RDI Empowers Parents and Child
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What is RDI?
Relationship Development Intervention (RDI) has been mistakenly described as a social skills program. Unlike a program which teaches social skills, RDI teaches developmental skills and functions of social development. The initial skill that humans learn is to share enjoyment and emotion with the parent. When a mother or father holds their newborn infant and makes cooing sounds the child typically enjoys this interaction. They learn very early that the parent is an important and meaningful part of their life. Immediately, the infant begins to smile back and respond to a variety of games that parents and caregivers play. The responses vary from gurgles to cooing to squeals of delight. That is the beginning of a human infant's first relationship.

Many of our children who are on the autism spectrum or who have other neurological differences have great difficulty with that basic social development skill. In my experience, I have worked with 12 year olds of normal intelligence who do not see their parents as sources of learning, let alone enjoyment. Instead, they would rather interact with objects and electronics where no relationship is required and the outcome of the experience is static. Imagine how difficult it is for a child who has not experienced or learned emotion sharing or shared enjoyment to be expected to share emotion with siblings, other children, and adults. The result for those children is heightened anxiety and often inappropriate and misinterpreted behavior.

The Assessment – Activity Based
RDI, being a social developmental intervention winds back the clock. To determine what level the child is at, and what obstacles are preventing success, an assessment is conducted (Relationship Development Assessment – RDA). The RDA determines three things; the social development level of the child, obstacles preventing child and parent success, and strengths of the child and their parent. The three-part RDA leads to a clinical treatment plan. In the initial session (RDA-l) the parent and the child take part in a maximum of 15 play activities designed to observe the quality of the child's interaction with the parent and the amount of emotion sharing and other steps in the social development continuum. This first session is video taped and then examined by the consultant. The consultant formulates a hypothesis as to where to begin in the treatment plan. The RDA-2 involves the consultant working with the child to test out the hypothesis. Later, the consultant adjusts the treatment plan with the results of both RDA 1 and 2. During the RDA 3 the parent works with the child with coaching from the consultant. Afterwards the consultant and the family meet to discuss results and agree on the treatment plan before treatment begins.

The Intervention – Collaborative
Best practice in RDI focuses on parent and family empowerment in a planned sequential way. The treatment is not "administered" to the child; instead the consultant sets up a

systematic plan where the parent works in a lab session twice a month with coaching and modeling from the consultant. Parents return home and record video as they work with their child using the techniques and objectives provided and modeled by the consultant. Those tapes are forwarded to the consultant prior to their next appointment and the consultant spends time viewing them and preparing written feedback and coaching notes for the family. Notes are reviewed with parent's t the next lab session, and used as basis for work with the child at that session. A total of two lab sessions are schedule each month and two tape viewing sessions.

The Focus – Family Empowerment

RDI is heavily focused on hands-on training with the parent, the goal being that the parent will be skilled and empowered to work with their own child. In my practice it is not unlikely that a family works for one year with the consultant and then takes a few months off to work alone with their child. This all depends on how comfortable parents feel they have become. This approach assures that parents are empowered and their positions are not replaced by the professional.

The Philosophy

The philosophy of RDI is that the intervention should empower parents and allow the child to "use his mind" to solve social problems. There is a heavy emphasis on declarative communication as opposed to directive communication. Individuals need not be told what to do, but instead allowed with guidance to use skills of problem solving in social situations to become more independent and competent. Children on the autism spectrum and others with neurological differences are typically very prompt dependant. When they are not verbally or physically prompted they often do not know what to do and become very uncomfortable. RDI teaches parents to use declarative communication so their children are not dependant solely on prompts, instead to "use their minds" and seek their parent's assistance to solve problems.

Master Apprentice Relationship

The Master/Apprentice Relationship is perhaps the strongest skill learned by parents. We are often told to follow a child's lead which is a good technique in many situations. However, when you are dealing with a child with a very early social development level, following the child's lead in social situations where skills and functions must be learned may not be helpful. Recalling the Master/Apprentice Relationship when thinking of learning any skill is helpful. A medical student is an "apprentice" and learns medicine from a "master", the experienced medical doctor. If the medical student was deposited in a hospital with a trained physician teaching him, if it was the student who asked for information, skills would not be learned in a sequenced orderly manner and many skills would be missed. The result would be a medical student who would have an incomplete skill set and would not know how they were related. RDI is similar; the child's first teacher is his parent, not his teacher or therapist. A double edged sword situation occurs when parents feel incompetent when a child performs in the therapeutic setting but not at home. The questions arise, Why can't I get him/her to do that? Additionally, if the child is successful in the therapeutic situation the parent feels a different incompetence. "Why can't I parent this child better?" In these scenarios the parent is likely to feel

incompetent. If a child does not have the foundation of sharing emotion and enjoyment with their parents or viewing their parents as a source of learning and comfort, it will be very difficult for the child to build other social relationships.

Support for Families

Finally, RDI seeks to support the whole family. Initially, if the child is at the novice level, the work is centered on the child and the parent. Most parents claim that once they understand that RDI is not a therapy but a way to parent their child they feel very comfortable and even free to parent their child without fear that they are doing harm. They realize that their child is a child with autism, not an autistic child and they are quite capable of being the parent of that child.