AUTISM SPECTRUM NEWS™

YOUR TRUSTED SOURCE OF SCIENCE-BASED AUTISM EDUCATION,
INFORMATION, ADVOCACY, AND COMMUNITY RESOURCES

SPRING 2015 VOL. 7 NO. 4

Addressing the Challenging Behaviors Associated with Autism

A Proven Method to Reduce Challenging Behaviors in Any Environment

By George Suess
Chief Executive Officer
The Arc of Delaware County, NY

The behavior challenges related to autism can feel daunting for family, caregivers, and community service organization professionals alike. But dwelling on challenging behaviors leads to a focus on questions such as, “What will we do when this individual displays this challenging behavior again?” The answers often lead to a culture focused on intervention and physical restraints.

Caregivers often feel that this approach is not effective, and they’re right—physical intervention to address behavior challenges can result in escalation, humiliation, and injury. But the field of community support services has relied on these traditional, reactive approaches for so long there is little belief and less conviction that positive, proactive philosophies and approaches can work.

But instead of focusing on handling negative behaviors, what if the question caregivers asked was, “What will we do to *prevent* this individual from behaving in this negative way again?”

It’s possible to break the cycle of negative reinforcement and physical restraint, and shift to a dynamic that focuses instead on encouraging positive behaviors. At The Arc of Delaware County, the team has created a positive, restraints-free environment for people with autism and many other developmental disabilities—and helped other organizations reduce their use of restraints too, with the same step-by-step approach used internally.

This approach is based on a series of proven steps that move toward a culturally reinforced positive approach to reduce and even eliminate challenging behaviors in a way that is actionable for organizations, schools, and home care environments.

By applying these steps, other professionals and family caregivers can do the same:

1. *Let Go of Preconceptions* - There is a common belief that in order to prevent people from hurting themselves or others, one must physically intervene. This idea is outdated, ineffective, and can hold teams back from making the all-in personal investment that is necessary to gain real results from a positive approach.

The most effective way to dramatically

see Proven on page 28

Assessment and Treatment of Problem Behavior for Adults with ASD

By Ethan Eisdorfer, MA
Mikala Hanson, BA, and
Robert H. LaRue, PhD, BCBA-D
Douglass Developmental Disabilities
Center at Rutgers University

As individuals with autism age out of the educational system, families are faced with a number of challenges. Maladaptive behavior, in particular, can be a significant stressor for families of adults with Autism Spectrum Disorder (ASD). While estimates of the prevalence of problem behavior vary considerably, it tends to be more common in individuals with ASD relative to other disorders. Common topographies of problem behavior include aggression, self-injurious behavior, property destruction, ritualistic behavior, disruption, and inappropriate vocalization, as a few examples. While procedures for assessment and treatment for these kinds of problem behavior are well-established in the behavioral literature, the adult population presents unique challenges for families and care providers.

Functional Assessment of Problem Behavior

Functional assessment is an important first step in the effective treatment of maladaptive behavior. Functional assessment represents a collection of procedures used to determine the environmental factors that cause and maintain maladaptive behavior. Functional assessments may include indirect assessment procedures (e.g., questionnaires and structured interviews), descriptive assessment (e.g., collecting observational data related to the antecedents and consequences of maladaptive behavior), and functional analysis (e.g., hypothesis testing and the manipulation of environmental variables).

Over the last several decades, a robust literature validating the effectiveness of functional assessment has emerged. The literature has shown that these assessment procedures are effective for identifying the function of maladaptive behavior and that treatments based on these procedures are more effective than treatments that are selected arbitrarily (Pelios, Morren, Tesch & Axelrod, 1999). While the literature validating the effectiveness of these procedures is clear, assessing the maladaptive behavior of adults with autism presents unique challenges as compared to assessment with younger populations. Some of these challenges are highlighted below.

Legislation - Perhaps one of the most significant barriers for older individuals with autism is the fact that legislation mandating the use of functional assessments only extends to individuals up to age 21. As a result, adults diagnosed with autism are not entitled to the same behavioral supports as their younger counterparts. Consequently, adults diagnosed with autism have fewer opportunities to have sound functional assessments conducted, which can lead to poorer outcomes over time.

Cost of services - Providing services for adults with autism spectrum disorders represents a substantial economic expense for families and government agencies (Cimera and Cohan, 2009; Ganz, 2006; Järbrink, McCrone, Fombonne, Zanden, & Knapp, 2007). It has been estimated that it costs approximately $3.2 million dollars to financially support an autistic person over their lifetime (Ganz, 2006). With limited funds available, assessment and treatment practices are more likely to use less thorough models of assessment and treatment which require less time, money and other resources.

Lack of qualified staff - Another significant challenge is the lack of available trained staff with experience working with adults with ASD. Many staff members tasked with assessment and treatment plan development lack the necessary training to do so effectively (Sigafoos, Roberts, Couzens, & Caycho, 1992; Wood, Luiselli, & Harchik, 2007). This gap in the availability of well-trained professionals can lead to poorly designed assessment and treatment.

Severity of the maladaptive behavior - Another barrier to effective assessment and treatment is the severity of the behavior being treated in adults. Adults with autism

see Adults on page 26

Mental Health News Education, Inc.
460 Cascade Drive
Effort, PA 18330

NON PROFIT
ORGANIZATION
U.S. POSTAGE PAID
MONROE, CT
PERMIT NO. 137

Autism Spectrum News Editorial Board

Cindy Alterson, PhD, BCBA, Principal and Program Director
Devereux Millwood Learning Center

Joel Bregman, MD, Medical Director and Director of Psychiatry
The Center for Autism

Joseph D. Buxbaum, PhD
Director, Seaver Autism Center
Icahn School of Medicine at Mount Sinai

Susan M. Cortilet-Jones, MS, LMHC
Licensed Therapist/Adult Coaching Specialist for Autism and Neurodiversity
Discovering Your World

Stephen E. Freeman, LCSW
The Freeman Group

Lynda Geller, PhD, Founder
Spectrum Services, A Cooperative of Independent
Practices and Organizations, New York, NY

Ami Klin, PhD, Director
Marcus Autism Center

Harold S. Koplewicz, MD, President
Child Mind Institute

Cecelia M. McCarton, MD, Founder and Executive Director
The McCarton Foundation
The McCarton School (for Autism)

Judith R. Omidvaran
Autism Parent Advocate, New York

Theresa Pirraglia, Co-Founder and Board Member
FECA, The Foundation for Empowering Citizens with Autism

John C. Pomeroy, MD, Founding Director
Cody Center for Autism and Developmental Disabilities
Stony Brook University Medical Center

Patricia Rowan, LMSW, Consultant and Advocate
Kid's Connection

Pat Schissel, LMSW, Executive Director
Asperger Syndrome and High Functioning Autism Association

Alison Singer, President
Autism Science Foundation

Richard Swierat, Executive Director
ARC of Westchester

Fred Volkmar, MD, Director
Yale Child Study Center

Dianne Zager, PhD
Michael C. Koffler Professor in Autism
Dyson College of Arts and Sciences, Pace University

Carey Zuckerman, President
Autism Society of America, Manhattan Chapter

Mental Health News Education, Inc. Board of Directors

Chairman

Jorge R. Petit, MD, President
Quality Healthcare Solutions Group

Vice-Chairman

Barry B. Perlman, MD, Legislative Chair
New York State Psychiatric Association

Secretary

Peg Moran, LMSW, Vice President, Operations, Center for Regional Healthcare Innovation
Westchester Medical Center

Treasurer

Debra Pantin, LCSW, Associate Executive Director
VIP Community Services

Members of the Board

Peter D. Beitchman, DSW, LMSW, Principal
Behavioral Health Consultation

Constance Y. Brown-Bellamy, MPA, Vice President, Community and Government Relations
ICL

Carmen Collado, LCSW, Chief Networking and Relations Officer
ICL

Jonathan P. Edwards, LMSW, Training Specialist, Parachute NYC
NYC Department of Health and Mental Hygiene

Alan Eskenazi, MA, CPHQ, CASAC, Senior Associate Executive Director
Department of Psychiatry, Woodhull Hospital

Mary Hanrahan, LCSW, Behavioral Health, Clinical Services Management
New York Presbyterian

Joseph Krasnansky, LCSW, Vice President and Chief Program Officer
Lower Eastside Service Center

Judith R. Omidvaran
Autism Parent Advocate, New York

Theresa Pirraglia, Co-Founder and Board Member
FECA, The Foundation for Empowering Citizens with Autism

Janet Z. Segal, LCSW, Executive Vice President Emerita
Four Winds Hospital and President, Four Winds Foundation

Alan Trager, LCSW, Chief Executive Officer
Westchester Jewish Community Services

Naomi Weinstein, MPH, Director, Center for Rehabilitation and Recovery
Coalition of Behavioral Health Agencies

Kimberly Williams, LMSW, Vice President, Integrated Policy and Program Solutions
Mental Health Association of New York City

Dianne Zager, PhD, Michael C. Koffler Professor in Autism
Dyson College of Arts and Sciences, Pace University

Founding Chairman

Alan B. Siskind, PhD, LCSW

Executive Staff

Ira H. Minot, LMSW, Founder & Executive Director
Mental Health News Education, Inc.

David H. Minot, BA, Associate Director and Publisher
Mental Health News Education, Inc.

***Autism Spectrum News* is a Publication of Mental Health News Education, Inc, a Nonprofit Organization.**

460 Cascade Drive, Effort, PA 18330 • (508) 877-0970 • dminot@mhnews.org • www.mhnews-autism.org

Mental Health News Education, Inc. does not endorse the views, products, or services contained herein. We are not responsible for omissions or errors.

Mental Health News Education, Inc. is not responsible for articles submitted to us without the final approval of the organization's Executive Director, CEO, or Public Relations Department. All articles and Advertisements are subject to final approval by our Editorial Board. We reserve the right to edit any article sent to us.

Letters to The Editor should only be sent to *Autism Spectrum News* and not to other publications. We do not publish open letters or third-party letters Letters for publication should be no longer than 150 words, must refer to an article that has appeared in our last issue, and must include the writer's address and phone numbers. No attachments, please. We regret we cannot return or acknowledge unpublished letters. Writers of those letters selected for publication will be notified prior to press date. Letters may be shortened for space requirements. Send a letter to the editor by emailing: dminot@mhnews.org.

Copyright © 2015 Mental Health News Education, Inc. All rights reserved. Content contained in this publication may be reproduced for one-time personal use. However, anyone wishing to reproduce and distribute any content from within this publication for purposes other than personal use must request this intention in writing directly to the publisher. Failure to do so will be in violation of the copyright held by this publication.

Table of Contents

Addressing the Challenging Behaviors Associated with Autism

Autism Spectrum News Sponsors

Gold Sponsor

The YAI Network

Silver Sponsor

Jewish Child Care Association's
Compass Project

Help Support Our Nonprofit Mission

Become an Honored Sponsor
of Autism Spectrum News

To Discuss Our Sponsorship Opportunities,
Please Contact David Minot, Publisher
(508) 877-0970 • dminot@mhnews.org
or visit www.mhnews-autism.org/sponsor.htm

2015/2016 Editorial Calendar

Summer 2015 Issue:
"The Changing Landscape of Autism Education"
Deadline: June 4, 2015

Fall 2015 Issue:
"The Criminal Justice System and First Responders"
Deadline: September 3, 2015

Winter 2016 Issue:
"Technology's Growing Impact on Autism"
Deadline: December 3, 2015

Spring 2016 Issue:
"Supporting Adults with Autism"
Deadline: March 3, 2016

To Submit an Article or Advertisement
Call us Today: (508) 877-0970
or email dminot@mhnews.org

Steps to Increasing the Success of a Behavior Plan

By Lana Small, MSW
The YAI Network

A large percentage of caregivers of children with autism will want (or need) to implement a behavior plan. When I ask a parent what he or she wants out of a behavior plan designed for his or her child the answer can usually be found among the following: "I want my child to be more compliant with requests. I want her to be less resistant to participating in tasks. I want her to develop more appropriate skills. I wish he could let me know what he wants so I don't always have to be guessing. I want him to make better choices. I want her to give up her own desires and interests sometimes and engage in other activities."

These are all worthy outcomes for behavior plans. For a child with autism who gets stuck in routines, responding to the requests that do not include reinforcing activities from his/her point of view, successfully communicating needs and learning skills that will help him/her be more effective in the environment are all important skills.

A successful behavior plan benefits the parent as well. A parent develops a more positive view of the child, gains confidence in parenting skills, feels more in control of the environment and achieves a healthy respect for the child and his/her abilities. A well implemented plan benefits all parties.

Lana Small, MSW

As the implementers of the plans, we are motivated for change with all of the benefits. But why are behavior plans so difficult to execute? Even the clearest written and detailed plan can be challenging to start, keep going and see through. The problem I have discovered – no discussion about the pre-plan preparation and overall planning.

Before a builder starts his construction, he surveys the land, develops the blue prints, looks at his budget and gets all his certifications. Before we implement a plan we also need to do some pre-planning. The writer of a behavior plan would have assessed the target behaviors, the learner's skill set and the needs of the environment. The person who will implement the plan often does not properly assess his/her preparedness to put the plan in action. One of the things that we overlook is that a behavior plan for the child is also a behavior plan for the parent, caregiver or professional who will implement it.

Here are some important strategies to prepare for implementing a behavior plan:

1. Acknowledge that you, as the implementer, are also on a behavior plan. A behavior plan has instructions for the implementer, as well as what is expected of the child. If a schedule is to be employed to produce specific actions, the instructor must abide by the timeframe for prompting appropriate behaviors. A behavior plan depends on the implementer's ability to produce the right behavior at the right time. The person employing the plan must be able to change his or her behavior as needed. The child is not the only one who needs to do something different.

2. Take the time to learn the basic theory on which the strategy or plan is based. The knowledge of why you perform a particular behavior at a specific time gives credibility to what you do and makes it easier. It will also help you avoid making "adjustments" to the plan without evaluating the possible outcomes.

3. Know yourself, especially your kryptonite. Remember that green crystal that could turn the man of steel into a weak, bumbling mess? Each of us has our weaknesses in areas that would prevent the implementation of a behavior plan. Plans require consistency, attention to detail, and clear and logical thinking. When would either of these be a problem in your interactions with your child? Is it when your child does a particular behavior that you find just unbearable? When you are tired? After a stressful day at work? When others are present in the environment? Knowing these weaknesses and deciding how to deal with them is important to your success.

4. Practice managing your feelings. Some of us are better at this than others. If you wear every emotion on your sleeve or in your posture, others, including your child, will read them and respond. Many parents tell me they do not pay attention to their child's inappropriate behavior because they understand that the behavior is motivated by a need for attention. While it is true that they may not respond verbally, the contortions of their face and the stress that is obvious from their body language says, "I see you, you got my attention." Or, by

see Success on page 35


it takes BRAINS ...to solve autism

The Effects of Cortisol on Individuals with ASD

By Jeanne D'Haem, PhD
and Irene Van Riper, EdD
William Paterson University

Jeanne D'Haem, PhD

Irene Van Riper, EdD

One Saturday, Catherine Maurice took her son and daughter, Daniel and Anne-Marie, for a walk. Anne-Marie has autism. A little black dog ran out of a driveway, yapping excitedly. Ann-Marie was afraid and began to cry. This excited the puppy then began to jump up on her. The dog was not dangerous, he just wanted to play. Anne-Marie started to run around screaming and would not respond to her mother's efforts to reassure her. Her mother finally picked Anne-Marie up and took both of the children home. Daniel cried for about five minutes and was soon calm. Anne-Marie cried for the rest of the weekend.

This scene is described in the book, *Let Me Hear Your Voice: A Family's triumph over Autism*. Similar situations take place every day in classrooms and homes with individuals with autism. A neurobiological perspective can help us to understand incidents like this and assist those with autism.

When an individual becomes stressed by a strange dog, for example, the body produces cortisol; a neurobiological stress hormone reflecting hypothalamic-pituitary-adrenal (HPA) axis activity. It has been termed the *stress hormone* because it is secreted at higher levels during a flight or fight response to stress. Small increases have positive effects. However, higher levels have been shown to impact cognitive function.

When we are highly agitated and therefore cortisol levels are high, thinking and memory are affected (Jacob and Nadel, 1985). Anne-Marie's body was flooded with cortisol and she could not process her mother's reassurance. It is not that she *would* not listen to her mother. Her brain was so chemically stressed she *could* not respond as she would normally. Spratt et al (2014) found significantly higher serum cortisol response in children with autism. Analysis showed significantly higher peak cortisol levels and prolonged duration of the cortisol elevation in children with autism. Daniel, who was also frightened of the puppy, was able to calm down after a little while but his sister was upset for the entire weekend.

According to the research of Corbett, et al, 2014, there may exist a spectrum of responsivity to stress. Some individuals have abnormally high levels of cortisol when faced with a stressful situation, while others have abnormally low levels (Ruttle, et al, 2011). The length of time the behavior persists is also relative to the level of cortisol. In some individuals, stress arousal heightens the level of cortisol, but this reaction begins to decrease as time elapses. This same research study explains that an individual may adapt to long-term stress with a decrease in cortisol, demonstrating under-arousal in stressful situations.

Individuals with ASD, like Anne-Marie, often have hyper-responsivity to stress (Corbett, Schupp & Lanni, 2012). Stress levels are related to factors such as age, gender, SES and context in relationship to the individual. If an individual with ASD, as in Anne-Marie's case, is faced with an unexpected situation, the event may be experienced as quite stressful.

Once we understand what is happening, physically, to individuals with autism when they are stressed it becomes clear that having appropriate interventions in place is crucial. Walker (1995) conceptualized the "acting out cycle." The phases of calm, agitation, out-of-control, de-escalation and

see Cortisol on page 38

From Crisis to Competence - ABA Used to Improve Communication Skills in Developmental Center

By Vivian Attanasio, BCBA,
James O'Brien, BCBA,
and Amy Bukzspan, BCBA
Services for the UnderServed Inc.

Applied Behavior Analysis (ABA) is a science wherein procedures, based on basic principles, are applied to important matters of everyday life in order to help individuals increase functional skills, while decreasing problematic ones (Cooper, Heron, & Heward, 2007.) Most notably, ABA has been utilized to improve the quality of life for children with developmental disabilities, specifically children who have been diagnosed with Autism Spectrum Disorder. ABA teaching strategies have been highly successful in improving functional communication skills, self-help skills and social skills. Moreover, they have been extremely successful at helping to decrease maladaptive-problematic behaviors such as physical aggression, repetitive self-stimulation, and self-injurious behaviors.

After the behavior technician engaged Stephen with the balloon for a few minutes, the behavior technician held the balloon. Stephen then said, "Balloon" on his own without prompting to gain access to the balloon and continue the social interaction with the behavior technician.

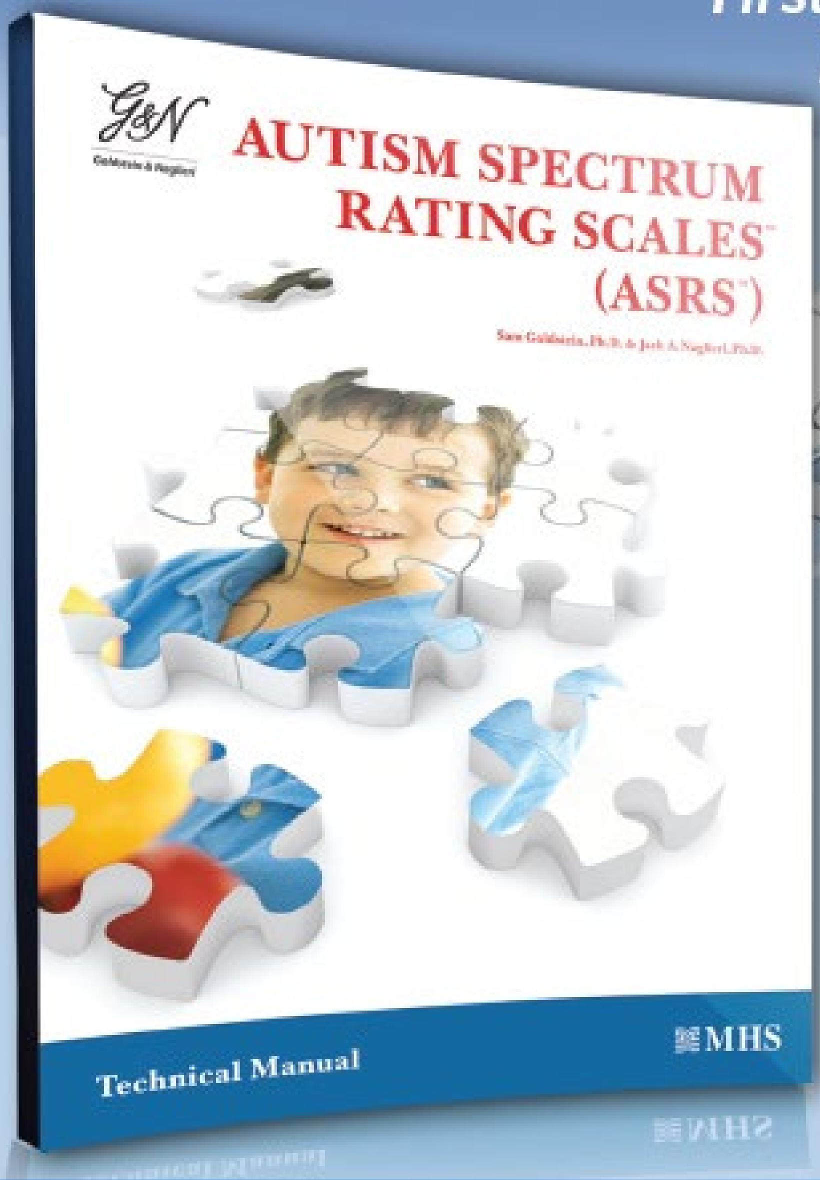
B.F. Skinner's analysis of verbal behavior (1957) suggests that language is behavior and can be thought using behavioral procedures (e.g. reinforcement). Arguably, one of the most important skills we all first naturally learn is asking for things we want. This produces an immediate and specific response. That is, we get what we want! Many individuals with developmental disabilities have learned problematic ways to request (mand) for the things they want. These include physical aggression, self-stimulatory behavior, and self-injurious behavior. For instance, an individual may collapse on the floor, kicking and screaming when his/her favorite television show is turned off. A concerned caregiver will typically turn the television back on, console the individual or find another way to make the individual happy and calm. In this way, the caregiver has reinforced the problematic request (the mand) of the individual to restart the television show.

Research from thirty years ago suggested replacing problematic ways of requesting with more appropriate forms. This is known as Functional Communication Training (Carr & Durand, 1985) or mand training. This involves teaching individuals an appropriate alternative way to request for the things they want instead of the problematic ones. The form of the request can be utilized through vocal, signs, picture exchange system (such as PECS), or any augmentative device (vocal output systems).

In August 2014, the Services for the UnderServed in New York was awarded a federal Balanced Incentive Program Innovation Fund grant (BIP) to transfer the technology of ABA generally used with children to adults with developmental disabilities. Services for the UnderServed (SUS) is a nonprofit human services agency who serves individuals and families with a wide range of challenges; mental illness, intellectual/developmental disabilities, HIV/AIDS and veterans compounded by histories of homelessness, substance abuse, poverty and unemployment.

The BIP grant is looking to transition individuals over the age of 21 in the borough of Brooklyn from institutional care

see Competence on page 34


G&N
Goldstein & Naglieri
AUTISM SPECTRUM RATING SCALES™ (ASRS™)
Sam Goldstein, Ph.D. & Jack A. Naglieri, Ph.D.
Technical Manual
MHS


AUTISM
ASPERGER'S DISORDER
PDD-NOS

Autism and Safety: It's Unpredictable

By Jill F. Harris, PhD and
Adrienne P. Robertiello
Children's Specialized Hospital

Jill F. Harris, PhD

Adrienne P. Robertiello

While safety is important to everyone, it is a major concern among many people with autism spectrum disorder (ASD) as the complex communication, social, sensory and behavioral challenges associated with ASD may place people with this disorder at increased risk of injury or death. Indeed, research indicates that nearly half of children with ASD have eloped from a safe place with 26% having gone missing long enough to cause concern and be in danger of drowning or being injured by a vehicle. Yet, only half of parents of children with ASD report receiving guidance on preventing or addressing elopement behaviors (Anderson, Law, Daniels, et al., 2012). While the disorder is felt to not affect life expectancy, Danish researchers found that the ASD mortality rate may be twice as high as the general population (Mouridsen, Bronnum-Hansen, Rich, et al., 2008). Shavelle and colleagues (2001) found that accidents from suffocation or drowning may contribute to elevated death rates among people with ASD. People with ASD may also experience other safety concerns such as increased risk of victimization due to bullying or harassment (Carter, 2009), sexual abuse (Sullivan & Knutson, 2000), or injury resulting from restraint or seclusion (Kutz, 2009).

Some common reasons for ASD-related emergency calls include events where the person has escaped from a caregiver, home or school; wandered to an unsafe place including attempting to enter nearby buildings; caregiver actions being misinterpreted; a person with unusual behavior being interpreted as suspicious, threatening or on drugs; rearranging store materials being interpreted as shoplifting; or when a person displays escalating behaviors and the caller is unaware of the autism (Debbault & Legacy, 2004). It should be noted that accuracy of statistics regarding safety issues and people with ASD may be in question since data recorded in emergencies may not include whether a perpetrator or victim has a disability such as ASD. Clinical use of the medical diagnostic code for wandering (V40.31) is one way to promote appropriate treatment planning and accuracy of tracking data.

Characteristics of ASD and Relationship to Safety

ASD may impact safety in a myriad of ways. Social communication deficits associated with the disorder may affect the ability of the person to effectively communicate concerns or understand verbal directions. Nonverbal communication including body language and tone may be misunderstood. For example, commands such as "stop" or "look out" may be misinterpreted, resulting in reduced response to community officials and emergency warnings. Social challenges may impact recognition of harassment or bullying and effective handling of such situations. Restricted interests and repetitive behaviors may also place a person with ASD at increased risk. For example, the person with ASD may be drawn to water or fire. The person may also consider a place or object comforting and not recognize that their "safe place" has become hazardous. Insistence on sameness may lead to meltdowns and increase in physical aggression or self-injurious behaviors during transitions between tasks or when routines are changed. Sensory issues may lead a person with ASD to be hyper-sensitive to temperature, pain, sound, light, texture, or crowds. This may result in challenging behavior as an attempt to avoid the stimuli. Hypo-sensitivity may result in seeking out stimuli as demonstrated by reduced sensation of pain, recognition of injury or ability to gauge rough from gentle touch. Co-morbid conditions that affect some people with ASD may further impact on safety. For example, cognitive impairment may affect ability to recognize safety risks and to follow directions. Motor difficulties may reduce balance and coordination, placing the person at increased risk of injury. Feeding issues may affect regulation of pace or amount of food, resulting in choking or vomiting. Pica may also be a concern. Seizure disorders may increase risk of injury or death. Sleep difficulties common among those with ASD may result in the person with ASD being awake and unsupervised when others in the residence are asleep. Increased activity level may contribute to elopement, darting into traffic, or having difficulty remaining seated during travel.

Features often associated with emergency situations such as alarms, flashing lights, crowds, and commotion may trigger increased agitation among people with ASD. First responders may misconstrue features in the home environment such as scars from self-injurious behavior, extra security on windows and doors, and less home decorations, which may or may not indicate abuse or neglect.

In order to address this major concern, it is important that people with ASD, their families, and service providers including first responders (police, fire, emergency medical technicians, paramedics), daycare, school, therapy and healthcare workers, child protection workers, and emergency shelter staff receive training to improve safety awareness in order to prepare, prevent, and more effectively intervene.

With funding from Kohl's Cares, Adrienne Robertiello, Autism Outreach Educator at Children's Specialized Hospital, has created training curricula and materials to address this need.

Sample curriculum for the person with ASD may include but not be limited to:

- Circles of intimacy and body boundaries
- Recognizing community partners – Who can help and how to interact
- Recognizing, preventing, and responding to bullying
- How not to bully others
- What to do if I am harassed – How not to harass others
- Sexuality, sexual expression, and protection from abuse
- Safety workers and their roles

Sample curriculum for first responders and other service providers may include but not be limited to:

- Overview of autism spectrum disorder
- Personal, social, and societal aspects; Effects on daily life through the lifespan
- Dangerous situations; Reduced fear of danger; Unpredictable responses/behaviors
- Personal safety; Vulnerability; Challenges/adaptive methods of reporting danger/incident
- Community and citizen safety: Water dangers; appropriateness of communication/behaviors; Potential inability to seek help
- Vehicular and travel safety: Personal vehicles; pupil transportation; mass transportation; traffic control devices
- Law enforcement and criminal justice system: Minimizing confrontational encounters; Person with ASD as victim; Perpetrators with ASD; Competence and consent; Strategies to reduce incidents; Judicial system
- Neglect, abuse, bullying, exploitation: Increased risk; Misconstrued environments and behaviors; Victims/perpetrators; Red flags; Assessment and response
- Search and Rescue: Common challenges; Modified responses; Prevention; identification and response options (personal tracking devices, medical alerts, etc.)
- Crisis intervention: Understanding ASD and family dynamics; Misinterpretations of household environments; Prevention and mitigation; Response modifications/de-escalation; Restraint issues
- Emergency response and management: Preparedness; Assessment; Response; Recovery; Mitigation; Communication channels and methods; Evacuation; Shelter challenges/supports; ASD-specific emergency preparedness materials
- Community education and supports: Safety education and resources; identification and communication options (augmentative communication, medical alerts, personal tracking, etc.); 911 Identifiers; Register Ready; State autism registries; Service animals; Adaptive safety equipment

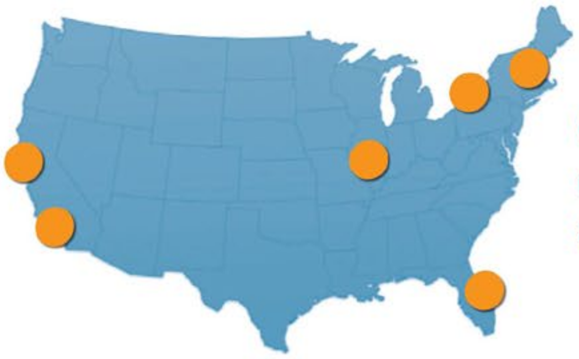
While some emergency responders have adopted online training on ASD and safety, interactive workshops may be more comprehensive and effective as they provide opportunities for direct interaction and focus on specific concerns.

