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The Impossible Child

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The Impossible Child

A New Treatment Offers Hope for the Undiagnosable

by Karen Smith

I'm sitting on a metal folding chair in the corner of a large, open room watching my son misbehave. I'm trying not to interfere. He is being tested by Rebecca, an occupational therapist, but he is not cooperating. She asks him to imitate a simple sequence of hand movements: she taps the child-size table where they are sitting with her right hand once, then with her left hand, then with her right hand once again. Evan flashes her a beautiful 5-year-old's grin, but then beats out his own rhythm on the table. She calmly repeats the instructions and tries again, with no success.

Next, she demonstrates a sequence of foot stomps. He ignores her and asks if he can play on the mats in the center of the room. I wonder, "Does he understand what he is supposed to do?" I suggest that I show him how to do it. Rebecca indulges me and I carefully copy her alternating foot movements. Evan just laughs at us both and runs off.

I cringe. This is exactly why we're here: He won't follow directions. For weeks now, Susan, his Montessori preschool teacher, has been greeting me with a furrowed brow when I arrive to pick him up each afternoon. She catches me on the playground and, with increasing agitation, catalogues the ways in which Evan refuses to follow the routine, respond to direction or make any apparent attempt to stay out of trouble.

He bumps into other children, steps on their work, makes loud noises, jumps and wanders aimlessly around the room, refuses to stand in line or join the group at circle time. He talks about poop and penises, obsesses about Scooby-Doo, generally acts the fool. When told to choose among the array of activities lining the shelves of the classroom, he rejects all of the options. When asked to sit on the back porch of the school building where his noise making won't disturb other children, he explodes. When forced to talk about his misbehavior, he shows little remorse and avoids looking Susan in the eye.

I am struck silent by these descriptions of Evan. As a child psychologist, I've heard parents of so-called oppositional children describe similar behavior, and I've made scores of recommendations about how to handle these kids at home and at school--how to set limits, define boundaries, support change. My practice is full of parents and children burdened by their individual and shared failures; and I have based my efforts to help them on the unspoken belief that good parents raise good children, despite the inevitable problems that come their way. But, now my child is failing. Now, I'm questioning whether I know how to be a good parent. What can I tell Susan? I'm not the expert here. I have no suggestions to offer about how to entice or coerce my own son to cooperate.

For months, I have been feeling helpless as a mother and utterly without grounding as a psychologist and family therapist. I watch myself get tangled up in power struggles with Evan. I hear myself bully him in ways that I could never admit, let alone recommend, to my patients. I ask myself how I can expect a preschooler to control himself when I'm so out of control. I joke, half-heartedly, that the day is coming when I will have nothing more to offer families than a sympathetic ear and a sad story of my own.

At home, my husband and I constantly argue with Evan about the simplest everyday things: getting dressed, washing his hands, picking up his toys, turning off the TV, taking a bath, brushing his teeth, going to sleep. He ignores us, then complains, whines, resists, falls on the floor, cries, screams. Really screams. We try being firm, we try

being playful, we repeat ourselves over and over again. Then we give warnings, threaten, yell.

Nothing is easy at our house. Everything is hard.

Now as I watch Evan with Rebecca, I recognize the battle lines that are being drawn. She reminds him of the rules. He insists that he needs a snack. She bargains with him and promises a break after he does more work. He falls out of his chair onto the floor. I roll my eyes. She asks, "Does it feel good to fall?" He doesn't answer, but the question intrigues me.

I'm reminded that six months ago Evan rolled around on the floor at the Parents' Breakfast while his classmates stood in two neat rows singing Woody Guthrie favorites. At the time, Mr. Warren, the director of his school, characterized Evan as a "contrarian." He meant this in a vaguely complimentary way, and I actually took some comfort in his description. I could imagine a contrarian growing up to be a social activist, an artist, even a Pulitzer Prize winner.

