Communication Disorders and Their Impact on the Family Experience

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Summary:

In the context of our interventions with children with mental disabilities, we observed the impact and influence of the disability on the development of the children we monitored as well as on the household as a whole, and found that the effect could be two-way.

Therefore, we decided, through our research paper, to present the case of a child, referred to us before the age of 3, who was suffering from a social communication disorder. After about two years of working with the child, and when noticeable changes in the child's condition began to occur, we noticed concurrent changes occurring in the family dynamic : The father was more present during the classes, the mother is less anxious and more free in her time, as well as changes in the brothers. Accordingly, we will try to address and explain the group of transformations that occurred in this family, in conjunction with the very positive developments for her son.

Keywords: parenting, family pension, autism spectrum disorder, social communication disorders.

اضطرابات التواصل وتأثيرها على المعاش الأسري

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الملخص:

في إطار تدخلاتنا بالقرب من الأطفال الذين يعانون من إعاقات عقلية، لاحظنا وطأة وتأثير، وكذا تأثر المعاش الوالدي، على التطور الإيجابي للأطفال الذين تابعناهم، تأثير قد يكون ثنائي الاتجاه.

ولهذا، ارتأينا من خلال ورقتنا البحثية تقديم حالة طفل تم توجيهه إلينا قبل سن 3 سنوات، والذي كان يعاني اضطرابا في التواصل الاجتماعي، بعد حوالي سنتين من العمل مع الطفل، وظهور تطورات ملحوظة في حالته، لمسنا في الوقت ذاته التغيرات التي حدثت في الدينامية الأسرية: أكثر حضورا للأب خلال الحصص، أقل قلقا لدى الأم وأكثر حرية لها في وقتها، وأيضا تغيرات لدى الإخوة: وعليه، سنحاول تناول وتفسير مجموعة التحولات التي حدثت لدى هذه الأسرة، بالتزامن مع التطورات الجد إيجابية لابنها.

الكلمات المفتاحية: مرافقة والدية، معاش أسري، اضطراب طيف التوحد، اضطرابات التواصل الاجتماعي.

Introduction:

The role of parents and the family is a pivotal element in any therapeutic work we to do with a child, and this is regardless of the field and specialization of our intervention.

The family constitutes and builds the basic rules for forming the personality of any child in the world, with its strengths and weaknesses, and interacts with a collection of genetic, environmental, and social factors to ultimately, reveal a single personality, with unique traits that make it different from others.

In the field of psychological disorders, these principles remain the same. The family is a fundamental and essential axis in the development of the therapeutic process, especially in the field of mental disability because we often find ourselves presented with children with limited cognitive and/or relational abilities, for whom a few hours of professional treatment may not suffice, rather, it requires continuity and regular therapeutic work in the social and family environment.

In what follows we present a case study which addresses the importance of intensive and close work with the family for the improvement of the child on the one hand, and for restoring a balance to the household on the other hand; And also shed light on the family’s suffering, arising from the belief that they are the cause of this child's disorder.

Section 1: A Theoretical Overview

The following is a review of the most important theoretical elements of interest to our research and clinical observations:

The first requirement: Autism Spectrum Disorders (ASD) and Social (pragmatic) Communication Disorder (SPCD)

Social Communication Disorder is considered a new classification within the framework of neurodevelopmental disorders and is included in the fifth edition of the Statistical Manual of Mental Disorders (DSM-5).

The DSM-5 stresses the creation of a distinction between the new SPCD classification and ASD. Since the general criteria are almost convergent, it is necessary that the ruminative aspect be present for the disorder to be classified as autism spectrum; If all the conditions are met except for rumination, it should be referred to as a social communication disorder.

