



KIT

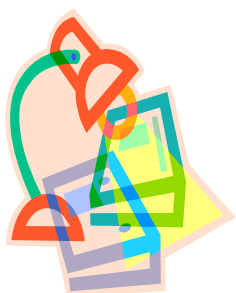
"Keeping In Touch"

December 2009



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Resource Article



The article this month, "Straight Talk About Autism: Treatment Options and Parent Choice - Is ABA the Only Way?" comes from Barry Prizant, Ph.D., CCC-SLP. It was published in the spring 2009 edition of Autism Spectrum Quarterly.

Dr. Prizant has an impressive record of publications and contributions to the work of advancing the quality of life for individuals with autism spectrum disorders (ASD). To learn more about Dr. Prizant's work and The SCERTS Model, co-authored by Dr. Prizant readers are directed to www.barryprizant.com

Not discounting the value of applied behavior analysis (ABA) Dr. Prizant presents arguments and clarifies some myths about ABA, which is often touted as the be all end all treatment for children with ASD. He approaches these arguments from the perspective that interventions should be family-centered. Therefore, treatment options and information about those options should be readily available for parents to review and consider rather than automatically being directed to an, often adult-directed, ABA treatment approach.

Making the point that ABA is often misunderstood, Dr. Prizant reminds readers of the array of practices associated with ABA, including discrete trial instruction (DTI) and

discrete trial training (DTT), as well as more contemporary and less adult-directed practices such as incidental teaching and pivotal response training.

As a means to clarify claims that traditional ABA is the option for families, Dr. Prizant identifies the myths associates with the following six claims (pg. 28-30).

1. *Research has concluded that ABA is the only effective or most effective approach for children with ASD, and therefore it is the gold standard.*
2. *Once a child is diagnosed with ASD, he or she must receive ____ (24, 30, or 40 hours) of ABA services...*
3. *A child with ASD will benefit the most from ABA services that use a DTT format.*
4. *If a child does not receive intensive ABA by five years of age, the "window of opportunity" for learning will close, or it will be missed.*
5. *ABA is the only educational approach that results in "recovery" from autism...*
6. *There are hundreds of studies that demonstrate that ABA works...*

It is important that parents of children with ASD understand the treatment approach options as well as any myths associated with claims that one particular model is *the best*. Thinking about the rich degree of diversity across families it seems realistically impossible to support an argument that one treatment model could be best for all.

Prizant, B. M. (2009). Straight talk about autism: Treatment options and parent choice is ABA the only way? *Autism Spectrum Quarterly*, Spring 2009, 28-32. Retrieved from <http://www.pasadenachilddevelopment.org/articles/Prizant-IsABATheOnlyWaySpring09.pdf> December 2009.

On the WWW

The www resource this month is from the UC Davis M.I.N.D. Institute. The M.I.N.D. Institute is made up of nationally known physicians and doctoral level clinicians working together studying neurodevelopmental disorders.

Included at this site is a series of webcasts from distinguished speakers and researchers in the field of autism. Each webcast is approximately one hour and includes both audio and video of the presentations. Also included are downloadable abstracts of each lecture. This is a goldmine of knowledge on autism that can be viewed at your leisure. If you scroll down to the 2006-2007 lecture series you can see Dr. Temple Grandin's lecture "Exploring the Mind of a Visual Thinker: Thinking in Photo-Realistic Pictures."

The direct link to the lecture series is:
http://www.ucdmc.ucdavis.edu/mindinstitute/videos/video_autism.html



Don't miss this wonderful opportunity to learn from leaders in the field. Thanks to Julie Brannon, OT from Heidelberg EDIS for sharing this great resource!

What Do the Data Say?

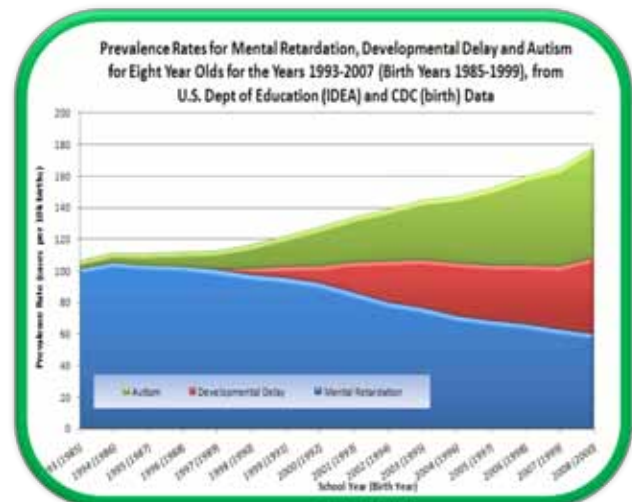


Is there a shift in diagnosis from mental retardation to autism that may be contributing to the increase in autism?

This question was posed and answered at FightingAutism.org, which is part of Thoughtful House Center for Children. The following information, included in this month's "What do the data say?" section of the KIT, is reprinted with permission and is available online at: <http://www.fightingautism.org/idea/autism-diagnostic-substitution.php>

In addition to the debate about the autism epidemic there is also debate about the increase in autism cases being caused by a diagnostic substitution or diagnostic shift from the mental retardation category to the autism category.

This theory is supported by a paper published in the journal *Pediatrics* in 2006 (Shattuck, PT), where the author illustrates that as the autism prevalence increased, the prevalence of mental retardation decreased by an approximately equal amount. However, the paper does not directly analyze the possibility of diagnostic substitution between mental retardation and developmental delay. The developmental delay category was introduced in 1997.