Recommended specific strategies for first responders include:

- Ask basic closed-ended information questions.
- Avoid unnecessary touching or restraint.
- For crisis de-escalation, approach in quiet non-threatening manner, calm tone, reduce gestures and reduce touch; reduce sensory challenges; provide familiar objects; watch personal space; simplify language and be concrete; don't insist on eye contact or verbal response; and recognize that self-stimulatory behaviors may be calming.
- During Search & Rescue, be aware of need to use forced entry due to extra locks; may be hiding in personal "safe place;" search areas with water first, and expand search parameters and don't ignore dangerous places.
- Teach 911 dispatchers to recognize characteristics of ASD; use simple concrete

see Safety on page 41


AUTISM
AWARENESS
COMMUNITY HUB
Medical Center
Teen Center
College
A+
School
A B C
Child Care Center
Concert Hall
Movie Theater
Museum
Welcome Center



Awake Challenged, Punctually Challenged, and Underground Thursday Challenged

By Jennifer Kolarik, BS
Lead Career Coordinator
CIP Brevard

One of the biggest hurdles that adolescents and young adults on the ASD or LD Spectrum face is having a reversed sleep schedule where they stay awake at night (often playing video games or surfing the internet) and sleeping during the day. This is especially so if students are living independently for the first time. No one is around to tell them to “go to bed.”

This impacts their work lives whether it’s volunteering, interning, or doing a paid job. Even if they make it to work on time, they may lack energy and even nod off because they are tired and/or sleep deprived.

Meet Melanie. Melanie was very bright and enthusiastic about her internship working with animals. Soon after she started her internship, her supervisor noticed that when Melanie sat down during slow times, she would close her eyes for what she thought was a moment and then fall fast asleep. It was my job to figure out how to best help her stay awake at work. I came up with some strategies so Melanie and others like her, who were continually “awake challenged,” could do their jobs without falling asleep on the job or nodding off.

Suggested Strategies for “Awake Challenged” Students

Help your “awake challenged” students realistically decide how many hours of sleep each one will need each night and what time he/she needs to wake up by in order to get ready and “make it to work on time.” Based on that information, decide (together) on a good bedtime and get a promise (in writing if you can) that he or she will try to stick to it.

Students might ask a roommate or their roommates to support the fact that he or she will be going to bed at this time each night. Students like Melanie can also use a simple spreadsheet and record how many hours per night they sleep, as well as the time they went to bed and got up in the morning. As patterns develop you can further aid students with positive reinforcement or extra help and encouragement.

Encourage students to develop a wind-down routine. A hot drink, reading for half an hour and then turning off the light, having a hot shower or relaxing bath, or doing some gentle yoga or stretching right before bed will set the scene for a solid night’s sleep.

Ask the student to set an alarm or multiple alarms to help her/him remember when it is time to go to bed and time wake up.

Have the “awake challenged” young person bring healthy snacks and drinks to work each day and take occasional breaks so he/she can eat, hydrate, and boost energy levels. The student should not develop an overdependence on caffeine or energy drinks to keep awake. Instead encourage him/her to keep a food or energy journal to learn more about his or her daily patterns.

“Punctually Challenged”

Most of my students have “Executive Function” challenges that impact them on the job. Ken, one of my favorite students, was severely “punctually challenged” due to “EF” issues.

Ken had his Associate’s degree and several certifications. He was very bright and had a great sense of humor. Ken often showed up at my office 15 minutes before he was supposed to be at work and let me know he didn’t have enough gas to get to his internship. It turns out he liked to drive around over the weekend and then realized his car was on empty just as he was about to leave for work on Monday morning.

To make matters worse, Ken did not carry his debit card with him and would have to go to into the nearest bank to withdraw money from his checking account to put gas in his car. He knew by that point that he would be late for work. Ken would then need to contact his internship supervisor again and explain that he was going to be late.

I helped Ken by working on his organizational and planning skills. We made evening and morning checklists to address everything that needed to be done (including checking the gas tank the night before) so that he allowed time to buy gas in the morning, if he needed it. We put this in the form of a reproducible checklist that he would fill out each night.

We decided that each night he needed to: Check the car for gas, lay out work clothes, shower and shave, make a lunch, charge his cell phone, and make sure that his keys and backpack were by the front door.

It was a long slow process until Ken finally saw this routine’s value. By preparing the night before, he could identify if he needed to plan extra time in the morning to address any glitches or things that would make him late for work.

Ken is an example of a student who had the education and experience to succeed but didn’t have the “EF” skills in place to make sure he had gas or plan ahead for getting gas.

Repetition and routine turned out to be the key in helping Ken. Over time with repetition, repetition, repetition, and occasional nagging from me, this young man made wonderful strides in his punctuality. Ken now has worked nearly full-time for the same company for a number of years.

“Underground Thursday” Challenged

What is “Underground Thursday” do you ask? It could really fall on any day of the week - but for Zach, his “underground” day would always be a Thursday. He used up so much effort and energy to get through his Monday to Wednesday work days that he would call in “sick” almost every Thursday or every other Thursday. It was as predictable as the tides.

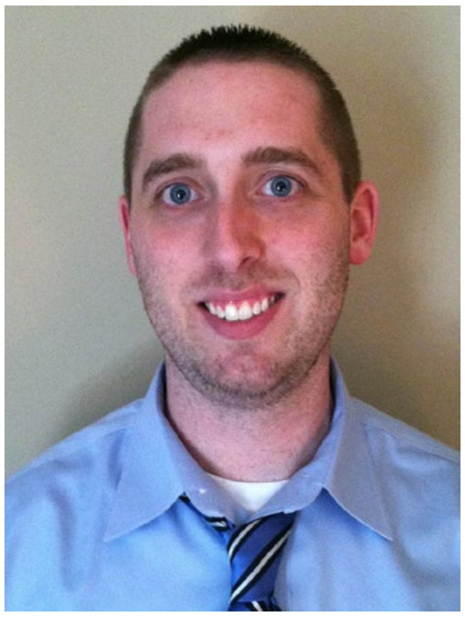
Zach and I had many one-on-one chats about this. I finally determined that Zach lacked the key skill of “perseverance” for the times when he was feeling overwhelmed,

see Challenged on page 35

What to Expect When Expecting a Functional Behavior Assessment

By Melissa L. Olive, PhD, BCBA-D,
Patrick N. O'Leary, MA, BCBA,
and Abigail V. Holt, MA, BCBA
Applied Behavioral Strategies, LLC

Melissa L. Olive, PhD, BCBA-D



Patrick N. O'Leary, MA, BCBA

Abigail V. Holt, MA, BCBA

In 1994, the Individuals with Disabilities Education Act (IDEA) mandated the use of Functional Behavior Assessment (FBA) under certain conditions for special education students. Today, FBA is used to set the foundation for treatment of challenging behaviors in schools, homes, group homes for adults with disabilities, and even in-patient hospitals for the treatment of severe challenging behavior.

Over thirty years ago, scientists first made connections between challenging behavior and consequences associated with behaviors. For example, Horner and Budd taught communication to a participant and noted that challenging behavior decreased when communication increased (Horner & Budd, 1985). Iwata and colleagues (Iwata, et al., 1982/1994) demonstrated they could cause challenging behavior to increase or decrease simply by changing consequences to targeted behaviors. As a result of these initial investigations, researchers later began designing treatments for challenging behavior based on its function. Specifically, the function or the payoff of the behavior is maintained by the individual gaining or avoiding consequences. See Table 1 on page 37 for a list of possible consequences and examples.

In order to determine the function of behavior or why behavior is occurring, assessors must complete a number of steps. These include indirect assessments, direct assessments, and functional analysis. We will describe each step with more detail. This paper will not focus on *how* to do an FBA but rather *what ingredients to look for* when an FBA is being completed.

Indirect Assessments

Indirect assessment, the first step in the FBA process, is designed to drive future assessment steps (O'Neill et al., 1997). Information gathered during these initial assessments help the evaluator identify specific areas that should be of further focus. These assessments do not typically involve clients themselves, but rather include interviews and record reviews about the client, her history, and potential settings and circumstances that are most problematic.

At the onset of the indirect assessment, evaluators will identify and define targeted behaviors using objective, observable, and measurable descriptions (Alberto & Troutman, 2012). Evaluators will also review related records and documents to determine how information about the client's history

see Expect on page 37

Contributing Factors of Aggression and Self-injury in Autism

By Jenny E. La Barbera, PsyD, BCBA-D
Co-Director
NY Behavior Analysis and
Psychological Services

Jenny E. La Barbera, PsyD, BCBA-D

Although self-injury and aggression are not included in the diagnostic criteria for a diagnosis of autism, they are often associated with the diagnosis (American Psychiatric Association, 2013). These symptoms are often the most problematic and concerning symptoms that caregivers face when seeking treatment for their loved ones. Best practices indicate that the first course of action is for the person to receive a thorough assessment that not only assesses specific times and activities in which the behaviors may be more severe, but the function or purpose of the behavior itself. Information from multiple respondents is typically necessary to obtain adequate information regarding the nature of the individual's difficulties. This assessment process is called a functional behavior assessment (FBA). Once a functional behavior assessment is conducted, the results of the assessment are then used to develop a treatment plan that is individualized and specifically addresses the method in which interventions and modifications will be implemented to assist the individual in obtaining his or her needs with a more acceptable form of behavior. A second assessment option is a functional analysis (FA), which is a type of functional behavior assessment. This type of assessment is considered to be the standard in assessing problem behaviors (Hanley, Iwata, & McCord, 2003). A functional analysis is a standardized procedure, conducted in a controlled setting, in which the presentation and removal of stimuli is systematically conducted for the purpose of identifying which stimuli results in the highest proportion of problem behaviors. Once the stimuli can be identified the function of the problem behavior can be determined and a behavior intervention plan can be developed.

These methods are highly effective in identifying the function of an individuals' self-injurious and aggressive behaviors, however, when the results are indicative of a behavior that serves multiple functions or a sensory function, treatment options may become more complicated. In these situations, an individual's self-injurious behaviors may initially serve the function of obtaining access to a desired object or activity, however, if the object or activity at that moment is not of the quality or quantity that the individual desires, he may resort to engaging in self-injury to obtain a reaction from another individual. Hence, self-injury serves multiple functions and although initially it was the result of a desire to obtain access to an item or activity, it may have transformed into fulfilling a desire to obtain attention.

Occurrences such as these become even more complicated when an internal drive (sensory function) is responsible for the behavior. It is often difficult to identify the motivating drive of sensory maintained behavior and offer a competing response. Confusion and doubt of initial hypotheses are common responses to behaviors such as these when behavior intervention plans do not produce the desired effect on the target behavior.

When these situations occur, there are multiple options for conducting an ongoing assessment of the individual's needs and behaviors and examining extraneous variables that may be at play. Furthermore, additional evidenced-based treatments geared towards reducing other interfering symptoms could prove to be beneficial and should be sought out.

When an individual is engaged in what has been determined to be a sensory maintained behavior or a behavior that appears to serve multiple functions and has not been successfully addressed, it is critical to rule out other variables that are likely compounding the problem. Sleep and mood disturbances, side effects of medication, diet, and medical problems can result in physical or mental challenges.

For example, Johnson, Giannotti, and Cortesi (2009) found that 40% to 80% of children with autism spectrum disorders (ASD) experienced insomnia. Furthermore, anxiety, autism symptom severity, gastrointestinal problems, and sensory sensitivities were found to be associated with sleep disturbance in individuals with autism spectrum disorders (Hollway, Aman, & Butter, 2013).

With regard to medication, side effects of commonly prescribed medications for aggression and self-injury, such as Aripiprazole (Otsuka Pharmaceutical Co., Ltd.,

see Self-injury on page 43

Managing Challenging Behavior Due to Autism During Emergencies: Advice for First Responders

By Vanessa Tucker, PhD, BCBA-D
Assistant Professor of Special Education
Pacific Lutheran University

First responders are by definition available and on call twenty-four hours a day to provide emergency services ranging from medical to safety and protection needs. In most cases these encounters are brief, intense and are paired with stressful episodes including medical emergency, fire or other life threats. These encounters must be managed well and require expert intervention on the part of first responders to quickly provide assistance. These encounters intensify when a child or adult with Autism (ASD) is involved. First responders, including police, fire and Emergency Medical Services (EMS) can benefit from guidance regarding the needs of this population.

The literature regarding this topic is sparse at best. A review indicates that first responders need more training in this topic as well as other disabilities (Good, 2011; White, 2012). A child or adult diagnosed with ASD is seven times more likely to need emergency medical services as compared with a typically developing comparison group (McDermont, Zhou & Mann 2008). Mims (2008) classifies this population as "high risk" in terms of medical and emergency care needs. The literature highlights higher risk in terms of such emergency situations as elopement, wandering (Law & Anderson, 2011) and drowning (Myers, 2012). Greater research into techniques that positively support those with ASD during emergencies is needed for training purposes and effective intervention (Kupietz, ND).

Vanessa Tucker, PhD, BCBA-D

ASD is defined by social communication impairments and the presence of restricted and repetitive patterns of behavior (American Psychiatric Association, 2013) paired with atypical responses to sensory stimuli. A person with this diagnosis may react very differently to the stimulation and demands of an emergency situation. These issues set the stage for challenging behaviors. A person with ASD may have limited communication skills impacting their ability to respond to commands, provide information about their internal states or resulting in behaviors that increase risk such as running or aggression to self and others. Sensory stimuli in the form of lights and sirens may be misinterpreted by the person as threatening or aversive. The presence of strangers dressed in unfamiliar clothing with equipment that invades personal space can be a trigger for behavior. Tactile defensiveness (dislike of being touched or touching things) can create tremendous barriers to a physical exam or to the use of equipment designed to obtain vital signs.

Behaviors can create tremendous risk to all involved and should be addressed by both through prevention and response tactics. Prevention is the first line of defense followed by using strategies that meet the unique needs associated with ASD. Resources will be provided for more specific supports, training and information available for first responders and families.

Prevention Tactics

The first priority is to provide high quality training in the basic aspects of ASD to all first responders during initial ongoing training. This content needs to highlight the unique learning and behavioral needs of those with ASDs including specific tactics that can be used to quickly interpret and respond to behaviors. Training should emphasize the incredible variability of this population as well as the need for partnership with families and caregivers. Training should focus on the core impairment areas of ASDs as they pertain to the demands of an emergency situation. First responders need to understand that children and adults with ASD may not respond to commands, may struggle with the sensory aspects of the situation, will not be good reporters of symptoms, may not comply with medical examinations and might run away from supports. They also need to be prepared for aggression and to interpret this as a probable communication breakdown rather than an intentional act.

Familiarity with EMS agencies is a viable prevention tool. For example, a child with ASD may be prone to running/eloping from her home. This child may not react in a typical manner to interactions with

see Emergencies on page 32

Should Parents Tell Their Children They Have Asperger's?

By Shuli Sandler, PsyD
Spectrum Services
and Michael Rosenthal, PhD
Child Mind Institute

A diagnosis of Asperger's can be an overwhelming experience for parents and children. Some parents may feel an initial sense of relief at finally finding an answer to their child's difficulties; at the same time, it also can foreshadow a long and trying road ahead full of therapies, academic difficulties, and social skill building. As clinicians who often evaluate and treat children with Asperger's, one of the major questions parents frequently ask us is whether they should share the information about the diagnosis with their child. This is a complicated decision that deserves careful consideration.

Children who have been given an explanation and understanding of the label of Asperger's may feel a sense of belonging after realizing that there are lots of children out there just like them. Rather than feeling stigmatized or defective, they may experience a sense of empowerment in having a community of like-minded children they may find at school, camp, or in various social skills groups or other treatment settings. It can offer inroads for forging connections with others who share similar challenges. Children may use their Asperger's label as a potential cornerstone for building self-advocacy skills, and it can help facilitate a sense of control in their lives. For some, Asperger's may be seen less as a disorder and more as a positive and fundamental part of their self-concept.

Shuli Sandler, PsyD

Michael Rosenthal, PhD

On the other hand, learning about their diagnosis can also feel oppressive. Children may feel a sense of shame or embarrassment. To some, the word Asperger's can feel like a disease or a term describing what is "wrong with them." We have seen children who were exposed to the word Asperger's when they were diagnosed but avoid saying it at all costs, because of the sense of impairment it represents. In this regard, it can feel like an albatross. They may see Asperger's as a challenge that holds them back from their potential. Disclosing the diagnosis can present other issues. For example, because children with Asperger's often have difficulties with the subtle nuances of communication, it may be hard for them to learn when it is appropriate or inappropriate to share the information with others. Furthermore, there is misunderstanding about the diagnosis at a societal level and all too often it is framed in terms of its deficiencies rather than its differences.

We think this is an extremely important yet complicated issue, and one that needs to be dealt with carefully and sensitively to maximize the child's adjustment to what lies ahead.

This article presents some ideas for consideration, as well as guidelines for parents struggling with this very issue to help them make the right decision for their child.

Psychiatric Versus Medical

For better or for worse, our society feels differently about psychiatric diagnoses and medical diagnoses. Interestingly, many parents feel less conflicted about the prospect of telling their child that they have a pervasive medical condition such as diabetes

see Asperger's on page 28

Addressing Setting Events to Make Behavior Plans More Effective for Individuals with Autism Spectrum Disorders

By Philip Smith, PhD, and
Daniel J. Baker, PhD, NADD-CC
The Boggs Center on Developmental Disabilities at Rutgers Robert Wood Johnson Medical School

Challenging, disruptive, and potentially dangerous behaviors frequently are a concern for caregivers and family members of individuals with Autism Spectrum Disorders (ASD). In recent years, the methodology of Functional Behavior Assessment (FBA) has come to be recognized as one of the most effective means of addressing these behaviors (Carr, 1994). The technology of this approach has been developed through the efforts of practitioners working under the Positive Behavior Supports (PBS) model, building on research that has grown out of the scientific endeavors of Applied Behavior Analysis (ABA).

Philip Smith, PhD

Daniel J. Baker, PhD, NADD-CC

What this approach has come to show is that even behaviors that look the same to a casual observer (physical aggression, self-injury, destruction of objects) may actually be quite different depending on who performs the behavior, what setting it occurs in, and a variety of other conditions or circumstances. For example, self-injury exhibited by one person might be motivated by escape from a task demand, while another person might be motivated by an effort to alleviate pain or discomfort. Through systematic analysis, behavioral scientists have been able to identify circumstantial factors that help in understanding what influences the motivation and/or meaning of the behavior for the person the individual (Wacker et al., 1990).

The value of this approach is that researchers have come to recognize that effective intervention strategies need to be individualized and based on the function. This involves adapting behavior plans based on recognition of the identified needs and using that insight, first to focus on meeting those needs in order to prevent problem behavior. Once this has been accomplished, efforts are directed to teaching and supporting the development of more positive alternative behaviors that meet the same needs. In this way, behavior specialists have the opportunity to individualize the development of behavior intervention and support plans, much in the way that clinicians individualize the treatment of mental health disorders based on the feelings and past experience of the patient.

Since most individuals who engage in problem behavior either don't know or can't communicate why they engage in the behavior, it is necessary for support providers to assess the behavior in order to determine the function of the behavior. This is true both for individuals with strong cognitive skills, as well as those who have some degree of intellectual disability, because most of us are not very good observers of ourselves. In order to do this objectively and effectively, researchers have demonstrated that in most cases, the function of a behavior can be discovered by identifying the typical antecedents that immediately precede the behavior, and the consequences that typically follow these the behavior (Carr, 1994). The circumstances that precede the behavior are considered to serve as triggers for the behavior, while the conditions that follow the behavior have come to be understood as rewarding, or in

see Setting Events on page 39

Why Emotional Literacy Is So Important

By Jaime Fleckner Black, PsyD
Spectrum Services

Social and emotional literacy develop over time and need to be nurtured just like any other skill such as math or riding a bike. Unlike math or bike-riding, however, the teaching of emotional literacy is often overlooked. It has been referred to as the “missing piece” of education despite its profound impact on children’s well-being. Emotionally competent individuals are able to communicate effectively, empathize, problem solve, and resolve conflict. Studies have shown that kids who develop these skills are more likely to do well at work as adults, have longer-lasting marriages, and have lower rates of anxiety and depression. Studies also suggest that emotionally-literate characteristics like self-restraint, persistence, and self-awareness are better predictors of life outcomes than common academic measures. In addition, these children tend to do better in school due to their ability to work well with others, control impulses, and appropriately channel emotions.

What Is Being Done In Schools?

Many schools are embracing the research and implementing social-emotional learning (S.E.L) programs. Mark Brackett, senior research scientist at Yale University and former bullying victim, developed one such program called Ruler. Ruler’s goal is to develop children’s capacity for self-reflection and critical thinking. Students and teachers use concepts such as “mood meters” to help gauge emotions. Teachers encourage children to develop coping mechanisms, such as using self-talk or taking a walk when upset. S.E.L. has received more attention in the past few years due to concerns about bullying, violence, and suicide, but these programs are certainly not the norm at this time.

Jaime Fleckner Black, PsyD

Social Skills Groups Teach More than Manners

Certain children, particularly those with autism, Aspergers, and social phobia require more guidance and support in developing social and emotional competencies. Social skills deficits are a hallmark of these conditions and they tend to persist into adulthood due to a dearth of interpersonal experiences. How can a child learn conversation skills, conflict negotiation, and perspective taking, for example, if she has no one to practice with? The right kind of social skills group could help a child develop these kinds of skills, but not all social skills groups are created equally.

Effective groups:

- Promote skill generalization to the outside world and often take place on the playground or in other real-world locations where real-life problems tend to unfold
- Stimulate social motivation
- Reinforce appropriate social responding
- Increase the understanding of nonverbal communication

The best programs help children become better observers of themselves and others. They guide them in appropriate ways of expressing themselves. Parents of children in school groups should request specific plans and ask about generalization strategies. Parents can reinforce practiced skills at home and with play-dates.

Social Skills Groups Specific to Adults

There are also groups available for adults who struggle socially and emotionally. The goal is to increase social awareness and for members to develop a better understanding of the world around them. Social skills groups can help adults navigate the interpersonal complexities of the workplace, establish platonic and romantic relationships, and understand social norms in different situations.

What Parents Can Do with Children

There are many opportunities in daily life to learn and reinforce social awareness. At the park, for instance, while observing a group of people interact, try asking your child to describe the relationships among them. It does not matter whether they get it right - what’s important is that the child is thinking about how social cues are informative. If your child is hesitant to engage,

see Emotional on page 46

Common Mealtime Concerns in Individuals with ASD

By Brandon Nichols, MSEd, BCBA, LBA
and Michelle Myers, BA, BCaBA
The Tom Golisano Center
for Autism at Springbrook

Feeding problems in children with ASD may include selective eating or “picky eaters,” rapid eating (child takes numerous bites within a short period of time), inappropriate mealtime behaviors (e.g., tantrums), and inadequate intake/food consumption. These behaviors can lead to numerous health (e.g., aspiration, choking), developmental, and social concerns for children. Feeding problems occur more frequently in children with ASD than in typically developing children (Burklow, Phelps, Schultz, McConnell, & Rudolph, 1998). Studies have shown that 72% of children with ASD eat a “narrow” variety of foods, 31% display sensitivity to various food textures, and 53% of children with ASD have some type of nutrient deficiency related to feeding patterns (Schreck, Williams, & Smith, 2004; Field, Garland, & Williams, 2003; Cornish, 1998). Additionally feeding issues can be extremely stressful for both the child and the family. Therefore, the successful treatment of feeding problems can have significant impacts such as improved health, improved quality of life for both children and families, decreased mental health problems in families, and reduced risk of long-term eating problems (Piazza & Carroll-Hernandez, 2004).

Michelle Myers, BA, BCaBA and Brandon Nichols, MSEd, BCBA, LBA

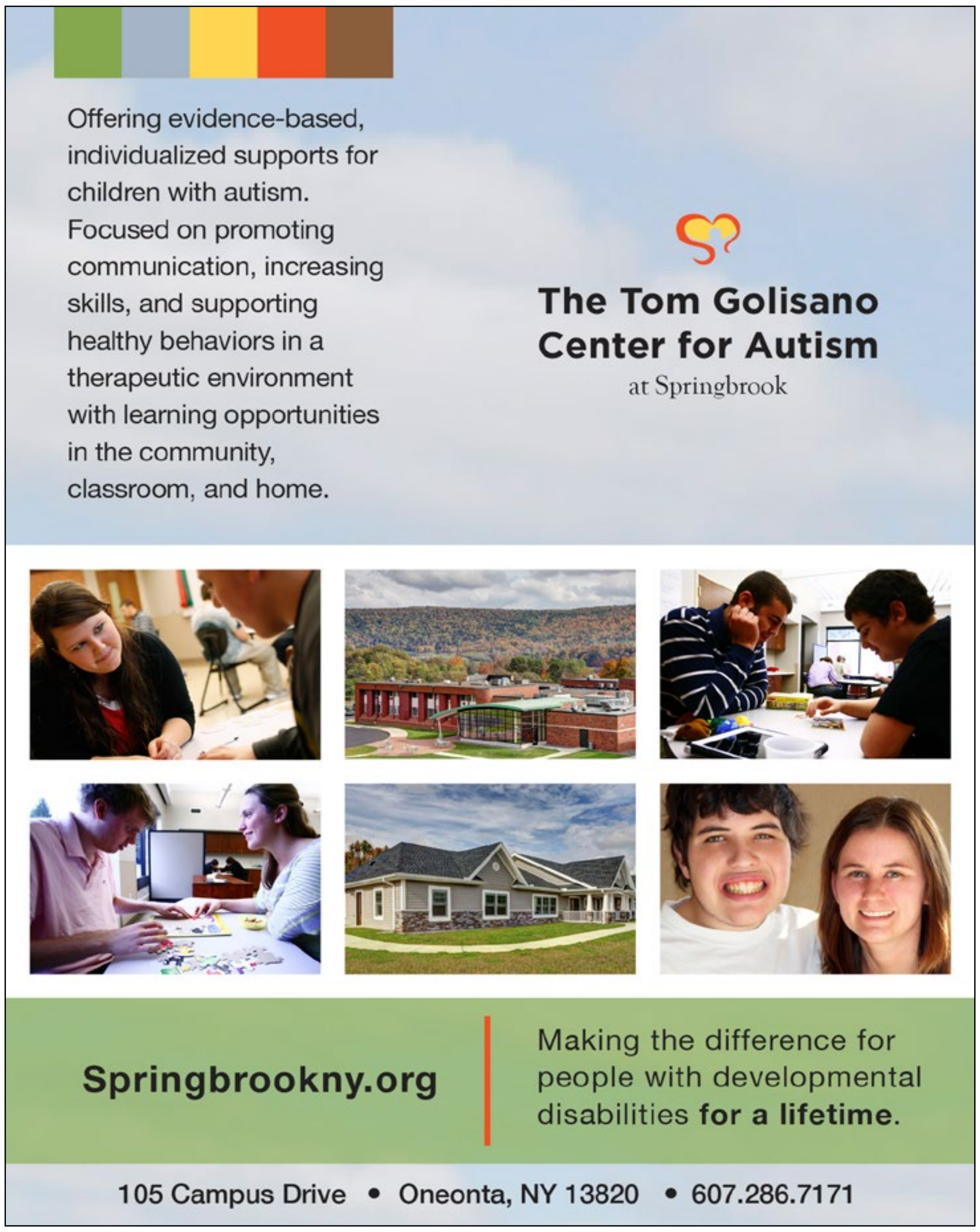
Feeding behaviors in children with ASD may occur for numerous reasons and are specific to each individual. These include medical, sensory, and behavioral causes. If a child is having medical problems such as constipation, stomach aches, or toothaches then this may result in a child refusing to eat. Similarly, many children with ASD have difficulties with sensory processing and this can make eating certain foods a challenge (Baxter, Bellando, Pulliam, Watson, Powell, Srivorakiat, & Bing, 2014). This can include but is not limited to certain textures and colors (e.g. child only eats beige food or refuses to eat any green foods; a child may not eat crunchy or soft foods). Numerous researchers have reported that the inadvertent reinforcement of inappropriate mealtime behaviors frequently contributes to the onset and maintenance of feeding problems (Piazza et al., 2003). For example, if a caregiver removes non-preferred food items when a child refuses to eat or consume the correct amount of food, the child may be more likely to display inappropriate behaviors during meals to avoid eating less preferred food (Bachmeyer, 2009). Similarly, if a caregiver provides access to preferred food items when a child refuses to eat less desirable food items, the child may be more likely to refuse in the future in order to gain access to the preferred foods.

