

Evidence Based Treatments
for Children
with Autism

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Do we need evidence-based guidelines?

- ◆ Concerns with options
 - ◆ Not all treatments are equally effective
 - ◆ Huge number of choices
 - ◆ Effective early intervention shown to produce the best outcomes
 - ◆ Learning is lifelong – broadest opportunities available when all individuals reach their potential

Guaranteed success.

I'll grant your wish or your money back – guaranteed!

My name is [Chris Roller](#).

WishMission

www.WishMission.com

Make a wish, anything that ails you –
backache, cancer, aids, bad knee,
MS, **AUTISM**, etc.

My technique is based from
proven techniques like [EFT](#), [TFT](#) and [VT](#).

I have a patent pending on my technique
based on the power of suggestion
(like hypnotism),

-I will provide instructions on tapping points
throughout your body, and phrases to say.

My research is ongoing, but I should be able to grant your wish, and if it doesn't work, money-back guaranteed. 30 day guarantee for most cures. You are protected by Paypal and your credit card bank.

If it doesn't work, all you need to provide me is a signed statement by you or your doctor and you get your money back - guaranteed. I will believe you. In fact, I'll give you 110% refund if I can't help you. You can't go wrong. You have nothing to lose and everything to gain. So far, no one has requested a refund, making me 100%.

Some suggested prices are listed below, but if your problem isn't listed, make me an offer in your wish. Or if you are financially strapped, explain your situation, and I will consider it.

This site used to be free, but ***my research has found there is truth to, "you get what you pay for"***. If you believe you've paid for something, you feel better that it is indeed better and worth it. It's almost a mind over matter, a form of power of suggestion, similar to a placebo. Also, money needs to be charged to filter out the serious wishers from the pessimistic troublemakers. If you're wondering how the prices are so low for curing cancer...I do realize cancer treatments cost \$250,000. Well maybe, just maybe, you're dealing with a nice guy, with an impressive talent, who's generous and non-greedy, and wants to help you. And you have nothing to risk in trying this. But if you feel your life is worth a \$1,000,000 offer for a cancer cure or terminal pain, I'm not going to disagree. When I help heal you with my techniques, you might think it's a miracle, but actually, the treatment is completely natural.

Cancer	\$1,000
Muscular Dystrophy	\$1,000
Cerebral Palsy	\$1,000
Migraine	\$100
Brain Tumor	\$1,000
Body part pain	\$100
Smoking cure	\$100
Diabetes	\$1000
Whole body pain	\$500
Hair (bald) Re-growth	\$500
Breast Enlargements	\$500
Autism	\$1,000
Scar removal	\$50
US Military Soldiers only - protection bubble from injuries/death (info). \$500	
Anti-aging spell	\$500

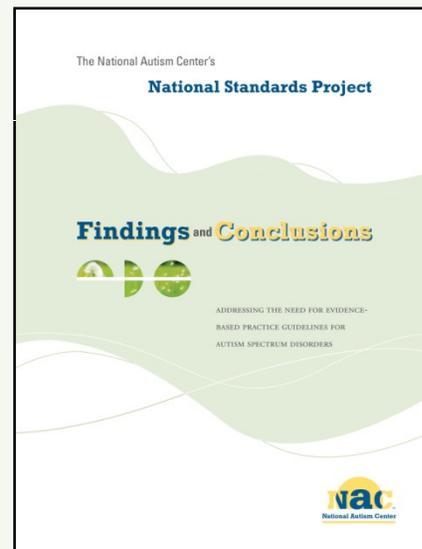
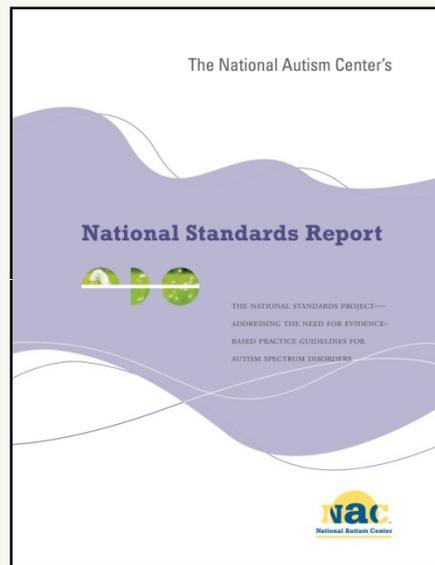


The National Standards Project

1. Provide straightforward information to parents, educators, and service providers that can help them make treatment decisions
2. Create an evidence-based practice guideline for ASD that address some of the limitations of previous guidelines
3. Identify critical areas in which additional research should be conducted – which is different from most guidelines!
4. Promote evidence-based practice in the treatment of ASD

