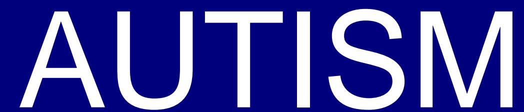


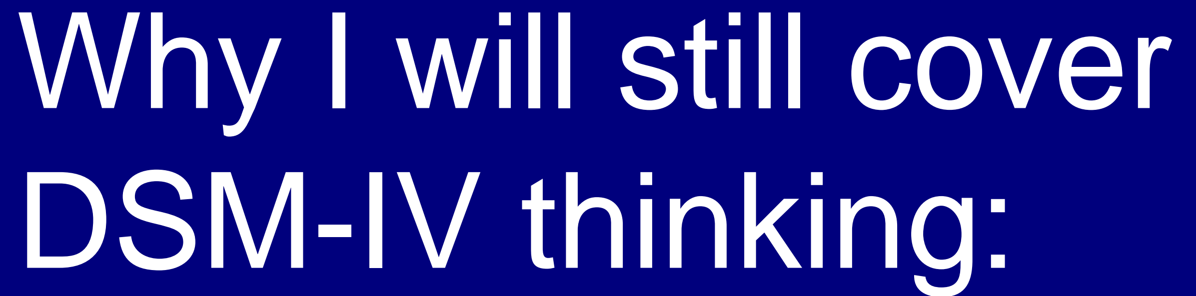
the spectrum of disorders
disorder dis order d i s o r d e r of s p ec tr u m s

by Joseph McCoy, Ph.D.

30
19 - 4 h

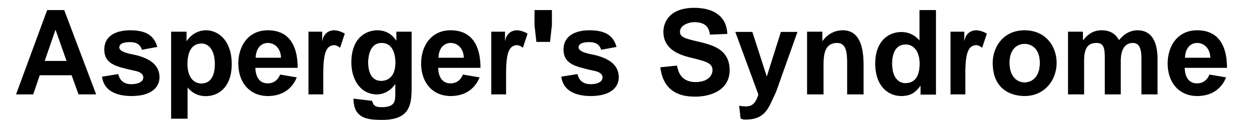
Autism Spectrum Disorder (ASD)

Gone (really?) are:
Childhood autism
Asperger's syndrome
Childhood disintegrative disorder
Rett's disease
PDD NOS (pervasive developmental disorder not otherwise specified)



1) **The schools**
2) **State Programs**
3) **Healthcare providers who haven't yet learned the new way**

- deceleration of head growth between ages 5 and 48 months
- loss of previously acquired purposeful hand skills between ages 5 and 30 months with the subsequent development of stereotyped hand movements (e.g., handwringing or handwashing)



- There is no clinically significant delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years).

Childhood Disintegrative Disorder

- Apparently normal development for at least the first two years after birth as manifested by the presence of age-appropriate verbal and nonverbal communication, social relationships, play, and adaptive behavior
- Clinically significant loss of previously acquired skills (before age 10 years) in at least two of the following areas:
  - expressive or receptive language
  - social skills or adaptive behavior
  - bowel or bladder control
  - play
  - motor skills

  [often have history of seizure-like symptoms or full seizure disorder or other neurological problems]

PDD NOS

- When there is a severe and pervasive impairment in the development of reciprocal social interaction or verbal and nonverbal communication skills or when stereotyped behavior, interests, and activities are present **but** the criteria are not met for a specific pervasive developmental disorder, schizophrenia, schizotypal personality disorder, or avoidant personality disorder.
- (now history but …..)

AUTISTIC DISORDER

- A disorder of development in which a person has:
- 1) qualitative impairment in social interaction
- 2) qualitative impairments in communication
- 3) restricted repetitive and stereotyped patterns of behavior, interests and activities
- And there were symptoms of this prior to age 3.
- (full diagnostic DSM-IV criteria later in presentation)

Prevalence (2002)

- 5 cased per 10,000 people is the median number reported.
- The range is 2-20 cased per 10,000
- With the RGV having 1.2 million that means we probably have no less than 600 cases here in the Valley.
- Some feel we may have much more

Prevalence (2011)

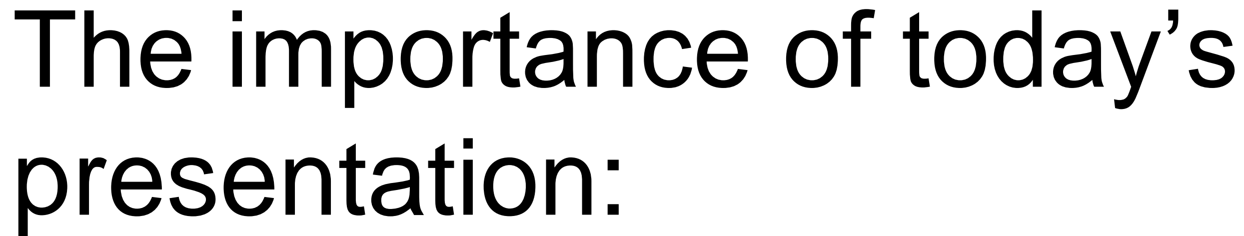
- 1 case per 150 people is the median number reported.
- Why the huge change? (discuss in a moment)
- With the RGV having 1.4 million that means we probably have no less than 9,333 cases here in the Valley.
- Some feel we may have much more