Knowing the signs and symptoms of feeding issues for children with ASD can be challenging. Many caregivers are unfamiliar with common symptoms and struggle with knowing when to get help. Some of the most common signs and symptoms of feeding problems include:

- If there are weight changes (loss or gain)
- If a child only eats a limited number of food items or only certain textured food (e.g., only soft foods)
- If mealtime behaviors are causing stress
- If a child complains or shows signs of pain (e.g., constipation, tooth pain, food allergy/rash)

Even when a caregiver observes these signs or symptoms, identifying what to

see Mealtime on page 45



Is the Label or the Person the Focus?

By Patricia Fratangelo
Executive Director
Opportunities and Choices in Life

Patricia Fratangelo

People who are diagnosed with Autism are often seen first for the diagnosis that they have. Many times programs are developed by organizations that have expertise with the labeled disability. People with autism are often accepted into programs based on this diagnosis. This is not unlike many other disabling conditions, hence the many programs that are available for elders, people with developmental disabilities, people with mental health diagnosis, people with autism, the list goes on. As the saying goes, “birds of a feather flock together.”

Although these programs are not wrong or do not mean to harm, it is just the nature of the program that may not meet the needs of each person involved. When you truly begin to know a person and see them for the unique individual that they are, you may find that the predetermined program may not be the best fit.

To bring this to point, while sitting at a meeting with many Commissioners of our state, a conversation began about the need for proper assessments. Of course every department in each state feels that they are properly assessing its clientele and has the proper programs to meet their needs. But the real question is, are the assessments for a *program*, or are the assessments really weighing the needs of the person being assessed? When this question was brought up, it struck a nerve. The reaction was, if we really evaluated what each person needed, they may not fit into the “silos” we have developed.

This is exactly the reason why predetermined programs do not work for all people. Could this not be the cause of why many behavioral problems then begin to rise?

Listening to each person with autism has taught us a lot about how a system can best support each individual. As with each of us, every person with autism has different aspirations, skill sets, histories, communication needs, and goals that they wish to work on and move towards. It is with taking the time to try to understand this, that one can pick up on what is sometimes referred to as authentically important in that person’s life.

I will introduce you to two men who are each diagnosed with autism. Each of their names has been changed. Each person and their story is very different from the other. Their success is in the planning that occurred to get them what was needed, not just what was available. One of the men was previously in a situation that did not work and caused great angst. The other was asking to continue life with a normal lifestyle. The success is with each individual’s journey. The downfall would be if these men had been grouped together.

Steve Learns to Stand Up for Himself

Steve always lived a sheltered life with family who adored him and always took care of him. As Steve got a bit older and moved into being an adult, he began to struggle with standing up for what he felt was right, and at the time it was right for him. After a lot of planning, Steve moved into his own apartment with a combination of paid and unpaid support to equate a 24 hour service.

At first mom was extremely involved, helping to decorate or stopping in unexpectedly. But as Steve became more secure in his lifestyle, he began to hold a line. He would move things that mom brought in and put them where he wanted, saying it was his home. When she walked in unexpectedly, he learned to tell her to knock first and remove her shoes, as this was his home. If anyone tried to put his clothes away he would tell them No! This was important for him to do.

As Steve began to know more people at his housing complex, he began to get involved in community BBQ’s and would take his turn to host one. He would get help from his housemate and his staff to invite people to come over. If mom showed up he would make it clear that this was his party not hers.

Steve went through a tough and embarrassing experience at the State Fair over 20 years ago that left an obvious scar on him that drew negative attention and forced his family to leave. As he would drive by with staff he would say, “I want to go to the fair…I want to go…I can’t go…I can’t go…” Year after year he would say this and every year he would say, “Maybe next year.” After about five years, Steve asked if he and the staff could go together. The staff told him yes and that they could leave whenever he wanted. The day arrived and without anxiety Steve went to the fair and had a great time. After being there for about two hours Steve said, “I need to go.” They quietly left the fair and went back to this apartment. On the way home, Steve shared the following:

“Sometimes it takes me more time… sometimes I can’t just do something the whole day. I can get filled up like a pool of water - but when the pool is full, the water just runs to the ground. When I get filled

see Focus on page 40

Positive Behavioral Interventions and Supports: An Effective Approach for Schools to Prevent and Manage Challenging Behaviors

By Christine Alter, LCSW
Social Counselor
New York Institute of Technology
Vocational Independence Program

Christine Alter, LCSW

Positive Behavioral Interventions and Supports (PBIS) was developed in the 1980s as a data based behavioral intervention for students with behavioral disorders (BD). Positive Behavioral Interventions and Supports (PBIS) is an evidence based approach which incorporates behavioral and academics supports within a comprehensive framework. The PBIS philosophy gained support in the 1990s, with the reauthorization of the Individuals with Disabilities Act (IDEA) of 1997. A subsequent grant and its funded research indicated that PBIS should focus on prevention, data driven decisions, school-wide programming, and direct social skill teaching, all within a collaborative team-based approach (Sugai and Simonsen, 2012).

Positive Behavioral Interventions and Supports is a great tool to help schools prevent and manage challenging behaviors, as well as teach and reinforce school wide expected behaviors. The PBIS process emphasizes consistency and continuity and therefore would work well in addressing the needs of students on the spectrum who learn best with routine and repetition. Under the PBIS framework, schools create their own unique set of expectations which they define with explicit and concrete behaviors. Staff and students alike are taught the school specific "code of conduct" which is usually developed around a school mascot or theme. Student behavior is evaluated based upon the school's clear expectations. For example, "Responsibility" is a common value for PBIS schools. It might be defined by arriving to school and/or class on time.

Staff is trained to use the code of conduct to acknowledge or address both appropriate and inappropriate behaviors. Schools develop clear protocol for recognizing and rewarding those students who meet school expectations. They also intervene when students are not meeting expectations. Protocol usually includes reviewing the school value and explaining how to demonstrate the value with behavior. If required, more specific skill development can be offered. More serious or repetitive violations become disciplinary matters which are handled by administration's predetermined data-based procedure.

According to the DSM-V, Autism Spectrum Disorder (ASD) has two key characteristics; deficits in social communication and restricted or repetitive behaviors and interests. Students with ASD often experience difficulties with; social reciprocity, interpreting nonverbal social cues and developing social relationships. (www.autismspeaks.org/what-autism/diagnosis/dsm-5-diagnostic-criteria). PBIS focuses on both academic and social skill building. This school-wide behavioral framework clarifies expected behaviors and uses re-teaching and reinforcement to encourage development of appropriate behaviors.

PBIS schools support students with a three-tier behavioral approach. The Positive Behavioral Interventions Supports framework incorporates more intensive supports for those individuals and groups of individuals who need it. The multi-tiered approach gives schools the flexibility to handle all types of behaviors, including the more challenging ones.

Universal expectations or tier one supports set school wide guidelines for the behavior of all students. Students (and staff) are explicitly taught the expected behaviors. Interventions focus on teaching students to understand the school's social, behavioral and academic rules. Students are held accountable to this "code of conduct". By incorporating a PBIS approach schools are able to explicitly explain their culture. Students are better able to understand and navigate school expectations. Students who meet or exceed school expectations receive reinforcement or rewards.

Tier-two and tier-three interventions offer additional assistance to individual(s) who are exhibiting more challenging behaviors and might need extra attention or skill development to meet school requirements. Tier-two and tier-three supports help schools meet the needs of students who require

see Effective Approach on page 40

YAI International Conference May 4-7, in New York City

By The YAI Network

Autism will be a major focus at YAI's 2015 International Conference, Living, Loving, Working & Learning in Intellectual and Developmental Disabilities, May 4-7, in New York City.

Over 200 presenters, from as far as Australia and Alaska, will provide attendees with techniques and strategies that can be effective with children, adolescents and adults with autism and other developmental disabilities. YAI's annual global gathering at The Hilton New York Midtown serves as a major forum for the exchange of ideas and information in the field.

"As we mark the 25th anniversary of the Americans with Disabilities Act in July, we should remember that many children with disabilities grew up under ADA and are living and working in the community today as adults," said Matthew Sturiale, CEO of YAI. "But as our field continues to change, so has the definition of inclusion and quality of life. Children and adults on the autism spectrum, and their families deserve the same dignity, freedom of choice, and sense of belonging to a community as anyone else in society. We need to listen to the individuals we support to see what is important to them."

Among some conference highlights are:

Living

Dr. Stephen Shore, Clinical Assistant Professor of Special Education, Adelphi University, New York (www.autismasperger.net/bio.htm), on the benefits of teaching individuals with ASD a music curriculum and how it can enhance social skills, communication, and other aspects of life.

Loving

Dr. Isabelle Hénault, an expert on relationships and sexuality in individuals with autism and Asperger's syndrome (www.clinique-autisme-asperger-mtl.ca/brunowicker/Isabelle_Henault_en.html). She is the author of Asperger's Syndrome and Sexuality: From Adolescence through Adulthood. Her book has been translated in eight languages. Her newest book written with Tony Attwood and Nick Dubin is titled, The Autism Spectrum, Sexuality and the Law.

Working

Anita Lesko, BSN, RN, MS, CRNA, of Flying High with Autism Foundation, Florida (www.bornwithaspergers.com).

see Conference on page 36

Growth Hormone Treatment Improves Social Impairments in Patients with Genetic Disorder Known to Cause Autism

By The Mount Sinai Hospital at
The Mount Sinai School of Medicine

A growth hormone can significantly improve the social impairment associated with autism spectrum disorder (ASD) in patients with a related genetic syndrome, according to a pilot study conducted at the Icahn School of Medicine at Mount Sinai and published today on *Pub Med*, a public database of biomedical topics maintained by the National Institutes of Health (study originally published in the December 12 issue of the journal *Molecular Autism*).

The study results focus specifically on the use of insulin-like growth factor-1 (IGF-1) to treat Phelan-McDermid syndrome (PMS), a disorder caused by a deletion or mutation of the SHANK3 gene on chromosome 22. Along with facing developmental and language delays and motor skill deficits, most people with PMS also have autism spectrum disorder.

SHANK3 is a focus of research in the field because of its essential role in the function of synapses, the gaps between nerve cells that "decide" whether messages continue along nerve pathways as they regulate bodily processes. While Phelan-McDermid syndrome is a rare disorder, advanced genetic technology has revealed it to be a relatively common cause of ASD.


Alexander Kolevzon, MD


Joseph Buxbaum, PhD

"Ours is the first controlled trial of any treatment for Phelan-McDermid syndrome," says Alexander Kolevzon, MD, Clinical Director of the Seaver Autism Center at the Icahn School of Medicine at Mount Sinai. "Because different genetic causes of ASD converge on common underlying chemical signaling pathways, the findings of this study may have implications for many forms of ASD."

IGF-1 is a commercially available compound that promotes nerve cell survival, synaptic maturation and synaptic plasticity, the ability of synapses to strengthen or weaken over time, in response to increases or decreases in their activity. It is currently approved by the Food and Drug Administration for the treatment of short stature.

The Mount Sinai study is the first to suggest that IGF-1 is safe, tolerable and associated with significant improvement in both social impairment and restrictive behaviors (fascination with one subject or activity; strong attachment to one specific object; preoccupation with part[s] of an object rather than the whole object; preoccupation with movement or things that move) in people with Phelan-McDermid syndrome, said the study authors.

Researchers enrolled nine children aged 5-15 years who were diagnosed with Phelan-McDermid syndrome in a placebo-controlled, double-blind, cross-over design study. All participants were exposed to three months of treatment with IGF-1 and three months of placebo, in random order. Compared to placebo, the IGF-1 phase was associated with significant improvement in social withdrawal and restrictive behaviors as measured by the Aberrant Behavior Checklist and the Repetitive Behavior Scale respectively, both standard behavior scales used to assess treatment effects in ASD.

Preclinical studies of SHANK3 deficient

see Hormone on page 27

The Changing World of OPWDD Services and Supports

By Peter Pierri
Executive Director
InterAgency Council of Developmental Disabilities Agencies, Inc.

For every parent who watches their child morph into a young adult right in front of their eyes, this transformation is filled with anticipation, uncertainty and limitless challenges. For the parent with a child on the autism spectrum these issues are magnified as they begin to explore the world of supports funded and regulated by New York State's Office for People with Developmental Disabilities (OPWDD). Of course, many families receive some OPWDD services when their children are younger, often in the form of respite or after school programs. In fact, almost 25% of all people served by OPWDD are under the age of 22. However, by the time students reach 16 years of age, families need to begin planning for the days after graduation from school. Effective and thorough transition planning is absolutely crucial to help determine what supports the young adult will need to lead a productive and fulfilling life. Complicating this process is the current transformation of virtually every service offered by OPWDD, including various day and residential supports, employment services, as well as those services offered through a self-determination approach. Some of these changes are driven by reforms of long-standing funding reimbursement formulas. However, much of OPWDD's transformation is derived from initiatives on the part of the Federal government, whose effort is focused on ensuring that individuals with developmental disabilities are actively engaged in the full complement of available community experiences.


Peter Pierri

Employment Opportunities

Nationally, the rate of employment among individuals with developmental disabilities is extremely low and New York lags behind many other states. OPWDD submitted a plan to the Federal government focused on how they would improve this situation. The plan calls for the number of people in competitive employment to increase by at least 700 individuals annually. Competitive employment is defined as employment in an integrated setting, in the general workforce, where a person earns at least minimum wage. To achieve this goal, OPWDD is creating a new service called Pathway to Employment, which focuses on comprehensive career planning. It will provide assistance for participants to obtain or maintain competitive employment. This service is now becoming available and it engages a participant in identifying a career direction; provides instruction and training in pre-employment skills; and develops a plan for achieving competitive, integrated employment. Within 12 months, the outcome of this service is intended to be a determination of the participant's stated career objective; a detailed career plan to guide individualized employment supports; and preparation for supported employment services and obtainment of a job.

Current reimbursement rates for OPWDD's supported employment service are problematic as they are designed in such a manner that assumes a job coach will eventually fade from the job site and the individual will remain employed without on-site supports. We know that for many individuals on the autism spectrum, acquiring job skills is only part of the reason why support on the job is necessary. Often their communication deficits and/or behavioral challenges require long-term supports in order for them to retain their employment, and therefore, a job coach may be needed long-term to ensure long-term success for the individual. Fortunately, OPWDD's proposal for revising the funding for supported employment is being designed to allow a job coach to remain in place as long as the individual needs that support.

OPWDD's plan also calls for the closure of all sheltered workshops in 6 years, due to the fact they are segregated environments that do not afford the opportunity for typical interactive exposure with people without disabilities. New York's sheltered workshops collectively serve almost 8,000 individuals. OPWDD anticipates 50% of these individuals will transition to some form of competitive employment within the next 6 years and OPWDD will be giving individuals, and their families, information regarding employment alternatives. Those that will not choose this path may have either medical or behavior-related issues that would create significant barriers

see OPWDD on page 30

Rumination: Past, Present, and Future

**By Jennie England, MA, BCBA,
and James T. Chok, PhD, BCBA-D
Melmark**

Jennie England, MA, BCBA

James T. Chok, PhD, BCBA-D

Rumination is characterized by regurgitation of previously ingested food into the mouth, and re-chewing, re-swallowing or expelling that food (Chial, Camilleri, Williams, Litzinger, and Perrault, 2003). Although rumination is typically observed in infants and individuals with developmental disabilities, it does occur in adolescents, children, and adults with normal intelligence (Chail, Camilleri, Williams, Litzinger, and Perrault, 2003). It is estimated that an average of 6-10% of individuals with severe intellectual disability who are living in a residential treatment facility engage in rumination (Lang et al., 2011). There are several medical conditions/diagnoses that could result in ruminative behavior. These include gastro-esophageal reflux disease, upper gastrointestinal motility disorders (e.g., gastroparesis), and bulimia nervosa (Chial, Camilleri, Williams, Litzinger, and Perrault, 2003). The medical consequences of engaging in rumination over a prolonged period of time range from halitosis to malnutrition, dental erosion, and weight loss (Chial, Camilleri, Williams, Litzinger and Perrault, 2003). In addition to medical complications, several social consequences of ruminative behavior have been identified. These include, but are not limited to, unkempt personal appearance and foul odor, which can result in social isolation and/or decrease in educational or vocational opportunities (Lang et al., 2011). Thus, it is important that behavioral treatments for ruminative behavior, in conjunction with medical interventions (when applicable), are evaluated.

Since Iwata et al.'s (1982/1994) seminal article on the importance of determining the function of behavior prior to treatment, the use of functional analysis has become a cornerstone assessment in the field of applied behavior analysis. Functional analysis results allow clinicians to determine what types of environmental conditions evoke challenging behavior and what consequences maintain it. Functional analyses have been conducted for behaviors such as aggression, self-injury, property destruction, and more recently food refusal and rumination. Although not within the scope of this article, the majority of functional analyses of rumination conducted have revealed that, in most cases, rumination is maintained by an automatic reinforcer (Lyons, Rue, Luiselli, and DiGennaro, 2007; Wilder et al., 2009; Woods, Luiselli, and Tomasson, 2013), meaning that often the reinforcer for ruminative behavior is produced by the behavior itself and is not socially mediated. However, the use of functional analysis to determine the functional reinforcer of ruminative behavior is limited and more research is needed in this area.

Several treatment options have been used to treat ruminative behavior, including punishment, differential reinforcement of alternative behavior, differential reinforcement of other behavior, the delivery of a competing item, and manipulation of meal variables. Positive punishment, which involves the presentation of an aversive stimulus following a response, and a subsequent reduction in behavior, has been effective at decreasing rumination. Sajwaj, Libet and Agra (1974) were able to eliminate rumination in an infant, by squirting unsweetened lemon juice into the infant's mouth at the first sign of rumination. The elimination of rumination also resulted in increased weight gain, babbling, smiling,

see Rumination on page 44

Best Practices for Understanding and Managing Challenging Behavior at School: Using an FBA and BIP

By Meir Flancbaum, PsyD,
Elena Zaklis MA, BCBA,
and Michael Selbst, PhD, BCBA-D
Behavior Therapy Associates

When addressing behavior problems, a careful assessment provides the foundation for effective and efficient intervention. Consider the following scenario: After struggling with headaches for nearly a week, you visit a doctor. Following a brief discussion, the doctor suggests brain surgery. While surgery may be effective, it is also possible that your headaches are related to the fact that the prescription in your glasses is out of date. Or, they may be caused by not drinking enough fluids on a daily basis.

You would not want to undergo an eye exam if the headaches could be alleviated by drinking more water. And you would not want to undergo surgery, if the headaches could be treated by purchasing updated lenses. While there are multiple treatment options for headaches, the quickest and most effective way to alleviate them is to precisely identify the cause.

Similarly, effective management of challenging behaviors in children, such as tantrums and non-compliance, must begin with a careful, detail-oriented assessment.

Meir Flancbaum, PsyD

Elena Zaklis MA, BCBA

Michael Selbst, PhD, BCBA-D

Conducting an FBA and Developing a BIP

The most effective way to understand and manage these behaviors is to conduct a Functional Behavior Assessment (FBA) and develop a Behavior Intervention Plan (BIP). The New Jersey Special Education Code (Chapter 6A:14) requires school personnel to complete an FBA and BIP when a student displays behaviors that significantly interfere with daily functioning.

An FBA refers to the full range of procedures to identify a specific problem behavior, to understand the factors leading up to and following it, and to generate hypotheses about the reasons the problem behavior maybe occurring. A BIP refers to strategies designed to reduce the problem behaviors and increase desired behaviors.

It helps to think of an FBA/BIP as a five step model:

see Best Practices on page 46

Understanding the Father Factor While Raising Children with ASD

Robert Naseef, PhD
Psychologist
Alternative Choices

Fathers of children with autism tend to be either very involved or withdrawn and virtually absent from interactions with professionals—with the majority seemingly uninvolved. From this observation, many professionals assume that fathers do not wish to be involved. Is this really the case, or do men relate and need to be engaged somewhat differently?

Fathers are often poorly represented at IEP meetings, conferences, and support groups for parents of children with autism. Usually they are at home watching the children so that their partners can attend, or they are at work providing for their families. Men generally prefer to do things to help out as opposed to connecting by talking about the stresses and strains.

Robert Naseef, PhD

Until relatively recently, the role of fathers in child development was largely ignored in the professional literature. While traditionally regarded as providers and protectors, fathers were not expected to be involved in day-to-day parenting, with the notable exception of discipline. In emphasizing the importance of mothers, researchers lost sight of the father in the family context. The word parent became synonymous with mother. This same trend applied to fathers of children with disabilities. Consequently the literature specifically about fathers of children with ASD is limited; however, the broader literature can inform contemporary practice and research.

Father Involvement

Lamb (2010) found that past studies consistently reported that fathers tend to "specialize" in play, whereas mothers specialize in caretaking and nurturance. This narrow view failed to capture similarities of fathers and mothers on child development. The emerging role of fathers over the past three decades has spurred research. Increased father involvement has been demonstrated to result in improved cognitive competence, increased empathy, fewer sex-stereotyped beliefs, and better self-control.

Lamb further speculates that increased paternal involvement promotes both parents' fulfillment. Fathers can be close to their children while mothers can also be close to their children and pursue career goals. Lamb concludes that fathers and mothers seem to influence their children in similar rather than dissimilar ways. Parental warmth, nurturance, and closeness are associated with positive child outcomes regardless of whether the parent involved is a mother or a father.

Jones and Mosher (2013) in a nationally representative survey of over 10,000 men found that most American fathers say they are heavily involved in hands-on parenting. This results in significantly better outcomes for their children in academic success, fewer behavior problems, and healthier eating habits. Fathers living with children younger than 5 reported that 90% bathed, diapered, helped toilet or helped their children to get dressed at least several times weekly. Even more played with their children and ate meals with them frequently. Two-thirds read to them several times weekly. Ninety percent of fathers living with children ages 5 to 18 reported eating meals together several times per week and talking with them about their day. Two out of three fathers helped with homework frequently, and about half took their children to or from activities.

Father Involvement in Clinical Interventions

Men are less likely than women to seek mental health services and medical treatment across race, ethnicity, age, and parental status (Addis & Mahalik, 2003). Not surprisingly, fathers are significantly less involved in clinical interventions for their children than mothers, and fathers tend not to be included in the overwhelming majority of research on child- and family-related therapy. Nonetheless there is evidence suggesting that fathers have a positive influence on child behavior when they are included in the mental health treatment.

Research has consistently shown that men are less likely than women to admit to uncomfortable or negative feelings (Addis & Mahalik, 2003). Seeking help typically involves recognition of problems and is in direct conflict with the masculine gender

see Father on page 36

The Lighter Side of the Spectrum ~ A Mom's View

By Carrie Cariello

Why I Wasn't Afraid to Label My Son

Dear Jack,

When you were about year old, we saw a bunch of doctors and specialists to try and figure out why you didn't talk or point or look at us. And at that time, many people told us not to rush to give you a label.

"Be careful with a label, because it will be on all of his forms and medical records," one man advised.

"It will follow him for the rest of his life," another woman warned.

See Jack-a-boo, people don't like labels. No one wants to be limited or boxed in or classified. They especially don't want to be pigeon-holed, which actually has little to do with a bird and more to do with compartmentalizing people into teeny-tiny, mutually exclusive categories.

But at the tender age of 18 months, the doctor diagnosed you with autism spectrum disorder, and from that point forward, you were labeled.

Honestly? I'm glad.

Now, I'm not saying I'm glad you have *autism*. I'm not really sure how I feel about that.

I'm just saying I'm glad we *know* you have autism. I'm glad for the label.

Jack proudly writing out his Valentine's Day cards

See, if you didn't have this label, I would probably snap at you to stop jumping and rocking and flapping.

I would think you were naughty and rude and disrespectful.

I might rush you whenever you try to explain something to me in your halted, robotic speech.

Every day I would feel exasperated and frustrated and angry and scared. I might even feel embarrassed or ashamed.

Maybe we would hide in the house like we did when you were a toddler, avoiding play dates and trips to the library so I didn't have to see all the other kids who could wave bye-bye and blow kisses and play peek-a-boo.

But now, we don't hide. We go to the movies and to church and to restaurants and roller skating. We go on vacation.

Jack, you are labeled. And every day I feel exasperated and enlightened and aware and frustrated and thrilled and angry and scared. I feel protective and vulnerable and inspired.

However, I never, ever feel embarrassed or ashamed.

(Well, I might have been a little bit embarrassed the time we went to see Maleficent and you announced, "We don't need to BUY your candy. We have some HIDDEN IN MY MOTHER'S PURSE," to the guy who took our tickets.)

Renouncing your label would be a fundamental rejection of who you are, like denying that you have blue eyes or long legs.

If I didn't know you had autism, I might call to you impatiently when you stop to count all the tubs of frosting in the aisle of the grocery store.

"Jack, come on. Let's go!"

But instead, I will myself to slow down, to stop the cart next to you and help you choose the best, most perfect pink frosting for the heart-shaped Valentine's Day cake you've been talking about baking for weeks and weeks.

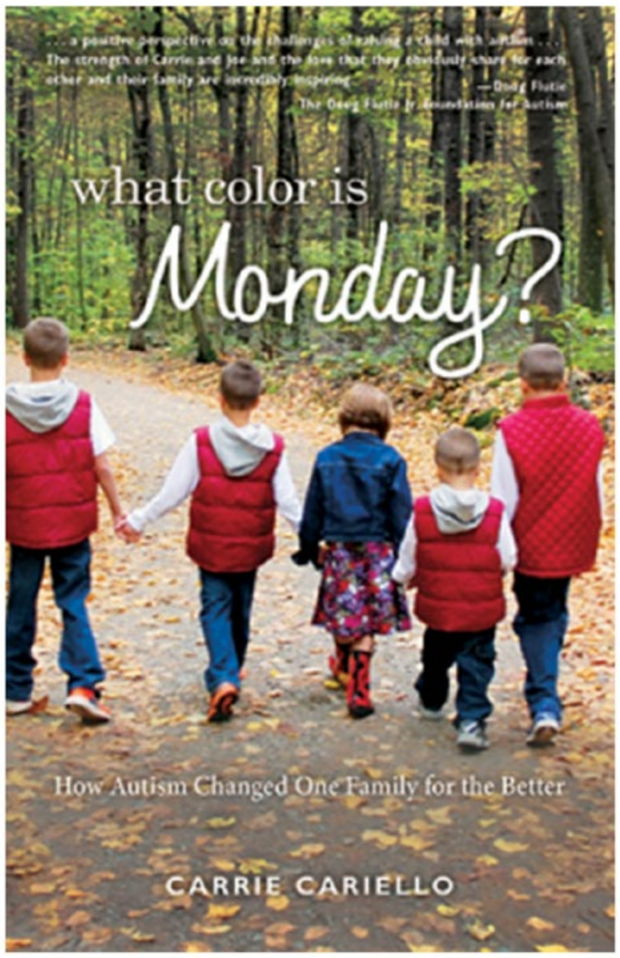
Maybe I would wish your baking phase was over, because sometimes it wears on me. But as I become more and more acquainted with autism, I know there will just be another phase lurking right behind it—it could be something innocuous like when you used to rub soap all over the walls, but maybe it will be something dangerous and scary, like when you used to try and run behind cars to see the license plates.

With your label, I have learned to enjoy the hoof beats of horses, because I know there are zebras ahead.

If we didn't know you had autism, Daddy and I would probably be divorced. The pressure of fitting a square boy into a round world would be way too much for us, and we would crack apart.

Oh, we still argue. You know that. We disagree on whether or not you should wait

see Label on page 38



Behavior as Desire for Control in Autism Spectrum Disorders

By Daniel Crofts, MA
Day Habilitation Assistant
Genesee County Chapter NYSARC

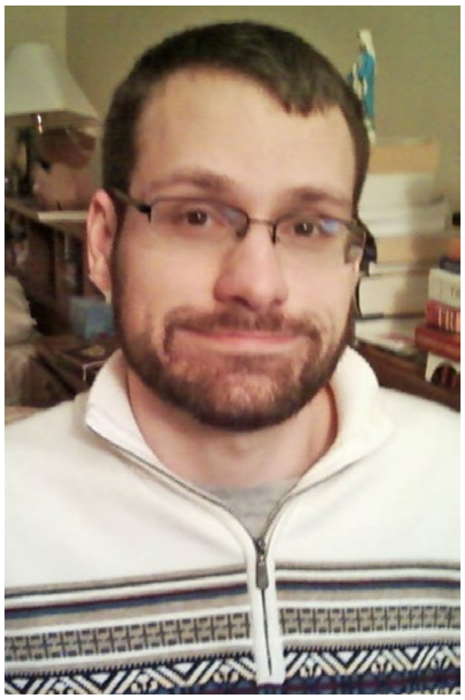
Occasionally we all need a gentle reminder that autism is not an abstraction floating around in the ether. Autism is real precisely because *people* experience it, and separate cases of autism spectrum disorders differ so markedly because their subjects are unique individuals with different personalities, experiences, genetic and environmental influences, etc.

For that reason, in my opinion, any exploration of behavioral issues in autism should be prefaced by a consideration of human behavior in general.