National Standards Project

- The most comprehensive systematic analysis of the autism treatment literature conducted to date



Download free at www.nationalautismcenter.org

- Identification of 11 Established Treatment
- Promotes evidence-based practice
- Describes outcomes based on diagnostic classification, age, and treatment target

	Established	Emerging	Unestablished	Ineffective/Harmful
	<p>Several¹ published, peer-reviewed studies</p> <ul style="list-style-type: none"> • Scientific Merit Rating Scales scores of 3, 4, or 5 • Beneficial treatment effects for a specific target <p>May be supplemented by studies with lower scores on the Scientific Merit Rating Scale.</p>	<p>Few² published, peer-reviewed studies</p> <ul style="list-style-type: none"> • Scientific Merit Rating Scale scores of 2 • Beneficial treatment effects reported for one dependent measure for a specific target <p>These may be supplemented by studies with higher or lower scores on the Scientific Merit Rating Scale.</p>	<p>May or may not be based on research:</p> <ul style="list-style-type: none"> • Beneficial treatment effects reported based on very poorly controlled studies (scores of 0 or 1 on the Scientific Merit Rating Scale) • Claims based on testimonials, unverified clinical observations, opinions, or speculation • Ineffective, unknown, or adverse treatment effects reported based on poorly controlled studies 	<p>Several¹ published, peer-reviewed studies</p> <ul style="list-style-type: none"> • Scientific Merit Rating Scales scores of 3 • No beneficial treatment effects reported for one dependent measure for a specific target (Ineffective) <p style="text-align: center;"><u>OR</u></p> <ul style="list-style-type: none"> • Adverse treatment effects reported for one dependent measure for a specific target (Harmful) <p>Note: Ineffective treatments are indicated with an "I" and Harmful treatments are indicated with an "H"</p>
<p>¹Several is defined as 2 group-design or 4 single-case design studies with a minimum of 12 participants for which there are no conflicting results or at least 3 group design or 6 single-case design studies with a minimum of 18 participants with no more than 1 study reporting conflicting results. Group and single-case design methodologies may be combined.</p> <p>²Few is defined as a minimum of 1 group-design study or 2 single-case design studies with a minimum of 6 participants for which no conflicting results are reported*. Group and single-case design methodologies may be combined.</p> <p>*Conflicting results are reported when a better or equally controlled study that is assigned a score of at least 3 reports either (a) no beneficial treatment effects or (b) adverse treatment effects.</p>				



Outcomes



Established Treatments

- ◆ Antecedent Package
- ◆ Behavioral Package
- ◆ Comprehensive Behavioral Interventions for Young Children
- ◆ Joint Attention Intervention
- ◆ Modeling
- ◆ Naturalistic Teaching Strategies



Established Treatments

- ◆ Peer Training
- ◆ Pivotal Response Treatments
- ◆ Schedules
- ◆ Self-Management
- ◆ Story-based Interventions



Summary Points

- ◆ Two-thirds of Established Treatments come from the behavioral literature
- ◆ Of the remaining third
 - ◆ 75% represent treatments for which research support comes predominantly from the behavioral literature; developmental psychology also influenced some of these treatments
 - ◆ One approach comes from the theory of mind perspective*



Summary Points

- ◆ Even among Established Treatments, research must be extended to expand the number of age groups associated with favorable outcomes:
 - ◆ 0-2 years
 - ◆ 15-18 years
 - ◆ 19-21 years



Emerging Treatments

- ◆ The vast majority (22) of educational and behavioral treatments fall into the Emerging Treatments category
 - ◆ Augmentative and Alternative Communication Device
 - ◆ Cognitive Behavioral Intervention Package
 - ◆ Developmental Relationship-based Treatment
 - ◆ Exercise
 - ◆ Exposure Package
 - ◆ Imitation-based Interaction