But in the fall of Evan's second year of preschool, Mr. Warren's view of my son's future took a turn. He began describing him as "disruptive," "aggressive" and, on one occasion, "violent." He hinted that his school might not be the right place for Evan and suggested that we get a "behavioral analysis" at the university psychology clinic. I was furious--and grateful--that he didn't seem to remember that I analyze behavior for a living.

In our culture, we don't take kindly to children who refuse to do what they are told. We label them with euphemisms, such as difficult, willful or spirited. When these kids show up in my office as early as age 3 or 4, their parents--often tearful, angry, guilt ridden--want quick advice about how to win the battles they are losing. In single-minded pursuit of control, they contort themselves and try to twist their offspring into whatever shape fits their idealized notion of how parents and children should behave.

Sometimes these families don't seek help until the children run into trouble at school.

There, where the rules don't bend, kids who push against the system are punished for their resistance. And parents are held culpable if they can't, or won't, make their kids knuckle under.

If their defiance persists, we call these kids maladjusted, antisocial or delinquent. We send them to the principal, to the school counselor, to a therapist--perhaps to their physician and a pharmacist. When these efforts fail, we send them to the judge, to the parole officer, to the warden.

I remember clearly the day my father asked me if Evan might need to see a psychiatrist. His well-intended suggestion landed on me like a slap in the face. From his point of view, Evan's misbehavior seemed pathological. But, as I saw it, the standard psychiatric tools were unlikely to be helpful. I knew the DSM-IV forward and backward, and our situation didn't fit into any of those boxes. This was not Depression, nor was it Anxiety. It was not Post-Traumatic Stress Disorder, Pervasive Developmental Disorder or Attention-Deficit/Hyperactivity Disorder. Maybe it was Oppositional Defiant Disorder, but what was a psychiatrist going to do about that?

One day as I was driving Evan to school, he said, "I wish Maria Montessori was in my class." I looked at him quizzically and asked why. "Because then maybe I could have a good day," he explained. As he saw it, only the benevolent spirit of the founder of his preschool could help him. The rest of us were clueless.

A week later he was sent home from school for slapping Susan in the face. I held him in my lap and tried to comfort him as he cried hysterically.

"We have to take down the school," he sobbed. "We have to, Mom. All the boards and all the nails. We have to take it down."

"Why?" I asked.

"Because I'm always bad there," he insisted.

These conversations--and many more just like them--devastated me. Every night, I fell into bed, exhausted by the day's failures, by my confusion, by the unrelenting struggle. And Evan was unhappy. "I wish God didn't make me to do bad things," he lamented one night just before he drifted off to sleep. As I groped in the dark for a reply, he added, "I think God feels sorry for me."

I imagined that my life would be spent clearing a path for my son in this world. A path where he would not be penalized for his obstinance. But I didn't feel up to the job. I was tired of pushing him through each day, trying to keep him on track, telling him every step to take and then arguing with him about why he had to take it. How could I expect his teacher or anyone else to tolerate his constant resistance?

Near desperation, I followed a friend's suggestion and called her son, a newly licensed neuropsychologist with a small practice and time to talk. That conversation led me to a murky netherworld outside the DSM-IV, where I discovered alternative diagnoses such as nonverbal learning disabilities, regulatory disorders and sensory integrative dysfunction. I wasn't sure where we were headed, but I knew that the map I had been using for years as an expert on children and families couldn't get us to where we needed to go.

This is how we came to Rebecca. Cautiously. Sceptically, even. I knew that occupational therapists sometimes worked collaboratively with psychologists; yet, in five years as a staff psychologist at one of the leading pediatric hospitals in the country and eight years in private practice, I had never met an OT. I had a vague notion that they helped babies with feeding problems, children with fine-motor delays and survivors of traumatic injury. What was an OT going to do for my precocious, uncooperative son?