Certain behavioral issues are particular to autism. This is especially true of *sensory*-related behaviors, and I would say that the sensory component, after consideration of possible medical concerns, should come first.

At the same time, there are as many reasons for human behavior as there are ways of behaving, and people on the autism spectrum are no different in that regard. That said, I want to focus on a motivation for human behavior that is perhaps not attended to as much as it might be: Control.

No one likes to lose control. Most of us – even if unconsciously – will latch onto it wherever we can, however superficial our control might be in any instance. So imagine being a child on the autism spectrum: Your sensory sensitivities are such that the world seems always to be either attacking you or *preparing* to do so; your understanding of social, personal and practical norms are so different from those of the world around you as to make you feel like you are on another planet some days; and you find yourself often unable to comply with what is expected of you.



Daniel Crofts, MA

Doesn't sound so easy, does it? In similar circumstances, who wouldn't look for and seize whatever little control they could? Here is where behavioral concerns can come into play.

If you think about it, disruptive behavior is almost like a kind of magic. In your mind, play the part of the misbehaving child a moment: With a single word, gesture, action or refusal, you can exercise a powerful influence on your environment. Facial expressions change, adults turn their attention away from whatever they were doing before in order to handle the situation you are creating, the whole mood and atmosphere of your surroundings change, and your peers might even have behaviors of their own. Quite possibly, you may even be able to get out of unwanted situations or obtain something that you desire.

How's That for Control?

Again, there are many kinds of behavior. For people on the autism spectrum as well as for everyone else, these tend to be rooted in deeply ingrained habits and patterns of thought. To be sure, an individual person's *free will* is the only factor in *direct* causal relationship with his/her behavior (except in cases of severe intellectual incapacitation). But there are a variety of key influences that are, like so much else in human life, a combination of nature and nurture, heredity and environment, inner and outer. I would say, therefore, that we need to look at behavioral issues in autism in reference not only to autism as a diagnosis, but also to autism as a *human* phenomenon – which is to say, we have to look *outside* as well as *in*. The whole "dance" of nature and nurture, which profoundly influences behavioral habits, starts in the formative years of infancy. For that reason, I make a momentary digression.

Why do babies cry? In a word, *desire*. They want to be fed. They want to be put to bed. They want to have their diapers changed. They want to be cuddled and loved. And lest we think that crying is the only infantile behavior associated with such needs, let us keep in mind the "sucking" gestures a baby will make with his/her mouth in anticipation of receiving milk from the breast (or from the bottle, depending on the mother's method).

Many psychologists will tell us that this is part of the infant's desire for integration of experience, for correspondence of *inner needs* and *outer reality*. A major need of the infant is, of course, learning to understand his world and himself. But s/he is so radically dependent on adult caregivers that his/her self-confidence and self-control will only attain healthy development to the degree that adult controls and aids

see Control on page 35

Adults from page 1

often engage in challenging behavior that is considerably more intense in comparison to that of the behavior of their younger counterparts. The risk of injury may deter staff members from running sound functional assessments despite the empirical support for their use.

Concern with running traditional functional analyses - While traditional functional analysis represents the most accurate way to determine the function of the behavior, it is also the most intrusive and time-intensive assessment method. Furthermore, there is a concern that this kind of assessment involves the evocation of maladaptive behavior, which increases risk to the learner and the staff who are conducting the assessments.

Complexity of challenging behavior in adults - Intervening with challenging behavior in adult populations with autism tends to be more labor-intensive and difficult, in that it tends to be more complex. Maladaptive behavior that has occurred over the course of many years may be controlled by many different factors and have multiple forms, which can increase the difficulty and the duration of the assessment and intervention process.

These concerns often lead to the use of less intrusive, yet less empirically sound modes of assessment. The use of less supported methods of assessment increases the likelihood of errors occurring in the assessment process, which in turn, compromises the subsequent effectiveness of interventions and worsens outcomes for the adult ASD population.

Robert H. LaRue, PhD, BCBA-D

Assessment Solutions

In light of these challenges, there have been a number of less intrusive assessment variations that may be of particular use for older learners exhibiting challenging behavior. These procedural variations include: AB models of functional analysis, trial-based functional analysis, and the functional analysis of precursor behavior.

AB models of functional analysis - AB models of functional analysis involve manipulating the settings or antecedents for problem behavior and observing the effect on the occurrence of the behavior. For example, a practitioner may expose a student to low levels of attention (e.g., acting distracted) or presenting difficult demands (e.g., a math worksheet) and then observe the effects on problem behavior. These manipulations may provide valuable information about what triggers and maintains problem behavior. For instance, if an individual engages in problem behavior when presented with demands, but does not engage in the absence of demands, it suggests that escape may be the function of the behavior. The outcome data recorded from this type of assessment is comparable to traditional functional analyses and has been shown to be empirically sound (Freeman, Anderson, & Scotti, 2000; Anderson & Long, 2002).

Trial-based models of functional analysis - Trial-based models of functional analysis involve running extremely brief sessions (e.g., 1-2 minutes) and only reinforcing the *first instance* of the maladaptive behavior. This method of assessment has garnered empirical supported and has been shown to correspond well with traditional functional analysis (Bloom, Iwata, Fritz, Roscoe, & Carreau, 2013; LaRue, Lenard, Weiss, Bamond, Palmieri, Kelley, 2010). In addtiion, this assessment method reduces the overall occurrence of maladaptive behavior, thus mitigating concerns about evoking and reinforcing maladaptive behavior.

Functional analysis of precursor behavior - Precursor models of assessment generally involve conducting a functional analysis for a less severe problem behavior that reliably precedes the more severe challenging behavior. For example, if inappropriate vocalizations were to occur immediately prior to aggression, conducting a functional analysis of the vocalization may yield information about the function of the aggression without actually evoking it. Precursor models of assessment have garnered empirical support for their use (e.g., Smith & Churchill, 2002) and may be particularly useful for limiting the occurrence of problem behavior during the assessment process.

Intervention Strategies for Adults with Autism Spectrum Disorders

Broadly speaking, best-practice interventions can occur at one (or more) of three points along the ABC sequence of problem behavior described above: doing something to the environment before the behavior happens, training an alternative behavior to replace the maladaptive behavior, or changing what happens after the behavior has just occurred. It bears repeating that the implementation of all of these strategies either require or are greatly enhanced by an accurate understanding of the *function* of the maladaptive behavior in question, which may be determined through functional assessment techniques. The bottom line is that better assessments permit better treatments.

see Adults on page 41

Understanding Aggressive and Self-injurious Behavior

By Rachel LaPiana, MSEd, BCBA
ABA Training Coordinator
QSAC

When addressing challenging behaviors, specifically when it comes to aggressive behaviors and self-injury, it's important to understand the reason as to why these behaviors are occurring before determining a solution. The behavior of all living organisms serves specific purposes; and the reason behavior occurs varies depending on an individual's need in a given moment. Dependent on the circumstances, one behavior can serve multiple functions or multiple behaviors can serve one purpose.

Understanding the basic function of behavior is pertinent when dealing with the behaviors related to individuals on the autism spectrum. Research indicates that individuals with greater skill deficits often engage in higher rates of aggressive behaviors. This is likely due to inefficient communication abilities, reduced socials skills and social supports, as well as a greater degree of intellectual disabilities (Sturmey, n.d.). Aggressive behaviors tend to be more prevalent during the younger years of a person's life and appear to be directed toward familiar people and caregivers as opposed to strangers (Autism Speaks, 2012). Further, some studies suggest that self-injurious and aggressive behaviors can be a result of biological or biochemical components leading to compulsive type behaviors that are difficult to treat (Autism Speaks, 2012). However, in general, most behaviors are learned and reinforced over time.

At the very core of most human behavior is the inherent need to satisfy primary needs. The primary needs of all living beings are classified as unlearned and natural; these include hunger, thirst, sexual drive, and the ability to maintain appropriate temperature. Once basic needs are met, individuals then look to satisfy what are known as secondary needs. Secondary needs include items and activities that are learned and are comprised of things that living beings desire but do not require for survival.

In relation to human action and primary vs. secondary needs, the term reinforcement is widely used in the behavior analytic community. Reinforcement refers to the presentation or removal of a stimulus immediately following a behavior which in turn, encourages the behavior to occur more frequently in the future. Reinforcement is individualized and personal and must possess desirable properties. Behavior is maintained through reinforcing consequences present in the environment; however, not all items and activities will maintain the same reinforcing value over time, across environments and across people as the significance of things change day to day and often moment to moment.

In relation to severe problem behavior that can put an individual at risk or risk the safety of others, experts strive to identify the function and the maintaining reinforcer as soon as possible in order to implement an intervention quickly. Initially, a clear description of the behavior is required in order to assess the function. Antecedents, setting events and environmental factors are all subject for review when determining the function of any behavior. Experts often look to do a functional assessment and sometimes a functional analysis to determine a cause or pattern in behavior.

Maintained across all functions, aggressive behaviors toward one's self or others serve to meet the needs of the individual. Often times, individuals with autism are unable to make requests for the things they need and want. Once identified, the function of aggressive behaviors that are emitted can be replaced with a more appropriate

see Aggressive on page 32

Hormone from page 22

mouse models developed at Mount Sinai and human neuronal models derived from pluripotent stem cells (stem cells that have the capacity to produce several distinct biological responses) of humans with SHANK3 deficiency previously suggested that IGF-1 can reverse synaptic plasticity and motor learning deficits. These studies formed the basis of this clinical trial and the results provide support for the ongoing effort to develop related drug treatments.

"This clinical trial is part of a paradigm shift to develop targeted, disease modifying medicines specifically to treat the core symptoms of ASD," says Joseph Buxbaum, PhD, Director of the Seaver Autism Center and Professor of Psychiatry, Genetics and Genomic Sciences and Neuroscience at Mount Sinai. "Results from this pilot trial will facilitate larger studies that more definitively inform efficacy and better targeted therapeutic treatments."

This study was funded by that Beatrice and Samuel A. Seaver Foundation and by the National Institute of Mental Health, part of the National Institutes of Health.

About the Seaver Autism Center for Research and Treatment at Mount Sinai

The Seaver Autism Center for Research and Treatment at Mount Sinai conducts progressive research studies aimed at understanding the multiple causes of autism spectrum disorders (ASD). The multidisciplinary team is comprised of experts in the fields of genetics, molecular biology, model systems, neuroimaging, and experimental therapeutics who are dedicated to discovering the biological causes of ASD. The Center strives to develop innovative diagnostics and treatments for integration into the provision of personalized, comprehensive assessment and care for people with ASD. The Seaver Autism Center was founded through the generous support of the Beatrice and Samuel A. Seaver Foundation. For more information, visit www.seaverautismcenter.org.

About the Mount Sinai Health System

The Mount Sinai Health System is an integrated health system committed to providing distinguished care, conducting transformative research, and advancing biomedical education. Structured around seven member hospital campuses and a single medical school, the Health System has an extensive ambulatory network and a range of inpatient and outpatient services—from community-based facilities to tertiary and quaternary care.

The System includes approximately 6,600 primary and specialty care physicians, 12-minority-owned free-standing ambulatory surgery centers, over 45 ambulatory practices throughout the five boroughs of New York City, Westchester, and Long Island, as well as 31 affiliated community health centers. Physicians are affiliated with the Icahn School of Medicine at Mount Sinai, which is ranked among the top 20 medical schools both in National Institutes of Health funding and by U.S. News & World Report.

For more information, visit www.mountsinai.org, or find Mount Sinai on Facebook, Twitter and YouTube.

***Proven** from page 1*

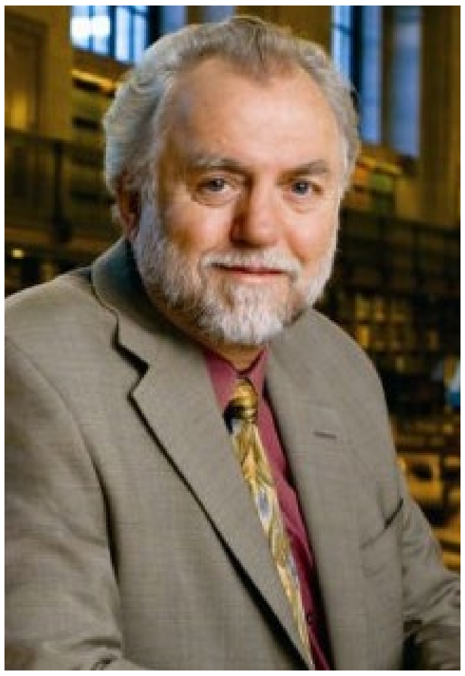
reduce challenging behaviors and see positive improvement is to fully commit to bringing about a new kind of environment—the caregivers have to change before the individual with challenging behaviors will.

2) *Gather Data* - It's important to start by collecting baseline data for several reasons. Having a quantitative measure of the starting point allows accurate and objective progress tracking, encourages new thinking, and demonstrates ultimate success.

The first step is to determine what the caregiver or organization wishes to measure, and how that data will be collected. Examples include: number and types of physical interventions utilized by the organization and its various departments, numbers of injuries, number of tantrums, the amount and extent of damage to property, and others as relevant. Each organization may determine what it will measure, but, measurement is critically important.

3) *Assess Internal Team* - This is primarily geared toward organizations, but would be relevant for any group working together to create a more positive environment for an individual with autism to reduce challenging behaviors, including families, caregiving teams, and others.

Instituting this type of change will go more or less easily depending on the expertise of the team involved, and their willingness to embrace whatever changes affect them individually. An early step in the process should be to objectively assess team expertise as well as their willingness to change or improve.



George Suess

4) *Define a Plan and Goal* - Depending on their size and current expertise any given organization should be able to dramatically reduce their reliance on physical interventions within one to three years. A proper internal assessment will generate the information and analysis necessary to set a proper goal within a reasonable time frame.

For an organization, that goal might look like "The XYZ Organization will reduce the number of physical interventions by 80 percent within 18 months." For a family or individual caregiver, it may be "I will work with [name] to reduce tantrums by 10 percent this month."

Organizations should make sure that measurable goals are announced loud and clear throughout the organization.

5) *Share the Plan with the Full Team* - Dramatically increasing the effective use of praise and reinforcement is an essential element of a positive approach. Most people who work in this field have never worked in or experienced an environment where praise and reinforcement are used lavishly.

This presents a dilemma whereby many staff members feel they use praise and reinforcement effectively when, in fact, significant improvement is needed.

An immediate step can be taken to collect base line data. The types and rates of reinforcement should be counted for a particular time interval. Then goals can be established and an organized effort can be initiated to dramatically increase both the types and rates of praise and reinforcement. Consider challenging staff to praise or reinforce each person they are working with once per minute for one week.

6) *Increase Praise and Reinforcement* - Positivity means focusing on the good in people and on the good times. It nourishes strong, caring and productive relationships. The most powerful tool for positivity is consistent use of praise and reinforcement. This practice frees caregivers to use their creative power to find solutions rather than manage problems.

When consistent in this practice, the benefits will quickly become evident—people respond well to praise and reinforcement when it is properly and lavishly used.

This applies to how staff training is approached in addition to direct interaction with individuals with autism.

7) *Redefine Key Support Roles* - This is especially important in organizations, where the roles of specialists like psychologists and behavioral specialists need to evolve from doing to teaching. Job descriptions may need to be rewritten to reflect this change. They should adopt a view of themselves as behavioral mentors to direct service, supervisory and clinical staff.

The goal of this process is to put the tools of positive practice in the hands of the people who do the work. Rather than the traditional paradigm of having a very small percentage of "behavioral specialists" on staff, the emerging new paradigm will use existing specialists to train and develop the entire workforce so that 100 percent of the team will become specialists in positive behavioral approaches.

Outside of organizational settings, caregivers should consider, who else plays a role in the individual's life? Be sure everyone is on the same page with this new positive approach.

8) *Limit the Availability of Physical Intervention* - Another way to help reduce the implementation of physical intervention is

see Proven on page 42

***Asperger's** from page 16*

or asthma then a psychiatric one. So, why the difference? One of the big answers is stigma. Despite how far we've come in the field, psychiatric disorders of the mind are viewed and treated differently than those of the body. And even parents of special needs children, while likely more sensitive to the effects of the stigma, are not necessarily immune to them.

This issue is especially complicated when it comes to autism spectrum disorders. There are some in the field who don't view Asperger's or autism spectrum disorders as disorders at all but rather as unique ways of perceiving the world that should be embraced rather than cured. All of this makes it even harder for parents to gauge the meaning of the diagnosis and cautious about attributing a label that can be lifelong.

Parents Processing Their Own Experiences

Another important consideration is the parents' reactions to the diagnosis. One thing to keep in mind is that our children are reflections of ourselves. More often than not, one or both parents identifies with what their child is going through because they experienced similar struggles themselves. There are times where a child's diagnosis may also bring to light a parent's undiagnosed condition that has been untreated or misunderstood for many years. Acknowledging their child's disability may therefore trigger painful memories and powerful defenses for parents which, if left unattended or unresolved, can have a meaningful impact on how their child makes sense of their diagnosis. Therefore, if you are considering having this discussion with your child, we recommend first investing time into exploring your beliefs and biases about their diagnosis. Even if you hold these views close to your chest, your children may pick up on them implicitly. We are big advocates of parents scheduling meetings with a psychologist as a means of processing through their own feelings about their child's diagnosis before sharing it with their child. These meetings can help parents clarify some of their own feelings and help them formulate a language and description that they are comfortable with in speaking with their child.

Thinking about the Child's Age and Level of Functioning

Children are diagnosed at various different ages, across different times in their lives. They can be diagnosed as young as two or three or well into adolescence, so the discussion about when and how to talk to a child about the diagnosis will likely be impacted by the age of the child. In addition, the Asperger's diagnosis can be given to a wide range of children with various challenges and levels of emotional maturity. Some children may be able to grasp the nature of the diagnosis at seven and eight, while for other children, it may seem too abstract, even at 16 years old. Both a child's

see Asperger's on page 33

Bitten by the Truth

By Alexandra Bricklin, MA, MT-BC
Parent and NSEAI Certified
Special Education Advocate

Three years ago, at 4 am in the morning, my life began to unravel when my daughter sank her teeth into the fleshy part of my inner thigh. “Mommy, please help me!” she begged as she fell to her knees and grabbed my legs. Then she clamped down hard and held on tight like a pit-bull. I screamed, her teeth still embedded in my inner thigh. When the policeman approached her, she kicked him. He faced her down and handcuffed her. Two emergency responders strapped her into a gurney and shuttled off to the hospital. That morning we had seen a Cognitive Behavioral Specialist for my daughter’s nocturnal panic disorder and its resulting insomnia. This specialist had confronted her: “If you continue keeping your mommy up at night, she will get sick!” This, of course, was the trigger that set her off that night. Ever since her dog had died, she had been terrified of falling asleep. Her solution was to stay awake.

When I arrived at the ER, I learned she had bitten hospital personnel. This explained the 4-point restraints and a bleeding catheter hanging between her bare legs. She remained in 4-point restraints until evening when involuntarily admitted into acute psychiatric care.

Alexandra with her daughter Rebecca (above)

How had my cute, beloved autistic child grown up into such an ugly dangerous adult? For 26 years I had allowed myself be held captive by her angry outbursts, and had vehemently sought absolution. What more could I do to help this wild (adult) child acquire impulse control?

Five Days Later

The jury approved an additional two week commitment, but I convinced them to discharge her into pending 24/7 in-home supports. Within two weeks, I had two awake staff all night long, 7 nights a week. They blocked her from beating on my bedroom door. In response, she threw household objects at them and threatened to kill them.

Each night, I lay wide awake locked up in my bedroom listening to her tirades, shuddering like a victim of an air-raid. In the morning, I got up, made her breakfast and went to work, leaving her in the care of the next shift.

It was agonizingly stressful trying to adjust to the 12 different people coming and going in and out of my house day and night. My feelings of discomfort with the strange people awake all night in my living room resulted in forfeiting all urges to go downstairs for anything, not a cup of tea or a snack, not for anything. I reassured myself that all of those people were necessary to keep my daughter out of institutionalization. I honestly did appreciate them tremendously. So, why was I so miserable?

Even when her screaming out for me began to diminish and her insomnia improved, I did not. It wasn’t until she began smiling again saying, “I love you mommy!” that I began to confront the source of my own pain and suffering.

At first I thought I was merely sick from the deadly antibiotic I had taken in order to prevent infection from the human bite I had sustained. The antibiotic did carry a warning label: *Can cause serious diarrhea.* I had a stool sample taken. The lab test came back negative. Then I rationalized that it must be exhaustion and disorientation from my loss of control over my own home that was causing me to feel so ill. I was having flu-like symptoms - night sweats, chills, chronic diarrhea, stomach pain and no appetite. I was restless, irritable and couldn’t concentrate.

When I could no longer eat anything, I took myself to the emergency room with my suitcase packed. I wanted to be admitted. At least I could receive IV fluids and some rest. The ER doctor grinned. “You think you need to be admitted, huh?” he joked. He had been on duty that dreadful night. When he inquired if she was still living at home, he ordered a CT scan, pumped me intravenously with Pepcid AC and sent me home with a tranquilizer.

“Ok, so now what?” I argued with myself. And then, in the midst of my angst, a subtle but miraculous thought revealed itself. “I don’t want to live with her

see Truth on page 34

Building Comprehensive, ABA-Informed Services in an Adult Residential Setting

By Rishi Chelminski, BCBA,
Terence G. Blackwell, BCBA,
and Louis Cavaliere
Services for the UnderServed Inc.

Throughout the United States, services for school-aged children with Autism have been bolstered by IDEA (the Individuals with Disabilities Education Act). Of the services IDEA has made available, those informed by the science of applied behavior analysis (ABA) are gaining broad recognition as the most successful (Lilienfeld, 2005; Rogers & Vismara, 2008). A review of recent publications, whether it be the National Institutes of Health, the US Surgeon General, opinions of a variety of State and national departments of health, or over 50 years of scientific research, points to the fact that ABA-informed services are the foundation for effective treatment of individuals with Autism Spectrum Disorders (ASD).

At the age of 21, many people with ASD transition into systems where ABA-informed services are few and far-between, and the barriers to receiving such services are high. The needs of these individuals do not cease once they reach 21. To the contrary, a review by Happe and Charlton (2012) published in the journal *Gerontology* identifies many ways in which the needs of adults diagnosed with ASD are likely to *increase* over the lifespan. If their needs persist, the applicability of ABA-informed services persists as well. In order to provide the highest-quality of services across the lifespan, new models of ABA-based practices need to be developed that work beyond the school setting. This task is daunting on many levels; the world of adult services exists on framework of funding and oversight that presents challenges not seen in the school setting. However, in 2011 Services for the Underserved Inc. (SUS) committed to taking on this challenge, and many of the individuals we serve have already begun to benefit from this decision.

We were fortunate in our timing. Although ABA is often thought of as a field suited to working with children, many of its guiding principles dovetail well with recent trends in adult services. In recent years, “one size fits all” models of care have given way to an emphasis on person-centered interventions (for a review on Person-Centered Planning, see the NYS OPWDD website www.opwdd.ny.gov). ABA-based services have, by their fundamental nature, always been entirely person-centered. Indeed, this is one reason why they are so readily funded in the school setting through IDEA. Practitioners who use ABA to inform their work take a functional analytic approach to treatment. This means that interventions are chosen based on direct, empirical observations of each individual’s own preferences and values, skills, and relationship with their environment (Hagopian & Boelter, 2005).

Along with the movement towards person-centered planning, there has been a concerted movement towards evidence-based, data-driven interventions. This is another area in which ABA-based services are fundamentally well-suited to provide solutions. Under an ABA-based model, treatments are not only developed based on empirical observations, but are continuously evaluated using data analysis of an individual’s behavior.

Finally, the coming climate in our field is one that recognizes interdisciplinary collaboration as an essential part of high-quality, person-centered care (World Health Organization, 2010), an idea bolstered by the implementation of initiatives such as the Affordable Care Act. Such collaboration requires a natural science-based language and set of principles that crosses disciplines. Within a medical environment, practitioners of myriad medical disciplines collaborate well with one another because they are united by the common language and principles of biology, chemistry, and physics. Much in the same way, at SUS we have found that therapists of many disciplines, direct-service professionals, and care coordinators can collaborate well when their work is unified by the language and principles of ABA.

This last idea is one which may require perhaps the most difficult cultural shift within adult service agencies. Although ABA is a science which informs practice, and therefore a potential tool for uniting many disciplines and providing comprehensive care, it is often used in isolation from other services that an individual may receive. As an agency wishing to integrate ABA into our palate of services, at SUS we have chosen to move away from the mindset of “having an ABA therapist that is available to our individuals,” and instead move toward the more comprehensive goal of “having a range of therapists available, all of whom use ABA to inform their practice.”

Creating such a comprehensive clinical environment requires long-term strategic planning. It is probably not surprising that we have chosen our Behavior Intervention Specialists to take on the role of bringing ABA-informed services to our programs. However, we also recognized early on that this project required commitment

see Residential on page 31

The Effect of Preceding or Antecedent Physiological and Environmental Factors on Challenging Behavior

By Mindy Scheithauer, PhD, BCBA,
Joanna Lomas Mevers, PhD, BCBA-D,
and Nathan A. Call, PhD, BCBA-D
Marcus Autism Center
Emory University School of Medicine

Challenging behaviors (e.g., aggression, self-injury, and disruption) are prevalent among individuals diagnosed with an autism spectrum disorder (ASD; Hartley, Sikora, & McCoy, 2008). These behaviors are a common referral concern for treatment because they can cause injury, interfere with adaptive development, and increase familial stress (Herring et al., 2006).

Behavioral treatment techniques are an effective way of addressing challenging behavior for individuals with ASD exhibiting a range of challenging behavior (e.g., Horner, Carr, Strain, Todd, & Reed, 2002). The basis of behavioral treatments focuses on three factors: 1) the antecedent or what occurs before challenging behavior; 2) the behavior itself; and 3) the consequence or what happens after the behavior. Through careful consideration of these three elements, a clinician can determine the behavior's function, or reason "why" the individual engages in challenging behavior. For example, some individuals engage in problem behavior to get attention while others may engage in the same behavior to get out of doing work. By determining the reason challenging behavior occurs, therapists can tailor treatment to address the individual's specific needs. The majority of these techniques address the consequence aspect of behavior by ensuring that, following the challenging behavior, the individual does not receive the preferred outcome that motivated that behavior and instead receives the preferred outcome for more adaptive/appropriate responding.

These consequence-based strategies are extremely important and effective, but it is also important to consider how antecedents can guide treatment, especially for individuals who engage in challenging behavior infrequently (e.g., only engages in challenging behavior once a month) or at variable rates (e.g., a lot of problem behavior for two days followed by a week with none). In these situations, it may be especially important to consider antecedents to identify when problem behavior is most likely and develop a treatment that will work specifically during these times.

Several variables may serve as antecedents for problem behavior in that, when these variables are present, they increase the likelihood of problem behavior in a certain context. For example, a child may become aggressive every so often when asked to do homework. When this happens his mother may give him breaks to allow him to calm down. When the child is tired, homework is likely to be even less enjoyable than normal (or more aversive). Thus, if homework is more aversive and aggression results in avoiding homework, aggression might be more common during homework time when the child is tired. In another example, a child who engages in aggressive behavior to gain access to food (e.g., when the child aggresses caregivers assume he/she is hungry and offer a snack) may be more likely to aggress if he/she is particularly hungry. In this case, being hungry makes food even more preferred and is therefore likely to increase aggression that often results in food. Variables that make an event more or less preferred or reinforcing are referred to as *motivating operations.*

Physiological states may frequently serve as motivating operations by changing preferences for certain items or activities. Past research suggests that individuals experiencing pain and discomfort may exhibit more problematic behavior, especially when problem behavior results in escape (or a break) from aversive activities such as homework or chores. For example, Kennedy & Meyer (1996) found an individual's self-injurious behavior was more likely when he was exhibiting allergy symptoms, and this increase was most commonly observed during academic work.

The physiological effects of medications may also result in certain activities being more or less preferred. For example, Northup, Fusilier, Swanson, Roane, & Borrero (1997) found that access to food and activities was less reinforcing when a child was on methylphenidate (e.g., Ritalin, Concerta). In another study, methylphenidate was found to specifically decrease disruptive behavior when an individual was given attention following this behavior (Dicesare, McAdam, Toner, & Varrell, 2005). Research has also suggested that menses (Taylor, Rush, Hetrick, & Sandman, 1993), ear infections (Carr & Smith, 1995), and sleep deprivation or fatigue (Kennedy & Meyer, 1996) are all physiological states that may increase the likelihood of problem behavior in certain contexts.

In addition, environmental variables may serve as motivating operations. Kennedy and Itkonen (1993) found that one individual with a developmental delay engaged in more self-injury and aggression when she woke-up late and had a hurried morning routine, whereas another individual with similar problem behavior was more likely to exhibit this behavior when encountering traffic on the way to school. For both of these individuals, behavioral treatments

see Effect on page 43

OPWDD from page 22

to employment, or they may be of the age to retire. Alternate options for these individuals include: support services at one's home, self-directed supports, or a day habilitation program. Many who are new to the workforce will begin with part-time positions as they test out their job skills and attempt to match their interests and skills with available jobs. In addition, there are other individuals with more severe and complex disabilities that may not have the interest or skills to acquire employment. In either situation, there must be a system in place to ensure there are meaningful activities available during times when their family or caregiver is working. Traditionally, New York State has always made this commitment, while many other states have not. With the myriad of changes in OPWDD services, advocates need to ensure this level of commitment is maintained. The Commonwealth of Massachusetts published a document in November 2013 regarding their supported employment program entitled "Blueprint for Success," which states that Massachusetts "…remains committed to providing individuals' needed day services in a manner that maintains stability for families and residential providers during non-work hours." If New York reaffirms a similar commitment, it would alleviate many uncertainties families may have.