Prevalence (2013)

- 1 case per 88 people is the median number reported. http://www.cdc.gov/ncbddd/actearly/index.html
- With the RGV having 1.4 million that means we probably have no less than 15,909 cases here in the Valley.
- My schedule is filled for diagnostic rule outs of ASD, of several a day

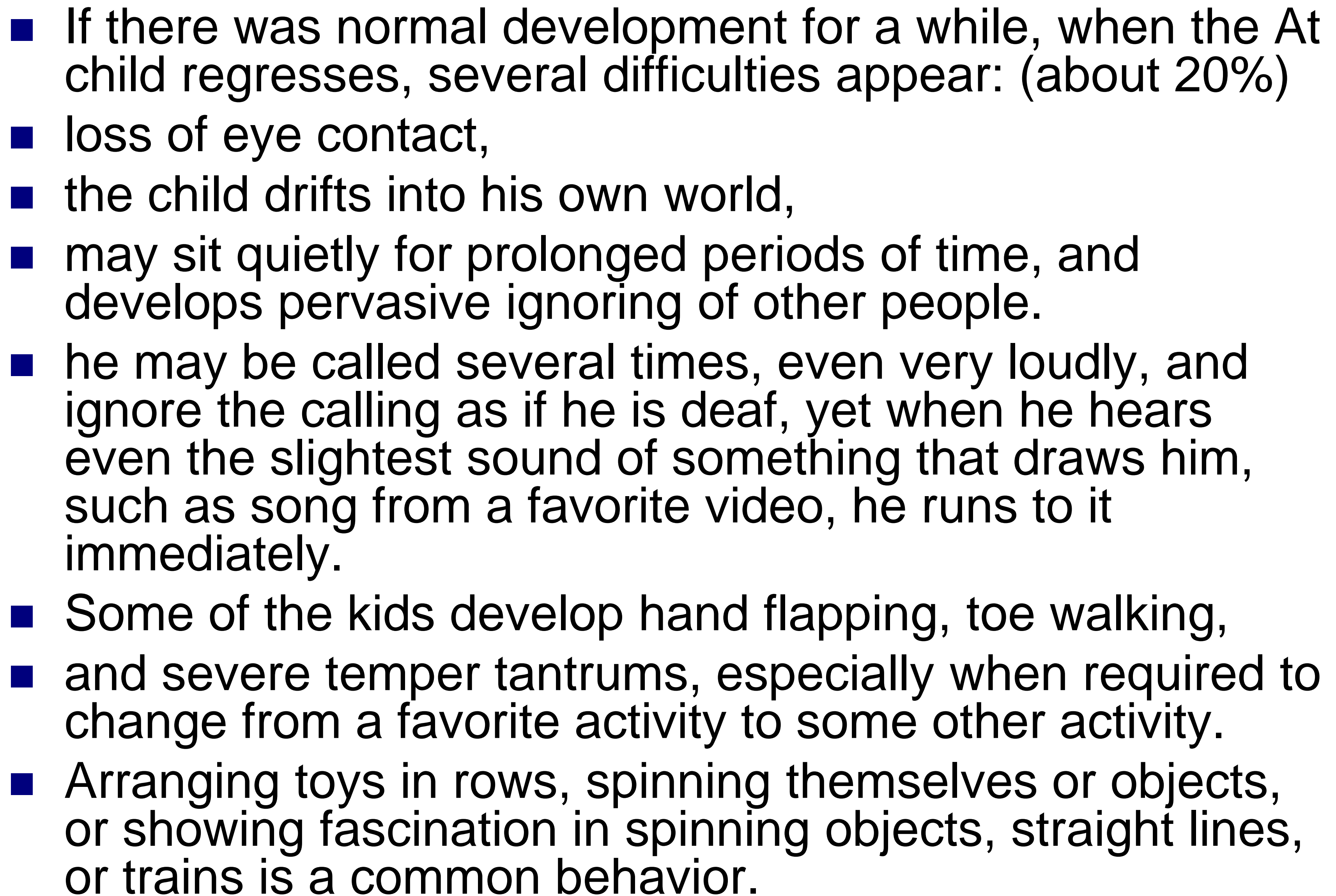
How does a typical child with autism present?

- language delay.
- echolalia
- Some never acquire language,
- but most will have a slight regression, losing the ability to say a few words that they've already learned. This may occur at around 18 months of age.
- Most parents will report no difficulties prior to this period, but some may observe a "different interactive," eye contact or socialization impairment, lack of pleasure with regard to being touched, or other unusual behavior from as early as 1 to 3 months of age, in extreme situations.



The importance of today’s presentation:

- Typically, kids with PDD's will not get diagnosed initially. The statistics indicate that only about **10%** of kids with autistic disorders get diagnosed following the initial complaint of the parents that "something is wrong" with their child. (this is changing but likely slowly)



- If there was normal development for a while, when the At child regresses, several difficulties appear: (about 20%)
- loss of eye contact,
- the child drifts into his own world,
- may sit quietly for prolonged periods of time, and develops pervasive ignoring of other people.
- he may be called several times, even very loudly, and ignore the calling as if he is deaf, yet when he hears even the slightest sound of something that draws him, such as song from a favorite video, he runs to it immediately.
- Some of the kids develop hand flapping, toe walking,
- and severe temper tantrums, especially when required to change from a favorite activity to some other activity.
- Arranging toys in rows, spinning themselves or objects, or showing fascination in spinning objects, straight lines, or trains is a common behavior.

