

How to tailor a transdiagnostic intervention to the individual state of mind of individuals with ASD?

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Short Communication

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Abstract

INTRODUCTION: ReAttach is a trans-diagnostic tailored intervention based on a conceptualization model. The intervention includes arousal-regulation, multiple sensory processing, conceptualization, affective mentalization and associative memory formation (active learning). Autism Spectrum Disorder is a clinical diagnosis for a heterogeneous group of individuals who experience pervasive neurodevelopmental problems including perceiving the world in a fragmented way: the pre-conceptual state of mind. Tailored ReAttach sessions support individuals with ASD to develop a coherent sense of the self and the world.

OBJECTIVE: The aim of this article is to describe how a to tailor a ReAttach session to the individual state of mind of individuals with ASD.

METHOD: ReAttach-C.A.T. is a Computer Adaptive Tool, built to assist therapists to map the individual state of mind before the start of ReAttach sessions. The instrument is in its early stage of development.

RESULTS: A group of 52 patients with complex developmental challenges were interviewed by their ReAttach therapist, using the inclusive ReAttach-C.A.T. Mapping the individual state of mind in co-creation with the individual with ASD, makes sense and is helpful for a variety of reasons. It also sheds a new light on the Forms of Vitality of the co-creators.

Keywords: *ReAttach, Autism, Forms of Vitality*

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Introduction

ReAttach therapy strives to facilitate optimal conditions for processing sensory information, cognitions, emotions and events (Bartholomeus, 2012) (Bartholomeus, 2015). It claims to be a trans-diagnostic approach: ReAttach applies to the whole array of trans-diagnostic symptomatology networks across neuropsychiatric presentations (Petter, 2018). The intervention can be adjusted to treat most emotional, psychological, developmental, behavioral or physical challenges (neuro-rehabilitation/top-sports) (Weerkamp-Bartholomeus, 2018).

Although ReAttach is a tailored approach for all individuals receiving ReAttach sessions, there is an urge to explicitly tailor the intervention even more for individuals with autism spectrum disorders (ASD), neuro-rehabilitation or psycho-geriatrics. The tailored version of ReAttach helps to overcome the developmental arrest of individuals with ASD or neuro-developmental disorders and many psychologists were eager to learn about this specialization.

At least partially due to a waiting list for supervised trainings, many psychologists were so eager to work with ASD that they started without learning the adaptations. It was exciting to experience whether or not they would succeed in activation of growth. It was disappointing to find out that basic ReAttach training was not enough to learn how to provide the ReAttach for autism even though the therapists had lots of diagnostic and clinical experience in the field of ASD.

In this article it is not my goal to write about the ReAttach protocol for autism. I have done so elsewhere (Weerkamp-Bartholomeus, 2018) and it turned out to be insufficient. A diagnosed-based ReAttach protocol is an oversimplification of the individual complexity and unusable to embrace the complexity of the individual's state of mind.

First, I will explore why it is so difficult to learn to adapt ReAttach to individuals with ASD. Later on I will describe the first steps that are taken to solve this difficulty: A Computer Adaptive Tool (C.A.T.) in combination with a manual (Weerkamp-Bartholomeus, 2018) might help to map the individual complexity and to make better decisions in designing ReAttach therapy sessions for individuals with ASD.

ReAttach Protocol for Complexity?

ASD refers to a complex and heterogeneous area of clinical characteristics (American Psychiatric Association, 2013) which highly overlap with other clinical neuropsychiatric disorders. Adapting ReAttach according the ASD diagnosis is too simplistic and turned out to only alleviate some amount of distress. That was disappointing because the aim of ReAttach for ASD is to activate development in terms of multiple sensory processing, coherence, conceptualization, affective mentalization, self-reflection, self-regulation, autonomy and pro-active coping.

I previously assumed that ReAttach had to be different for individuals with ASD because at the start of the sessions these individuals are in the pre-conceptual stage of development (Weerkamp-Bartholomeus P. , 2018). This literally means that, for various reasons, they can't process multisensory information in coherent concepts yet.

ReAttach contains a social cognitive training component that is based on a conceptualization model. At first, we develop a coherent self, differentiation between the self and others, later we develop theory of mind, affective mentalization and finally we develop a sense of relationships in which we have no part. Taking into account the pre-conceptual state of mind at the start of the ReAttach sessions, the social cognitive training component consists of new skills. That is why we need extra guidance and instructions and why professionals need perfectly attunement at the level of proximal development of each individual with ASD.

A second difference with so called neuro-typical individuals with diagnoses other than ASD that I expected was that the Social Reward System might be under-activated in individuals (Bartholomeus, 2012) with ASD. A consequence of that, is that especially children with ASD, are more interested in objects than in people. We need to pay extra attention and wait until the individual with ASD is taking social initiative towards the therapist instead of the other way around.