Day Services

For individuals who will not be entering the world of employment anytime soon, OPWDD's day habilitation programs offer an alternative service. These programs are designed to assist an individual to acquire needed skills in self-help, communication, social and recreational areas, among others. Due to the Federal government's advocacy to ensure full community integration, over the next couple of years many of the existing day habilitation locations will need to modify their programs to ensure that participating individuals receive their services in as integrated environments as possible. This will result in participants spending more time in volunteer experiences, or receiving their supports in natural community locations surrounded by people without disabilities—as opposed to segregated large program locations.

Residential Services

Over the past 5 years, OPWDD's funding for new residential services has decreased significantly when compared to previous levels. In addition, the Federal government has been advocating the greater use of integrated environments for residential supports. As a result, the focus on residential services has changed from one that relies primarily upon OPWDD certified group residences to a greater emphasis of providing supports in families' own homes or in typical community-based housing. This approach may certainly benefit many individuals, however, those who need a greater level of support or supervision may find this approach lacking. For individuals residing with aging parents, remaining in their family's home may not be a realistic option. In addition, with the lack of affordable housing in many communities, most individuals' SSI payments are insufficient to afford rent in regular community-based housing. Even if affordable housing is found, sometimes the budget created for an individual may not cover the cost of 24-hour staffing. This specifically becomes a major challenge for individuals on the autism spectrum. Reliable residential waiting list data is admittedly limited. However, according to June 2014 information from OPWDD, there were 6,436 individuals in need of residential services within 2 years and another 5,309 individuals who needed residential service by 2020. These numbers are daunting by anyone's measure, and it is highly unlikely OPWDD will have the resources in the near future to address this level of need.

Managed Care

Since 2011, OPWDD has been planning to convert its statewide system of services to a managed care model. This is, however, a New York State initiative and not a Federal one. Instead it is part of the Cuomo Administration's plan to bring all Medicaid under a managed care umbrella. While there are many divergent opinions regarding the benefits of managed care, it can be an effective method of delivering services and data does indicate improved healthcare outcomes for some people enrolled through Medicaid. However, its effectiveness as a tool to provide long-term support services to individuals on the autism spectrum (or any other developmental disability) with the statewide scope of New York's services is untested nationally. Under this plan, instead of paying providers directly for each service they provide for an individual, OPWDD will pay managed care entities a capitated rate (a per person per month amount) and they in turn will pay providers for each service. These managed care entities would be responsible for coordination of all Medicaid funded services including OPWDD, healthcare, mental health, substance abuse, and personal care. Enrollment in the managed care program will be voluntary for individuals during at least the first 2 years. While this program was originally slated to begin in 2013, it has once again been delayed. OPWDD has recently begun a review of its managed care plan and a new start date will not be announced until this review is completed.

In summary, the scope and pace of changes in OPWDD services is staggering to many. As a result, families need to ensure that they afford themselves sufficient time to properly plan the best match of services to meet their needs. In spite of the uncertainty that surrounds us, we still need to remember that New York maintains the most comprehensive array of services to people with intellectual and developmental disabilities in the nation. That still counts for a lot, and should provide a degree of comfort for the future.

For more information about the Inter-Agency Council of Developmental Disabilities Agencies, Inc., visit www.iacny.org.

Addressing Skill Deficits in Students with High Functioning Autism as a Proactive Approach to Prevent Behavioral Challenges

By Edel McCarville, PsyD
and Colleen Menard, MSEd
Levittown Public Schools

Students with high functioning autism (HFA) typically display cognitive abilities in the average to above average range, and some superior range; therefore often participate in general education classes. While these students have many strengths, specific educational approaches are often needed to address the core deficits of an autism spectrum disorder. Failing to address the specific needs of students with HFA may in turn lead to these students displaying challenging behaviors (Myles, 2005).

A proactive and multi-dimensional approach using antecedent interventions can be effective in addressing the core deficits associated with ASDs and the individual needs of students with HFA. Specifically, interventions addressing deficits in social communication, behaviors associated with having a restricted range of interests, or stereotyped patterns of behavior should be part of a student's educational program. Further, individuals with HFA often struggle with adaptive functioning; meaning they may need support to complete certain daily activities in school. Also, it is important to note that 70% of individuals with an ASD may have one additional diagnosis, and 40% may have two additional diagnoses. Common comorbid conditions are ADHD, developmental coordination disorder, anxiety disorders and depressive disorders (American Psychiatric Association, 2013). Therefore, when educating students with ASDs, it may be necessary to consider these additional skill deficits. If core deficits are not addressed, then students are likely to experience more significant challenging behaviors. Due to the variety of components involved in educating children with HFA, a multi-leveled intervention package is often necessary. Merely addressing challenging behavior that is occurring without addressing skill deficits that exist will not teach students replacement adaptive skills that they need in order to be successful. Adaptive functioning is important because adaptive skill is closely related to functional independence and quality of life (Scahill & Lord, 2004).

Colleen Menard, MSEd and Edel McCarville, PsyD

Students with ASDs experience delays related to social communication, therefore specific teaching to target these deficits can help to improve school performance. Lack in skill-set may appear as lack of motivation in a student with HFA. Additionally, difficulties with cognitive flexibility are common; meaning students with HFA often have difficulty in "going with the flow." Accepting changes or creating an alternative plan when a student's idea does not work out the way they anticipated can lead to behavioral challenges. A modified cognitive behavioral therapy (CBT) approach is effective in helping students to restructure thoughts that lead them to becoming "stuck." CBT approaches have been shown to significantly reduce mood disorders in children with ASDs (Bauminger, 2002). Educational staff can modify traditional CBT in order to accommodate the needs of students with HFA. Providing visual

see Deficits on page 42

Residential from page 29

from a broader array of stakeholders, from the direct service professionals up through the agency to the CEO and Board. Integrating ABA as a science that informs practice (rather than a practice that exists in isolation) means that in some way, an ABA-based solution must be offered to meet the needs and expectations of all of these stakeholders.

Towards this end, we undertook this project with the consultation of experts within the fields of ABA and residential care, who have helped bring ABA-informed services to other settings. In particular, the leadership of Dr. Brian Iwata has proven essential to our progress; Dr. Iwata is among the world's foremost researchers in the clinical application of behavior analysis. With his assistance we were able to mount a series of lectures and discussions that generated interest in ABA among our agency's management and clinical staff. In this way, we learned what these stakeholders needed from us, and addressed their needs by developing policies and procedures that satisfied both their requirements, and the best-practices models common to the field of ABA.

These policies and procedures primed the environment within our agency for the substantial part of our ABA project: bolstering the ranks of our clinical staff with Board-Certified Behavior Analysts, and (more recently) Registered Behavioral Technicians. These clinicians have brought ABA's functional-analytic perspective to our agency, and with it a person-centered, data-driven, highly-collaborative model of services that has already begun to produce results for the individuals we serve. We would like to close this article with an exciting example of these results.

In recent years, SUS has begun serving a large number of individuals with very complex needs. These young adults came to us from agencies specializing in the treatment of very severe self-injury and aggression, as they were deemed as having behavior "too severe" to be treated in a traditional setting. Following their transition to adult services, SUS was able to use ABA-informed services to not only manage these individuals' behavior service plans, but also conduct a controlled reduction of the restrictive and intrusive interventions that many of them had grown accustomed to. In one house alone, we were recently able to fade away 1:1 staffing for *half* individuals living there, while still making progress in reducing their challenging behavior and strengthening their adaptive skills.

In much of the nation, 1:1 staffing is regarded as one of the most restrictive and intrusive services that can be prescribed to an individual. These individuals' ABA-informed services have not only furthered their clinical progress, but have also given them new measures of independence and dignity. It is with this vision that we continue our roll-out of ABA-informed services, and look forward to seeing similar developments from our colleagues in New York State. As we face the challenge of adapting ABA from the school setting to the adult services setting, we hope to create an environment in which individuals with ASD can continue to access cutting-edge treatments after 21, and across the lifespan.

Rishi Chelminski, BCBA, is Director of Behavior Services, Terence G. Blackwell, BCBA, is Chief Operating Officer, and Louis Cavaliere is Executive Vice President of Developmental Disabilities Services at Services for the UnderServed Inc. For more information, contact Rishi Chelminski at rchelminski@sus.org or visit www.sus.org.

References

Hagopian, L. P, & Boelter, E. W. (2005). Applied behavior analysis and neurodevelopmental disorders: Overview and summary of scientific support. *Kennedy Krieger Institute.*

Happe, F., & Charlton, R. A. (2012). Aging in Autism Spectrum Disorders, a mini-review. *Gerontology.* 58:70-78.

Lilienfild, S. O. (2005). Scientifically unsupported and supported interventions for childhood psychopathology: a summary. *Pediatrics*. Mar; 115(3):761-4.

New York State Office for People With Developmental Disabilities (2014). "Person-Centered Planning."

Rogers, S. J., Vismara, L.A. (2008). Evidence-based comprehensive treatments for early autism. *Journal of Clinical Child and Adolescent Psychology*. Jan; 37(1):8-38.

World Health Organization (2010). "Framework for action on interprofessional education and collaborative practice."

Emergencies from page 15

strangers nor respond to commands to stop, come here or to get into an unfamiliar vehicle. Preventative supports in the home include making sure there are door locks and alarms as well as instructional methods to teach replacement behaviors. Parents can also address this behavior by making their local EMS agencies (e.g. police and fire) aware of the situation and making a face to face visit. Personnel should be made aware of the child's unique communication, behavioral and sensory needs and any other limitations. Introductions in advance of emergency situations can go a long way to increasing the effectiveness of a possible intervention.

Emergency situations can cause the most rational of adults to struggle with remaining calm and organized. The parent or caregiver may be distracted with the responsibilities of comforting the person with ASD and less able to provide history to the EMS provider. Parents and caregivers might consider making a "quick guide" to keep by the door that includes pertinent medical information, insurance numbers and basic visual systems that can support communication. All household members should be aware of the location of this guide for quick access it in the event of an emergency.

Intervention Tactics

First responders can make multiple changes to their approach and responses to address communication, sensory and resultant behavioral needs. Sensory responses are an issue in ASD and warrant certain adjustments to the typical response pattern. First responders may consider decreasing the amount of lights and sirens on approach to the scene. They should limit the number of personnel who enter a home and consider a "two at a time" approach if possible. A person with ASD may retreat in fear based upon presence of strangers. Limiting the number of strangers as well as devices and noise can help in these situations.

Sensory reactions (hypo or hyper, depending on the person) may influence the responder's ability to effectively use equipment and/or to touch the person during a physical examination. The responder should ask the parent or caregiver to assist whenever possible during an intervention. Effective techniques include starting the examination in a distal to proximal fashion (Rzucidlo, 2003) and modeling what is going to be done with the caregiver or parent first. Other techniques might include using a doll to demonstrate what you are going to do (e.g. checking heart rate) before attempting to use this on the person. Caregivers and parents can help responders to understand what kinds of touch are likely to be met with tactile defensiveness and can demonstrate effective strategies. Carefully explain, in very simple language, what you are doing if it involves touch or the use of equipment on the person's body. Overall fear of the unfamiliar can be addressed by allowing the child or adult to have a favorite comfort object, to retreat (if safe and feasible) to a familiar area or to sit with a familiar person. Emergency situations such as fires or car accidents may require different response methods and are beyond the scope of this particular article.

Communication difficulties can be dealt with during situations by relying on parents or caregivers if available and following their lead. Responders must remember that a person with ASD may very not respond to commands the first time and will need processing time as well as possible augmentative systems. The team should delegate one person to be the main communicator in any situation. This person should speak calmly and avoid the tendency to repeat or raise their voice to gain compliance or a response. Providing a few extra seconds of wait time to process language is critical. Use a "talk, wait, person" model when asking questions or providing basic commands. Repeating of questions or commands should be paired with a visual, action or model on a caregiver or other safe person. The language should be kept as literal as possible, while avoiding the use of humor or sarcasm, as these are often misinterpreted by persons with ASD. Eye contact may be fleeting, avoidant or otherwise impaired. Demanding eye contact may result in less compliance and more refusals. Encourage the person to look at the responder by using a favorite object or other item and bringing it to their eye level. Do not insist on "look at me" during an examination.

The person with ASD may require transport in a vehicle to obtain further intervention. The unfamiliarity of the vehicle paired with strangers, lights and other sensory influx may trigger stress reactions leading to refusal behavior. Encourage the caregiver or parent to be the model for any action including, for example, the use of a backboard, neck brace or other immobilizing device. The action of a familiar adult "doing it first" may change the level of compliance with the actual person. Physical interventions may lead to increased refusal and aggression. In these situations the first responder should limit conversation and verbal input to one person who speaks calmly, literally and provides visuals whenever possible. Recognition of these events as frightening and unpredictable can contribute to the prevention of frustration and impatience on the part of the first responder.

Resources

Behaviors that are emitted by individuals with ASDs during emergencies can be unpredictable, frightening and difficult for all involved. There are a number of resources available that are openly accessible for any interested party. For example, the National Fire Protection Association (www.nfpa.org/disabilities) has a web page dedicated to providing information about emergency response issues. In 2010 this organization released an interactive social story specifically designed to address the unique needs of children with ASD in response to smoke alarms entitled "I Know My Fire Safety Plan" (NFPA, 2010). This book can be personalized to the individual child and interacts with electronic platforms. Autism Speaks (www.autismspeaks.org) has a basic information page dedicated to best practices in an emergency situation. Their list of "Quick Facts for EMS" provides concise and helpful strategies (www.autismspeaks.org/family-services/autism-safety-project/first-responders/emergency-services). Training, prevention and intervention strategies can all assist to create a more positive experience for those with ASDs and the first responders who provide emergency assistance.

Summary

Training is a vital component of the first responder's ongoing professional development and should include a focus on the variability of ASDs as well as the general needs that encompass the definition of this disorder. Ongoing research into best practices during emergencies is needed along with a continued focus on training for all providers. Emergency situations for children and adults with ASDs require a special focus on prevention through building familiarity as well as intervention that considers the core impairment areas.

Vanessa Tucker, PhD, BCBA-D, is Assistant Professor of Special Education at Pacific Lutheran University. For more information, please contact Dr. Tucker at tuckerve@plu.edu.

References

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders. (5th ed.). Arlington, VA: American Psychiatric Publishing.

Good, D. (2011). Autism Spectrum Disorder: A fire/EMS challenge. *Fire Engineering*, 164 (3), 42-51.

Kupietz, K. (ND). Best practices for Autism during emergencies. Retrieved from: http://www.usfa.fema.gov/pdf/efop/efo46708.pdf.

McDermont, S., Zhou, L. & Mann, J. (2008). Injury treatment among children with Autism or Pervasive Developmental Disorder. *Journal of Autism and Developmental Disorders*, 38(4), 626-633.

Mims, T. (2008). Seeing an invisible disability: Autism spectrum disorder awareness training for firefighters in Tuscaloosa, Alabama. National Fire Academy EFO Paper.

Law, P. & Anderson, C. (2011). IAN research report: Elopement and wandering. Retrieved from: http://iancommunity.org/cs/ian_research_reports/ian_research_report_elopement.

Myers, S. (2012). Review of mortality in autism drowning. *Association for Science in Autism Treatment*. Retrieved from: http://asatonline.org/resources/articles/mortality.htm.

National Fire Prevention Association (2010). *I Know My Fire Safety Plan*. http://www.nfpa.org/press-room/news-releases/2010/nfpa-releases-interactive-fire-safety-storybook-for-children-with-autism-spectrum-disorder Retrieved from www.nfpa.org.

Rzucidlo (2003). Autism 101 for EMS practitioners. Retrieved from: http://www.paemsc.org/assets/files/Autism%20101%20for%20EMS%20Practitioners.pdf

Quick Guide for Emergencies (ND). https://www.autismspeaks.org/family-services/autism-safety-project/first-responders/emergency-services. Retrieved from www.autismspeaks.org.

Stelter, L. (2013). First responders, take note: CDC reports 1:50 children has Autism. *Firehouse*, 38 (8), 101-107.

White, B. (2012). Autism awareness for the fire service. *Minnesota Fire Chief*. January/February, 30-32.

Aggressive from page 27

and socially acceptable behavior. For example, if an individual is hungry and is not able to request food items effectively, upon seeing food he or she might hit a caregiver to alert attention in order to be given a meal or a snack. Similarly, if a teacher asks a child to put away a favorite toy and, in turn, the child begins to pull at his/her eyelashes it is likely that the child is not ready to put away the toy and would like more time to play.

At times, an individual might act aggressively or demonstrate self-injurious behaviors as a result of being presented with a change in the environment that is thought to be aversive. He or she may engage in particular behavior to escape a place, person, or task. If historically, the task is removed or the individual is taken away from the original environment upon demonstration of aggressive or self-injurious behavior, it is probable that he or she may have learned that in order to escape or avoid something that they "don't like," aggression or self-injury is what is necessary in order to have the aversive stimulus removed under a specific circumstance. By identifying causal factors (e.g. patterns in behavior and antecedents and/ or consequences to behavior), a clinician or teacher can create a plan to teach the individual to make requests more suitably.

Some studies suggest that aggressive or self-injurious behavior can be an extreme result of attention seeking motivating systems. These studies have found that children learn to emit problem behavior in response to low level adult attention (Carr &, Durand, 1985). Treatment packages must focus on teaching individuals to request attention aptly.

An individual may present with aggressive or self-injurious behaviors as a result of a medical issue. If the person has a limited ability to communicate, he or she may not be able to explain to a caregiver that they are not feeling well or that something is wrong. It can very difficult to identify as the reason for particular behaviors if there are no observable symptoms of illness. If aggressive behaviors are new and have not been a part of the individual's history of behavior, best practice is to first rule out any medical issues or concerns by seeking medical attention to the problem immediately. If there are no medical reasons as to why the behaviors are occurring, professionals can then look to identify the maintaining variables and execute appropriate behavior strategies.

Self-injurious behaviors can be the result of a motivational system that does not require any other person to mediate (i.e. provide), which is known as automatic reinforcement. When the behavior itself is motivating and enjoyable to the individual person and he or she is not looking to acquire

see Aggressive on page 40

Opinion Piece: Standardized Testing in Schools Inadequately Accommodates Special Education

By Vicki Ofmani, MEd, LDT-C
Supervisor/SLE Coordinator
The Forum School

Vicki Ofmani, MEd, LDT-C

No Child Left Behind (NCLB) covers many federal education programs. The act, in 2001, was put forth to strengthen America's educational system by requiring States to implement accountability systems covering all schools and all students. Although NCLB covers various education programs, the requirements for testing accountability and school progress undoubtedly receive the most attention. No Child Left Behind requires each state to test each student in reading and mathematics each year in grades 3 – 8 and once during high school. In science, states must test one time in grades 3-5, 6-8, and high school.

It seems improbable that any educator would argue the point that all our students should be proficient in grade-level math and reading. It is also plausible to trust that the school system should have expectations that adequate yearly progress will be made and that it should be measurable. In order for a school to have made adequate yearly progress, it must meet its target for student reading and math aptitude each year.

No Child Left Behind also requires that all teachers be highly qualified. This term refers to the fact that each teacher within the school should be fully certified by the state and that they must demonstrate their knowledge of the subject they teach through specific credentials or scores on tests. Though a teacher with Special Education certification may pass subject area Praxis exams, they are not considered "highly qualified" to teach those subjects at the high school level without taking a mandated number of college credits in that specific subject area. This is discriminatory as at the high school level the general education subject area teacher may teach the special education students with NO special education experience or coursework. Again, the emphasis is placed on achieving subject matter knowledge, not necessarily meeting the unique needs of the classified student.

As many of us in the special education arena would lament, there is a gap in reasoning here. At a time where more and more of our students are identified with disabilities such as Autism Spectrum Disorder, Behavioral Disabilities, and Specific Learning Disabilities, regular education teachers are not required to be highly qualified in areas such as "applied behavioral analysis" or "best practices in differential instruction." However, special education teachers must be highly qualified in academic areas which mean they are tested on items such as the Asia/Pacific economic indicators. Far be it from offering ideas of isolationism, special educators are, however, focused on the child's social, psychological and physiological development as a whole being. Their understanding of typical and atypical child development and instructional methodologies is one of the core foundations that have kept New Jersey's reputation as the premiere state for educational practices in force. However, theories in economics are easily accessible from the internet.

Standards are necessary in education. The Common Core State Standards (CCSS) are what is expected. They are criteria, ideals, goals. They are the top rung. Academic content standards are statements about what students should know and be able to do upon finishing point of each grade level. There are simply too many. It has been the intent of the states' consortiums to make the standards rigorous to "make" us Americans more competitive in the global market. They simply have not taken into consideration developmental markers. Our students meet these markers at a far different pace than their typically developing peers. That is explicitly why they have been classified in New Jersey for educational consideration under the law (N.J.A.C. 16A:14).

The intent is clear and admirable. The content standards are proclamations that should ensure teachers that their students have the skills and knowledge they need to be successful at each stage of learning. However, the vastness of them; the complex

see Testing on page 44

Asperger's from page 28

age and developmental level should be factors when thinking about disclosing the child's diagnosis and considering ways to share this important information.

How to Talk with Your Child

The decision to share the diagnosis is a deeply personal and heavily nuanced one; a one-size-fits-all approach does not apply. Obviously, there are lots of things to consider. Our view is that in most cases, there is tremendous value in having an open discussion with your child about the nature of his or her difficulties and sharing with them their diagnostic label may be an important part of this conversation as well.

Whether this conversation is being prompted by a recent evaluation and diagnosis, or parents have chosen to disclose this information after keeping it quiet, odds are your child knows something is different about them. In general we have found that children construct all sorts of fantasies and ideas about what is wrong with them and having a candid discussion may actually dispel some of their worst fears. Below are a few suggestions to foster an open discussion with your child:

1) Highlighting strengths and weaknesses: We all have things we are good at and things we are not as good at. It's pretty easy to come up with a list for each of us. It might be helpful for each of the family members, including parents, to speak about three things they are good at and three things that they struggle with. What is unique about the child with Asperger's is the level of discrepancy that can exist between different areas. A 10-year-old with Asperger's may have a reading level equivalent to a teenager in high school but math abilities of a five year old. What can be difficult for the child is the feeling of having such a large split inside of them. It can also be valuable to highlight the feeling of this dramatic chasm between the areas.

2) Using metaphors: Even though each child's challenges are unique, there are certain characteristics that are fairly common in children diagnosed with Asperger's. It might be helpful, again depending on the age and maturity of the child, to use metaphors to talk about some of these symptoms. For example, to explain executive functioning difficulties, we may talk about a huge pile of papers, with no folders to organize them. To explain cognitive inflexibility, we may talk about a child's brain getting "stuck" and unable to move past something. For emotional dysregulation, we may talk about a child whose feelings feel way too big for his little body, and for social deficits, we may talk about going to visit a foreign country and feeling like we have a hard time understanding the language or culture. We have found the use of metaphors particularly valuable in highlighting what it can feel like for a child with Asperger's dealing with these difficulties. These metaphors can also be used to explain to siblings, family members, friends or teachers when they don't understand why these children are having a difficult time in some of these areas.

3) Role models: Many role models exist that speak openly and share their challenges. Having your child learn about different role models in pop-culture or sports with specific areas of difficulty who model perseverance, hard work, and embracing their challenges can be helpful. Thankfully, we have many role models in our culture that are open about their challenges, so it might be helpful to find a role model that connects with the child's area of interest. For example, finding a baseball player with an area of difficulty for a child interested in baseball, or learning about an engineer with difficulties for a child who loves transportation, or an actor on a child's beloved television show who has shared some challenges.

4) Respect their processing style: Children's reactions to these talks reflect a full range of responses. Some children will have many questions and want to understand more. They may want to look up what different words mean and feel like they can't stop talking or thinking about it. Other children will be resistant to talking more about it, and will want some space to process this information in their own quiet way. The biggest gift you can give to your child is to respect his or her own unique self and provide space and an opportunity to think and reflect about this information. You may want to enlist the help of mental health professionals to facilitate the healthy processing of some very complicated information. We very much believe that the understanding and synthesizing of this information is an important part of the developmental process and integral to your child's forging of his or her unique identity. While it may take time, we believe treating your child with respect and support when sharing this information will help your child to integrate this information and empower him or her for success and self-actualization through hard work, insight, and understanding.

Over the years in diagnosing and working with children with Asperger's and their families we have been humbled and challenged by this complex issue. As mentioned earlier, there is no singular approach because each child is unique and what will work for one child may not work for another. We hope that this article has stimulated some "food for thought" or ideas about how to empower our children by helping them get to know themselves better.

Shuli Sandler, PsyD, is a Psychologist with Spectrum Services in NYC. For more information, please email shulisandlerpsyd@gmail.com.

Michael Rosenthal, PhD, is a pediatric neuropsychologist with expertise in the evaluation and treatment of children and adolescents from pre-school through early adulthood. He is specialized in diagnostic, developmental, and neuropsychological evaluations of children with ADHD, executive dysfunction, learning disabilities, social cognitive weaknesses, and emotional/behavioral challenges. Dr. Rosenthal is also an expert in the identification and management of children when complex questions exist about autism spectrum disorders. For more information, please email michael.rosenthal@childmind.org.

Competence from page 8

placements to individual residential alternatives (IRA) or other less restrictive placements and avoid reliance on long-term care services. The BIP grant specifically targets individuals living at home in the community with significant high risk for placement in an institutional setting, individuals being discharged from residential school setting out of state and individuals being discharged from NYS Developmental Centers.

The main objectives of the project are to decrease poly pharmacology, decrease visits to the emergency room and hospitalization due to maladaptive behavior by increasing functional communication skills, teaching age appropriate leisure skills using ABA technology.

The behavior staff at SUS began screening individuals from a state intermediate care facility in August. The individuals transitioned to SUS in October 2014. During this time, preference assessments and functional analysis were conducted to develop effective treatment plans that included high preference items and activities for the BIP participants. Direct care staff were trained with specific behavior techniques for 15 individuals. Preferred items and activities were also purchased and made available to the individuals upon returning from their day habilitation program. Behavior technicians trained caregivers to pair themselves with the delivery of preferred items and activities for each of the clients participating in the BIP grant. During the screening process, individual's communication systems were assessed and forms of communication were identified for each client.

The individuals demonstrated a wide range of communication skills. Approximately 9 of the individuals were able to communicate using vocal speech. They were able to request basic wants and needs, label common items and objects in their environment and engage in beginning communication skills. Two of the clients used minimal vocal communication skills with high rates of maladaptive behaviors. The last four clients were nonverbal and were learning to mand (request) using ASL (American Sign Language) in addition, they also engaged in moderate frequency of maladaptive behaviors on a daily basis.

The behavior technicians began the treatment session with one manding session (Sundberg & Partington, 1998) daily during snack time at the residence with the clients that were non-verbal. The behavior technician was seated at a table with preferred food items for the assigned individual he/she was paired with during the session. In addition, the assigned program specialist was also present during the teaching session. The behavior technician would present 2 preferred items to the individual. Once the individual declared his/her choice, the behavior technician would vocally or physically prompt the correct form of the mand either vocally or using ASL. Data were collected on each presentation of the item being requested. Prompts were faded as needed based on the motivation of the individual for the item being presented. Additional data were collected daily on targeted challenging behaviors. The behavior intervention specialist would then review these data to determine if challenging behaviors were decreased due to the manding intervention.

The findings across the four individuals who were non-verbal show a range of 3%-67% decrease in challenging behaviors once the manding intervention was implemented. These findings suggest that when individuals with limited communication skills were provided the opportunity to request their specific preferred items, the frequency of maladaptive behaviors were decreased, therefore demonstrating that ABA technology is an effective intervention for decreasing challenging behaviors such as aggression, self-injury and self-stimulatory behaviors.

In summary, ABA is a hard science that teaches replacement skills to individuals with disabilities who have developed a maladaptive manding repertoire over their lifetime. The preliminary results from the BIP grant suggest that adults with developmental disabilities can benefit from the technology of ABA, along with the use of Skinner's analysis of verbal behavior (VB). Moreover, they can improve the lives of those with limited communication skills. ABA/VB should be considered best practices for teaching adults with disabilities so that they can continue to grow and change over time in the least restrictive environments.

Vivian Attanasio, BCBA, is Director of BIP, James O'Brien, BCBA, is an ABA Consultant, and Amy Bukzspan, BCBA, is a Behavior Intervention Specialist at Services for the UnderServed Inc. For more information, contact Vivian Attanasio at vattanasio@sus.org *or visit* www.sus.org.

References

Carr, E.G., & Durand, V.M. (1985). Reducing behavior problem through functional communication training. *Journal of Applied Behavior Analysis, 33,* 53-71.

Cooper, J.O., Heron, T.E., & Heward, W.L. (2007). *Applied behavior analysis: 2nd edition.* Upper Saddle River: New Jersey: Pearson Prentice Hall.