Thus, the diagnostic criteria for autism spectrum disorders are as follows:

A. Persistent delay in social communication and social exchanges in numerous past and present contexts;

1. Delayed social-emotional exchange (reciprocity) ranging from an atypical social approach, to a failure of conversational discourse; or from a limited ability to share interests, emotions, and feelings to a failure to initiate or respond to, social interactions.
2. Delays in nonverbal communication in social relationships. From verbal and nonverbal communication that is not properly integrated, to defects in visual communication and body language, or delays in understanding and using gestures or movements, to a clear lack of facial expressions and non-verbal communication.

3. Delayed ability to develop, maintain and understand social relationships. This delay can range from difficulty in adapting to different social settings to difficulty sharing imaginative games, making friends, or a lack of interest in peers.

B. Models of limited and recurring behaviors, interests, and activities in number past or current contexts, which are manifested in two of the four areas mentioned below:

1. Rumination or repetition of movements, ruminative use of things or words: adjusting objects, throwing things, repeating sounds or words (echolalia);
2. Emphasis on the stability of their surroundings, flexible adherence to routines, or to verbal or non-verbal behavioral models. Inability to tolerate transitions and even minor changes in meals, routes of travel, in thoughts or in greeting rituals.
3. Limited and consistent interests, with unusual or exaggerated intensity: as a strong attachment with unusual objects;
4. Hyperactivity or deficiency in the way of responding to sensory stimuli or unusual sensitivity to sensory phenomena in the surroundings.
    a. Symptoms should be present during early childhood, but they may not be entirely apparent, as long as social requirements do not exceed limited abilities, or symptoms are accommodated with strategies learned later in an individual's life.
    b. Symptoms result in clinically significant limitations in social, occupation, or other areas of current functioning.
    c. These disorders cannot be explained by mental retardation or a general delay in development.

(Cottraux وPartners 2015 ،4)

The clinical specialist in the DSM is also required to complete severity scale rating, which is related to sub-classifications based on the presence or absence of the need to use the drug, and it creates three levels:

Level 3. Requiring very substantial pharmacological support

Level 2. Requiring substantial pharmacological support

Level 1. Requiring support

(DSM V, 2013, 50)

- **The diagnostic criteria for Social Communication Disorders are:**

A. Continuing difficulties in the social use of verbal and non-verbal communication, as indicated by the following characteristics:

- Deficiencies in the use of communication for social purposes in a manner appropriate to the social context, such as greeting or exchanging information.
- Limited ability to change communication according to the context or the listener's needs, such as speaking differently in a classroom than one might do in a playground, talking differently with a child compared to an adult, and avoiding using exaggerated formal language.
- Difficulties in adapting to the rules of conversation and narration, such as speaking in turn during a conversation, paraphrasing in the face of misunderstanding, and knowing how to use verbal and nonverbal cues to organize a conversation.
- Difficulty understanding what is not said clearly (explicitly) and use of figures of speech such as metonyms and metaphors.

The additions that the DSM-5 contributes, by including social communication disorders, is a positive step that is welcomed by every specialist in the field of autism.

Indeed, for many years, as specialists, we found ourselves with patients whose clinical presentation seemed very close to autism, while the elements of rumination and the need for stability in one’s environment were absent, unspecified disorders.

The second requirement: Working with the Parents

In the field of analytical therapy, Bowlby was one of the first to take an interest in integrating parents into the therapeutic process.

Many like him came from the likes of Monnoni, Lebovici, and others.

The importance of this inclusion imposes itself, especially in the field of disability, as the suffering of parents, the history of their living with their children’s difficulties and their perceptions, and the real impact of their lives in its various fields, must have a direct impact on them and their fate, especially since the different readings, or even their personal perspectives, may They create an excessive feeling of guilt about their children. (Lebovici, 1985)

The ways of integrating parents into the therapeutic work vary. It may be related to mere directives, linked to an objective view of children’s problems (for example, independence, modifying some behaviors, ..), where the specialist here gives some instructions that allow parents to get to know more about their children, their capabilities, their limits, ... thus helping them more. (Laupies, 2004)

In some cases, the specialist must accompany parents, different from the previous ones, by the need to continue in time, as the parents may need more support and help in understanding the various manifestations of their child, and they also need more support in their “parental function”, support that may reach for a type of individual therapy for one or both parents; Since the child’s problem may greatly affect their household, and reflect a complex past life history, the child's disorder has added to its complexity and difficulty.