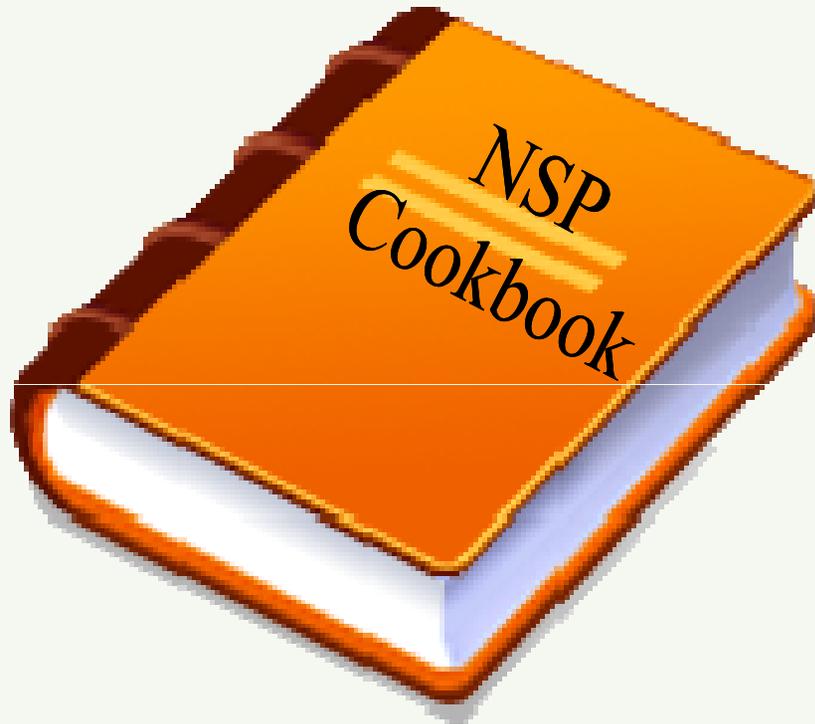


Emerging Treatments

- ◆ Initiation Training
- ◆ Language Training (Production)
- ◆ Language Training (Production & Understanding)
- ◆ Massage/Touch Therapy
- ◆ Multi-component Package
- ◆ Music Therapy
- ◆ Peer-mediated Instructional Arrangement
- ◆ PECS
- ◆ Reductive Package
- ◆ Scripting
- ◆ Sign Instruction
- ◆ Social Communication Intervention
- ◆ Social Skills Package
- ◆ Structured Teaching
- ◆ Technology-based Treatment
- ◆ Theory of Mind Training

Emerging and Unestablished Treatments

- ◆ Only five treatments for which research has been conducted fall into our Unestablished category
 - ◆ Academic Interventions
 - ◆ Auditory Integration Training
 - ◆ Facilitated Communication*
 - ◆ Gluten- and Casein-Free Diet*
 - ◆ Sensory Integrative Package
- ◆ Many additional treatments for which no studies have been published may fall into this category