Skinner, B. F. (1957). *Verbal behavior.* New York: Appleton-Century Croft

Sundberg, M. L, & Partington, J. (1998). *Teaching language to children with autism or other developmental disabilities.* Pleasant Hill, CA: Behavior Analyst Inc.

Truth from page 29

anymore!" I heard myself blurt out loud. This was not a new revelation but I now had a new level of conviction. The power of that thought in that particular moment opened me up to a visceral state of self-preservation. *When your baby bites your breast, it is time to wean!* And so, I went home that night a changed mother.

Initiating the Disengagement Process

I began keeping an overnight bag packed. On nights that I suspected she might tantrum, I called on friends for a place to sleep. When she started screaming at me, I walked out and sat in public places like the library, or my car. Instead of attending to her every need, I began focusing on my own health.

Eating caused an icy feeling that started in the pit of my stomach to shoot up my neck and down my arms and legs ultimately produced a sickly weakness similar to shock. My temperature hovered between 96.1 and 97. I was cold all of the time. I lost 15 pounds. I took a cot and sleeping bag up to our third floor finished attic space, put a "PLEASE DO NOT DISTURB" sign on the door and installed a chain lock.

Was I insane? For 27 years, I had been a mommy that tolerated being hit, kicked, screamed at and even bitten. I had been a mommy who would religiously wake up each morning and serve breakfast with a smile as if nothing bad had happened! For the past 27 years, I had been possessed by motherly preoccupations with a child who would never grow up and may never stop being abusive! It was time to take charge over this intolerable situation! I requested an out-of-home placement.

Crushing News Leads to Greater Understanding

My heart sank when we were denied residential housing. Again, my daughter went out of control! I barely escaped out the front door. She pursued for a full city block screaming at the top of her lungs that she was going to kill me. A neighbor called the police. By the time they arrived we were both back inside and she was calm.

That's when it dawned on me! My daughter thought being a tyrant was normal. That night, I had the most important conversation with her I will ever have. I calmly and clearly explained that if she ever tried to hurt me again, she would go back to the psychiatric hospital and NEVER RETURN HOME. I meant it. This was not a threat. I finally was able to communicate in a way that she understood. If she wanted all of the good things her mommy and daddy provided her, she needed to stop hurting me.

Service Dogs to the Rescue

After a year and a half of waiting, our daughter was finally matched with a specially trained companion dog. His name was Hagley, a strapping 83 lb. yellow Labrador Retriever. His "work" was to sleep with our daughter. With the comfort of his warm body snuggled up against her, she began sleeping through the night.

Through commitment to her new dog, she began caring for others in a way that 25 years of strategic interventions had not accomplished. One day she instructed him to "load up" into the car. She had forgotten to stand out of the way. As he jumped through the opening between her head and the back seat, he hit her chin so hard it caused her teeth to sink into her lip and split. She had bitten herself. When I then explained, "You have to get control over yourself, so you can get control over your dog," she didn't start screaming at me. Instead she just replied: "You're right mom."

In three short months, Hagley single-handedly replaced the need for all overnight staff. I moved out of the attic and back into my bedroom and resumed enjoying tea and TV in my living room until the fatal night we rushed Hagley to the emergency animal hospital where he was diagnosed and died of kidney failure. We were devastated! And, our daughter's sleep disorder returned with a vengeance. We were all miserable, and grief-stricken but at least the violence did not return. Soon, the service dog agency replaced her yellow lab with a black one. We participated in the graduation ceremony all over again with a new dog named Duff. It was love at first sight! We all breathed a sigh of relief.

Temporary Inconvenience, Permanent Improvement

We decided it was time to initiate the next level of separation by selling our town house and buying a duplex: one side for her and the other for us. We figured we could at least afford a wall between us.

We found a house with a mother-in-law apartment and frantically stepped up the process of selling our home. Cleaning, painting, floor replacements and trying to keep it looking like Better Homes and Gardens was a feat, but we moved into our new life on a cold afternoon in March. The plan was simple: Daughter gets the 3-bedroom house and rents 2 rooms to compatible peers. We live in the efficiency apartment. This was the best we could do, and all that we could afford.

The Final Battle

We had moved twice before, each time had resulting in psychiatric hospitalization. This time was different. I could retreat into my apartment and lock the door. It worked for a few months. Then one day she launched a physical attack. I reached the door of my apartment, entered quickly and locked it. I warned her: "If you don't calm down, I will call the police!" She replied in her evil cartoon voice: "HA HA HA, I will NOT allow this door between us. Then she picked up a chair and began beating the door down. Unfortunately it was hollow. I grabbed my cell phone and her service dog and headed for the car. I called the police. Four policemen arrived. The next day we bought a solid wooden door. I reiterated: "Either you accept the door, or back to the psychiatric hospital you will go." She conceded. And that was the last physical attack she ever launched on me. Twice she initiated a head butt maneuver. Both times her head came within two inches of mine and stopped. She was acquiring rudimentary impulse control.

Hope is Restored

Today marks our first year anniversary of living with a wall between us. We now live in an old house with a huge yard, in need of extensive repair. Management is a full-time job, of which I do not get paid. Consequently, we have downsized to one salary and one car. But, we are making progress.

Our daughter continues to improve. Yesterday, while driving, she began running one of her standard petty tyrant routines. I reminded her she was dependent on us for the ride. She threatened me in her familiar sing-song voice, "I'll punch you in the face!" I ordered my husband, "Turn the car around!" She shouted, "No! No! No! I didn't mean that literally, I'm sorry!" We all laughed and kept right on going.

Alexandra Bricklin is a music therapist currently living with her husband in an apartment above the garage of the house owned by Rebecca Bricklin's Personal Assurance Team Inc., the corporation founded to create and protect quality of life across lifespan for their daughter Rebecca and two roommates. To learn more, visit our Facebook page, Rebecca Bricklin's Personal Assurance Team Inc. at www.facebook.com/CormmunityforRebecca *or contact Alexandra at* alexsolre@mac.com.

Challenged from page 12

anxious, depressed, or tired. Instead of hanging in there and getting himself to work on Thursdays, he'd give up and call in "sick."

Zach was working toward his A.S. in Information Technology and was very bright. When he was at his internship, he did a good job. But as Woody Allen said "Eighty percent of success is showing up." Here is how I helped Zach.

Strategies to Help "Underground Thursday Challenged" Zach

I had him turn in a copy of his internship timesheet to me every week or every two weeks so we could review work attendance and identify any reoccurring patterns. This allowed me to show him in black and white, that he was missing work on most Thursdays.

In addition to having Zach set multiple alarms to get up on Thursdays as an audio clue, we looked at his underlying problem of anxiety and depression and realized that Zach's stress was being dealt with by avoidance.

He also told me that he had trouble remembering to take his medications for anxiety and depression when he was feeling anxious or depressed. We looked at this pattern as well. Having Zach verify with me that he had taken his medication daily (via a quick check-in, text, or email) also helped.

Jennifer Kolarik and CIP Brevard student Thea Judin

We set up a sleep routine (that he would track and chart) and made getting a good night's sleep another self-help priority.

We asked his supervisor at work if Zach could start an hour later in the morning or stay an hour later in the afternoon. Zach was one of those people who just need a little extra time in the mornings. Being able to start his a job at 10 am instead of 8 am or 9 am allowed Zach to be on time and the accommodation was motivation to stop calling in sick half way through the work week.

At one point we considered having Zach work a part-time job. Although I would love for every young adult to maintain a full-time job (whether volunteer, internship, or paid), I would rather see a student work part-time 20-30 hours per week and be successful than try to unsuccessfully maintain a full-time job.

This article was excerpted from Chapter 5, *Autism and Learning Differences (An Active Learning Teaching Toolkit)*, by Dr. Michael McManmon, EdD, and Francine Britton, published by Jessica Kingsley Publishers, London 2015.

Jennifer Kolarik serves as the Lead Head Career Coordinator at The College Internship Program (www.cipworldwide.org). CIP is a comprehensive program serving teens and young adults with Asperger's, Autism and other Learning Differences. CIP offers year round and summer programs at six locations nationwide.

Success from page 4

the second time you give an instruction, your voice is raised, your nostrils are flared and the vein in your neck is throbbing. A neutral face and a calm tone are required and sometimes need to be practiced.

5. Don't take your child's behavior personally. Know that when your child is engaging in a challenging behavior, he/she is not doing so to offend you. People engage in behaviors because it meets a need. The principles of applied behavior analysis indicate that there are four reasons why behavior occurs: attention (I want something of or from you), escape (I need you to help me avoid or delay something), self-stimulation (I can make myself feel good) or pain. Even verbal statements like "I hate you," "You never … ," or "You don't love me" should be treated as behaviors to get his or her needs met, rather than an analysis of your parenting skills or the quality of your relationship. You are more likely to falter on your strategy if you feel guilty even when there is really nothing to be guilty about. Do not get distracted from your task.

6. Prepare the environment for what is about to come. This includes both the physical environment and the people in it. Ask yourself: "What will need to happen to make my plan work? Do I need to make arrangements for others in the home while I tackle implementation? Does someone need to take on some of the other caregiver responsibilities?" In some cases, you may want to make changes to the arrangement of furniture and other items to address safety. Consider if there are places you should designate for certain tasks because the space is quieter, better lit, etc.

7. Share your plans with others. Identify people who can support you by simply holding you accountable for your own behaviors or become more involved when you just can't. Who can prompt you with the "cut it out" sign from outside the view of the child? Who can give you the "thumbs-up" for keeping it together during a tough encounter? Is there someone you can defer to during your kryptonite moment? It is also helpful in general to get feedback on how you are doing. It can be difficult to objectively assess your own behavior during or after an interaction.

8. Be prepared for the behavior to get worse before it gets better. Often parents are gung-ho at the start of the plan but soon start to wane when the rate or intensity of behavior increases. This is in fact a good sign and means the plan is working. Do not stop now. The child recognizes that there is a change in his/her environment and is struggling against it. He/she liked it the way it was. It is up to the implementer to be consistent so that the child "learns" that the changes made are here to stay and there are new expectations for his/her behavior.

Often behavior plans are created to be implemented at a time when parents and caregivers are at their wits end, are frustrated by the child's behavior and environments are chaotic and out of control. Give your plan a greater probability of success by preparing yourself and your environment for its implementation.

One last suggestion - be kind to yourself. There will be times when you may analyze your actions and think that the plan dictated a different behavior. Do not beat yourself up. Identify what precipitated the error and make your adjustments. You can do it!

Lana Small, MSW, is Coordinator of YAI's Community Habilitation program. She has worked in the field for 21 years and holds an MSW from Hunter College School of Social Work.

Control from page 26

assist, rather than hinder, this development.

Erikson (1963) touched on something like this when referring to the phenomenon of "mutual regulation" (p. 68), and elaborated on it in the following passage:

The unavoidable imposition on the child of outer controls which are not in sufficient accord with his inner control at the time, is apt to produce in him a cycle of anger and anxiety. This leaves a residue of an *intolerance of being manipulated* and coerced beyond the point at which outer control can be experienced as self-control. Connected with this is an *intolerance of being interrupted* in a vital act, or of not being permitted to conclude an act in an idiosyncratically important way. All of these anxieties lead to impulsive self-will—or, by contrast, to exaggerated self-coercion by stereotypy and lonely repetition. Here we find the origins of compulsion and obsession and the concomitant need for the vengeful manipulation and coercion of others (p. 409, italics included).

This reinforces my earlier point about behavior being rooted in a quest for control, and about how relative lack of control can provoke unwelcome behavioral responses. As far as autism goes, I ask that the reader not misunderstand me. I am not trying to resurrect the outdated and very offensive notion that a child's autism is the fault of his/her parents (this may be true in rare and extreme cases, but not for the most part). Rather, it is precisely the genetic and interior component of autism that prompts me to cite the above passage from Erikson's book.

Presumably, the brain of someone on the autism spectrum differs (that is, in some respects) from the neurotypical brain right from the very beginning. So already, infants with autism spectrum disorders are at a disadvantage when it comes to "mutual regulation." Their modes of "inner control" will differ from those of neurotypical children, and will likely be in conflict with standard modes of "outer control." If we follow Erikson, we must conclude that self-confidence and personal adjustment will inevitably suffer as a result (not irreparably, but enough to cause problems). This is why I would heartily support research into signs of autism in the early stages of infancy; this could perhaps give us some clues as to how the receptivity of children on the spectrum to modes of environmental conditioning, in combination with the latter, might influence later autistic behaviors. Something makes me think that this would be much more fruitful than focusing *only* on the neurological component of autism, as if these children came "pre-wired" for later behavioral patterns.

Again, I am not suggesting that parents are to be blamed for their children's autistic behaviors – any more than fluorescent lights should be "blamed" for an autistic child's sensory meltdowns. But autistic children, like all other human beings, are *social beings*, and the interaction of inherited traits and exterior influences (both interpersonal and environmental) is as important for them as for anyone else. That said, I think it would be helpful to both parents and children if we knew a little more about this, and if we were able to detect (and respond to) signs of autism spectrum disorders earlier.

In the meantime, let us remember that behavior is a *language*. Bad behavior should not be tolerated, but neither should we just try to "squash" it, and in so doing stifle the symptom at the expense of the underlying issue. There is a whole personal history, a whole story to be told in anyone's behavior – a story of needs, fears, wants, anxieties, and perhaps even a desire to communicate.

Daniel Crofts is a 30-year-old man with Asperger Syndrome. He has an MA in English/Literature from the State University of New York College at Brockport and experience in the fields of freelance journalism, substance abuse prevention, online higher education, and service to people with developmental disabilities. He may be contacted at danielcrofts31@yahoo.com.

References

Erikson, E.H. (1963). *Childhood and Society* (2nd ed.). NY: Norton.

Father* from *page 24

role which includes lack of emotional expression, control, and self-reliance. Typically men have a more active coping style than women and prefer active problem solving rather than talking about the problems. The general misconception that therapy involves merely talking about problems rather than actively solving problems tends to deter men from participating in treatment. Engaging fathers requires effort by mothers and therapists whose attitudes about the importance of involving fathers in child and family are important.

Fathers of Children with Developmental Disabilities

Prior to 2000, there was a consensus in the professional literature that mothers and fathers initially respond differently to a child with a disability. Fathers seem less emotional and focus traditionally more on long-term problems such as the financial burden. Mothers respond more openly with their emotions and are more concerned with the challenges of the daily care of the child. Consequently, fathers who are less involved in daily interaction with their children tend to have a prolonged period of denial about the disability and its implications (Seligman and Darling, 2007).

Parental roles were thus polarized, and fathers were observed to be uncomfortable with female-dominated service systems. The daytime hours of schools and agencies did not accommodate fathers' working lives. In their discussion of fathers in early intervention and family support programs, Davis and May (1991) pointed out that fathers of children with intellectual disabilities were frequently considered as an afterthought by professionals.

Fathers of Children with Autism

Recent research literature on fathers of children with autism lacks topics that relate to the involvement of fathers in intervention for their child and intervention on fathers themselves. In research on mothers and fathers of preschool and school-age children with autism, Hastings et al. (2005) found that fathers reported using more avoidant coping strategies and less problem-focused coping than did mothers. The emotions of fathers are often unacknowledged or seen as secondary to the needs of the child and mother, and these findings have clear implications for clinical practice.

While mothers typically seek help from external sources, fathers are more likely to rely on the support of their partner (Bristol et al., 1988). The implication is that clinicians will best meet the needs of fathers by working toward strengthening the relationship between the parents and facilitating communication on the day to day issues. Some fathers have expressed a wish to be supported by other fathers of a child with an ASD. Clinicians can facilitate these connections where men can discuss their concerns and possibly show emotion with peers.

Until recently, there was a trend toward research questions which looked only at stress and burden in families of children with developmental disabilities. Recent studies show that these negative impacts are neither as common nor as severe as previously believed. Blacher and Baker (2007) emphasize the shift to investigate the positive and negative impact in order to arrive at a more balanced view. Clearly, there is a role for incorporating positive perceptions in parent education and intervention programs.

Increasing Father Involvement

Given the increased evidence of greater male parent involvement with their children, one would expect greater participation of fathers in early intervention for their children with ASD. Nonetheless, mothers continue to be the primary participants in both autism research and early intervention. This de-facto one-parent participation model ignores the growing evidence that mothers and fathers each play an early and integral role in the development of their children, perhaps particularly in their social and communicative skills (Flippin & Crais, 2011). Continuing to ignore fathers may result in missing opportunities to maximize social-communicative gains for young children with ASD.

Evidence from studies of father–child interactions with typically developing children indicates that fathers offer different language models than mothers which make important contributions to children's language development (Clarke-Stewart, 1980). Fathers tend to use a more complex language model with their children than do mothers such as with vocabulary that is more varied. Although it is likely that this may apply to communicative development for children with ASD, there is sparse data to confirm this. In their extensive review, Flippin and Crais (2011) found only three single-subject experiments that specifically reported that fathers participated in parent communication training with their children with autism. An assumption seems to be that outcomes for mothers also apply to fathers. However, as discussed, fathers have different language models and may have a unique influence on communication development of their children.

Also through play, both mothers and fathers help their children achieve higher level language and symbolic abilities, and there are qualitative and quantitative differences between parents. A father's play with his child is typically more active and rough-and-tumble. In addition, fathers are more likely to engage in play that stretches beyond the physical properties of the toys (Labrell, 1996). As their child's primary play partner, fathers have a distinctive role in supporting their child's development through play. Research has demonstrated that interventions can improve both play and language outcomes for children with ASD, but the intervention did not record data specifically on fathers (Kasari, Paparella, Freeman, & Jahromi, 2008).

From a parental perspective, it tends to be more difficult to engage in play with a child who has less repetitive and more varied play. However, with intervention fathers may be uniquely suited to support the play development of their children with ASD.

Conclusion

By focusing primarily on mothers, researchers, and interventionists may be inadvertently placing burdens on mothers. Since fathers more commonly work more hours outside the home, employment provides a respite and may in part explain their lower levels of stress as compared to mothers. Increasing father involvement in early intervention and special education may have positive outcomes for both children and parents.

Flippin and Crais (2011) conclude that fathers have unique ways of playing and interacting with their children. Incorporating more play activities that reflect fathers' tendency toward physical or "rough-and-tumble" play and increasing active sessions with fathers, as opposed to more didactic sessions, is a first step in making interventions more father-friendly. On the other hand, in general women tend to gather explanations and directions. Early intervention is a predominately female field which is relationship oriented, providing supportive feedback to parents, primarily mothers. Men prefer receiving feedback from peers. As opposed to waiting until all the information is gathered, men are more comfortable jumping in to take action and problem solve.

Increasing fathers' involvement will likely require implementing more father-friendly learning and teaching styles such as peer feedback, task-oriented learning, and video modeling. Focusing on communication and play interventions in ASD research has potential to help fathers to feel more effective in their relationship with their child with ASD. Reduced maternal stress and greater family cohesion could be important collateral effects for the family.

Robert Naseef, PhD, is a psychologist and father of an adult son with autism. His latest book is Autism in the Family: Caring and Coping Together (2013) by Brookes Publishing. He also moderates a monthly father's discussion group at www.autismbrainstorm.org. He can be contacted at RNaseef@altenativechoices.com, and he blogs on his practice website, www.alternativechoices.com.

References

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist*, 58, 5-14.

Blacher, J. & Baker, B.L. (2007) Positive impact of intellectual disability on families. *American Journal on Mental Retardation* 5, 330-48.

Bristol, M. M., Gallagher, J. J. & Schopler, E. (1988) Mothers and fathers of young developmentally disabled and nondisabled boys: Adaptation and spousal support. *Developmental Psychology*, 24, 441-441.

Clarke-Stewart, K.A. (1980). The father's contribution to children's cognitive and social development in early childhood. In F.A. Pedersen (ed.) *The father-infant relationship: Observational studies in the family setting* (pp. 111-146). New York, NY: Praeger.

Davis, P.B. & May, J.E. (1991). Involving fathers in early intervention and family support programs: Issues and strategies. *Children's Health Care* 20, 87-92.

Flippin, M. & Crais, E. R. (2011). The need for more effective father involvement in early autism intervention: A systematic review and recommendations. *Journal of Early Intervention*, 33, 24-50.

Hastings, R. P., Kovshoff, H., Brown, T., Ward, N. J., Espinosa, F. D. & Remington, B. (2005) Coping strategies in mothers and fathers of preschool and school-age children with autism. *Autism the International Journal of Research and Practice* 9, 377-91.

Jones, J. & Mosher, W. D. (2013). Fathers' involvement with their children: United States, 2006-2010. National Health Statistic Reports; no. 71. Hyattsville, MD: National Center for Health Statistics.

Kasari, C., Paparella, T., Freeman, S., & Jahromi. L. B. (2008). Language outcomes in autism: Randomized comparison of joint attention and play interventions. *Journal of Consulting and Clinical Psychology*, 76, 125-137.

Pleck, J. H. (2010). Fatherhood and masculinity. In M. E. Lamb (Ed.) *The role of the father in child development* (pp. 27-57). Hoboken, NJ: John Wiley & Sons, Inc.

Seligman, M. & Darling, R.B. (2007) *Ordinary families special children: A systems approach to childhood disability*. New York: The Guilford Press.

Conference* from *page 21

Not knowing she had Asperger's until age 50, Anita managed to successfully maintain a full time career as a Certified Registered Nurse Anesthetist. She will share her strategies and mechanisms of coping in a world of neurotypicals.

Learning

Carol Kranowitz, MA, Author of "Out-of-Sync Child," and President of Out-of-Sync Child, Inc, Maryland (http://out-of-sync-child.com/about-carol). This presentation for parents, educators, therapists and other professionals will review how Sensory Processing Disorder plays out at home and school and how to recognize underlying sensory issues.

Other topics throughout the conference include: Advocacy, Aging, Arts, Communication, Community Building, Community Inclusion, Early Childhood, Employment, Family Empowerment, Health, Management, Person-Centered, Planning, Post-Secondary Education, Quality of Life Residential, Self-Advocacy, Self-Direction, Sensory Integration, Social Skills, Special Education, Staff Development, Technology, and Transition.

The conference is designed for family members, people with ID/D, physicians, Direct Support Professionals, social workers, physical and occupational therapists, speech-language pathologists, administrators, higher education faculty, early intervention and special education professionals, behavioral health professionals and anyone working or committed to creating a society that embraces difference.

To register or for more information, visit yai.org/conference2015. Questions? Contact Abbe Wittenberg, Conference Planner, at 212-273-6472 or abbe.wittenberg@yai.org.

Shop now for YAI's award winning DVDs, Digital Downloads, YAI Resource Center memberships and New Videos on Demand at YAI's Online Training Store at yai.org/trainingstore.

Expect from page 13

may impact behaviors. For example, evaluators may review prior medical records (with appropriate consent, of course) to identify potential medical causes or influences on the behavior. In this example, evaluators may discover that the client has a history of chronic ear aches and infections. Evaluators may look to identify how these aches and infections may impact the target behavior. Prior testing results, previously attempted interventions, and recommendations of past service providers may also yield helpful information.

Evaluators should also complete an interview with relevant parties including parents, caregivers, teachers, siblings, or anyone else with consistent client contact (in some cases, even the client herself) (Alberto & Troutman, 2012). The information provided is necessarily impacted by the interviewee's relationship with the client. Evaluators are interested in the form or *topography* of the behavior, the contexts where the behavior occurs, situations when the behavior never occurs, and the time of day behaviors are most likely to occur. Sleep patterns, medication, medication changes, and dietary factors may also be important types of information.

Finally, rating scales are another type of indirect assessments used to help evaluators ascertain why individuals believe behaviors are occurring. Specific rating scales, like the Motivation Assessment Scale (MAS; Durand & Crimmins, 1990) or the Questions About Behavior Function (QABF; Mattson & Vollmer, 1995), provide a series of questions interviewees answer on a Likert-scale rating (e.g., 1 is less likely to 6 is most likely). These assessments do not rely on direct observation of the target behavior, rather, evaluators rely on others' statements who have had direct experiences with target behaviors. Direct assessments, where the practitioner has direct contact with the target behavior, often follow indirect assessments.

Direct Assessments

Evaluators utilize direct assessments once target behaviors have been identified and indirect assessments have been completed. Direct assessments consist of an examiner or other trained observer viewing students and their behaviors in natural environments where behaviors occur while simultaneously taking notes and/or scoring data. Several types of direct observation data may be collected. In particular, examiners note antecedents and consequences surrounding behaviors. Examiners also make note of the time behaviors occurred as well as other important variables such as who was present with the student and what types of activities occurred. This type of data collection is most often referred to as ABC Analysis (Bijou, Peterson, & Ault 1968) where A stands for antecedent, B stands for target behaviors, and C stands for consequences.

Evaluators may also collect data using a scatterplot form. This data collection procedure allows evaluators to note if behaviors occurred often, some, or none of the identified time periods throughout the day. These data provide evaluators with more specific information about the contexts where behaviors occur.

During the direct assessment process, evaluators may also examine setting events. Setting events refer to the setting, climate, or context within which the behavior and consequence occur. Setting events are antecedents and may occur immediately before a problem behavior or hours or days in advance. Setting events can include environmental factors (noise, temperature level, unplanned schedule changes, overstimulation), social factors (a death or illness in the family, an encounter with a peer, receiving a bad grade), or physiological factors (lack of sleep, side effects of medication, medical condition, illness, pain). Once specific setting events are identified by the evaluator, this information may be used to determine how to prevent a behavior from occurring or how to decrease the likelihood of a behavior.

A final direct assessment evaluators may use is called a preference assessment. Evaluators may conduct preference assessments to assist them in identifying stimuli likely to serve as reinforcers specific to an individual student. Preference assessment may also be completed indirectly by interviewing others or by completing rating scales about reinforcers. However, research has shown that direct preference assessments yield most accurate results.

Data Analysis

Following the completion of indirect and direct assessments, evaluators analyze all the data. The purpose of the data review is to illuminate any patterns among antecedents, behaviors, and consequences (O'Neill et al., 1997). While reviewing assessment data, evaluators seek to answer the following questions:

- Are the same antecedents occasioning behaviors?
- Are behaviors followed by similar consequences?
- Is the behavior occurring within the context of the same activity, materials, and/or people?
- Does the individual terminate the behavior following a particular consequence?

A high quality FBA will include data and graphs to depict the findings of the analysis. The results of an FBA lead to a hypothesis about why behaviors occur. Hypotheses may include any one of the 8 functions shown in Table 1 below or any combination of those functions.

Scientific studies have yet to prove that anxiety is a function of behavior. However, when a student feels anxious about a situation, he may engage in a behavior in order to escape the situation. Similarly, a student may have anxiety because she cannot have something she wants. She may engage in behaviors in order to have her way or obtain what she wants. Similarly, "control" is not a function of behavior. While it may feel that a student is trying to *control* the adult's behaviors, ultimately, the student is either obtaining desired consequences or avoiding undesirable situations.

Occasionally, and often for research purposes, evaluators need to complete an additional step in order to demonstrate or prove the function of the behavior. Outside of research, evaluators may not be certain why behaviors occur even after analyzing all the data. Then, evaluators or researchers would complete a functional analysis. During a functional analysis, antecedents and/or consequences are experimentally manipulated systematically and behaviors are measured precisely under each condition. Evaluators create detailed graphs to reveal how behaviors are affected by various antecedents and consequences. It is only through experimental analysis that evaluators know with certainty the function of target behaviors.

Linking the FBA to the Behavior Intervention Plan

Once the evaluator has determined the function of the target behaviors through careful assessment and data analysis, the behavioral team, including parents, teachers, and other relevant members will develop an individualized behavior intervention plan (BIP) to specifically address target behaviors. The FBA results should be used to develop the BIP. The team will create a plan for adults to modify trigger antecedents to prevent target behaviors from occurring. Replacement behaviors will be taught for the student to use in lieu of challenging behaviors. A plan will be developed to teach team members how to reinforce the new replacement behaviors. And finally, strategies will be identified for team members to utilize following instances of challenging behavior.

In summary, when expecting an FBA, consumers of behavioral services should anticipate an indirect assessment phase consisting of interviews, record reviews, and rating scales, followed by direct assessments consisting of direct observations with data collection, and a detailed analysis of the data complete with graphs. A function or combination of functions should be identified for each target behavior. And finally, the results of the FBA should be used to develop an appropriate BIP for the student.

Melissa L. Olive, PhD, BCBA-D, is Executive Director, Patrick N. O'Leary, MA, BCBA, is Clinical Case Supervisor, and Abigail V. Holt, MA, BCBA, is Clinical Supervisor and Feeding Clinic Manager at Applied Behavioral Strategies, LLC in New Haven, CT. Correspondence concerning this article should be addressed to Melissa L. Olive, P.O. Box 3957 New Haven, CT. E-mail: missy@appliedbehavioralstrategies.com.

References

Alberto & Troutman (2012). *Applied behavior analysis for teachers* (9th ed.). Upper Saddle River, NJ: Pearson Education.

Bijou, S. W., Peterson, R. F., & Ault, M. H. A Method To Integrate Descriptive And Experimental Field Studies at the Level of Data And Empirical Concepts. *Journal of Applied Behavior Analysis, 1*, (1968): 175-191.

Durand, V. M. & Crimmins, D. B. The Motivational Assessment Scale. In V.M. Durand (Ed.). *Severe Behavior Problems: A Functional Communication Training Approach*. New York: Guilford Press, (1990).