Intellectual functioning

- 60%–IQ below 70
- 20%–IQ 50 to 70
- 20%–IQ above 70 (high functioning)
- Savant characteristics

Family Characteristics/Clues

- give in to temper tantrums. This in turn develops a "pathologic" situation, where instead of the parents teaching their abnormal children normal socially accepted behavior, the entire family "learns" the abnormal behavior from their affected children. This causes the child to lose his chance of being appropriately directed into socially accepted behavior from early on, as should be done. **But this does not cause ASD.**

- The correct approach must include a firm, strict appropriate discipline/guidance to correct all their child's abnormal autistic behavior.
- Typical mistakes in this regard include letting the kids run around with food because they refuse to sit by the table, allowing their children to carry an exaggerated variety of objects or toys everywhere they go in order to pacify them, letting their kids get away with holding their bottles or pacifiers, or refusal to eat certain consistencies of foods in order to keep the peace and prevent temper tantrums. [some symptoms may require specialists]
- In the long run, however, tantrums are unavoidable because there is a point where the parents cannot keep up with their children's unreasonable requirements, and if the response of the parents to the unreasonable request is not fast enough or not complete enough, the tantrum will occur.
- The best way to stop the tantrums right from the onset is to help the child adjust to the requirements of society. In the long and short run, it will be easier to change the child's behavior rather than "change the world" and society to adjust to the child's abnormal requirements.

The PDD assessment scale/screening questionnaire

- **SOCIAL INTERACTION DIFFICULTIES** (with same age peer) [how to rate]
- 1. Poor eye contact, or staring from unusual angle
- 2. Ignores when called, pervasive ignoring, not turning head to voice
- 3. Excessive fear of noises (vacuum cleaner); covers ears frequently
- 4. In his/her own world (aloof)
- 5. Lack of curiosity about the environment
- 6. Facial expressions don't fit situations
- 7. Inappropriate crying or laughing
- 8. Temper tantrums, overreacting when not getting his/her way

Rated as (no, resolved, mild, moderate, severe)

http://www.childbrain.com/pddassess.html

Who should be evaluated for autism or PDD?

- No babbling by 12 months
- No pointing or waving bye-bye by 1 year
- No single words by 16 months
- No spontaneous 2-word sentences (for communication, not repetition) by 2 years
- Any loss of acquired speech or communication skills at any age
- New recs include screeners like M-CHAT,Ages & Stages by 18 months

National Guidelines For PCP (who will often expect you to do this)

- **Evaluation**
- There are three major diagnostic challenges in the comprehensive assessment of a child with a suspected ASD: (1) determining the overall level of functioning, (2) making the diagnosis of an ASD, and (3) determining the extent of the search for an associated etiology. To accomplish these goals, a comprehensive evaluation should include the following components:
- Health, developmental, and behavioral histories that include at least a three-generation family pedigree and a review of systems
- Physical examination, including a thorough search for dysmorphic features and neurologic abnormalities, and a Wood's lamp examination of the skin

National Guidelines For PCP (cont)

- Developmental or psychometric evaluation (depending on age and skill level) to determine the overall level of functioning and whether a discrepancy between motor-adaptive problem-solving and social communication skills is evident
- Determination of a categorical DSM-IV diagnosis
- Assessment of the parents' knowledge of ASDs, coping skills, and available resources
- A laboratory investigation to search for a known etiology or coexisting condition guided by information obtained in the evaluation
    - http://www.aafp.org/afp/2008/1201/p1301.html

Diagnostic Criteria for 299.00 Autistic Disorder

- [The following is from *Diagnostic and Statistical Manual of Mental Disorders: DSM IV*](I) A total of six (or more) items from (A), (B), and (C), with at least two from (A), and one each from (B) and (C)

(A) qualitative impairment in social interaction, as manifested by at least two of the following:

- 1. marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body posture, and gestures to regulate social interaction
  2. failure to develop peer relationships appropriate to developmental level
  3. a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people, (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)
  4. lack of social or emotional reciprocity (note: in the description, it gives the following as examples: not actively participating in simple social play or games, preferring solitary activities, or involving others in activities only as tools or "mechanical" aids)

(B) qualitative impairments in communication as manifested by at least one of the following:

1. delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
2. in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
3. stereotyped and repetitive use of language or idiosyncratic language
4. lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

(C) restricted repetitive and stereotyped patterns of behavior, interests and activities, as manifested by at least two of the following:

1. encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
2. apparently inflexible adherence to specific, nonfunctional routines or rituals
3. stereotyped and repetitive motor mannerisms (e.g hand or finger flapping or twisting, or complex whole-body movements)
4. persistent preoccupation with parts of objects

(II) Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years:

- (A) social interaction
- (B) language as used in social communication
- (C) symbolic or imaginative play