A third difference that might be important for ReAttach therapists is that some individuals with ASD have no imagination. This needs to be assessed so it can be addressed during the ReAttach trainings.

It turned out to be extremely difficult for the therapists to decide for their patients whether the basic ReAttach Protocol (Bartholomeus, 2012) was sufficient or not. The more complex the clinical presentation, the more important it became to understand the individual state of mind in ReAttach terms rather than in diagnostic categories. The urge arose to develop a trans-diagnostic ReAttach for Complexity Protocol to design tailored interventions.

An inclusive tool for neurodiversity

The main goal was to explicitly distinguish elements of the ReAttach intervention that need to be tailored for individual patients and to draw a line between the basic ReAttach Protocol and specialization. The ReAttach for Autism protocol was written to describe most common adaptations for individuals with autism, however it didn't cover individual differences over time. Instead of writing a large catalogue with different ReAttach protocols for different types of patients it seemed more realistic and efficient to write a manual with adaptations for specific elements that embody ReAttach itself:

1. Arousal regulation
2. The Social Reward System
3. Multiple Sensory Processing
4. Protection
5. Joint Attention
6. Conceptualization
7. Imagination
8. Communication
9. Emotion Regulation

10. Coping

Clinicians who work with complex patients are well trained in analyzing clinical presentations, but it makes perfectly sense to add the perspective of the patient to get a clearer picture. If it is not possible to include a patient's view the option to interview a parent, partner or care-giver will be chosen instead. The therapist will communicate that a survey is used to tailor the ReAttach sessions in order to facilitate optimal conditions for individual growth. For each of the above items, 1 main question and 4 sub-questions were formulated in order to process the input of the patient in mapping his or her individual state of mind. A decision tree model was used to find out which areas should be adapted from the patient's point of view. The therapist was instructed to interview the patient and offer time to argue about the questions and talk about himself.

The Decision Tree Structure

The structure of the interview is based on asking the patient to define himself by identification with a one of 2 groups of characteristics. Figure 1 represents the decision tree structure of the first main question which is about the choice between stressed or calm: "Some people are stressed, and other people are calm. To which group do you belong?" The sub-questions provide the opportunity to either nuance the choice or to confirm this choice. The interview items were divided in A and B reflecting either too much or too little and for each item a main question was designed with 4 sub-questions:

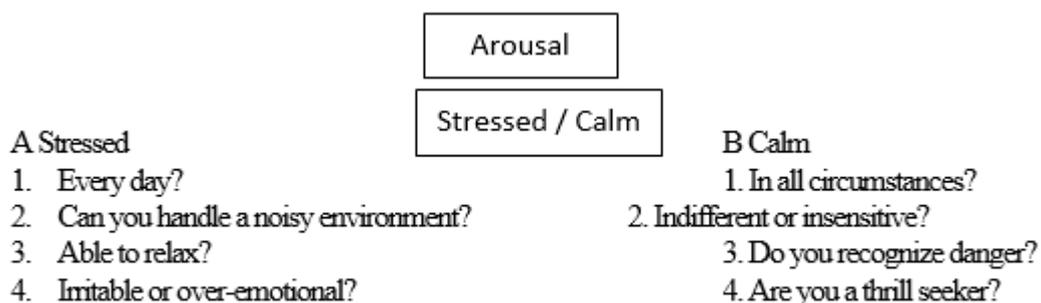


Figure 1: Decision Tree structure of the interview

Arousal A: hyper, Arousal B: hypo
Social Reward A: Hyper, Social Reward B: Hypo
Multiple Sensory Processing A: Mono / Hypo,
Multiple Sensory Processing B: Multi / Hyper
Family A: Over-Protection, Family B: Over-Demand
Joint-Attention A: Hyper, Joint-Attention B: Hypo
Conceptualization A: Hyper, Conceptualization B: Hypo
Imagination A: Hyper, Imagination B: Hypo
Communication A: Hypo, Communication B: Hyper
Emotion Regulation A: Hyper, Emotion Regulation B: Hypo
Coping A: Hyper, Coping B: Hypo
The chance of confirmation or nuancing the answer of the main question was estimated 50%. In the early stage of exploring the benefit of this type of tool this was the starting point. This provided the following percentile scores based on *confirmation* of the answer on the main question by the sub-questions 1,2,3 or 4:
Questions 1,2 percentile 90
Questions 1,2,3 percentile 96
Questions 1,2,4 percentile 93
Questions 1,3,4 percentile 85
Questions 1,2,3,4 percentile 99
Percentile scores 84-97 (high) and 98-100 (very high) were selected as indicators to tailor the ReAttach intervention and use the manual.

The tool was meant to give a rough indication of the items that need to be adapted for ReAttach sessions in term of advice: “You can provide a regular ReAttach session” or “Please check the chapter in your manual about this item and act accordingly”

Mapping

A coloured score-form was designed to map the patient’s view and to gain an oversight of the complexity before consulting the manual.