In my first conversation with her, I sensed that Rebecca knew something about Evan that I didn't know. She was the first person who suggested that he wanted to please me, but couldn't. That in most situations he was doing his best. That many things that seemed simple and reasonable to me were, in fact, impossible for him. That there might be reasons for everything he did--and didn't do. That there was help.

She tested him on 17 different tasks that measured visual skills, coordination between the right and left sides of his body, balance, sensitivity to touch, accurate positioning of his body in space, imitation of movement and the ability to follow a sequence of instructions. Initially, the tasks were nonverbal but highly visual, like recognizing a picture embedded within another picture or copying geometric designs. Then she asked him to do things like move his finger from one spot on a map to another--without looking at the map--or to stand on one foot with his eyes closed. At first, he seemed to do pretty well, despite his reluctance to participate. But when he was forced to rely on touch, balance and sensory information coming from his muscles and joints rather than from his eyes and his ears, he flat out failed. For example, when Rebecca lightly touched one of his fingers without allowing him to look at his hand and then asked him to identify which finger she had touched, he couldn't do it. In most instances, he chose the wrong finger.

I was shocked. Evan was a creative, vivacious character who could talk circles around anyone on almost any subject. I had never thought of him as anything other than gifted. "He escapes into language," Rebecca explained. "He uses it as a distraction from tasks that are too difficult." Tasks too difficult? For Evan? With that comment, my understanding of my son began to change dramatically.

Several days later, my husband and I sat with Rebecca in her clinic. She reminded us that she had not evaluated Evan's intelligence, only his ability to process sensory information. And she confirmed that she had, in fact, found evidence of sensory processing problems. He was extremely sensitive to touch, but he often couldn't tell where he was being touched. As a result, he responded to tactile sensation defensively. His balance was shaky and his upper body was weak, so he often held his left arm bent and close to his body to stabilize himself. Because of this, he didn't use the right and left sides of his body in a coordinated manner. He also had a great deal of difficulty with what Rebecca called motor planning--the ability to plan, organize and carry out new or unfamiliar movements. She explained that these weaknesses interfered with his

ability to pay attention, follow basic directions, participate in group activities and engage in purposeful, independent activity. They were also likely explanations for his emotional reactivity, his resistance and his sense of helplessness.

According to Rebecca, Evan was not oppositional by nature. (And he had not been poorly parented.) He was at the end of his rope, trying to meet the behavioral expectations of a typical preschooler's world without the neurological equipment required. Trying--but failing--to please his parents, who were dragging him through his life oblivious to the challenges he faced every day.

For most of us, the delicate interaction between the brain and body known as sensory integration (SI) is nothing short of marvelous. It allows us to move purposefully through the world without being driven to distraction by the cacophony of sensory experience that bombards us each minute we are awake. It is how we can sit at a computer, concentrating on abstract ideas without thinking about how to position our body in the chair so that we don't fall on the floor, or where to move our fingers on the keyboard without looking at them or when to ignore the sounds of the wind at the window and the barking dog and when to tune in to the ringing telephone or the crying child.

Rebecca talked to us about "sensory integrative dysfunction," a malfunction in the brain's translation of sensation into meaning and action. For example, the brain might not automatically recognize that pressure on the skin and muscles of the abdomen is coming from a too-tight waistband. It may not judge accurately whether the sensation is important or trivial, dangerous or benign and, therefore, may not respond logically or efficiently. It's like there is a traffic jam in the lower brain. Important information that needs four-lane access to the thinking centers of the brain--like the awareness that you're about to lose your balance--can't get through. Other information that should be diverted into a parking lot--like the feeling of a shirt tag rubbing against your neck--gets full attention, creating havoc and confusion.

When brain-body connections are intact, the lower brain constantly interprets input from sensory receptors all over the body and responds with motor reactions. Those actions

create more sensory feedback, which provides self-correcting information to the brain in a never-ending cycle. Thankfully, this occurs outside of our awareness in most instances. We are free to focus on conscious thoughts, while our subcortical brain and its agents, literally, keep us from bumping into walls.