(III) The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder

Diagnostic Criteria for 299.80 Asperger‘sDisorder

(I) Qualitative impairment in social interaction, as manifested by at least two of
the following:
(A) marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body posture, and gestures to regulate social interaction
(B) failure to develop peer relationships appropriate to developmental level
(C) a lack of spontaneous seeking to share enjoyment, interest or achievements with other people, (e.g.. by a lack of showing, bringing, or pointing out objects of interest to other people)
(D) lack of social or emotional reciprocity

Diagnostic Criteria for 299.80 Asperger‘sDisorder

(II) Restricted repetitive & stereotyped patterns of behavior, interests and

activities, as manifested by at least one of the following:

(A) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus

(B) apparently inflexible adherence to specific, nonfunctional routines or rituals

(C) stereotyped and repetitive motor mannerisms (e.g. hand or finger flapping or twisting, or complex whole-body movements)

(D) persistent preoccupation with parts of objects

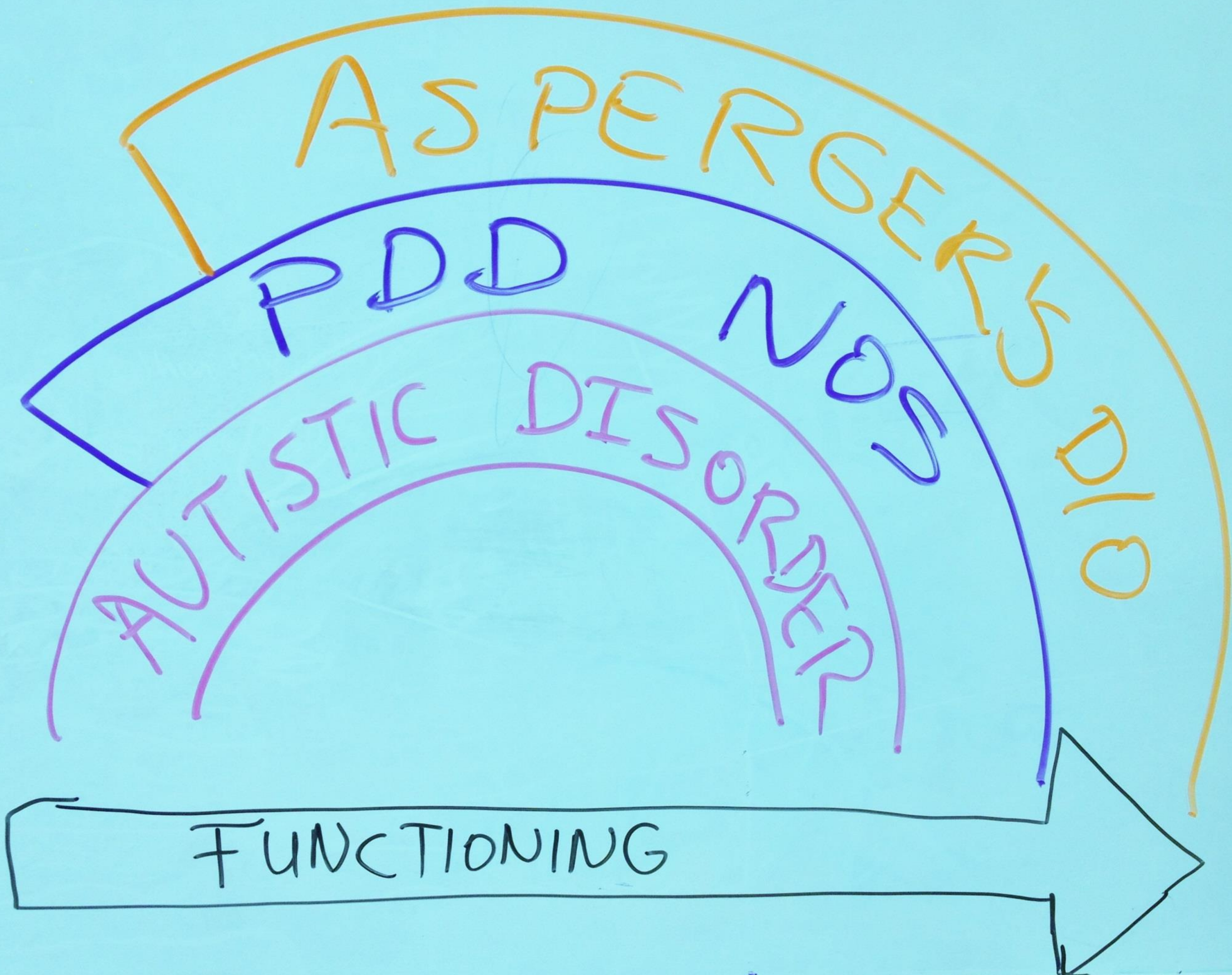
Diagnostic Criteria for 299.80 Asperger's Disorder

(III) The disturbance causes clinically significant impairments in social, occupational, or other important areas of functioning.

(IV) There is no clinically significant general delay in language (E.G. single words used by age 2 years, communicative phrases used by age 3 years)

(V) There is no clinically significant delay in cognitive development or in the development of age-appropriate self help skills, adaptive behavior (other than in social interaction) and curiosity about the environment in childhood.

(VI) Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia."