The graph on the previous page directly examines the possibility of a diagnostic substitution between mental retardation, developmental delay and autism. The graph illustrates 3 key points:

1. **The prevalence of mental retardation does not start to decline until the introduction of the developmental delay category.** The introduced the 1997 school year, which is the 1989 birth cohort on the graph above. For school years 1993 to 1997 there is no decline in mental retardation, while the autism prevalence increases.
2. **A diagnostic substitution between mental retardation and developmental delay fits the data better than a diagnostic substitution between mental retardation and autism.** If you assume a diagnostic substitution from mental retardation to developmental delay the combined prevalence does not show a significant change from 1993 to 2006 birth cohorts. During the same time period there is a significant increase of autism prevalence.
3. **The decline in mental retardation prevalence from years 1993 to 2006 only accounts for 69% of the increase in autism prevalence during the same time period.** Autism prevalence increased from 5.48 to 56.23 per 10,000 births, while mental retardation declined from 101.13 to 65.99. Therefore, if there was a diagnostic substitution from mental retardation to autism it could not fully explain the increase in autism prevalence.

The arguments above and graph were submitted to the journal Pediatrics in 2006 by Mark Blaxill and Dan Hollenbeck in a response to the Paul Shattuck paper. Pediatrics declined to publish them.

Reference:

Shattuck, P. T. (2006). The contribution of diagnostic substitution to the growing administrative prevalence of autism in U.S. special education. *Pediatrics*, 117:1028-1037.

Local Look



Fort Knox EDIS will start the New Year with nearly an entirely new staff.

Alison Hardaway, who has been with the program since its inception in 1994 retired in November with 15 years of service to EDIS. She will be missed.

Linda Medley has filled Alison's high, high heels. Linda comes to EDIS with 25 years experience in the Fort Knox Community Schools, the last 15 of which have been spent working as the speech pathologist for the three year old program. She has a Bachelor's Degree in speech pathology and a Master's Degree in early childhood special education with a concentration in visual impairment. She is very familiar with EDIS from the other side of the transition divide.

Kim Barrett has signed on as our part-time occupational therapist/motor expert. We are especially happy to welcome Kim as it has taken more than 1 ½ years to fill her position. She has experience in a variety of settings, including clinics, hospitals and schools, but is new to early intervention. She has a strong background in sensory integration, NDT and feeding issues.

Kim and Linda complete the Fort Knox EDIS team. We welcome them to the EDIS family.

Consultation Corner

From September 2009 through January 2010 the consultation corner topic is:

ASD and the Role of Early Interventionists

Celine Saulnier, Ph.D., the Training Director for the Autism Program at the Yale Child Study



Center and Karyn Bailey, the Social Work Director for the Yale Child Study Center's Post-graduate Social Work Training Program are the KIT Consultation Corner experts sharing their knowledge and experience.

How can early intervention providers help families and diagnostic professionals with the evaluation (recognizing that it may vary depending on the diagnostician)?

Early intervention providers have the challenging task of being among those on the "front line" for detecting children at risk for autism spectrum disorders (ASD); thus, these professionals can be helpful in many ways. First, early intervention providers can utilize early detection screeners, such as the *Modified Checklist for Autism in Toddlers* (M-CHAT; Robins, Fein, & Barton, 1999; www.mchatscreen.com) to identify any red flags in a child's development that merit further evaluation. This information can then be discussed with parents as areas of concern (in fact the M-CHAT has a follow-up phone interview) to determine the next appropriate steps in evaluating the child more thoroughly. Second, an increasing number of early intervention programs are creating autism-specific groups that will train providers to conduct diagnostic evaluations using instruments such as the *Autism Diagnostic Observation Schedule* (ADOS; Lord, Rutter, DiLavore, & Risi, 1999) and *Autism Diagnostic Interview, Revised* (ADI-R; Rutter, LeCouteur, & Lord, 2003) in order to assess for autism symptomatology in addition to developmental delays. If a particular early intervention program does not have this expertise, then providers can work with parents to determine who in the community is qualified to conduct an appropriate evaluation (e.g., speech pathologists, psychologists, developmental behavioral pediatricians, etc.).

For very young children, it is standard practice to evaluate a child's developmental skills in the areas of receptive and expressive language, fine and gross motor development, nonverbal

reasoning skills, and adaptive behavior. For higher functioning children on the autism spectrum who may not exhibit developmental and/or speech delays, more experienced clinicians who are familiar with the subtleties of social communication, play, and behavioral characteristics of ASD are needed. Thus, if early intervention providers can complete components of the assessment within their realm of expertise (e.g., developmental, speech, occupational therapy, and physical therapy assessments) and then refer out for the diagnostic component, that is recommended.

**Continuing Education
for KIT Readers**



The Comprehensive System of Personnel Development (CSPD) is offering a continuing education opportunity for EDIS KIT readers.

In line with the focus on ASD and the Role of the Early Interventionist, readers are invited to receive four continuing education contact hours for reading the monthly KIT publications (September 2009 through January 2010) and completing a multiple choice exam about the content covered in these KITs.

KIT readers will receive the exam in February 2010. There is no need to register for the CEUs. Rather, if you are interested simply complete the exam and return it to Naomi Younggren. Upon successful completion of the exam, you will receive a certificate for four non-discipline specific continuing education contact hours.

*Please send your Consultation Corner questions and
KIT ideas via email to
Naomi.Younggren2@us.army.mil*

***Happy
Holidays!***