Children like Evan are not so fortunate. They vacillate between states of over- and under-stimulation and, as a result, often act in ways that are erratic and inconsistent. Everyday tasks--washing their hair or brushing their teeth--quickly overwhelm them. Complex tasks--learning to ride a bike or cleaning up a messy room--totally confound them. They become discouraged, irritable, whiny, explosive.

Because we assume that these children are neurologically and physiologically capable of doing what we ask them to do, we may describe them as inattentive, hyperactive or clumsy and complain that they are stubborn, angry or oppositional. In fact, they are all of those things--but for a reason. That reason is faulty sensory processing. Sensory integrative dysfunction is not a diagnosis like AD/HD, which is merely a list of symptoms that can be identified reliably. Rather, it is a conceptual framework for understanding what is causing some of the symptoms on that list (and others).

I was flooded with sadness and relief as I listened to Rebecca's descriptions of Evan. Through her eyes, I saw a boy who couldn't-- absolutely couldn't --stop thinking about the seam of his sock, or the waistband of his underwear or the tag on the back of his shirt. A boy who didn't yet button his pants, zip his jacket or fasten his seatbelt because he wasn't able to determine which of his fingers were touching the things he was handling. A boy who constantly made noise in order to screen out noise. A boy who had to bump into things or keep moving in order to maintain his balance. A boy who felt under attack by his skin, by smells, by noises. By his friends. By his father. By me. No wonder he was pushing back. His body was in a constant state of alert--and he was putting out tremendous effort just to get through each day.

It was the first explanation of Evan's behavior that made sense.

We quickly learned to recognize the obvious examples of sensory interference in his life. His consistent, adamant refusal to hug his grandparents because of his fear of losing his balance and the confusion and discomfort that light pressure on his skin created. His extreme reaction to the least little bump, scrape or cut. With Rebecca's guidance, we learned to detect the more subtle clues: the times he was driven under the dining room table by the smell of a fish stew, collard greens or even fresh bay leaves. The severe meltdown following a friend's crowded, noisy birthday party. The way he avoided schoolwork that involved tracing or writing because he couldn't discriminate between his fingers and couldn't control a pencil.

We started taking him to Rebecca for twice-a-week therapy sessions, but I would have taken him once a day if she would have agreed to it. She predicted that he would respond well to treatment, but that it would take time--at least a year. This was not magic: it was hands-on, developmentally oriented therapy based on the notion that the brain is shaped by experience. Through play, Rebecca provided Evan with sensorimotor challenges difficult enough to be appealing, but easy enough to be attainable. She said that these experiences would build upon one another, gradually laying the neural pathways between body and brain that were necessary for more efficient sensory processing.

Watching Evan and Rebecca together, I had to remind myself that they were shaping his brain. To my untrained eye, it looked like they were just having fun--crawling through tunnels, spinning in tire swings, diving into bean bags, tooting on horns, jumping through hoops. But surreptitiously, she was working him. Decreasing tactile sensitivity. Increasing upper body strength and postural stability. Encouraging bilateral coordination. Practicing motor planning. Building self-confidence. Developing a sense of mastery.

Meanwhile, life at our house was still hard. Power struggles persisted and temper tantrums were a regular occurrence, usually just before dinner, when the accumulation of the day's irritations crashed in on us all. Even though we couldn't always figure out what was causing him to crumble, we no longer blamed Evan for his frustration. We

eased up and tried to listen.

With encouragement, he began to describe the peculiarities of how his body worked. Over a peanut butter snack one morning, he said, "Andrew is allergic to peanut butter, but I'm allergic to things on my skin." After we gave in to his request to wear the same pair of soft cotton shorts day after day, he happily said, "I love smooth. It's my favorite thing." When I asked him what happened when kids at school accidentally bumped into him, he replied, "Oh, I have to fall down to get away from them."