ASPERGERS D/O
PDD NOS
AUTISTIC DISORDER
FUNCTIONING

A 09 Autism Spectrum Disorder Diagnostic Criteria

- Autism Spectrum Disorder
- Must meet criteria A, B, C, and D:
- A. Persistent deficits in social communication and social interaction across contexts, not accounted for by general developmental delays, and manifest by all 3 of the following:
- 1. Deficits in social-emotional reciprocity; ranging from abnormal social approach and failure of normal back and forth conversation through reduced sharing of interests, emotions, and affect and response to total lack of initiation of social interaction,
- 2. Deficits in nonverbal communicative behaviors used for social interaction; ranging from poorly integrated- verbal and nonverbal communication, through abnormalities in eye contact and body-language, or deficits in understanding and use of nonverbal communication, to total lack of facial expression or gestures.
- 3. Deficits in developing and maintaining relationships, appropriate to developmental level (beyond those with caregivers); ranging from difficulties adjusting behavior to suit different social contexts through difficulties in sharing imaginative play and in making friends to an apparent absence of interest in people

A 09 Autism Spectrum Disorder Diagnostic Criteria

- B. Restricted, repetitive patterns of behavior, interests, or activities as manifested by at least two of the following:
- 1. Stereotyped or repetitive speech, motor movements, or use of objects; (such as simple motor stereotypies, echolalia, repetitive use of objects, or idiosyncratic phrases).
- 2. Excessive adherence to routines, ritualized patterns of verbal or nonverbal behavior, or excessive resistance to change; (such as motoric rituals, insistence on same route or food, repetitive questioning or extreme distress at small changes).
- 3. Highly restricted, fixated interests that are abnormal in intensity or focus; (such as strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
- 4. Hyper-or hypo-reactivity to sensory input or unusual interest in sensory aspects of environment; (such as apparent indifference to pain/heat/cold, adverse response to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects).

- C. Symptoms must be present in early childhood (but may not become fully manifest until social demands exceed limited capacities)
- D. Symptoms together limit and impair everyday functioning.

- New name for category, autism spectrum disorder, which includes autistic disorder (autism), Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified.
- Differentiation of autism spectrum disorder from typical development and other "nonspectrum" disorders is done reliably and with validity; while distinctions among disorders have been found to be inconsistent over time, variable across sites and often associated with severity, language level or intelligence rather than features of the disorder. (This was the point of my rainbow picture)
- Because autism is defined by a common set of behaviors, it is best represented as a single diagnostic category that is adapted to the individual's clinical presentation by inclusion of clinical specifiers (e.g., severity, verbal abilities and others) and associated features (e.g., known genetic disorders, epilepsy, intellectual disability and others.) A single spectrum disorder is a better reflection of the state of knowledge about pathology and clinical presentation; previously, the criteria were equivalent to trying to "cleave meatloaf at the joints".

A 09 Autism Spectrum Disorder Rationale for the Change

- Three domains become two:
- 1) Social/communication deficits
- 2) Fixated interests and repetitive behaviors
- Deficits in communication and social behaviors are inseparable and more accurately considered as a single set of symptoms with contextual and environmental specificities
- Delays in language are not unique nor universal in ASD and are more accurately considered as a factor that influences the clinical symptoms of ASD, rather than defining the ASD diagnosis
- Requiring both criteria to be completely fulfilled improves specificity of diagnosis without impairing sensitivity
- Providing examples for subdomains for a range of chronological ages and language levels increases sensitivity across severity levels from mild to more severe, while maintaining specificity with just two domains
- Decision based on literature review, expert consultations, and workgroup discussions; confirmed by the results of secondary analyses of data from CPEA and STAART, University of Michigan, Simons Simplex Collection databases

A 09 Autism Spectrum Disorder Rationale for the Change

- Several social/communication criteria were merged and streamlined to clarify diagnostic requirements.
  - In DSM-IV, multiple criteria assess same symptom and therefore carry excessive weight in making diagnosis
  - Merging social and communication domains requires new approach to criteria
  - Secondary data analyses were conducted on social/communication symptoms to determine most sensitive and specific clusters of symptoms and criteria descriptions for a range of ages and language levels
- Requiring two symptom manifestations for repetitive behavior and fixated interests improves specificity of the criterion without significant decrements in sensitivity. The necessity for multiple sources of information including skilled clinical observation and reports from parents/caregivers/teachers is highlighted by the need to meet a higher proportion of criteria.

- The presence, via clinical observation and caregiver report, of a history of fixated interests, routines or rituals and repetitive behaviors considerably increases the stability of autism spectrum diagnoses over time and the differentiation between ASD and other disorders.
- Reorganization of subdomains increases clarity and continues to provide adequate sensitivity while improving specificity through provision of examples from different age ranges and language levels.
- Unusual sensory behaviors are explicitly included within a sudomain of stereotyped motor and verbal behaviors, expanding the specfication of different behaviors that can be coded within this domain, with examples particularly relevant for younger children
- Autism spectrum disorder is a neurodevelopmental disorder and must be present from infancy or early childhood, but may not be detected until later because of minimal social demands and support from parents or caregivers in early years.