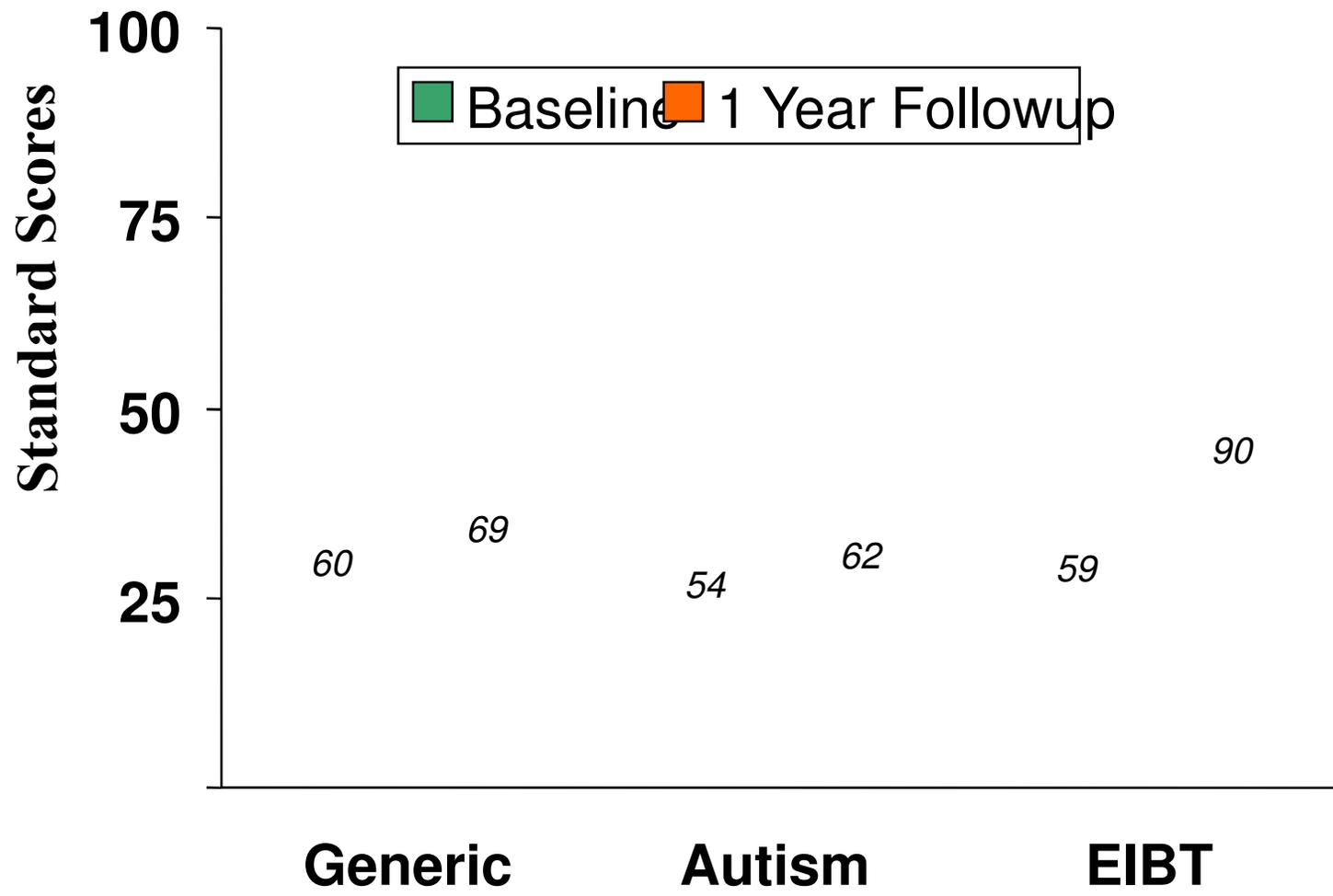
Recipe: Selecting Treatments

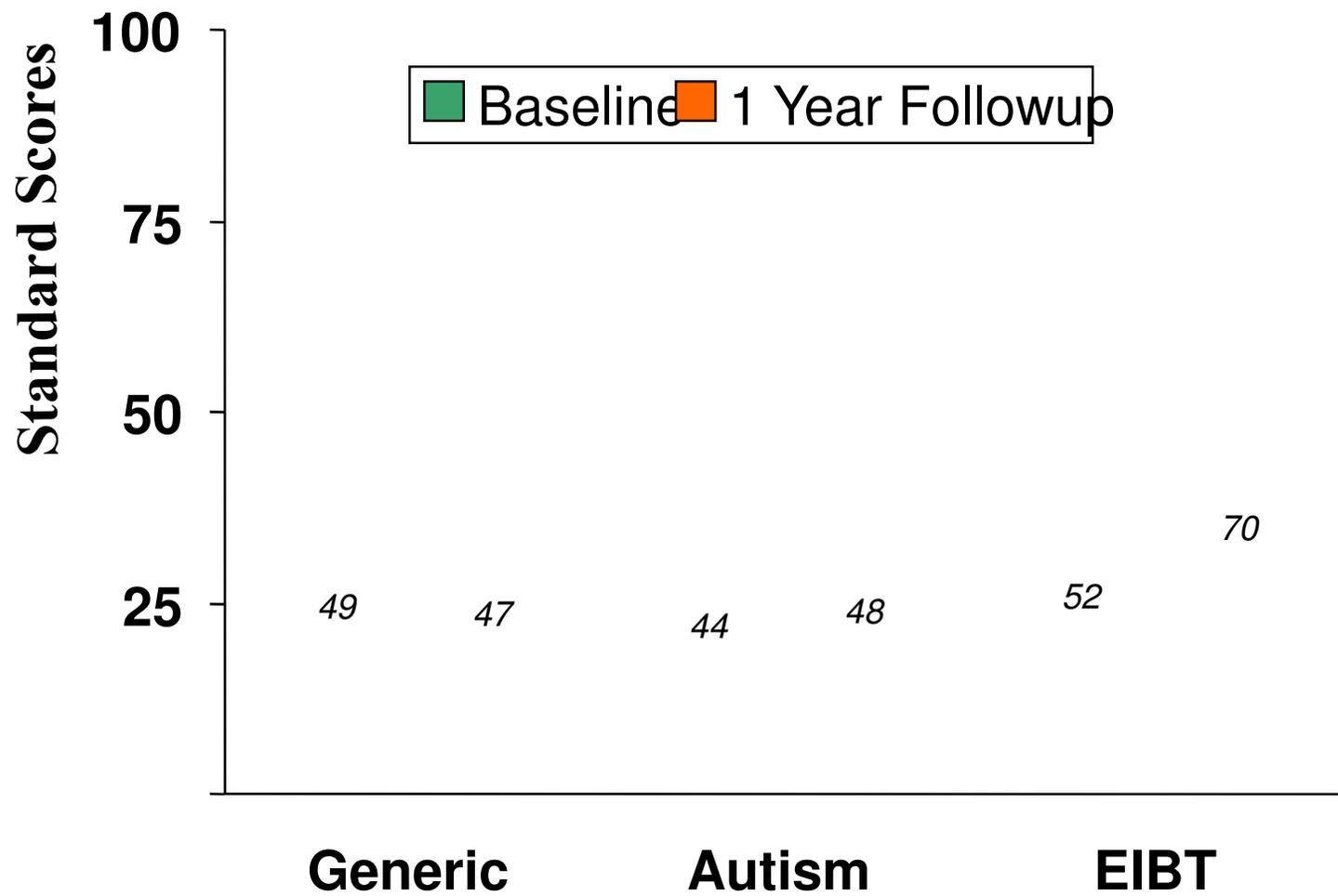
- 1 cup of treatment outcomes
- 1/2 cup of treatment targets
- 3 oz. age
- 6 oz. diagnostic classification