Horner, H. R., & Budd, M. C. (1985). Acquisition of manual sign use: Collateral reduction of maladaptive behavior, and factors limiting generalization. Education and Training of the Mentally Retarded, 20, 39-47.

Iwata, B., Dorsey, M., Slifer, K., Bauman, K., & Richman, G. (1982/1994). Towards a functional analysis of self-injury. *Journal of Applied Behavior Analysis, 27*, 197-209. (Reprinted from *Analysis and Intervention in Developmental Disabilities, 2*, 3-20, 1982.)

Matson, J. L., &Vollmer, T. (1995). Questions About Behavioral Function (QABF). Baton Rouge, LA: Scientific Publications.

O'Neill, R. E., Horner, R. H., Albin, R. W., Storey, L., & Sprague, J. R. (1997). Functional Assessment and Program Development for Problem Behavior: A Practical Handbook. (2nd ed.). Pacific Grove: Wadsworth.

Table 1.

Possible Functions of Challenging Behavior.

Possible Function	Variations	Examples
Get Something	Obtain Attention	Child hits sibling. Child receives long lecture about not hitting.
	Obtain Objects	Child throws tantrum at store in checkout line. Child gets candy to stop tantrum.
	Obtain Activities	Child has a meltdown so staff let him play on computer to self-calm.
	Obtain Sensory	Child rocks back and forth and wiggles fingers. Child receives visual input.
Avoid Something	Escape Attention	Child never raises hands during class to avoid being called upon.
	Escape Objects	During mealtime, child throws food and plate. Non-preferred food is removed.
	Escape Activities	During group instruction, child hits peers, child is sent to time out.
	Escape Sensory	Child has a stomach ache. Child hits self in the head and endorphins relieve the belly pain.

Cortisol* from *page 6

recovery are widely accepted. Occasionally we do not know what has triggered the agitation, since there are both fast and slow triggers. A person may become upset by a loud noise, or a series of small events such as their favorite shirt not being available and the bus running late. During this period stressed individuals are unable to stay on task and may be non-compliant. Confrontation or punishment at this stage may serve as an additional trigger and result in an even greater adrenal cortisol secretion.

During the acceleration phase, many individuals will attempt to draw others in by hitting or screaming. In peak, out-of-control periods, cortisol has impaired cognitive function. Restraint is sometimes needed in order to keep the person from harming themselves or others. During the de-escalation period, students become calmer. Finally the cortisol level diminishes and a period of subdued behavior and interactions follows.

Typical descriptions of the acting out cycle include “went crazy;” “lost it;” and “gone nuts.” These descriptions are harmful because they blame the person and do not acknowledge the cortisol excitation that has made them biologically unable to access normal thinking. We would not punish a person with cerebral palsy for walking slowly. It is well established that people with ASD become easily over aroused and, once over-stimulated, they remain so for extended periods (Baranek, 2002). We need to stop punishing individuals with ASD, in a state of adrenal cortisol arousal, for not being able to respond appropriately. It is impossible for them to do so!

Understanding that adrenal cortical excitation can last for hours, or even days in some individuals, is crucial when designing interventions. Every time Anne-Marie began to quiet down, she would remember the dog and “go off again,” crying and terrified. Her mother tried reassuring her and then ignoring her behavior, but nothing worked.

On Monday, Catherine tried to de-dramatize the incident by telling a social story about the dog. “The dog….made so much noise…and we all told that dog to stop. Ann-Marie was the bravest of all! She stood there and said, ‘Go away, dog!’”

Anne-Marie began to repeat, “Go away dog!” and smiled calmly. The cortisol had finally drained and she could access her neo-cortex and was able to learn a new skill (Maurice, 1993, pp. 179). Social stories, developed by Carol Grey (1993), are antecedent prompts to prepare individuals with ASD for events that are stressful. They describe situations from the person’s point of view and suggest different behaviors. Once a trigger has been identified, a story can be written to prepare the individual with a way to manage the stressful stimulus.

Nathan hated loud noises, especially fire drills. He would scream for hours after the loud warning rang. So we wrote The *Fire Drill Story* with him. The book acknowledged his stress, and related a sequence of events he should follow. He read the book over and over on fire drill days and was able to keep himself calmer, refraining from screaming.

The response to a student, who is agitated or even in the out-of-control phase, is critical. Punishment will only increase the stress reaction. There should be consequences for inappropriate behaviors. However during the throes of an episode is not the time to enforce them. A person in the midst of adrenal cortical excitation is not capable of learning, so response strategies need to be taught and reviewed frequently.

Breathing is an important tool in calming the mind. When an individual inhales slowly, with a longer exhale, it help the body to become calm. Individuals with ASD can be taught slow, careful breathing techniques. Directing a person to “breathe with me” is much more effective then shouting “calm down!”

Individuals have different ways to recover from stressful situations. When parents, teachers or caregivers are aware of individual preferences, they can offer choices. Music can be very calming. Some teachers use motor-related songs, beginning with large movements and ending with whispers and slow controlled movements. Backrubs, weighted vests or slow rocking can be soothing and allow the brain to quiet down. The old phrase, “take a walk and get a drink,” is often effective since the water can help to dilute the cortisol.

David became highly agitated if his bus was late or the daily schedule changed. Sending him to a “time-out” room, as punishment for screaming and biting, increased his behavior. A calm-down area was created in a private corner. David was introduced to the area and reminded that he could choose to listen to music, look at train schedules, or sit in the beanbag chair when he felt agitated. He found the beanbag chair soothing and would often pull a second one on top during highly stressful times, similar to Temple Grandin’s squeeze machine. He was usually able to return to his task after about 20 minutes. Eventually he learned to ask for the calm- down area.

Individuals with ASD are physiologically prone to higher levels of cortical excitation than others. Caregivers, teachers and parents must be aware of this chemical response to stress and its longer duration. Most people know when they are getting upset and have developed strategies to help them calm down. This is even more important for children and adults with autism.

Jeanne D’Haem, PhD, began her career as an ESL teacher in Somalia with the Peace Corps. She was a special education teacher and supervisor for many years. She worked with children from pre-school to high school with special needs, medical problems, and or limited English. She is now an Associate Professor of Special Education at William Paterson University, Wayne, NJ. Her areas of expertise are behavior management, education law and the inclusion of children with disabilities in general education programs. Dr. D’Haem may be reached at dhaemj@wpunj.edu.

Irene Van Riper, EdD, is an Assistant Professor of Special Education in the Department of Special Education and Counseling at William Paterson University in Wayne, NJ. Dr. Van Riper has had 90 hours of Orton-Gillingham training and is completing the 100 hours of practicum to be awarded the Associate Level from the Academy of Orton - Gillingham Practitioners and Educators. Dr. Van Riper is an authority in Autism Spectrum Disorders and is instrumental in building the graduate program for Autism Spectrum Disorders and Significant Disabilities at William Paterson. She is currently co-editing a book describing this program. Dr. Van Riper may be reached at vanriperi@wpunj.edu.

References

Baranek, G. (2002). Efficacy of sensory and motor interventions for children with autism. *Journal of Autism and Developmental Disorders. 32*(5). 397-422.

Corbett, B.A., Schupp, C.W. & Lanni, K.E. (2012). Comparing biobehavioral profiles across two social stress paradigms in children with and without autism spectrum disorders. *Molecular Autism 3*(13).1-10.

Corbett, B.A., Swain, D.M., Newsom, C.,Wang., L., Song.,Y. & Edgerton, D. (2014). *Journal of Child Psychology and Psychiatry 55*(8). 924-934.

Grey, C. (1994). *The new social stories book*. Los Angeles, CA: Future Directions.

Jacobs, W. and Nadel, L. (1985). Stress-induced recovery of fears and phobias. *Psychological Review 92*(4). 512-531.

Maurice, C. (1993). *Let me hear your voice: A family’s triumph over autism.* Fawcett Books, NY, NY.

Ruttle, P.L., Shirtcliff, E.A., Serbin, L.A., Fisher, D.B., Stack, D.M. & Schwartzman, A.E. (2011). Disentangling psychobiological mechanisms underlying internalizing and externalizing behaviors in youth: Longitudinal and concurrent associations with cortisol. *Hormones and Behavior 59* 123-132

Spratt, J. Nicholas, J., Brady, K., Carpenter, L., Hatcher, C., Meekins, K., Furlanetto, R., Charles, J. (2011). Enhanced cortisol response to stress in children in autism. *Journal of Autism and Developmental Disorders.* DOI 10.1007/s108033-011—1214-0 75-81.

Walker, M., Calvin, G. & Ramsey, D. (1995*). Antisocial behavior in schools: Strategies and best practices.* Brooks/Cole Publishing, Pacific Grove, CA.

Label* from *page 25

in line at Disney or order chicken fingers at dinner or apologize for the tantrum you threw at a barbecue. Ultimately, we are trying to figure out how to best soften your edges, so the world may look and feel and taste a little kinder.

But mostly, Daddy and I celebrate.

Without your diagnosis—your label—I’m not sure I would go to such lengths to decorate for every single holiday. But you remind me to go into the basement and bring up the green shamrocks and red, glittery hearts. Your delight is so tangible, your joy so real, that I can’t help but be swept up in the magic.

“Mom. The hearts. They go on the shelf again. And on the table.”

Then there was our trip to Walgreen’s to buy valentines.

“Two. I need to buy two boxes.”

“Why? Why two?”

“There are thirty-two. Thirty-two in each. I have a lot. Of friends now. I need two. For sixty-four cards.”

Standing under the fluorescent lights, in an aisle full of plastic flowers and teddy bears, I thought about how you haven’t been invited to a birthday party or play date in well over five years. In over five years, not a single person has called the house for you, or rang our doorbell, or sent an E-vite.

I could have asked you, “Who, Jack? Who will you send them to?”

Or told you, “No, Jack. I think one package is plenty.”

I didn’t. I simply said, “Definitely. Definitely get two.”

Watching you walk up to the counter clutching two boxes of red cards, I couldn’t help it. My throat tightened and my eyes welled.

Because there is some pain not even a label can abate.

But without it, our family would only appreciate normal. If we didn’t have a name for your unusual characteristics, you may have faded into the background, eventually known only as the difficult brother; the boy who would not play basketball or dance to Michael Jackson or watch The Muppets at night with rest of us.

You would have felt left out, isolated, angry. You would have hated us.

Then maybe the difficult brother would have grown into the troublesome teenager and eventually, the weird uncle no one wants to sit next to at Thanksgiving.

Instead, we see you. Because of a label, we actually see you for who you really are; a funny, quirky, original boy. And every day our family works to bridge the gap between usual and unusual, the neurotypical and otherwise.

“This is my brother, Jack. He has autism. He hears you differently.”

Because of autism’s label, we eat our dinner surrounded by hearts.

You have autism. This is not your fault or my fault or Daddy’s fault. This is not anyone’s fault. It just is.

But you are not limited by your label. You are not pigeon-holed or compartmentalized or reduced. You are loved and embraced, and maybe even the tiniest bit understood.

As for me, I have learned many lessons from the autism label. I have learned how to slow the cart in the grocery store and find the pinkest frosting. I have learned how to compromise with chicken fingers, and that we should always buy our candy at the movie theater.

And one cold afternoon in February, I learned that friendship’s truest measure is not how many times the phone rings or the amount of invitations in your mailbox.

It’s the courage to stand at the kitchen counter, student directory in hand, and write out sixty-four cards for Valentine’s Day.

“For my friends, Mom. I have so many.”

“What Color Is Monday?” is available on Amazon.com and BarnesandNoble.com. You can also follow Carrie on her weekly blog: www.WhatColorIsMonday.com and Facebook.com/WhatColorIsMonday.

Setting Events from page 17

behavioral terms, reinforcing the behavior. The reinforcement occurs because the outcome of the behavior either meets a felt need, or provides some type of physical, social, or emotional pleasure or satisfaction. A cornerstone of behavior intervention involves developing an understanding of the various factors that help to explain why the problem behavior occurs. This includes the identification of: (a) the settings events, described below, (b) the antecedents, which specifically cause the behavior to occur, (c) an operationally defined problem behavior, and (d) an outcome or consequence that results from the behavior, which the person finds rewarding and motivates them to engage in the behavior again. These four elements are sometimes are referred to as the "four-term contingency."

For example, an individual may be prompted to perform a task s/he does not wish to complete, and they may respond by engaging in problem behavior. When the caregivers shift their attention to managing the behavior, it may be difficult to follow through on efforts to get the person to complete the task. If the individual does not complete the task, the behavior is reinforced by the individual's escape from the demands. Researchers have identified a variety of other functional patterns in addition to escape, which include: gaining or avoiding social attention, gaining access to items or activities the individual desires, and creating patterns of sensory stimulation that are satisfying or comforting (Carr, 1994).

Accurate identification of these functions often leads to individualized strategies, and when these are applied systematically, proactively, and in conjunction with a wide array of educational and other support programs, can make a tremendous impact on effectively reducing the frequency and severity of problematic behaviors, and supporting more positive behavioral alternatives. One challenge in applying these strategies with individuals who have ASDs though, is that characteristics of the ASD may serve to increase the likelihood that the individual will engage in a particular behavior.

This type of influence on behavior would be classified as a setting event. These are conditions which alter what a trigger or stimulus means to the person (e.g., a reinforcer is more available), or influence the attitude, capacity, or need that a person brings to the circumstances in which a behavior may occur. While the antecedents and setting events both precede problem behavior, setting events do not trigger problem behavior by themselves. Rather, setting events can increase the likelihood that an antecedent will trigger problem behavior, either by putting the person in a state that makes the behavior more likely, or cuing the individual that an outcome they desire is available. Research has shown that setting events can include environmental conditions, social influences, or physiological factors. Examples of common environmental setting events for individuals with ASD include disrupting a person's routine, and/or being in a situation that he or she is unable to predict upcoming events. Social setting events may include being left alone for a period of time or fighting with a family member or roommate. Illness, pain, sleep deprivation, hunger and medication changes are just a few examples of internal factors that increase the likelihood of problem behaviors.

In some cases, the occurrence of a disorder, specific disability, or psychiatric illness may be considered a setting event for the occurrence of problem behavior. This is significant because psychotropic medications have the potential to alter an individual's response to environmental stimuli. For instance, researchers have recommended that selection of psychotropic medications include consideration of specific pharmacological treatment effects on an individual's response to environmental stimuli maintaining both adaptive and problematic behavior (Thompson & Symons, 1999; Schall & Hackenberg, 1994). This highlights an important concern regarding the relationship between functional assessment of behavior, function based behavioral intervention, and drug treatment.

These factors highlight a variety of concerns related to the impact of what would be considered setting events, on the development and implementation of effective behavior support plans for individuals with ASD. Several examples highlight this concern. First, many individuals with ASD have an unusual need or craving for specific types of sensory stimulation. Understanding the unique pattern of sensory needs and their relationship to problematic behaviors is an important factor in developing effective intervention and support strategies. The focus on setting events provides a means of making adaptations to proactively meet sensory stimulation needs part of a support plan designed to prevent the problematic behaviors.

A related consideration is the frequent co-occurrence ASD and anxiety disorders (White et al., 2009). The experience of anxiety, its impact on adaptive functioning, and the potential justification for diagnosis of a co-occurring disorder often are overshadowed by the symptoms and problematic behaviors that accompany an ASD. Appropriate identification of anxiety, and determination of the role this plays as a predisposing factor for problematic behavior, is an important factor in developing appropriate and effective supports. Specifying feelings of anxiety as a setting event would justify the inclusion of calming activities or relaxation exercises as a precursor intervention designed to prevent the problem behavior. Recognition of an anxiety disorder as a setting event would indicate that clinical intervention and treatment of that disorder should be identified as a prevention strategy for those problem behaviors. This kind of assessment of behavior and development of a Functional Behavioral Assessment hypothesis afford the opportunity both to recognize and address important factors that often are neglected in developing behavior plans, along with establishing a framework that facilitates the integration of behavior intervention and support planning with clinical intervention.

In addition to identifying environmental variables that precede and follow problem behavior, the functional assessment gathers information about an individual's communication, social skills, and other aspects of adaptive functioning and circumstances. This information can be used to design interventions to teach the individual new skills effectively competing with a problem behavior. For instance, an individual may engage in disruptive behavior at school or work in order to avoid persisting on a difficult task. The functional assessment process may indicate that the individual does not know how to ask for assistance or how to complete the task. In other cases, an individual may have strong social and communication skills that are not being used in settings where problem behaviors are occurring. Information related to an individual's social and communication skills will provide the foundation for selection and teaching of new, adaptive skills that may function to replace problem behaviors or reduce the motivation to perform them.

The clinician or behavior specialist who desires to work with individuals with ASD and who may be dually diagnosed should become familiar with the clinical literature regarding mental illnesses and their treatment. An understanding of psychiatric diagnoses and pharmacological treatments is extremely important in providing the most comprehensive and effective intervention and support. In the mental health literature, it has been noted that one of the most critical areas of support for families is information about mental illness, the impact it may have on behavior, and how these conditions can be treated. Valuable resources for obtaining such information can be found through the National Association for Dual Diagnosis, with a listing of resources on NADD's website (www.thenadd.org). Care providers also need to know how the mental illness will likely affect the behavior of the person. In conclusion, we wish to highlight the need for consideration of the very nature of ASDs as a potential setting event for problem behavior. We encourage the creation of comprehensive functional assessments that consider both ASDs and potential anxiety disorders among persons with ASDs. Effective treatment of challenging behaviors requires thinking across various ways in which we as a field have looked at understanding problem behaviors.

Philip Smith, PhD, is Assistant Professor of Pediatrics and Project Manager of Community Positive Behavior Supports and Daniel J. Baker, PhD, NADD-CC, is Associate Professor of Pediatrics, both at The Boggs Center on Developmental Disabilities at Rutgers Robert Wood Johnson Medical School. For more information, please visit www.rwjms.rutgers.edu/boggscenter.

References

Carr, E. G.. (1994). Emerging Themes in the Functional Analysis of Problem Behavior. *Journal of Applied Behavior Analysis 27,* 393–399.

Schall, D. W., & Hackenberg, T. (1994). Toward a functional analysis of drug treatment for behavior problems of people with developmental disabilities. *American Journal on Mental_Retardation, 99,* 123-134.

Thompson, T., & Symons, F. J. (1999). Neurobehavioral mechanisms of drug action. In N. A. Wieseler, R. H. Hanson, & G. Siperstein (Eds.), *Challenging behavior of persons with_mental health disorders and severe developmental disabilities* (pp. 125-150). Washington, DC: American Association of Mental Retardation.

Wacker, D. P., Steege, M. W., Northup, J., Sasso, G., Berg, W., Reimers, T., Cooper, L., Cigrand, K., & Donn, L. (1990). A component analysis of functional communication training across three topographies of severe behavior problems. *Journal of Applied Behavior Analysis*, *23*, 417-429.

White, S.W., Oswald, D., Ollendick, T., & Scahill, L. (2009). Anxiety in children and adolescents with autism spectrum disorders, *Clinical Psychology Review*, *29,* Issue 3, 216–229.

***Focus* from page 20**

up with too much stuff going on I get upset and cry. No one understands that just because I get upset and cry it doesn't mean that I do not like what I am doing. Sometimes, it is just too much - too long. I still like to do things like everyone else. Sometimes everything is too much for me, the noise, the people - I become very anxious and get very upset.”

That day the staff realized: We need to take the time to listen. Sometimes someone with autism cannot tell us what is not working or why. But with listening, gentle support, a deep respect, trust and meaningful relationship, different approaches may bring out wonderful experiences.

Institutionalized with No Potential Seen

When we met Mike, he was institutionalized and had been for most of his life. He was seen as severely autistic, non-communicative, with limited intelligence, and had many behavioral problems. He was destined to leave the institution because of the institution being closed, not because people there saw a brighter future for him. Once out, he moved in with his family and then began to receive support in his new home. One of his supporters felt that Mike was trapped into a web of autism and began to help him to have a voice. His supporter helped him to identify communication boards and devices. This support staff was amazed at the interest and intelligence that Mike exhibited as they began to research what might work for him. Mike essentially made all the decisions, and worked to order the device. Once the device was obtained, a flood of information came from Mike. He was so misunderstood before. He was a man of great strength, intelligence and aspirations for a better life. He was a man who had not had a bit of education who then enrolled in a supported service to audit classes at the local university while he also worked to obtain his GED diploma.

“I want to say this is the happiest I have felt in a long time. Also, I can't believe that I'm actually excited about the future. The actual thought of attending a university is now a living reality. A benchmark of some sort I am here today. I am very pleased at all of the progress we have made. Eats a person up inside when options are few and far between. I am looking forward to the day when abroad I can live. I mean not abroad but more independently. I think someday, all the world will see we disabled have much more in common than differences.

I want to complete my GED, see the world, and come to have a place of my own and my bachelor's degree. I want a more active say in what I want and need. I am building for the future and I need consistency on all of your parts, if I am to be successful in school or whatever else I pursue.”

Both of these men, classified with autism, have much to say with the experiences that they have had in their life. They each speak to how misunderstood each of them and others have become. It is this misunderstanding that leads people with autism down a path of overload and behavioral problems. These men do not profess to speak for all with autism, they only speak for themselves from their perspective on what is meaningful to them. The success of their support will only come when the direct care professional is able to earn the deep respect of the person who is labeled and help them down a path of being a distinguished member of their community and not just a client of a system.

For more information, please email patfrat@oclinc.org or visit www.oclinc.org.

***Effective Approach* from page 21**

extra support to meet universal expectations.

Tier-two interventions usually target a small group of students who demonstrate similar behaviors. Tier-two supports usually involve reviewing the rule or behavior not being demonstrated in a systematic way. Interventions which are embedded into the schools arsenal of support tools such as offering a social skills or academic skills group to students would be examples of tier-two supports. Such groups would focus on breaking down the steps to obtain a specific skill and then provide opportunities to practice this new skill. These supports provide increased attention, structure and skill development for the student(s). Such interventions can also be helpful in providing data driven feedback to both the student and the families about progress made in meeting expectations.

Tier-three supports are the most specific and intensive because they focus on individual student needs. At tier-three the emphasis is on understanding the function of the undesirable or challenging behavior for the particular student (obtain something, escape something, or just getting attention). Interventions are developed based upon individual evaluations such as functional behavioral assessments. Behavioral intervention plans are often developed in an effort to have a consistent response to the inappropriate behavior. Environmental factors such as when, where and how are examined. A plan for interrupting the pattern of inappropriate behavior and replacing it with a more appropriate behavior is developed. Any tier-three intervention would be communicated, monitored and implemented with school wide consistency and continuity in accordance with the data driven practices of PBIS (Lohrmann, Forman, Martin, Palmieri, 2008).

At school, students are expected to learn how to manage themselves and their schedules. The expectation of self-management and accountability is supported by the systems of PBIS. Evidence-based practices which are documented to work for individuals with ASD such as modeling, prompting, reinforcement, social skilled training, task analysis, video modeling and visual support can all be incorporated into the various tiers of the PBIS approach (Wong, C., Odom, S.L., Hume, K., Cox, A. W., Fettig, A., Kucharczyk, S., … Schultz, T.R., 2013).

It is widely accepted that students with Autism Spectrum Disorder learn best when given concrete rules and consistent reinforcement. Their stress level is also diminished when they can predict their environment (LaVoie, 2005). The schoolwide nature of PBIS is therefore ideal for students with Autism Spectrum Disorder. The explicit nature of the PBIS framework operationalizes pro-social values so students can better understand the behavioral expectations across all settings (i.e. classroom, hallways & cafeteria). Tier-two and tier-three interventions provide the repetitive teaching and progress monitoring to encourage appropriate behaviors across all school settings. As you would imagine, parental involvement and support is often crucial to the success of these supports.

PBIS focuses on student outcomes and behaviors in both the academic and social arenas. Students with ASD benefit from routine and structure. PBIS sets clearly stated rules and school–wide expectations. Consequently, the PBIS approach is helpful to promote appropriate behavior and address challenging behavior. Consistent teaching and re-teaching of expectations is an integral component of each tier of support under PBIS. The collaborative team approach and predictability of disciplinary procedures is a good fit when working on promoting appropriate behaviors for students with ASD.

Christine Alter, LCSW is a Teacher and Social Counselor at the New York Institute of Technology's Vocational Independence Program (NYIT-VIP). The Vocational Independence Program is a U.S. Department of Education approved Comprehensive Transition and Post-secondary (CTP) program. Ms. Alter is chairperson for VIP's Dare to Care PBIS Committee, which implements their school expectations known as “The Bears Code.” For more information, please visit www.nyit.edu/vip.

References

LaVoie, R, *It's So Much Work to Be Your Friend Helping the Child with Learning Disabilities Find Social Success*, Simon & Schuster, 2005.

Lohrmann, Forman, Martin, Palmieri, Understanding School Personnel's Resistance to Adopting School wide Positive Behavior Support at a Universal level of Intervention, Journal of Positive Behavior Intervention Vol 10 Number 4 October 2008 p. 256-269).

Sugai and Simonsen, Positive Behavioral Interventions and Supports: History, Defining Features and Misconceptions, Center for PBIS & Center for Positive Behavioral Interventions and Supports, University of Connecticut June 19, 2012.

Wong, C., Odom, S.L., Hume, K., Cox, A. W., Fettig, A., Kucharczyk, S., … Schultz, T.R. (2013*) Evidence-based practices for children, youth and young adults with Autism spectrum Disorder*, Chapel Hill: The University of North Carolina, Frank Porter Graham Child Development Institute, Autism Evidence-Based Practice Review Group.

***Aggressive* from page 32**

anything additional professionals are faced with a treatment and intervention challenge. Often, covert observations are conducted in order to ascertain that automatic reinforcement is the true function of self-injurious behavior (Toussant & Tiger, 2012). Professionals must discretely observe the individual engaging in this behavior in the absence of other people, without a response from anyone and across environments and various times of day. Once it is identified that the function of the behavior is automatic, therapeutic interventions can be designed and implemented. Although functional analyses are extremely useful for the basis of treatment development, assessments are often not possible due to the risks of harm to the individual or therapists (Borrero & Borrero, 2008).

Of all behavior that can occur, aggressive and self-injurious behaviors are by far the most dangerous and troublesome to treat. By identifying the reinforcing variables and the function of these behaviors, professionals can look to create treatment plans that will replace the harmful behavior and often functional communication training is pertinent to the treatment design. It is important to note, however, that behavior treatment plans must maintain a functional equivalence between the two behaviors. In other words, if for example, the function of the aggressive or self-injurious behavior is hypothesized to be attention seeking, the treatment plan must include a component to teach a more suitable way of requesting attention as opposed to providing an escape from a demand, additional access to preferred items, or using a time out procedure.

Due to the severity of aggressive and self-injurious behaviors, professionals strive to identify the cause of behaviors as soon as possible. By understanding the function of behavior as opposed to focusing on the form alone, lasting treatment interventions are possible.

QSAC (Quality Services for the Autism Community) is committed to providing the most appropriate interventions to our participants as possible. As a behavior analytic program, we continue to rely on evidence-based practices to improve the lives of our participants in a socially significant and safe way. For more information related to challenging behavior and/or treatment plans, please view our website at www.QSAC.com or contact Rachel directly at rlapiana@qsac.com or 718-728-8476.

References

Borrero, C., & Borrero, J. (2008). Descriptive and Experimental Analyses of Potential Precursors to Problem Behavior. *Journal of Applied Behavior Analysis, 41.1*(Spring), 83-96.

Carr, E., & Durand, V. (1985). Reducing Behavior Problems Through Functional Communication Training. *Journal of Applied Behavior Analysis, 18* (2(Summer)), 111-126.

Sturmey, P. (n.d.). Treatment interventions for people with aggressive behaviour and intellectual disability. Retrieved from http://www.wpanet.org/uploads/Education/Educational_Resources/autism-part4.pdf

Toussaint, K., & Tiger, J. (2012). Reducing Covert Self-Injurious Behavior Maintained by Automatic Reinforcement Through A Variable Momentary DRO Procedure. *Journal of Applied Behavior Analysis, 45.1*(Spring), 179-184.

Vollmer, T., & Iwata, B. (1991). Establishing Operations and Reinforcement Effects. *Journal of Applied Behavior Analysis, 24* (2(Summer)), 279-291.

Why is Autism Associated with Aggressive and Challenging Behaviors? (2012, January 1). Retrieved February 5, 2015, from https://www.autismspeaks.org/sites/default/files/section_1.pdf

***Safety** from page 10*

language; ask simple questions to identify real danger(s); clarify understanding of instructions; pause to allow time to process information; and redirect conversation to stay on topic.

Practical interventions for families:

- To reduce drowning risk teach water safety; use locked fences/gates around any source of water; train lifeguards to recognize ASD; utilize safety mechanisms including alarms; notify neighbors, pool owners, and local first responders; and ensure adequate supervision during outings near water.
- For elopement challenges, use video modeling, reinforcers, and social stories to teach person to walk safely. Use special locks, personal tracking devices and security alarms. Use identification such as ASD alert card, medical alert jewelry, or iron-on garment labels; child identification kits.
- In preventing abduction and sexual exploitation, use role playing, video modeling, and practice scripts with common lures. Use social stories relating to whom to approach for help, methods of recognizing and avoiding uncomfortable and unsafe situations.
- To increase travel safety, use adaptive car seats or transport safety restraint; establish travel rules; and use social stories.
- Consider the use of service animals to help protect, calm, regulate behaviors, and prevent escape.
- Evaluate if proper use of 911 should be taught if the person does not recognize real dangers or emergencies.