A 09 Autism Spectrum Disorder Severity

Severity Level for ASD	Social Communication	Restricted interests & repetitive behaviors
Level 3 'Requiring very substantial support'	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning; very limited initiation of social interactions and minimal response to social overtures from others.	Preoccupations, fixated rituals and/or repetitive behaviors markedly interfere with functioning in all spheres. Marked distress when rituals or routines are interrupted; very difficult to redirect from fixated interest or returns to it quickly.
Level 2 'Requiring substantial support'	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions and reduced or abnormal response to social overtures from others.	RRBs and/or preoccupations or fixated interests appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress or frustration is apparent when RRB's are interrupted; difficult to redirect from fixated interest.
Level 1 'Requiring support'	Without supports in place, deficits in social communication cause noticeable impairments. Has difficulty initiating social interactions and demonstrates clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions.	Rituals and repetitive behaviors (RRB's) cause significant interference with functioning in one or more contexts. Resists attempts by others to interrupt RRB's or to be redirected from fixated interest.

ICD-10 Autism Spectrum Disorder

Pervasive Developmental Disorders

DSM-IV	ICD-10
299.00 Autistic Disorder	F84.0 Childhood Autism
	F84.1 Atypical Autism
299.80 Rett's Disorder	F84.2 Rett's Syndrome
299.10 Childhood Disintegrative Disorder	F84.3 Childhood Disintegrative Disorder
	F84.4 Overactive disorder associated with mental retardation and stereotyped movements
299.80 Asperger's Disorder	F84.5 Asperger's Syndrome
	F84.8 Other pervasive developmental disorders
299.80 Pervasive Developmental Disorder not otherwise specified (PDD-NOS) (including Atypical Autism)	F84.9 Pervasive developmental disorders, unspecified

PDD-NOS in the DSM-IV includes F84.1, F84.8 and F84.9 from the ICD-10

The conditions labelled F84.2, F84.3 and F84.4 are considered rare. There is debate as to whether they are part of the Autism Spectrum.

"High-functioning Autism" (HFA) appears to mean Autistic Disorder (F84.0) with an IQ>70. It is not a formal category in either of these classifications.

Autism Spectrum Disorder

- Example of how to document it:
- DSM5 Diagnosis, Diagnostic Formulation, Diagnostic consideration (whatever your profession allows):
- 299.00(F84.0) Autism Spectrum Disorder, Level 1 Social communication, Level 2 Restricted, Repetitive Behaviors, without intellectual impairment, with pragmatic language difficulty
- When interfacing with school systems you should document DSM-IV and DSM5 language

What are the causes of autism?

- The causes for autism are most likely
- The general consensus is that autism and PDD NOS are genetic disorders that can't be identified specifically in current genetic testing. Though certain genetic disorders, e.g. Prader-Willie syndrome have associated risk of developing ASD and/or ID.
- It’s likely that different genes or different combinations of defective genes may result in the same presentation of PDD NOS or autism.

What are the causes of autism? Continued

- Testosterone Hypothesis/Extreme Maleness (Simon Barron-Cohen/ yep Sasha's brother)
- Epi-genetics is my take on why we've gotten a rapid advance in prevalence in half-decades
- Worse on border for 3 reasons:
  - Overlap of agriculture and industry (R.F. Palmer et al. / Health & Place 12 (2006) 203–209)
  - High stress of poverty
  - Obesity (Ozonof et al, Pediatrics 2012;129;e1121)

Differential diagnosis for autism

- **Hearing loss**
- **Landau Kleffner Syndrome or acquired epileptiform aphasia**
- **Mental retardation**
- **Childhood schizophrenia**
- Fragile X, Angleman's, PKU and other metabolic d/o, Touberouse sclerosis, Prader-Willie, Marfan's etc

Diagnostic Tools

- **M-CHAT (current age 18-36 months)**
- **M-CHAT (retrospectively to 24 months)**
- **GARS-2 (with interview on specific items; used as structured interview**
- **GADS (when Asperger's of higher functioning problems suspected)**
- **ADOS**

M-CHAT (retrospectively)

- M-CHAT (administered retrospectively) Score is 23
- (* means critical item, # original CHAT critical item, $non-critical risk factor) Mickey Mouse 's score is based on his/her behavior at 24 months of age. Mickey Mouse did not enjoy being swung, bounced on parent's knee etc.$ He did not take an interest in children when around them.* He didn't like climbing on things, such as stairs or playground equipment.$ Mickey Mouse didn't find pleasure in playing peek-a-boo/hide-and-seek.$ He didn't engage in pretending or make believe.# He did not use the index finger to point in order to acquire an object.$ Mickey Mouse didn't point to indicate interest in something.*# He didn't play properly with objects and ignored, mouthed, or just fiddled with them.$ He did not bring objects to parent to show them something.*# He didn't look parent int he eye for more than a second or two.$ Mickey Mouse was overly sensitive to noise.$ This child also didn't smile in response to parent's smile.$ Mickey Mouse didn't imitate parent(s) on a regular basis.* Mickey Mouse did not frequently or ever respond to name being called.* Mickey Mouse did not look if parent points to a toy or object across the room.*# He did not walk (at 18 months).$ He did not look at things the parent looks at.$ He did make unusual finger movements.$ Mickey Mouse did not try to attract parent's attention to the activity he/she is engaged in.$ His parent(s) wondered if he/she was deaf.$ Mickey Mouse did not understand what people said.$ Mickey Mouse sometimes stared at nothing and wanders with no purpose.$ He did not check parent's face for reaction to unfamiliar things.$.
- SUMMARY: Mickey Mouse would've been declared a risk of having or developing an Autistic Spectrum Disorder with 2+ critical & 3+ non-critical items present.

