternating. During these visits parents may observe therapist's demonstration, discuss problems in other areas of their home life with the parent consultant, or demonstrate their home program with the child. Occasionally other family members, such as siblings, are also involved in working with the child.

#### Therapy Demonstration

Parents observe through a one-way screen with their consultant, who focuses their attention on relevant aspects of the demonstration and answers questions parents may raise. This observation has several important advantages:

1. It avoids the mystique and unfounded authority of the therapist who reports to parents from only private observations of the child.
2. It guards the parents against recommendations which are more easily made than carried out.
3. It provides stimulation stemming from constructive competition between parents and therapist and also affords a realistic opportunity for parents to use the therapist for modeling behavior.
4. Direct demonstrations have a more immediate impact than verbal interpretation. They are more easily understood, especially by unsophisticated parents, than are eloquent verbal explanations.
5. When parents are allowed to see the therapist's struggles, frustrations, and occasional mistakes, they become less self-critical and are better able to resume responsibility for the bond with their own child.

The demonstrations play a key role in encouraging parents to use as guidelines their knowledge of successful experience in normal child rearing, but to apply this knowledge in the special way required by their autistic child. To do this, the parents have to develop a degree of self-consciousness inappropriate to normal child rearing. Indeed, they need to become experts on their own autistic child. Therapist demonstrations contribute to this in two general ways: They offer the therapist as a model for general attitudes and approaches, and they demonstrate specific teaching methods.

The therapist confers with the parent consultant prior to the demonstration and they agree on the session's focus. For example, parents often have unusual difficulties in controlling the child's behavior and they have adopted an air of resignation in accepting anything the child does. The therapist will show how to

get the child seated at the table, how to give him a swat on the behind to clarify communication, and how to maintain a meaningful interaction when the child withdraws. Specific interventions are evolved appropriate to the child's development. These can be grouped conveniently in four main areas of function with examples of typical interventions in each.

#### *Human Relatedness*

The children are impaired in their responsiveness to adults, including both social attachment and differentiated awareness. Since subsequent development, especially imitation for communication, is dependent on such responsiveness, improvement is especially useful during initial phases. This involves the adult's nonspecific impingement on the child and striving for clarity in both positive and negative responses. The child is not allowed to do anything—move about the room or use any object without the mediation of the adult. Similar to the common-sense suggestions of Des Lauriers and Carlson (1969). Gradually, as the child takes the adult into account, increasing degrees of frustration are imposed, such as demanding some action or task before satisfying the child's wishes. Self-stimulation and withdrawal by the child are met with immediate and direct intervention by the adult. With a child at a higher level of development, the therapist may be more passive and allow the child to initiate contact by responding immediately and positively. After breaking through a child's severe withdrawal, some object or food may be used as a means of exchange.

#### *Competence Motivation*

The appropriateness of materials used is important. The aims include helping the child to develop pleasure and interest in increasingly organized exploration and use of toys and educational materials. Increase in the child's sustained and spontaneous interest with materials when he is by himself appears to be one of the more efficient ways of promoting competence motivation. Initially, however, it is fostered externally and increased by improved relatedness to the therapist. As the child becomes more responsive to external motivation and his perceptual-cognitive organization increases, he is allowed to follow his own interests more freely. Exploration is then encouraged by association with meaningful use of materials. One child's perceptual skills may develop, enabling him to explore new materials spontaneously. For example, he may learn how to put a new puzzle together on his own. While such success is self-rewarding, the child also is encouraged to explore new materials. For another child human relatedness may be undeveloped, while his motivation to meaningful exploration

of materials is increasing quite rapidly. His motivation to organize materials may be used to improve responsiveness by making such materials contingent on responding to the adult. The main aim, however, is to enable the child to develop spontaneous, organized activity and play, reinforced by his own success. Methods such as these are specified for each child on a continuous basis and translated into specific tasks in a home program.

#### *Cognitive Functions*

The primary concern here is the child's development of both receptive and expressive communication skills. These involve recognizing and naming subjects, discriminating colors and shapes, learning concepts, action verbs, and their meaningful application. When special education is not productive, operant conditioning procedures are often effective.

A child without speech may first need to learn non-verbal imitations. He will be required to look at the adult's mouth while a desired object is named before it is given to the child. At higher levels of development, a sound already produced by the child may be encouraged and identified with an object. At still higher levels, concepts are encouraged through the use of modalities with immediacy for the child. "Up and down" can be taught initially by swinging the child up and down accompanied by the appropriate word. Eventually the word is required from the child before he is picked up. One child, for instance, would be held upside down until he asked to be picked "up." These concepts are then generalized through other activities.

#### *Perceptual Motor Function*

Exercises are developed for improving the child's awareness and coordinated use of his body. This may include practice with coordination between his eyes and hands, exercises for developing pincer grasp and other functions such as jumping, climbing, and balancing. Some children at very low levels of development initially need passive manipulation of their limbs to learn to use them. For example, one child never brought his hands together. In another, pincer grasp might be developed by manipulating materials that could not be grasped in any other way. For some children, experience with a graded series of puzzles or cups fosters increased perceptual discrimination, which often interacts with cognitive development as language is added. Development is uneven and sometimes unpredictable. One young child, after learning to discriminate geometric shapes, developed an interest in letters. Although this interest did not follow the normal developmental sequence, he was helped to learn the alphabet.