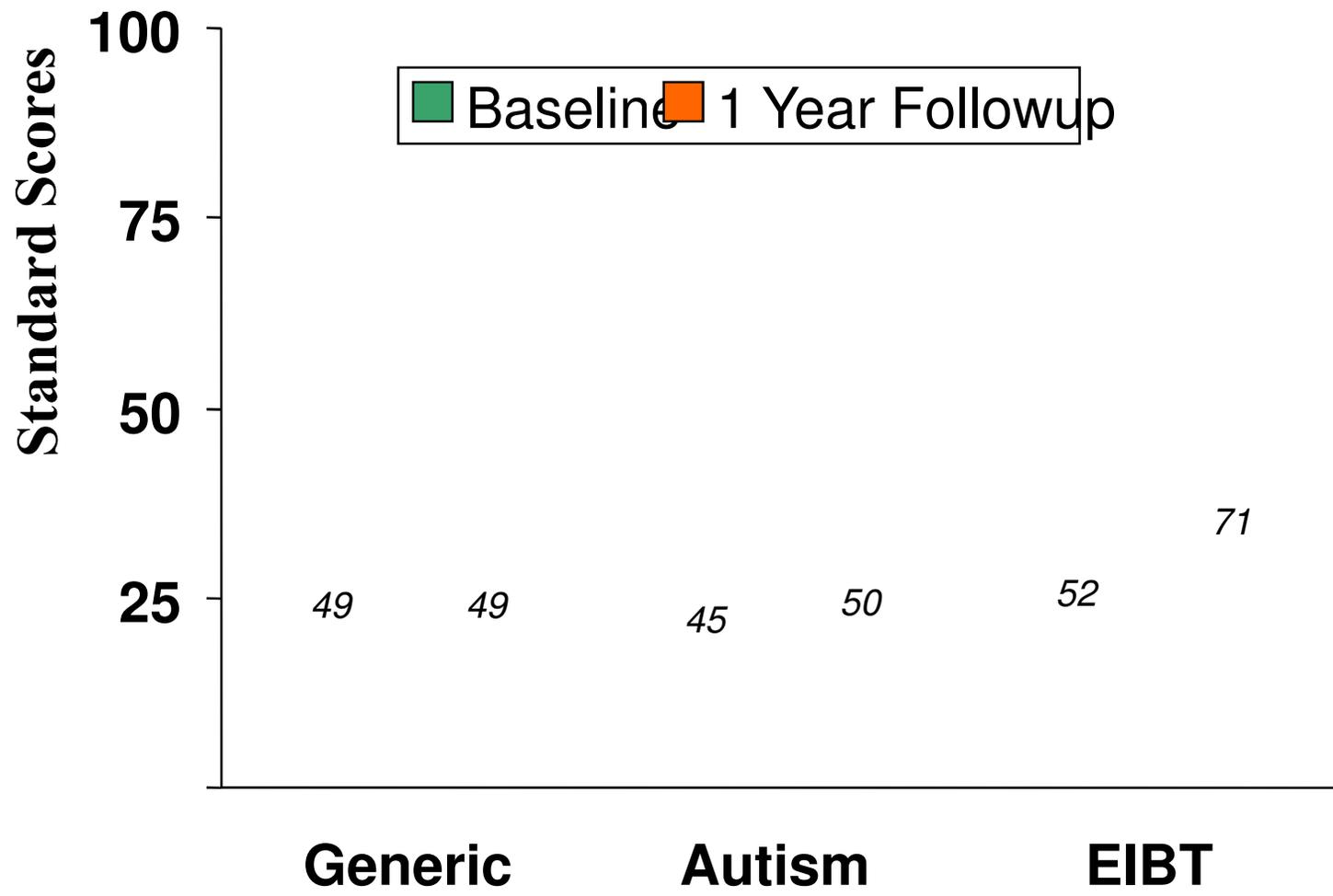
Treatment selection should not follow the cookbook method!