One of the children I wished he could get away from was a boy in his class named Jack. I didn't like Jack. He was loud and disruptive and annoying--and Evan was drawn to him like a pig to mud. Each morning, just as Evan was settling into some methodical Montessori-style activity, Jack would cavort by, chanting some nonsensical rap, tapping him on the head, knocking over his carefully arranged work. And Evan would be off in a flash. The two of them would bound around the classroom together, working each other into a frenzy that would usually get them both sent to time-out.

I was fighting my unfriendly feelings one afternoon as Jack stood in front of me in a new hooded sweatshirt. I dug deep to find something nice to say. "That's a great red jacket," I offered lamely. His mom, Terre, overheard me.

"Jack has just started treatment for sensory integration problems and we've discovered that he's very sensitive to noise," she explained. "He likes to wear jackets that he can pull up over his ears, even when he's inside."

I was stunned. I had dismissed Jack as a troublemaker, but now I could see that I had been wrong. He and Evan had the same fundamental problem. No wonder they couldn't resist each other.

Terre told me that Jack had been a difficult child from early on. As an infant, he didn't sleep, he couldn't breast-feed, he was restless, hyperactive, difficult to settle. From the first moment that he could crawl, he sought out small, enclosed spaces where he could

hide. Even though she had raised two older children, Terre didn't know what to make of Jack's unusual behavior. Before she knew about sensory integrative dysfunction, she had gone to see a family therapist, who had recommended a behavior modification program to decrease Jack's "aggressive behavior." It hadn't worked (just like a sticker chart I'd designed for Evan hadn't worked). "I felt desperate," she said. "I didn't know what to do. I had this underlying fear that if we didn't do something, we were headed for medication."

Jack was 5 years old when a family friend who was the director of an OT training program told Terre about sensory integrative dysfunction. She had Jack evaluated and immediately started him in therapy with Rebecca. For the first time since her son was born, Terre felt hopeful.

Fortunately for both Jack and Evan, their teacher, Susan, was interested in learning about sensory integration. She read everything that I downloaded off the Internet about school-based interventions for SI kids. She created work spaces away from the noise and activity of the busy, open classroom. She allowed us to set up an old refrigerator box as a sensory shelter, which we decorated and called the "chill zone." She consulted with Rebecca whenever their opposition to a task puzzled her. Most important, she maintained her composure in the face of their sensitivities.

Within a few months, Evan stopped hating school. He started to recognize his own weaknesses, which made it easier for him to calm himself when he got upset, rather than exploding or disintegrating into a crying heap. When the din of the classroom became too intense and he started to get jumpy and loud, he asked for permission to go into the refrigerator box for a break. As his sensory processing became more efficient, he was able to focus on learning and enjoy its natural rewards.

"I'm so busy doing work at school that I don't have to try to be a good boy," I heard him tell his grandmother one afternoon.

His body was now working for him rather than against him, and he gradually developed

the ability to ignore little discomforts. Because he was less sensitive to touch, getting dressed was no longer a painful chore. One morning, with wonder in his voice, he told me, "Mom, when I put on my underpants, they were too tight. But by the time I got downstairs, they were just the right size." Habituation--the brain's automatic modulation of sensory awareness--is no small miracle, when you think about it.

Emotionally, a vulnerable side of him emerged. "I don't want anyone to be mad at me," he said when he heard even the slightest irritation in my voice. This was the boy I had so recently thought of as impervious to my wishes. It was now painfully obvious that he had always wanted to do the right thing.

One night at dinner I found myself repeatedly correcting him: Lower your voice. Don't lean back in your chair. Stop teasing your sister. You know you can't have dessert until you eat your food. No singing at the table. Don't interrupt me. Suddenly, my patience ran out and I yelled at him before I could stop myself. He cried inconsolably, a wellspring of discouragement and self-doubt.

"Oh, I just hate it when this happens," he wailed. "What if it starts happening all the time? What if all my nights are bad nights? What if I never have a good night again?"