This increased his overall organization of his perceptual world and supported language development as well.

#### Home Program

Concurrent with their observations of sessions, parents are also given home programs, which are revised at regular intervals. These describe objectives, methods and materials for working with the child in daily sessions. The content of the home program is based on the therapist's assessment of the child and the parents' experience at home. Both parents are expected to share in these home sessions, though mothers usually work more frequently with their children than do fathers.

At regular intervals, parents demonstrate the home program with their child while therapist and consultant observe. Parents bring along the materials they had made or purchased for home use. They are aware of being observed and occasionally filmed. Although many of them are at first nervous about performing behind a one-way screen, the nervousness disappears after they have observed the therapist for a while. In fact, sooner or later most parents request additional demonstration sessions to show new developments of which they are especially proud. Not only do spontaneous demonstrations of new progress boost the parental ego, these sessions also maintain some motivating competition for understanding and improving the interaction with the child.

Generally the parents' daily home program sessions are more easily organized into an enjoyable and successful interaction than are problems in other areas of home life. To work out solutions to these problems the parent meets with his consultant in an office other than the observation room. The problems discussed often involve issues not practical or feasible for handling during demonstrative sessions, such as sleeping, eating, and difficulties with toilet training.

One child did not go to bed until eleven o'clock. He sat in the living room rocking himself for a half hour every night, and then slept in his parents' bed every night. This had been going on for several years. The parent consultant helped the parents to divide this bedtime problem into several units. First the rocking chair was moved into the child's bedroom as was a radio he liked listening to. After he became accustomed to this change he was consistently moved from the parents' to his own bed. A difficult struggle ensued, requiring parents to move the child 15 times to his own bed during the first few nights. Within three weeks, however, he was sleeping in his own bed.

Parents are required to complete daily logs. On this form each section of the home program is rated for changes in the child's responses. Once each week both parents complete the second part of the log, rating the child's progress in the other areas of home life. These logs form an important part in tracking changes and development in the child over time.

#### Research Participation

Parents have been involved directly in research relating to therapy. During the first year of the Project's operation, parents expressed considerable confusion about the meaning of "structure." How to differentiate between rigidity, clear structure, and lack of structure? Some of the parents had read about or had their children involved in relatively unstructured, nondirective, or psychoanalytic play therapy. Although these traditional therapies have certain ground rules of time, place, and safety, they have contributed to the belief that a disturbed child's difficulties can be improved if he is allowed free expression with a minimum of impingement of frustrating expectations from adults. This attitude played into the parents' own perplexity in dealing with the child and hence it became relatively easy for them to accept uncritically any of the child's autistic behavior.

Other parents had been exposed to operant conditioning therapy involving more rigid structures. A certain target behavior to be modified is explicitly identified by the therapist and specific reinforcement contingencies are established. The child is conditioned in a direction independent of his own preference or developmental organization. Even in this highly organized situation, factors outside the therapist's control affect his carefully designed structure. Such effects are rarely measured or reported; nevertheless they obviously exist.

Without dichotomizing therapeutic structure as present or absent, the parents were involved in a systematic study investigating the effects of degree in structure on the child's functioning. Both parents and therapist were asked to alternate the structure in working with their child at two-week intervals for an eight-week period. The interactions were rated by a time-sampling method. Results detailed elsewhere (Schopler & Reichler, 1971), showed that the children were able to function more appropriately during structured than during unstructured sessions on all variables rated. The degree of disorganization varied among children. There was less disorganizing effect in the unstructured condition for children functioning at higher levels of development. Conversely, children at lower levels reacted to the change in conditions with more disorganization.

These findings and their implications for education and therapy were consistent with our clinical observations. The autistic child responds best to relatively high structure. Accordingly, relatively unstructured play therapy is not an appropriate treatment. On the other hand, a rigidly applied technique, such as operant conditioning, may not offer the best help for an autistic child if the rates and levels of the child's development are disregarded. The optimal learning situation for autistic children, as for others, is one which has more external structure for acquiring new learning patterns, and relative freedom from structure for practicing those patterns which have been mastered and internalized. The parents' direct participation in this study contributed to their interest and sensitivity to more accurate appraisal of their child's functioning level. They used this information for becoming more active in finding and using appropriate methods of intervention.

#### OUTCOME TRENDS

Although developmental therapy with parent-child interaction was begun 4 years ago, only during the past 2 years has the program included at least 10 children. There has not been sufficient time to complete longitudinal evaluation. Even in this beginning phase, however, we have some clear indication for the success of this process for both parent and child.

Of the 10 families in the Project during the first 18 months, the following social class distribution occurred: using the Hollingshead Index (1957), three families are in social class I, three fall into class II, two into class III, and two into class IV. This trend is consistent with the distribution reported by Rutter and Lockyer (1967). Four of the 10 families are Negro, 6 are Caucasian. The direct demonstrations were especially effective at the lower educational level where verbal facility is limited. Although less verbal, these parents were capable observers and were effective in putting their observations to good use.