The specialist may need to resort to family therapy, or be inspired by it; As the child’s disorder, like any disorder, may be due to its appearance for many objective, and unforeseen reasons, the continuation of the disorder may respond to the fact that it has formed a kind of external element to create a fragile satisfactory family balance, but it plays adaptive functions for the family, which makes it may Shows unconscious resistance to change, because this change, which is accompanied by the improvement of the child, means the loss of the pathological balance around which it crystallized itself.

Section 2: Practice

Below we will review a clinical model encountered in a number of cases that during our clinical field work.

The first requirement: Methodology and Tools

We will review what we encountered in the field through a case study of the clinical approach, where the case was followed-up in the framework of our clinical work and our research in the field of autism.

In order to work with the child, we mainly used clinical interviews with parents (often semi-directed), play with the child (which will not be addressed here, because play does not directly affect our subject), and also upon pre and post measurements, both of which were aimed at evaluating the effectiveness of our clinical intervention on the CARS and ECAR scales.

The second requirement: Case study

We met the child Halim for the first time when he was three years old. He was suffering from difficulties in social communication, according to the DSM-5, but in 2012-2013 when we met him, this diagnosis did not exist yet, which confused the efforts of many specialists in reaching an accurate understanding of his condition.

He is the last of his five brothers, his parents are cousins, his father is a successful businessman, and his mother is a full-time homemaker with a high school diploma; The mother often passionately explained that her future was lost when her father decided to marry her to her cousin, even though she had wanted to continue her studies.

Halim experienced tension during his psycho-motor development. He displayed clear difficulty with eye contact, in integrating with peers, and in independence; He was comfortable with strangers, did not engage in symbolic play nor have ruminative interest in the nature of games, lacked verbal ability, and possessed limited nonverbal communication.

The result of the CARS scale was ‘low to moderate to autistic behaviors’ based on a score of 34.5.

After getting to know Halim and his condition, we determined the framework for action and how to intervene, for which was necessary to include the family, primarily his mother and the father. The parents agreed from the outset, to attend regular appointments, once every two weeks, throughout the therapeutic intervention.

We worked with Halim on many core concepts: independence, imitation, tolerating frustrations, respecting rules and structures.

On every level, the role of the family was very important, and gradually the characteristics of the family began to reveal themselves to us.

Sessions with the Parents:

They often occurred at the end of sessions with Halim to support the parents in work to be done with Halim in the home, to talk about their concerns regarding their son's difficulties, and to talk about what we did with him in the session.

The work with the Halim family has gone through several stages, which we can summarize as follows:

A. Support for the parents

- Encouraging parents to help the child achieve independent toileting, by emphasizing the necessity of linking behavior with speech, and persevering with the treatment even when the improvement is initially insignificant and seems unlikely to be successful.
- Halim’s episodes of frustration were also related to the refusal or delay in responding to his needs. Over time, because of his difficulties and the hospitalizations he underwent, Halim’s

parents tended to overprotect him, and did not impose rules, limits or consequences. The parents also asked the brothers to do the same.

B. Initiating a therapeutic relationship with parents:

A therapeutic relationship with the family was adopted as a number of factors emerged, such as:

- A difference in perception of the child's difficulties between the mother and the father.
- The suffering the mother exhibited related to her son’s difficulties, and the link between this suffering and her own past: “I didn’t go far in school and I wanted to. Papa took me out of school to marry with my cousin. What I want is for all of my children to succeed at school.”
- Despite her acknowledgment of her husband’s understanding and their affection for each other, the mother’s unresolved grief about her past, and her belief that her father and her husband were to blame for both her difficulties and the lack of improvement in her son, almost always arose in our conversations with her.
- When we gave the floor to the father, he seemed ready to take full care of his wife and son, and eventually he brought Halim for consultation on his own, and encouraged the mother to rest or to do something else.