In my therapy office, I began to recognize children who were similarly misunderstood. Children described as angry now sounded hopeless; kids whose parents complained that they were stubborn seemed stuck. Defiance became a red flag for me--as did explosiveness and even hyperactivity. My map was changing: perhaps being out of control was a survival strategy for some kids.

Now I frequently hear myself defending kids' best intentions to their exasperated parents: Nothing would make your son happier than to please you. He wants to, but he can't-- and it's up to us to figure out why. I find myself comforting parents who blame themselves for not being in charge of their children: It's not your fault. You have not caused this. I tell them honestly that I know how it feels to say things to your child that you deeply regret. I give them permission to ease up: It's okay to give in. Love is more

powerful than control.

Parents willing to accept alternative explanations for what appears to be misbehavior respond eagerly to my suggestion that these problems are not evidence of personal failure. "I'm hoping you'll tell me I'm not the worst mother in the world," the mother of an uncontrollable 4-year-old boy with significant sensory integration problems recently said to me. Once she and her husband recognized the source of their son's difficult behavior, they were able to appreciate his predicament, alter their expectations and rethink their ideas about how to discipline him. I encouraged them to accept and support him as he was, and to adopt a lifestyle that would accommodate his many needs. In consultation with their son's OT, they learned to control his environment in order to prevent sensory overload as much as possible.

But I'm still learning myself, and I'm not always certain when sensory integration is a reasonable framework for understanding behavior problems. When kids persist in everyday battles, I routinely inquire about their over- and under-sensitivity to sensory experience. I recommend an OT evaluation before a medication consultation for most hyperactive children. I don't want to overidentify sensory integration problems; on the other hand, I don't want to ignore the possibility that some kids cannot follow the rules, earn the points or honor the family contract despite considerable effort on their part.

I've discussed the possible connection between oppositional behavior and sensory integrative dysfunction with physicians, teachers and therapists--many of whom are considered authorities on the topic of disruptive behavior. Not one of them has been well informed about sensory integration theory. Most of them dismiss it out of hand because it has not been empirically validated. I find their closed-mindedness puzzling.

Therapists forced to appease managed care administrators are understandably hesitant to embrace alternative diagnoses. "Unproved" treatments are unlikely to be authorized. However, our track record for treating angry, defiant kids is not impressive. What I am discovering is that many difficult, oppositional kids can be helped. Not all of them have sensory integration problems, certainly, but a large number of them may. If they could

be identified and treated early--before they get labeled as "behavior disordered," before peer problems develop, before they alienate their teachers, before their relationships with their parents get tangled up in guilt and rage and shame, before they lose faith in themselves--they might be spared the social, emotional and psychological repercussions of repeatedly failing to meet the expectations of adults.

Evan is a different child today than he was 18 months ago, when I first sat on that chair in Rebecca's clinic watching him fail. Collaboration between a talented occupational therapist, a sensitive teacher and parents who were willing to be flexible opened up new possibilities for him. He is a happy, successful first grader in a public school. He makes it through most days without a serious problem. He is kind and funny and affectionate. He is still clumsy, and he will probably never be athletic; but he has developed an astonishing talent for art. Best of all, he believes in himself.

The other morning as I drove him to school, we were talking about all the things he can do now. "I just might be the best person there ever was," he said dreamily. I smiled at him through a sudden mist of tears and kept driving, convinced that we're heading in the right direction.

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Sensory Integration: A Primer

The theory of sensory integration (SI) attempts to explain a process so integral to our experience that few of us are aware of it--the organization, interpretation and utilization of the continuous stream of input from our eyes, ears, skin, tendons, muscles and joints. As Evan recently commented: "Your brain is all over your body." Once we understand that, we are on our way to appreciating the many ways children's lives can be disrupted by sensory integrative dysfunction.