Parent involvement has been greater than anticipated. Attendance has been quite regular although parents have to drive from 1 to 4 hours for each visit. Daily logs documenting the home program sessions have been maintained with high regularity. Mothers were more frequently involved in working with their children than were fathers, though both participated. Often, at the very beginning of the parents' participation, fathers were able to understand the child with more objectivity and to control the interaction more effectively than mothers. Mothers were often more confused, hopeless, and exhausted; spending most of their time with the child, they were more continuously affected adversely by his unresponsiveness. Nevertheless, improvement in the child was

more noticeable when mothers became more involved with the home program than when fathers attempted such dominant involvement. However, parents' capacity to shift primary involvement to each other made for greater adaptability in the child's behalf.

Recently a comparison was made between the ratings on the child's activities during sessions with his therapist and ratings on the demonstration sessions of parents. These time-sampled ratings were made on the child's attention, affect, relatedness, verbal behavior, and nonpsychotic behavior. The ratings for seven children who had been in the program for at least 6 months were averaged for a 4-month period. In spite of individual variation, there was a trend for parents to obtain higher ratings on these five variables more frequently than did the therapist during the same period. This is perhaps not surprising considering that parents spent much more time with their child than the therapist and worked with him in daily home program sessions. However, it also confirms our observation that parents often pull ahead of the therapist in their effectiveness in implementing therapy demonstrations. Nevertheless, parents continue to seek support for maintaining their efforts.

Many parents, especially mothers, have developed a degree of objectivity, investment, and skill found only in top-notch teachers. Indeed, 3 out of 10 of the mothers in our program have become actively involved in teaching and 3 more have expressed a lively interest in this direction.

In the Child Research Project, therapists and parent consultants have come from the fields of psychiatry, psychology, social work, and education. Their successful fulfillment of their roles seems less related to their professional training than it does to their enthusiasm and motivation to work with autistic children and their knowledge of normal child development. In the field of mental health, there is a reluctant but increasing acceptance that paraprofessional and relatively untrained workers are conducting important therapeutic interventions. This is usually justified with the explanation that the increase in demand for service accompanied by a shortage of trained personnel makes such use of subprofessionals necessary. Our experience suggests that it is not only expedient to use parents to supplement the shortage in manpower, but that they are also frequently the most effective developmental agents for their children.

In addition to working directly with their own children, the parents in our program have recently organized their own state chapter of the National Society for Autistic Children. They have been dedicated and effective in working toward the establishment of special education programs for their children in the public schools. Through meetings with legislators, educators, and professionals, they have succeeded in setting up two demonstration programs for special education

of autistic children. Parents have extended their capacity to bring more meaningful organization into their children's lives, into the broader social implications of the disorder.

Several trends for change in the children can be identified after this relatively brief period of time. For some, a recovery from autism to relatively normal function can be predicted.

One of our children had no communicative speech, did not relate, and had an IQ of 57. During the 3-year period of therapy, he learned to function sufficiently to attend a regular public school and not to be distinguished from other children in his grade. This youngster's IQ went to 101, advancing 44 points. He developed a personality that made him appealing to both teachers and peers. The only traces of his early difficulty can be detected in perceptual-motor awkwardness showing up in poor handwriting. It is quite likely that the traces of this impairment will become sufficiently camouflaged with further development to be unnoticeable.

For another child the psychotic symptoms, screaming, self-destructive behavior, and lack of relatedness, are no longer a problem. Even after the psychosis was no longer an issue, this child continued to function on a retarded level with an IQ of 56. It was possible to place her without any difficulty in a special class for retarded children in a public school, where previously she had been excluded.

A third child showed extremely slow progress during the period of therapy. His IQ remained about 39. There was some improvement in relatedness, and he was able to learn a few words. However, advances in his development were not firm and tended to disappear without continuous practice. Eventually, he showed symptoms that made it possible to report a diagnosis of tuberous sclerosis. Even before this diagnosis could be made medically, the staff and parents recognized that his rate of development was profoundly slow and unstable and suspected an active biological process. But even in this case involving progressive brain disease, some degree of improvement could be measured.

These trends in the children are consistent with those reported by Gittelman and Birch (1967) and Rutter (1968), linking prognosis with IQ. IQ's of less than 50 suggest a poor prognosis for normal development. IQ's over 50 indicate a greater variability in prognosis. Depending on the severity of the underlying impairment and the consistency of appropriate education, the child may reach optimal or normal levels of development.

In all our families, the parents' realistic appraisal of the child contributed to making their best energies available to him while either maintaining or improving the adjustment among all family members. Apparently, the recognition of the child's disabilities helps to improve the family equilibrium. Attention to the coping abilities of families faced with a difficult problem releases resources, energies, and abilities. These resources are often dissipated in other therapeutic enterprises in which parental adjustment difficulties are the primary emphasis. It is time to recognize the autistic child's parent as the integral agent to the solution of his child's problems rather than as having caused them.

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