A New, Effective Psychosocial Treatment for Autism

Report on a Site Visit to the Mifne Center, Israel, March 30-31, 2006

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Over the past decade the Mifne Center has pioneered a new strategy for the treatment of autism and early signs of autism achieving excellent outcomes. With a theoretical and therapeutic underpinning that posits that an underlying, multidetermined brain dysfunction interferes with the pre-autisitic infant's capacity to bond to its parents with severe consequences for social, emotional, and language development, the Center treats infants 6 to 12 months with prodromal signs of autism (e.g. stereotypies, lack of smiling and engagement with parents and others, lack of speech precursors) and youngsters 1 to 5 years who meet DSM-4 criteria for autism to redress impaired attachment. Their specific strategy brings the whole family (parents, child, and siblings) into intensive residential treatment for an initial 3 weeks, after which the family receives periodic outpatient consultation in their community or returns to the Center for occasional follow-up visits.

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During the residential stay a staff of experienced play therapists, rotating every 90 minutes, engages the child for all of its waking hours, drawing the child into age appropriate interpersonal contact and facilitating verbalizations (in a fashion remindful of Helen Keller's tutor working with her mute, blind charge). A physical therapist employs gentle postural corrections and stimulation for overly passive children or massage to replace autistic, hyperkinetic self-stimulation with gentle body contact. Additionally, parents and siblings observe the autistic child's treatment through a one-way mirror and receive individual and couples counseling to enhance their understanding of the child's deficits and to overcome personal conflicts or inhibitions that may prevent them from responding to the ill child optimally to facilitate social and communicative growth. Parents and siblings bring their increasing understanding and skills back into the playroom, under supervision, for further refinement of the family interaction. A pediatrician/child psychiatrist assesses any medical conditions and the child's diet.

I learned of Mifne ("turning point") during my participation in recent conferences on infancy signs of autism and early treatment at which the director, Hannah Alonim, presented the Center's work with videotapes of children and families before, during, and after treatment, which prompted my visit to learn first-hand of their approach. The Center has published their results in "The Mifne Method: Early Intervention in the Treatment of Autism/PDD: A Therapeutic Program for the Nuclear Family and Their Child," H. Alonim, *Journal of Child and Adolescent Mental Health,* Vol. 16, 39-43, 2004. This report includes an independent validation of initial diagnoses and outcomes by a team from the University of Tel-Aviv Schneider Children's Medical Center. A further report will appear as a chapter in *Signs of Autism in Infants: Recognition and Early Intervention,* S. Acquarone, ed., Karnac Press, 2006.

The intensive treatment is costly and demanding but much less so than for the most common therapy in the United States, Applied Behavioral Analysis (ABA), which requires approximately 40 hours per week of therapy for 3 years. ABA's originator Ivar Lovaas reported rates of cure of 43% with young children ("Behavioral Treatment and Normal Educational and Intellectual Functioning in Young Children," I. Lovaas, *J. Consulting and Counseling Psychology*, 55: 3-19, 1987), though other investigators have been unable to assemble similarly skilled treatment teams providing the same number of hours over as many years to duplicate Lovaas' initial effort and come close to replicating his results.

The Mifne Center's followup statistics indicate that 73% of children are functioning well in regular

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schools without special education or special classrooms, and without intensive therapy after the initial residential stay. Dr. Alonim reports that 21% of children they have treated no longer fall into the autistic spectrum. She estimates that approximately 90% of children who come to the program between 6 to 12 months normalize, although this high success rate may reflect the possibility that some infants with prodromal signs of autism may not develop the full syndrome even without early therapy.

That autism in young children can be cured is understandable given our contemporary knowledge of the plasticity of the human brain in early life, a period when new central nervous system connections are being laid down and others pruned. Children who do not have good outcomes at the Mifne Center or do not complete the 3 week stay typically are from single parent families or families in which the parents can't work together as a team and those with significant mental retardation.

Mifne is located in the small community of Rosh Pina in the heart of Israel overlooking the upper Galilee Valley and Lake Tiberias, two hours drive from Tel Aviv. It is equipped with advanced audio-visual recording that permits remote controlled videotaping and computer analysis of interactions and behaviors. The playrooms include kitchens that allow children, therapists, and family to cook and bake and eat together. Two on-site cottages house the families.

A second center is opening in Basel, Switzerland in the winter of 2006/2007. Referrals come largely from the Israel National Health Service with additional subsidies from private foundations. Mifne can conduct treatment in English and accepts referral from around the world, and may be able to provide stipends to offset the cost of private treatment.

Further information is available at: info@mifne-autism.com and www.mifne-autism.com. Feel free also to contact me with questions at my office in Berkeley at (510) 841-8107.

THE MENTORING COMMITTEE WANTS YOU!

For the past several years the Mentoring Committee has met with general and with child and adolescent residents at local training facilities, with the intent of welcoming them into our organization and assisting them in deciding where and how they might choose to transition after training into practice.

At our last two luncheons with residents (at Stanford: Andrew Haber, Basil Bernstein, and me; at UCSF: Bob Schreiber, Aubrey Metalf, Irene Sung, and again, Andrew and me), the residents expressed strong desires for more involvement with our organization.

Their requests ranged from issues which would require a change in our by-laws, such as the creation of a delegate-in-training position; to things such as more frequent meetings of graduate NC-ROCAP members with trainees, evening meetings which might facilitate the interaction of child and adolescent residents from Stanford and UCSF, and the possibility of each trainee having access to a specific mentor.

The Executive Committee is committed to exploring its role in meeting the wishes of trainees. For example, it has begun to considering a change in our by-laws, to allow for a delegate-in-training. As this will take time, it is now thinking about the possibility of immediately inviting one or more residents to sit informally in on Executive Committee meetings.

While these possibilities are being worked on, the Mentoring Committee would like to proceed with more quickly in gratifying the wishes of trainees for more exposure to our post graduate members.

If you would be interested in meeting with a group of trainees at UCSF, and/or in setting up potentially periodic mentoring meetings with a single trainee, please contact me. I would appreciate the opportunity to facilitate the interactions.

Edmund C. Levin, M.D.
Chair, Mentoring Committee
NC-ROCAP