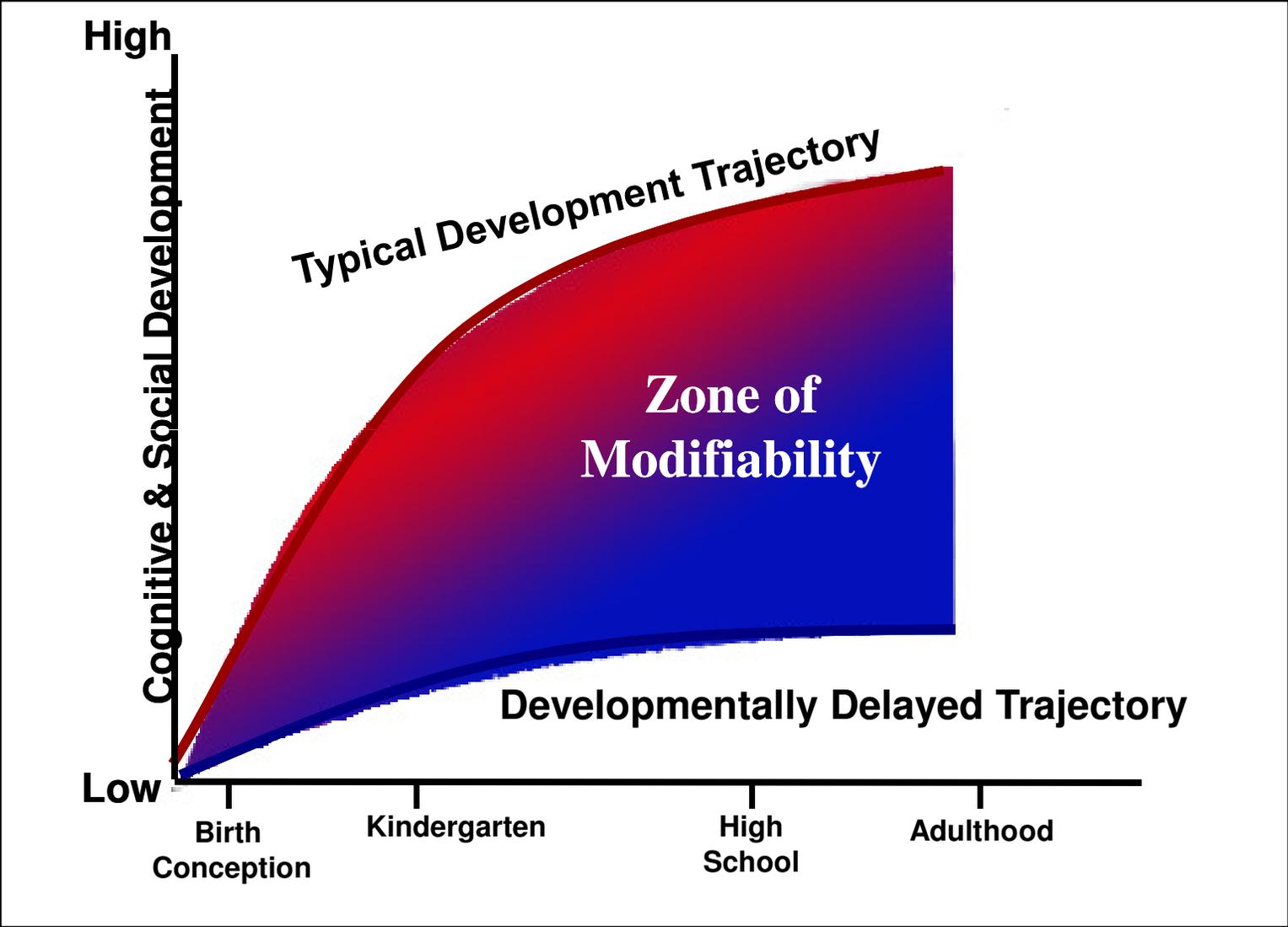
COLLABORATION

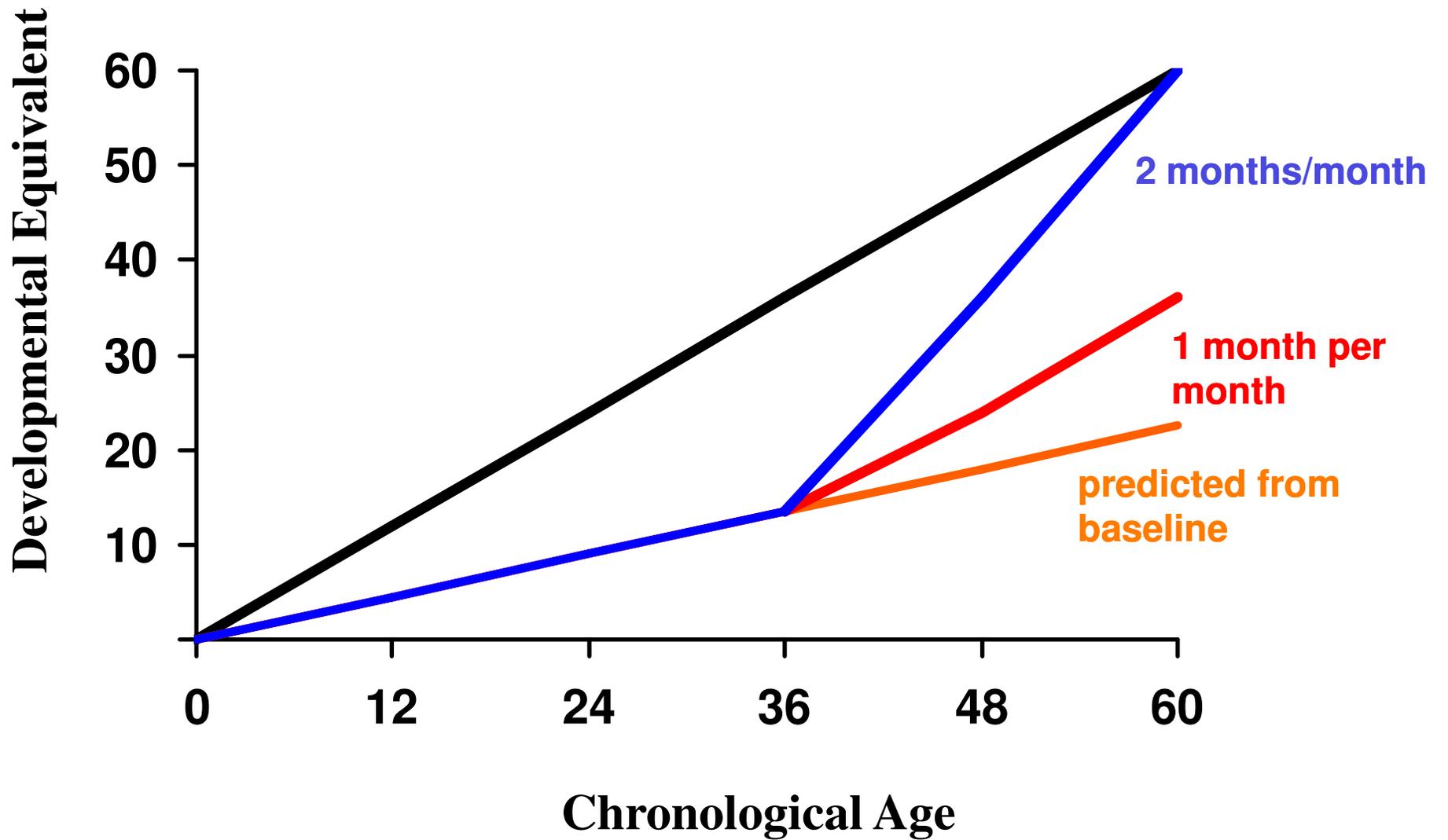
**Working together toward a
common goal**











Programming for:

Evidence Based
Practice

■ Don't fall into the trap =
Concomitant and
Inaccurate diagnoses

Caution:

- Apraxia
- Sensory Integration deficits
- Oral Motor Weakness
- Auditory processing



Defining Evidence-Based Practice

- ◆ Evidence-based practice involves the integration of research findings with
 - ◆ Professional judgment and data-based clinical decision-making
 - ◆ Values and preferences of families
 - ◆ Assessment and Improvement of the capacity of the delivery system to implement the intervention with a high degree of procedural accuracy

Where do we start?

- ◆ Behavioral Cusp”
 - ◆ “Behavior change that...has (important) consequences beyond change itself...exposes repertoires to new environments and contingencies”
- ◆ Examples?
- ◆ *Rosales-Ruiz & Baer, 1996; 1997*
- ◆ *Bosh & Fuqua, 2001*

“Behavioral Cusp” Programming

- ◆ Attending to environment
- ◆ Joint attention
- ◆ Generalized imitation
- ◆ Instruction following
- ◆ Robust verbal initiation
- ◆ Effective social contingencies
- ◆ Discrimination of inferential language
- ◆ Self-monitoring

First, address problem behavior(s)