SI theory is the life work of the late Jean Ayres, an occupational therapist and educational psychologist whose observations of neurologically impaired children caused her to wonder about the contribution of the senses to behavior. She was particularly interested in the "hidden senses"--those that provide information about balance, the position of our bodies in space, touch, pain and temperature. Her work at UCLA's Brain Research Institute in the 1960s convinced her that irregularities in sensory processing, which she called sensory integrative dysfunction, could lead to a vast array of problems, such as inattention and poor self-regulation, over- or under-sensitivity to sensory input, disturbances in activity level, floppy muscle tone and lack of motor coordination, emotional reactivity, speech and language problems and oppositional behavior.

Ayres developed a battery of tests (the Sensory Integration and Praxis Tests or SIPT) to assess the fundamental components of sensory integration: touch reception, balance, processing of input from the muscles and joints, form and space perception, visuomotor coordination, bilateral integration, sequencing and motor planning. Results from the SIPT, which was recently standardized on a large sample of American children, provide a profile of a child's strengths and weaknesses and can be used to set specific treatment goals.

The SI framework suggests an explanation for many of the symptoms associated with an assortment of behavioral, emotional and academic conditions, including specific learning disabilities, Developmental Coordination Disorder, Reactive Attachment Disorder, Fetal Alcohol Syndrome, Schizophrenia, Pervasive Developmental Disorders and Attention-Deficit/Hyperactivity Disorder. It offers promise for understanding difficult children without a specific diagnosis, like Evan and Jack.

SI treatment is based on the concept of neuroplasticity, the nervous system's capacity to modify its structure and function in response to environmental demands. There is increasing scientific evidence of the brain's capacity for reorganization throughout the life span. SI therapists believe that purposeful activities that stimulate sensory receptors

in the inner ear, skin, muscles and joints enhance the nervous system's ability to process and integrate sensory information, which in turn make higher levels of functional behavior possible.

Does SI treatment actually lay new neural pathways and reorganize sensory processing circuitry? Because we can't map or measure the complexity of neuronal connections, we can only infer neurological changes by observing a child's behavior. There is a great deal of anecdotal, clinical evidence of dramatic improvements in kids' emotional, social and academic functioning following SI treatment. What has caused those changes is unclear. Was it a natural process of maturation that would have occurred with or without occupational therapy? Was it the unconditional positive regard of the therapist? Was it the change in family dynamics once the parents understood the child's problem? Was it the SI treatment?

These are empirical questions and, admittedly, the empirical literature on sensory integration is limited. Occupational therapy is still a "young" discipline without a solid scientific foundation. Findings from studies of SI treatment outcome range from negative, to contradictory to positive; but many of those studies fail to meet the rigorous standards of scientific methodology. Nevertheless, a growing number of OT researchers are focusing on basic questions, such as how to reliably identify and classify children with SI problems, how to define SI treatment and how to select reasonable outcome measures. Until these questions are addressed with well-designed research, we will not have clear guidelines about when to recommend SI treatment and what to expect from it.

The fact that more progress has not been made in the 30 years since Jean Ayres first proposed her ideas about sensory integration is no reason to reject them outright. It wasn't so long ago that the empirical and theoretical underpinnings of psychotherapy were similarly shaky. SI theory could be a diamond in the rough, an unpolished gem with great potential value, a dream come true for many unhappy, unsuccessful children who are not receiving the help they need.

To consult with an occupational therapist who has a solid background in sensory integration, start by contacting local hospitals, pediatric rehabilitation clinics or early childhood intervention programs and asking for a pediatric OT with expertise in SI treatment. To refer a child for an SI evaluation, contact Sensory Integration International at www.sensoryint.com or call (310)320-2335 for a list of SIPT-certified occupational therapists in your geographical area. This organization also offers courses for parents, OTs and other professionals about SI theory and treatment. Another good source of information about SI research, clinical work and treatment resources is the website www.sinetwork.org, which is sponsored by the KID Foundation in Littleton, Colorado.

For more information about occupational therapy in general, refer to the American Occupational Therapy Association's website at www.aota.org .

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