ReAttach-C.A.T. Manual

Since average or above average scores refer to *basic* ReAttach sessions, the manual only focuses on high and very high scores. After mapping the individual complexity by assessment of the patient’s view, the professional input of the clinician and manual are added to broaden the perspective.

The manual is directly connected to the individual map by the same items and A / B structure in separate chapters. Besides guidelines, the manual asks questions and provides instructions for further examination. All chapters have the same content structure:

Meaning

A short explanation of the meaning of the high score and its consequences for the patient’s functioning and the ReAttach intervention.

Examination

Does the patient recognize the results? Does the therapist recognize the results?
Does it match with the clinical presentation?

Perception

How to objectify this high score? What may the therapist expect to perceive when this item is being regulated for optimization?

How to act

Concrete recommendations for advanced ReAttach sessions. Exercises to improve the results.

Results

After training the first group of ReAttach therapists working with individuals with complex neurodevelopmental challenges, a sample of 52 individual maps was gathered. Written informed consent was obtained.

Table 1 presents the percentage of high and very high scores on the Computer Adaptive Tool. Out of 52 cases (male 37%, age 7-65, M37, SD 9.5) there was only 1 individual map with only average or above average scores: a candidate for the basic ReAttach Protocol.

All of the 52 individual maps were unique. As expected from previous practical research (Weerkamp-Bartholomeus, 2018) more than 50% of the individuals reported significant problems with arousal regulation, multiple sensory processing, over-protection or over-demand, emotion regulation and coping. Individuals who didn’t respond well on the basic intervention now could benefit from the new insights and overall the tailored approach was received with motivation and enthusiasm.

Table 1: Percentage of high and very high scores on the ReAttach-C.A.T.

	A	B	A or B
Arousal	52%	6%	58%
Social Reward	2%	10%	12%
Multiple Sensory Processing	50%	13%	63%
Protection	4%	25%	73%
Joint Attention	17%	12%	29%
Conceptualization	12%	17%	29%
Imagination	32%	13%	45%
Communication	-	8%	8%
Emotion Regulation	27%	35%	62%
Coping	23%	34%	57%

Discussion

Why is it so difficult to work with individuals with ASD or other complex developmental challenges spontaneously? I would like to give this some consideration.

During the training of the ReAttach-C.A.T. it was comforting to see how difficult it was to suppress the *natural tendency of oversimplification*. Although all therapists had great knowledge about their patient groups, there was a tendency to neglect complicated factors or to zoom in on obvious solutions. Complexity itself was also the object of simplification in cases where the professional could not imagine a positive developmental outcome at all. Just the mapping of individual complexity was rather helpful in suppressing this tendency to oversimplify: it just reminded not to.

The basic ReAttach Protocol demands attunement and the professional skills to tailor the intervention for individual with less complex clinical presentations. In their therapeutic relationship with complex patients however, they seem to know “what” to do and “why” they should act in this way, but they experience problems in “how” to do it. The concept of Forms of Vitality (Stem, 1985) (Stem, 2010) (Krueger, 2019) might shed some light on this problem.

Forms of Vitality (FV) specify the overall style of an action (Krueger, 2019) and they are often co-regulated by others. The social perceptual world of individuals with ASD might be organized by different FV (Klin, Jones, Schultz, & Volkmar, 2003) which provides a possible explanation for the difficulties in designing the proper FD for the ReAttach intervention: this “how” must be

designed in co-creation with the individual with ASD. Personally, I find this a beautiful concept of inclusion and equality: it emphasizes the humble role of the therapist who as a music conductor supports the musician (the individual with ASD). It needs to be a two-way tailored ReAttach session design. In other words: one explanation for the need of this tool is that ReAttach therapists feel insecure in the company of individuals with complex developmental challenges such as ASD, because their FVs don’t interact smoothly enough to know “how” to co-create in general.

Another consideration is that therapists who are familiar in working with individuals with ASD might have a strong tendency to compensate feelings of social awkwardness by adapting their FV in an attempt to support the individual with ASD. The co-creation of a special ReAttach session for ASD will not succeed if there is too much compensation. Instead of making all this beautiful music *for* the individual with ASD so it sounds great, a ReAttach therapist should co-create as a conductor, accepting the unique FV and co-create a masterpiece as part of an exceptional team!

Recommendations

For individuals with ASD it is always important to take medical problems into account (Trajkovski, 2018), (Poletaev, 2018). We failed to include this with our ReAttach form, which will be adapted. All the materials will be evaluated and improved by the engagement of all who are involved: teachers, therapists, students, parents, partners and scientists. Mapping neuro-diversity raises an awareness of individual uniqueness and equality.

Asking the patients (which we tend to call students instead) to explain their own uniqueness is actually a step forward in inclusion.

Conflict of interests

Author declares no conflict of interests.

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