- Why? If not addressed...
 - Potential danger to self/others
 - Interferes with learning
 - ↓ intervention time - not available for learning
 - ↓ learning opportunities - lack of instructional control
 - Interferes with generalization of skills
 - ↓ generalized instructional control
 - Ignores behavioral cusp, “generalized instruction following”

Start building attending skills

- ◆ Why?
 - ◆ ↑ time available to learn
 - ◆ ↓ incompatible bxs (stereotypy)
 - ◆ ↑ ability to learn new skills
 - ◆ ↑ ability to demonstrate known skills
 - ◆ Sharpens discrimination skills
 - ◆ Addresses behavioral cusp,
“attending/monitoring the env’t”
 - ◆ Promotes observational learning

Typical Environmental Awareness video

ASD attending to environment videos

Start building imitation skills

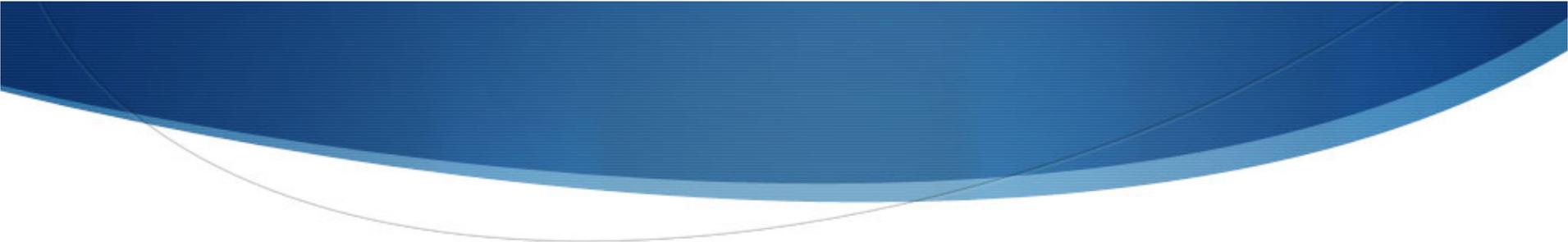
- ◆ Why?
 - ◆ ↑ modeling as an effective teaching tool
 - ◆ ↑ adults/peers' behavior as a resource
 - ◆ ↑ ability to learn new skills outside of instructional setting
 - ◆ Addresses behavioral cusp, “generalized imitation
 - ◆ Promotes observational learning

Generalized imitation videos

Start building language & initiation skills

- ◆ Why?
 - ◆ Typically, 2 years behind in language skills at start - need to “shovel in” as much/as fast as possible
 - ◆ ↑ zone of modifiability; ↑ catch up/close gap
 - ◆ Typically, no appropriate/functional communication skills - need to teach initiations/requests immediately
 - ◆ ↑ social validity; ↑ social contingencies
 - ◆ ↓ problem behaviors

Video



Inferential Language

Video: Typical Peer

Video: ASD

Other “Critical” Programming Considerations

- ◆ Pre-requisite skills
- ◆ Client’s chronological age/learning profile
- ◆ Developmental norms

How do we “aggressively” programming

- ◆ Goals
 - ◆ NOT equally weighted!
- ◆ Daily changes □
 - ◆ 2+ new programs per week
- ◆ Weekly modifications
 - ◆ w/in 3 days if progress not evident □
- ◆ 2000+ learning opportunities per day
- ◆ 500+ objectives per year
- ◆ Parent Participation

Clinician's Role

- ◆ Referencing data sheets for progress and speed of skill acquisition
- ◆ Probing
- ◆ Set size
- ◆ Field size
- ◆ Prompt Delay
- ◆ Mastery criteria
- ◆ Maintenance and Expansion
- ◆ Parent Participation

Monitor Data!!

- ◆ Mastery criteria within 5-7 sessions.
- ◆ Ensure all targets are unknown.
- ◆ Emphasis of domains
- ◆ Number of active programs
- ◆ Concurrent programming

Considerations with Probing

- ◆ Probe all targets from goals and objectives PRIOR to introducing.
- ◆ Probe future phases once others are mastered

Set Sizes

- ◆ ↑ learning rate/trajectory
- ◆ General guidelines:
 - ◆ Generally, no less than 3 and not more than 10
 - ◆ Gradual Increase
 - ◆ Random presentation
 - ◆ Novel presentation

Additional Considerations

- ◆ “Forgiving Learners” and “Fragile Learners”
- ◆ Multiple setting programming
- ◆ Peer programming
- ◆ Parent training/programming

Conclusion

- ◆ Providing appropriate care begins with understanding which treatments have evidence of effectiveness
- ◆ Treatment selection is complicated and requires not only an understanding of research findings, but considerations of professional judgment, values and preferences of families, and capacity.



For more information:
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