C. Rethinking the household and the assumptions of the parents and the rest of the family (siblings, if possible):

Approximately two months after Halim returned to consultation, a rebalancing appeared in the family:

- The father often brought him to sessions, while the mother bagan pursuing personal activities, such as learning French, driving, ...
- The older brother of Halim began to assert his presence and to complain that all the attention ws being given to his younger brother.
- It seemed that his family was searching for equilibrium in the face of changing circumstances related to the attentuation of the most serious and difficult symptoms of the patient.

The third requirement: Discuss the situation

Through work focused on Halim's difficulties in interacting with others, we noticed that our tendency to rebuild the stages of development of relationships, as well as our work with the parents to change perceptions of their son and support him to greater independence, contributed to the improvement of his condition.

In this case, in addition to Halim’s struggles, the issues of the difficult household dynamic and the suffering of all of the family members arose, and became aan aspect we confused on and tried to address in the second period of clinical follow-up. It seemed that the family members allowed themselves to express their struggles related to Halim's condition without feeling guilt after they started noticing improvement.

On the other hand, and in systemic concepts, it can be considered that the symptoms and difficulties of Halim, led to a kind of fragile stability in the family (Andolfi, M., 1993). The mother, who had a difficult home life due to the circumstances of her marriage (forced to drop out of school and marry her cousin), and problems that emerged with her family of origin and with her husband, found, in the case of Halim’s disability, despite the suffering, a way to avoid her own problems, and an outlet for her psychological discomfort. (where we note, for example, in reference to her father, there was no longer interaction between him and her husband due to a financial dispute, the appointments for Halim led to her father to providing transportation when her husband was not available).

Halim's disorder served to restore relations between family members; Although we could not get closer to the rest of them, with regard to Halim's father, the sessions in which the mother was absent were appropriate for him to express his feelings, as well as his love for his wife, when toward the end of the process he came with his son to allow her to continue the Freanch language and driving classes.

Accordingly, the various stages of Halim's treatment, resulted in the family taking several steps to change the relational dynamics between its various members.

Halim's difficulties led to a balancing function for various members of the family and presented a valuable opportunity for both parents to ask for help, and following them, for one of his brothers to express his suffering. (Neuburger, R., 1984). This son, who was silently suffereing from the responsibility placed upon him (and on the rest of his siblings), which is manifested in caring for the "sick" brother: a reality that is often experienced by the fraternal system when there is a disabled child within it, and Régine Scelles emphasizes it (Scelles, 2010).

Conclusion:

In every clinical study with a child with mental or physical disabilities, intervention involving the families is imperative; This intervention may assume two basic forms which are similar in appearance, but differ in the degree of their depth and in their objectives:

Directed parental accompaniment (to some extent): Here we support parents in a more directed way, we directly address their difficulties and the possibilities of helping them in the home and school environments.

In some, or many cases, it happens that we encounter resistance or difficulty in accepting change, which may reflect the needs developed by families or by parents regarding the symptoms of the child that may create a kind of psychological or interpersonal balance in the caregivers.

Therapeutic approach for parents: In the case mentioned above, it is necessary to pass from mere guidance to a deeper and more accurate look at the parental and/or family problems surrounding the child, which results in improving his condition by a large percentage.

This is what Mannoni and others have argued since the sixties of the last century, in explaining the imbalance and disturbances that may occur to mothers who do not consider their household as whole during therapeutic work with their children.

As Winnicott says: "There is no child alone" in the stages of his development, in the formation of his personality, he is affected by his surroundings, and this environment is inevitably affected by the child; Therefore, it is necessary to pay attention to both sides in every therapeutic intervention.

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