M-CHAT (retrospectively)

- 3 CHAT provider administrated items
  - Pointing to something and asking child to look
  - Asking child to point to something like a light or the door that you've been told by the parents that they know
  - Ask child to pretend to poor a cup of tea (England) or pretend a block is a car
- If child fails all three they have a 100% chance of receiving a future diagnosis of an ASD (in original study by Simon Barron-Cohen)

M-CHAT (retrospectively/EHR)

33

M-CHAT Retro

S F

Score = 23

(ALWAYS YES)
- (•) KEY

Age of Assessment
- ( ) Current age of ______
- ( ) 18 months of age.
- (•) 24 months of age.
- ( ) 30 months of age.

1Enjoy being swung, bounced etc?
- ( ) Yes (•) No

2 Take interest in children*
- ( ) Yes (•) No

3Like climbing on things, up
- ( ) Yes (•) No

4Enjoy peek-a-boo/hide-seek
- ( ) Yes (•) No

5Pretend, talk on phone etc#
- ( ) Yes (•) No

6Point to ask for things?
- ( ) Yes (•) No

7Point to indicate interest?*#

GARS-2 (EHR)

55

GARS-2 StereotypBxSc

S

Score = 20

StertypBXsubscale(Freqent)(max42

- [x] Always check(unless no 3's circled)
- [x] 1. avoids establishing eye contact, looks away
- [ ] 2. stares at his or her hands, objects are items in
- [x] 3. flicks fingers rapidly
- [x] 4. eating specific foods
- [ ] 5. licks, tasts, or eats inedible
- [ ] 6. smells or sniffs objects;
- [ ] 7. whirls, turns in circles
- [ ] 8. spins objects not designed for spinning
- [ ] 9. rocks back-and-forth
- [ ] 10. makes rapid lunging, darting movements
- [ ] 11. prances, i.e., walks on tiptoes
- [ ] 12. flaps hands or fingers or in front of face or at sides;
- [ ] 13. makes high-pitched sounds or other vocalizations
- [ ] 14. slaps, heads, or bites self
- [x] always check (period)

Stereotyped BX subscale(Sometime

- [x] Always Check (unless no 2's circled)
- [ ] 1. avoids establishing eye contact
- [x] 2. stares at his or her hands, objects are items in
- [ ] 3. flicks fingers rapidly
- [ ] 4. eating specific foods

- child older than 5
- We expect school to challenge diagnosis
- When all data to date is non-confirmatory
- When we suspect parent is over- or under-rating and behavior observations are not clear

TREATMENT

- **Behavioral modification**
- **Medications**
- **Speech therapy**
- **Occupational and Physical Therapy**
- **Others unsubstantiated, e.g., secretin(proven false), vitamins, gastric treatments, heavy metal “clearing” etc.(dangerous), gluten-free diet (sometimes helpful)**

Behavioral treatment

- **A structured daily routine** is important. The child will perform best under familiar conditions, including location and activities. Later, as the situation improves, the rigid routine may be gradually modified, as tolerated.
  - **Temper tantrum control:**
- **holding technique** One parent holding, while the other is smiling and trying to console the child, will cause confusion and the wrong message to come through.
- Messaging,rubbing, brushing technique
- **Communication**: Must be short, clear, loud (not yelling).
- **Individualization of care**:
- **Placement and education**:
- **Emotional aspects**: **The "A" word and the social stigma**:
- **Other treatment options**: “NEW” Rapid Prompting,
- I see families for one-on-one problem solving

Some Standard Recs

- RECOMMENDATIONS:
- It is recommended that one of those patients providers consider an appropriate medication to help with decreasing hyperactivity and the overall emotional tone/sensitivity of the patient, in hopes that they can respond more effectively to various therapies and tolerate the guidance that the parents are being instructed to provide to this child.
- Refer to Dr. _______ for genetic screening.
- It is recommended that his/her pediatrician to refer him /her to a neurologist to rule out presence of other neurological disorders/concerns.
- Patient to have family therapy (parent training) on an as needed basis to address giving the family direction on how to deal with specific behavior problems as well as properly using available resources to give him the 25 hours a week of engaging speech in social activity that is needed to produce the best outcomes for children with this condition.
- Patient will be referred for speech therapy at least four times a week possibly for a half-hour at first but for an hour as soon as he can tolerate it.*
- Patient will be referred for occupational therapy at least four times a week possibly for a half-hour at first but for an hour as soon as he can tolerate it.*

Some Standard Recs

- RECOMMENDATIONS continued:
- ***Therapists must give activities/exercises/homework for the parents to work on at home as we found children with Autism need 20-25 hours a week of intentional and engaging interaction with others to make significant gains. Failure to do so will lead to referral to another facility.**
- *(National Science Council Research Report at: http://www.nap.edu/openbook.php?record_id=10017&page=219)
- Patient's family was given standard list of resources for children with developmental delays as well as a specific one-page handout about the basic guidelines for providing interventions for a child with autism written by Dr. Marc Bower. (These can be provided upon request)
-
- TREATMENT GOALS
- His/her symptoms of behavior problems are to be manageable by client's treatment team within 6 to 24 months.
- To have ruled out genetic and neurological conditions by three months.
- To have all standard therapy in place by 3 to 6 months and we need to see this evaluator/therapist for specific behavioral problems as they arise.

Medication Observations

None treat ASD

Do treat associated symptoms

Always inform MD of concerns

Stimulant issues

Are meds forever?

I. Stimulants (Ritalin, Dexedrine,Adderall)
II. SSRI's (Prozac, Zoloft Paxil and Luvox).
III. At times, neuroleptics are used (Mellaril, Risperidal, Zyprexa) or
IV. tricyclics (Tofranil) may be helpful.
V. Beta blockers (clonodine, Kapvey)
VI. Intuniv an alpha-2 agonist

Treatment Options

- Social Skills Training/Social Stories
- Physical Therapy
- Speech Therapy
- Occupational Therapy
- RDI (Relationship Development Therapy)
- ABA
- FBA

Time is What Matters!

- It seems to be that 20-25 hours a week of some combination of these types of therapy is what makes the biggest impact.
- Essentially this means that the parent is also the therapist.

- SOCIAL THINKING by Michelle Garcia-Winner
- https://www.socialthinking.com/
- Welcome my two former interns
- Other group exercises are posted on website jhmccoy.wordpress.com

Today we will....

- Look at why focusing on social skills instruction is important
- What a social skills group should include
- Focus on how to develop social skills groups for individuals on the autism spectrum.
- Some examples of strategies

Focusing on social skills

- If we do not focus on developing social skills

Individuals with autism spectrum disorders may….

*have difficulty developing friendships

*feel alone or isolated

*demonstrate trouble in school

SOCIAL SKILLS GROUP

- **Social skills groups are used to teach individuals with autism ways to appropriately interact with typically developing peers.**
- **Size:**
- »Small groups of 2 to 8 individuals with an adult facilitator
-

- http://autismpdc.fpg.unc.edu/content/social-skills-groups

Tips for Social Skills Group

- Knowledge of group members
- Decide what skills need to be addressed
  - Locate Resources for those particular skills ahead of time
- Hands on activities and role playing is key

  -provide assistance when needed or suggest they ask for help from a group member

  - Pairing is another good way of getting them engage

What do we target?

- **Social skills groups should target:**
- **perspective-taking**
- **emotional regulation**
- **conversation skills**
- **theory of mind**
- **friendship skills**
- **problem-solving**
- **social competence**
    - http://autismpdc.fpg.unc.edu/content/social-skills-groups

SPECIFIC SKILLS

- **Specific skills taught should include:**
- **initiation giving/accepting compliments**
- **Responding turn taking**
- **Maintaining sharing**
- **greeting asking for help**

What is Social Thinking

- Form of thinking that helps a person problem solve how expected and unexpected behaviors can set off predictable chain reactions of emotions and related behaviors from others
    - Layman's terms- Social thinking is what we do when we interact with people we think about them

Social Thinking

What I do:
(expected bx)

How other's feel about what you did

How others TREAT you based on their feelings

How YOU FEEL about how they treated you

FORTUNE

Situation:

(unexpected bx)

FATE

Original Concept by Michelle Garcia Winner

Social Skills Activity

You notice someone is very hairy.

WHAT YO DO –	HOW PERSON FEEL ABOUT WHAT YOU DID	What they do b/c of how they feel @ you	How you feel @ what they did
[Expeted]		(Fortune)	
To say "hi"	Glad	Say "hi" back	Happy
Compliment their hair style	Normal	Smile (back)	[Accepted]
Smile	Accepted	Compliment you back	Proud
		Want to be your frd	
		" " play c̄ you	
[unexpected]		[FATE]	
Say "Gee you're really hair"	Sad	Ignore you	Confused
Make faces	Hurt	Slap ya	Rage
Say "you must be related to Big Foot"	Weird	Walk away	Guilty
	Angry	Cry	
	Rejected		

Goals of Social Thinking

- Aid the person in recognizing their own views and abilities and those of others and that they differ
- Learn to navigate social thinking, interaction and communication toward more reward outcomes (friendships, effective communication, etc)
- Learn to better adapt and respond to people and the situations around them
  - Dr. Michelle Garcia Winner

Typical Social Skills Group Agenda at VPS

- Greetings/Introductions
- Review Topic from previous session
- Introduce New topic
- Discuss meaning/definitions
- Conduct an Activity/Discuss objectives/why we are doing the particular activity
- Have members role play
- Review/Wrap Up
- Inform Parents of discussed topic
  - Provide them with handout/activity to work on until next session

Schools must consider:

- i.Behavioral program
- ii. Structured schedule
- iii. In home training
- iv. Extended year services
- v. Vocational programming
- vi. Impact of teacher to student ratio

Educational Plan Can Include

- hehavioral needs
- emotional needs
- social needs
- compitencies
- communication needs
- compliance training

RESOURCES

- Autism Society of America (800)-3AUTISM, extension 150
- Center for the Study of Autism http://www.autism.org/
- Jhmccoy.wordpress.com
- www.**cdc**.gov/**autism**
- http://www.autismspeaks.org/