Resources

Children's Specialized Hospital has assembled free, downloadable resources for people with ASD, caregivers, and service providers. Resources include the Autism Family Safety Handbook, "911 Means Emergency" pamphlet for individuals and first responders, emergency information forms, identification cards, and more available at www.childrens-specialized.org/KohlsAutismAwareness/safety.

Additional Resources

Autism Society Safe and Sound www.autism-society.org/living-with-autism/how-the-autism-society-can-help/safe-and-sound

Autism Speaks Autism Safety Project www.autismspeaks.org/family-services/autism-safety-project

National Autism Association Autism Safety www.autismsafety.org

Jill F. Harris, PhD, is Director of Program Development and Adrienne Robertiello is Autism Educator at Children's Specialized Hospital. Please visit www.childrens-specialized.org.

References:

Anderson, C., Kaw, J.K., Daniels, A., Rice, C., Mandell, D.S., Hagopian, L. & Law, P.A. (2012). Occurrence and family impact of elopement in children with autism spectrum disorders. *Pediatrics*, 130: 870-877.

Carter, S. (2009). Bullying of students with Asperger Syndrome. *Issues in Comprehensive Pediatric Nursing*, 32:145-154.

Debbault, D. & Legacy, D. (2004). Autism and law enforcement role call briefing video. Debbaut Legacy Productions, Prt St. Luice, Florida.

Mouridsen, S.E., Bronnum-Hannsen, H., Rich, B. & Isager, T. (2008). Mortality and causes of death in autism spectrum disorders: An update. *Autism*, 12(4): 403-414.

Shavelle,R.M.,Strauss,D.J.,&Pickett,J.(2001). Causes of death in autism. *Journal of Autism and Developmental Disorders*, 31(6): 569-576.

Sullivan. P.M. & Knutson, J. (2000). Maltreatment and disabilities: A population-based epidemiological study. *Child Abuse and Neglect*. 24(100): 1257-1273.

***Adults** from page 26*

Antecedent-based strategies - Techniques that modify the environment prior to the occurrence of a behavior in order to prevent that behavior from occurring are known as *antecedent-based strategies*. These techniques may include providing access to preferred items/activities or breaks from task demands on a schedule, independent of the occurrence of the maladaptive behavior in order to reduce an individual's motivation to engage in problem behavior. This procedure, referred to as *noncontingent reinforcement* (NCR), has been shown to be effective in reducing problem behavior in individuals with autism (Vollmer, Iwata, Zarcone, Smith, & Mazaleski, 1993), and may be effectively combined with other behavioral interventions.

Antecedent-based strategies are a particularly important tool in the treatment of problem behavior in adults with ASD. As noted previously, older individuals with ASD may be capable of extremely dangerous and harmful actions as compared to the capabilities of children. As the saying goes, an ounce of prevention is worth a pound of cure. However, the use of strategies like NCR require the presence of an adequate number of well-trained staff to ensure that the schedule is followed correctly and consistently.

Functional Communication Training (FCT) - FCT is an intervention strategy that involves teaching an individual to use an adaptive response to take the place of problem behavior (Carr & Durand, 1985). FCT consists of providing the individual with a means of accessing preferred items and activities in an easy and effective way (e.g., using a touch card, sign language, or an augmentative communication device). The unique appeal of FCT is that it leads to the acquisition of a new functional skill. This means that the benefits that are observed following FCT are more likely to result in enduring change, and may prevent the emergence of future maladaptive behavior. One special consideration in the use of FCT is that the behavior under treatment may have a long history of reinforcement, and therefore may persist even after the new alternative response has been trained.

Consequence-based strategies - The last category of interventions are those which alter the outcomes produced by the behavior in a way that make the behavior less likely to happen again in the future. Consequence-based strategies may include breaking the relationship between a behavior and the outcome that has previously been associated with it, known as *extinction*, and may also include adding or removing something from the individual's environment which makes the problem behavior less likely to occur in the future, referred to as *punishment*.

It is important to note that, in many cases, these interventions may be combined in a way that improves their effectiveness for addressing problem behavior. For example, when attempting to treat problem behavior through the training of a new adaptive communicative request with FCT, it can be advantageous to have problem behavior contact extinction. This effectively creates a scenario where the new response "works" and the old one does not, which can increase the speed at which the desired behavioral change occurs.

When intervening with adults with ASD in particular, the risks of implementing extinction may be prohibitive. Under these circumstances, practitioners need to emphasize the use of preventative procedures and FCT to address challenging behavior. Identifying strategies for decreasing maladaptive behavior *without* the use of extinction represents an important area in need of research.

In conclusion, as rates of autism diagnosis continue to rise, more and more adults on the spectrum will be in need of effective assessment and treatment procedures. Despite the fact that the majority of the related literature reflects the needs of children with autism, some helpful insights regarding working with the adult population have emerged. Assessment strategies, such as AB analyses, trial-based functional analyses (FA), and precursor FAs, represent empirically-sound assessment procedures that may limit the risks associated with challenging behavior in older populations. Relatively little research has investigated treatment issues as specific to individuals with ASD. Preventative strategies, replacement skills (FCT) and extinction all remain key components in designing effective interventions for this population. In cases in which extinction is not a viable option, practitioners must increase emphasis on other preventative treatment components to keep people safe.

There exists a troubling gap in state of assessment and intervention for older individuals with ASD. Failure to identify viable solutions for this population can lead to poor outcomes, including more intrusive interventions, more restrictive placements, and an increased likelihood of psychotropic medication use. The assessment and treatment approaches outlined above provide an important starting point in the development of a comprehensive model of care for this rapidly growing population.

Ethan Eisdorfer, MA, and Mikala Hanson, BA, are doctoral candidates at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University and Robert H. LaRue, PhD, BCBA-D, is Director of Behavioral and Research Services at the Douglass Developmental Disabilities Center at Rutgers, The State University of New Jersey. For more information, please contact Robert LaRue, PhD, BCBA-D, at (848) 932-4500 or larue@scarletmail.rutgers.edu.

References

Anderson, C. M., Long, E. S. (2002). Use of a structured descriptive assessment methodology to identify variables affecting problem behavior. *Journal of Applied Behavior Analysis, 35*, 137-154.

Bloom, S. E., Iwata, B. A., Fritz, J. N., Roscoe, E. M., & Carreau, A. B. (2013), Classroom application of a trial-based functional analysis. *Journal of Applied Behavior Analysis, 44 (1),* 19-31.

Carr, E. G. & Durand, V. M. (1985). Reducing behavior problems through functional communication training, *Journal of Applied Behavior Analysis, 18,* 111-126.

Cimera, R. E. Cowan, R. J. (2009). The costs of services and employment outcomes achieved by adults with autism in the US. *Autism, 13 (3),* 285-302.

Freeman, K. A., Anderson, C. M., & Scotti, J. R. (2000). A structured descriptive methodology: increasing agreement between descriptive and experimental analyses. *Education and Training in Mental Retardation and Developmental Disabilities, 35 (1), 55-66.*

Ganz, M. L. (2006). The costs of autism. In, S.O. Moldin & J.L.R. Rubenstein (Eds.), *Understanding Autism* (pp. 475-502). Boca Raton, FL: CRC Press.

Järbrink, K. McCrone, P. Fombonne, E. Zanden, H. Knapp, M. (2007). Cost-impact of young adults with high-functioning autistic spectrum disorder. *Research in Developmental Disabilities, 28*, 94-104.

LaRue, R. H., Lenard, K., Weiss, M. J., Bamond, M., Palmieri, M., Kelley, M. E. (2010). Comparison of traditional and trial-based methodologies for conducting functional analyses. *Research in Developmental Disabilities, 31*, 480-487.

Pelios, L., Morren, J., Tesch, D. & Axelrod, S. (1999). The impact of functional analysis methodology on treatment choice for self-injurious and aggressive behavior. *Journal of Applied Behavior Analysis, 32*, 185-195.

Sigafoos, J., Roberts, D., Couzens, D., & Caycho, L. (1992). Improving instruction for adults with developmental disabilities: evaluation of a staff training package. *Behavioral Residential Treatment, 7,* 283-297.

Vollmer, T. R, Iwata, B., Zarcone, J. R., Smith, R. G., & Mazeleski, J. L. (1993). The role of attention in the treatment of attention-maintained self-injurious behavior: Noncontingent reinforcement and differential reinforcement of other behavior. *Journal of Applied Behavior Analysis, 26*, 9-21.

Wood, A. L., Luiselli J. K., & Harchik, A. E. (2007). Training instructional skills with paraprofessional service providers at a community-based habilitation setting. *Behavior Modification*, *31*(6), 847-855.

Deficits from page 31

supports, scripts to outline the presenting problem, and coming up with reasonable solutions to the problem can be effective tools to use when students face scenarios that seem dire and hopeless to them. For instance, presenting a visual diagram of the problem helps students think about how they may adjust and modify their behavior.

When students expend their energy on small problems, they often get drained and become unavailable for learning. Oftentimes, these small problems can lead students to feeling overwhelmed. Frequently, students with HFA will need guidance in developing solutions to these problems to prevent an extreme emotional reaction. For example, not receiving a perfect score on a test could be experienced as a traumatic event for a student with a rigid thought process. Frequent practice is often required to prepare students for the fact that they will be presented with problems on an ongoing basis and that these problems will vary in magnitude depending on the issue. Forgetting to bring in your homework or losing a game is a less severe problem than getting into a fight on the playground. Learning to recognize the size of the problem and the reaction that matches that problem is an important skill that students must learn. Cognitive restructuring to address distorted thoughts and literal interpretations of events can be done using cartoon thought bubbles of specific scenarios. Using this type of visual modality can be an effective tool in teaching students how to modify how they think, feel and behave in a social context (Wellman, Baron-Cohen, Caswell, Gomez, Swettenham, Toye, & Lagattuta, 2002). Additional school based interventions such as modeling, reinforcement, and social stories can further improve skill development in natural settings (Gray, 2000; Matson, 2007). For example, the goal of a social story is to provide correct social information leading the student to more appropriate responses.

In school, many students with HFA often experience anxiety; which affects their ability to focus, participate in social activities with peers, and in instruction. Difficulties with communication and problem solving skills may lead to increased anxiety and behavioral challenges in school. Many students may appear to be noncompliant or oppositional, when in fact the behaviors they are demonstrating are more related to skill deficits. Many students with HFA experience anxiety related to specific fears which appear to be a result of conditioned learning (Koegel, Openden, & Koegel, 2004). These phobias may be successfully addressed using systematic desensitization interventions. Systematic desensitization can be done by gradually teaching students to tolerate stimuli that present as aversive to them.

Many students with HFA experience difficulties with emotional recognition and regulation. Teaching correct recognition of emotions can be done using visual supports or through video modeling. Video modeling for individuals with ASDs has shown to be effective in addressing social-communication skills, functional skills, and behavioral functioning. Additionally, those skills learned through video modeling can be maintained over time and generalized to other settings (Bellini & Akullian, 2007). Behavior mapping is another tool that teaches students to conceptualize what behaviors are expected in different situational contexts, and can increase a student's overall social competence (Winner, 2007).

Individuals with HFA frequently show deficits in executive functions (EF), hence often display problems with inhibition, planning and organizing, shifting topics, and self-monitoring behavior (Semrud-Clikeman, Walkowiak, Wilkinson, & Butcher, 2010). Arranging the instructional setting to address these EF deficits can further assist in preventing behavioral challenges. Environmental modifications can provide students with ASD the structure, visual supports, and predictability they may need in order to learn new skills (Henry & Myles, 2007). A distraction free environment consists of materials being well organized and shelves labeled. Color-coding students' materials (i.e. books, folders) specific to each subject is helpful. This provides critical information that assists in finding and putting away materials without additional support from the teaching staff. Visual cueing systems, such as models for writing assignments, and behavioral expectations should be displayed throughout the classroom and on the students' individual desks.

Behavioral interventions are most effective for students with autism (Horner, Carr, Halle, McGee, Odom, & Wolery, 2005). The behavioral principle of positive reinforcement can be used to increase the performance of desired skills. Positive reinforcement can occur as part of a class-wide or individual positive behavioral support system. Regardless of the reinforcement approach used, it is important to develop goals or targets for reinforcement collaboratively with the student. This will maximize the student's willingness to participate. When collaborating with the student, it is essential to clearly define and provide direct explanation of behavioral targets. A token economy is one method to deliver positive reinforcement for meeting behavioral objectives.

Many students with HFA lack appropriate coping skills. These skills are necessary to self-regulate, and often require specific instruction. Effective coping techniques such as: deep breathing using a visual counting chart, progressive muscle relaxation (systematically tensing and releasing major muscle groups), or "going" to a calm place (using guided imagery or visual supports) can help students calm themselves. Additionally, these supports assist students with self-regulation, and can interrupt the behavioral challenge while redirecting the student to a calm place. When presented with an intense behavioral situation (i.e., the student is completely unable to emotionally regulate), the removal of the stressor may be required. Very often students will tell you exactly what has caused them to become angry or frustrated, so it is important to listen to what they have to say. The use of Atwood's emotional thermometer (2004), to allow the student to self-rate the level of intensity of their emotions in the moment can be helpful. What is considered to be challenging behavior can take many forms and may require different reactive approaches. Whichever approach is used, it is important to remain calm while helping the student to de-escalate. When the student is calm, this serves as an opportunity to debrief and discuss possible alternative solutions to the challenging behavior that was exhibited, and to develop a plan should the student encounter this problem again.

Edel McCarville, PsyD, is a School Psychologist and Colleen Menard, MSEd, is a Special Education Teacher for Levittown Public Schools. For more information, please contact Edel at emccarville@levittownschools.com.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Attwood, T. (2004b). *Exploring feelings: Cognitive behavior therapy to manage anger*. Arlington, Texas: Future Horizons.

Bauminger, N. (2002). The facilitation of social-emotional understanding and social interaction in high functioning children with autism: Intervention outcomes. *Journal of Autism and Developmental Disorders, 32*, 283-298.

Bauminger, N. (2007). Brief report: Individual social-multi-modal-intervention for HFASD. *Journal of Autism and Developmental Disorders, 37*(8), 1593-1604.

Bellini, S., Akullian, J., & Andrea, H. (2007). Increasing social engagement in young children with autism spectrum disorders using video-self modeling. *School Psychology Review, 36*(1), 80-90.

Gray, C. (2000). *The new social story book*. Arlington: Future Horizons.

Henry, S. & Myles, B.S. (2007). *The comprehensive autism planning system (CAPS) for individuals with Asperger syndrome, autism, and related disabilities: Integrating best practices throughout the student's day*. Shawnee Missions, KS: Autism Asperger Publishing Company.

Horner, R. H., Carr, E. G., Halle, J., McGee, G., Odom, S., & Wolery, M. (2005). The use of single subject research to identify evidence-based practice in special education. *Exceptional Children, 71,* 165-179.

Koegel, R.L., Openden, D., & Koegel, L. K. (2004). A systematic desensitization paradigm to treat hypersensitivity to auditory stimuli in children with autism in family contexts. *Research and Practice for Persons with Severe Disabilities*, *29*(2), 122-134.

Matson, J. L., Matson, M. L., & Rivet, T. T. (2007). Social-skills treatment for children with autism spectrum disorders: An overview. *Behavior Modification, 31*(5)*,* 682-707.

Myles, B. S. (2005). *Children and youth with Asperger syndrome: strategies for success in inclusive settings.* Thousand Oaks, CA: Corwin Press.

Schaill, L., & Lord, C. (2004). Subject selection and characterization in clinical trials in children with autism. *CNS Spectrums 9*, 22-32.

Semrud-Clikeman, M., Walkowiak, J., Wilkinson, A., & Butcher, B. (2010). Executive functioning in children with asperger syndrome, ADHD-combined type, ADHD-predominately inattentive type, and controls. *Journal of Autism and Developmental Disorders, 40*(8), 1017-1027.

Wellman, H. M., Baron-Cohen, S., Caswell, R., Gomez, J. C., Swettenham, J., Toye, E., & Lagattuta, K. (2002). Thought-bubbles help children with autism acquire an alternative theory of mind. *Autism-The International Journal of Research and Practice*, *6*(4), 343-363.

Winner, M.G. (2007). *Social behavior mapping: connecting behavior, and emotions across the day.* San Jose, CA: Think Social Publishing.

Proven from page 28

to make it less available. In some organizations all employees are trained in the use of physical interventions. Simply adopting a policy whereby only the absolute fewest number of staff necessary in a given location are so trained sends a powerful message. As does adopting a policy that only our "best" or most "experienced" employees will be so trained.

In other settings, this can be applied by keeping tools used for physical restraint out of easy reach, and ensuring that all participants in the process understand that physical restraint is a last resort.

9) *Increase Scrutiny of Physical Interventions* - It's important to not only use positive reinforcement, but also to reduce the use of physical interventions. Taking a careful look at instances when physical intervention is used can help in this effort.

This means pausing after the situation is over and considering some key questions: What triggered the situation? What could prevent or minimize the challenging behavior in the future? Can the situation be avoided altogether? How could caregivers proactively reinforce positive behaviors to replace the challenging behavior?

In an organizational setting, scrutiny of these instances also sends a powerful message throughout the organization that these are serious goals being set. Scrutiny will be even more effective if it emphasizes a search for root causes rather than blame.

It's important that the entire environment's culture commit to making this change—one individual can't effect this change alone. But when these steps are applied consistently over time, this shift should be successful in most environments—The Arc of Delaware County team has seen it time and again within the organization, as well as in other organizations that adopt this method.

*George Suess is the CEO of The Arc of Delaware County, NY, and founder of fwd-*shift, *a suite of services designed to help human service organizations transform their cultures, and reduce behavior challenges. Contact him at (607) 865-7126 or georges@delarc.org and learn more at www.delarc.org.*

***Effect* from page 30**

based on why the behavior occurred were attempted, but it was not until strategies to address these specific environmental antecedents were implemented that problem behavior was consistently decreased. Horner, Day, and Day (1997), identified that delaying or cancelling a planned activity (e.g., school events and outings) increased the likelihood of problem behavior, specifically during academic work, for two individuals with developmental delays. For both individuals, the treatment included specific components (e.g., 10 minutes access to a preferred activity or rescheduling the event on a calendar) to prevent problem behavior during days that these antecedents occurred.

In summary when treating problem behavior, it is crucial to focus on how one can alter the consequences of problem behavior when developing interventions, but it is as important to consider antecedent events. In all of the studies discussed above, antecedents were strategically assessed, meaning that data were collected on a daily basis regarding problematic behaviors and specific antecedents. This type of assessment is crucial to determine if and how antecedent events are playing a role in an individual's challenging behavior. Following this assessment, strategies can be put into place to reduce the effects these variables have on problem behavior. It is important that these treatment components are used strategically before the occurrence of problem behavior. For example, if a child is found to be more likely to engage in problem behavior to get out of homework when he/she is tired, it may be beneficial to allow for a nap or decrease the amount of work on days that he/she is tired *before* problem behavior occurs. Reactive strategies, such as allowing a child to stop working following problem behavior and take a nap because the child is tired should be avoided, as this is likely to exacerbate the problem by teaching the child that problem behavior results in a break from work. Instead, caregivers/teachers should take data on sleep and problematic behaviors to determine if a relationship exists between them, and if it does then strategically plan for changes in the environment prior to starting homework on these days. Environment-behavior relationships are crucial in understanding challenging behaviors exhibited by individuals diagnosed with ASD, and best practice is to consider both antecedents and consequences in behavioral assessments and treatments.

Mindy Scheithauer, PhD, BCBA, is a Postdoctoral Fellow, Joanna Lomas Mevers, PhD, BCBA-D, is Assistant Professor, and Nathan A. Call, PhD, BCBA-D, is Assistant Professor at the Marcus Autism Center at Emory University School of Medicine. For more information, please visit www.marcus.org.

References

Carr, E. G., & Smith, C. E. (1995). Biological setting events for self-injury. *Mental Retardation and Developmental Disabilities Research Reviews, 1,* 94-98. doi: 10.1002/mrdd.1410010204

Dicesare, A., McAdam, D. B., Toner, A., & Varrell, J. (2005). The effects of methylphenidate on a functional analysis of disruptive behavior: A replication and extension. *Journal of Applied Behavior Analysis, 38,* 125-128. doi: 10.1901/jaba.2005.155-03.

Hartley, S.L., Sikora, D.M., & McCoy, R. (2008). Prevalence and risk factors of maladaptive behaviour in young children with Autistic Disorder. *Journal of Intellectual Disability Research 52*(10), 819–829. doi: 10.1111/j.1365-2788.2008.01065.x

Herring, S., Gray, L., Taffe, J., Tonge, G., Sweeney, D., & Einfield, S. (2006). Behaviour and emotional problems in toddlers with pervasive developmental disorders and developmental delay: Association with parental mental health and family functioning. *Journal of Intellectual Disability Research, 50,* 874–882. doi: 10.1111/j.1365-2788.2006.00904.x

Horner, R.H., Carr, E.G., Strain, P.S., Todd, A.W., & Reed, H.K. (2002). Problem Behavior Interventions for Young Children with Autism: A Research Synthesis. *Journal of Autism and Developmental Disorders,32(5),* 423-446. doi: 10.1111/j.1365-2788.2006.00904.x

Horner, R. H., Day, H. M., & Day, J. R. (1997). Using neutralizing routines to reduce problem behaviors. *Journal of Applied Behavior Analysis, 30*, 601–614. doi: 10.1901/jaba.1997.30-601

Kennedy, C. H., & Itkonen, T. (1993). Effects of setting events on the problem behavior of students with severe disabilities. Journal of Applied Behavior Analysis, 26, 321–327. doi: 10.1901/jaba.1993.26-321

Kennedy, C. H., & Meyer, K. A. (1996). Sleep deprivation, allergy symptoms, and negatively reinforced problem behavior. Journal of Applied Behavior Analysis, 29, 133–135. doi: 10.1901/jaba.1996.29-133

Northup, J., Fusilier, I., Swanson, V., Roane, H., & Borrero, J. (1997). An evaluation of methylphenidate as a potential establishing operation for some common classroom reinforcers. Journal of Applied Behavior Analysis, 30, 615–625. doi: 10.1901/jaba.1997.30-615

Taylor, D. V., Rush, D., Hetrick, W. P., & Sandman, C. A. (1993). Self-injurious behavior within the menstrual cycle of women with mental retardation. American Journal on Mental Retardation, 97, 659–664. doi:0.1352/0895-8017(2003)108<0117:MDAABS>2.0.CO;2

***Self-injury* from page 14**

2014, December) and Risperidone (Scahill, Koenig, Carroll, Pachler, 2007), can produce unwanted challenges. Two concerning side effects of Risperidone include weight gain and an increase in appetite (Scahill, et al., 2007), and these unintended results carry additional significance with a child who is already displaying aggressive behaviors. Additionally, if the function of the self-injury or aggression was to gain access to food or if food was the most reinforcing item to a child prior to the introduction of the Risperidone, the child's difficulties could be exacerbated.

A diagnosis separate to an autism diagnosis is another possible explanation for self-injury and aggression, so, it is critical that individuals undergo a thorough evaluation and receive accurate diagnoses. Tsiouris, Mann, Patti, and Sturmey (2003) found that aggression and self-injury was not an equivalent symptom of depression in individuals with intellectual disabilities. As a result, it would not be logical to assume that an individual with an intellectual disability possesses a dual diagnosis of depression due to displays of self-injury or aggression, however, it is worth considering if another underlying disorder is influencing the individual's behaviors. It is also beneficial to receive a second opinion when there are questions or inconsistencies within a diagnosis.

Medical diagnoses in combination with autism can also exacerbate a child's impairments. For example, seizure disorders are prevalent in individuals with autism spectrum disorders, particularly when there is a comorbid diagnosis of intellectual disability (Matson & Shoemaker, 2009), and studies have shown that children with seizure disorders display greater impairments in the areas of adaptive behaviors, personal/social abilities, communication, motor abilities, and cognitive abilities than children without seizure disorders (Matson, Neal, Hess, Mahan, & Fodstad, 2010). It is also suspected that seizure disorders impact children with ASD to a greater degree than children with other developmental delays (e.g., spina bifida, cerebral palsy, microcephaly, Down's syndrome). Undetected medical diagnoses, such as seizure disorders, can offer a possible explanation for delays in progress and conflicting hypotheses of the function of an individual's self-injury or aggression.

Given these aforementioned circumstances, it is critical that caregivers of individuals with autism consider all possible explanations for self-injury and aggression displayed by their loved ones and that psychological and medical professionals investigate alternate explanations for an individual's concerning behaviors and inform caregivers of any other possible explanation.

All treatment options explored should be evidenced-based in order to be confident that the treatment will produce the expected outcome and to avoid losing time in which effective treatments could be improving the individual's life. When challenging behaviors such as self-injury and aggression are of concern, an effective course of action includes conducting an FBA and FA early on to rule out any maintaining sources of reinforcement that could be addressed and possibly avoid unnecessary intrusive interventions with potential side effects, prior to considering other factors that could be impacting the individual's mood and behavior.

Jenny La Barbera, Psy.D., BCBA-D, is the co-director of NY Behavior Analysis and Psychological Services, an agency that provides assessment and treatment services to individuals with autism and other mental health concerns. She can be reached at Labarbera@nybaps.com or at 646-780-9227.

References

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

Hanley, G. P., Iwata, B. A., & McCord, B. E. (2003). Functional analysis of problem behavior: A review. *Journal of Applied Behavior Analysis, 36,* 147-185. doi: 10.1901/jaba.2003.36-147

Hollway, J. A., Aman, M. G., & Butter, E. (2013). Correlates and risk markers for sleep disturbance in participants of the autism treatment network. *Journal of Autism & Developmental Disorders, 43,* 2830-2843. doi: 10.1007/s10803-013-1830-y

Johnson, K. P., Giannotti, F., & Cortesi, G. (2009). Sleep patterns in autism spectrum disorders. *Child and Adolescent Psychiatric Clinics of North America, 18,* 917-928.

Matson, J. L., Neal, D., Hess, J. A., Mahan, S., & Fodstad. (2010). The effect of seizure disorder on symptom presentation in atypically developing children and children with autism spectrum disorders based on the BDI-2. *Developmental Neurorehabilitation, 13*(5), 310-314.

Matson, J. L., Shoemaker, M. (2009). Intellectual disability and its relationship to autism spectrum disorders. *Research in Developmental Disabilties, 30,* 1107-1115.

Otsuka Pharmaceutical Co., Ltd. (2014, December). *Medication guide Abilify.* Retrieved from http://www.otsuka-us.com/Products/Documents/medguide_abilify.pdf

Scahill, L., Koenig, K., Carroll, D. H., & Pachler, M. (2007). Risperidone approved for the treatment of serious behavioral problems in children with autism. *Journal of Child and Adolescent Psychiatric Nursing, 20*(3), 188-190.

Tsiouris, J. A., Mann, R., Patti, P. J., & Sturmey, P. (2003). Challenging behaviors should not be considered as depressive equivalents in individuals with intellectual disability. *Journal of Intellectual Disability Research, 47*(1), 14-21.

Rumination from page 23

reaching for objects, and interest in social attention. Another punishment procedure that has resulted in decreased rumination was reported by Singh, Manning, and Angell (1982). Singh, Manning, and Angell (1982) prompted twins, who engaged in ruminative behavior, to brush their teeth, for 2 minutes, with a toothbrush soaked in Listerine and wipe their lips with a face cloth dipped in Listerine. Results of the procedure showed a decrease in ruminative behavior and an increase in stereotypic and appropriate behaviors. Due to the rapid decrease in rumination and the serious medical and social concerns related to chronic rumination, positive punishment was historically used as an appropriate treatment for rumination. However, today clinicians evaluate the effectiveness of less restrictive procedures such as differential reinforcement of other behavior, the use of competing items, diet changes, and non-contingent access to stimuli prior to beginning a punishment based procedure to decrease rumination.

Non-contingent delivery of food or drink has been shown to reduce ruminative behavior (Lyons, Rue, Luiselli, and DiGennaro, 2007). However, in order for these treatments to maintain low levels of rumination they often need to be delivered frequently, which can be impractical for caregivers and result in undesirable side effects for the client, such as weight gain. Therefore, researchers have also evaluated treatments which can be easily delivered frequently in a natural environment. Rhine and Tarbox (2009) decreased ruminative behavior, in a 6-year-old, by providing non-contingent access to chewing gum. Kliebert and Tiger (2011) decreased rumination, maintained by automatic reinforcement, by providing access to apple juice every 15 seconds, after lunch. These results, however, did not maintain in post non-contingent juice sessions, which were conducted right after the 15 second access to apple juice sessions. Similarly, Wilder et al., (2009) decreased rumination in a 37-year-old male by delivering an apple pie flavored spray every 10 seconds. The researchers used an audible tone to signal delivery of the spray, which they had taught the individual to self-administer. Although both of these treatments were found to be effective, one major limitation exists to extending these treatments to a residential or home setting. The juice and flavor spray were delivered on a dense schedule, which would be difficult to implement across a school day or residential hours. However, these may be viable treatment options if individuals are taught to administer the item themselves or rumination does not occur throughout the day (Wilder et al., 2009).

Due to the limited success and cumbersome nature of the treatments described above, researchers have begun manipulating antecedent variables which may result in decreased rumination. Researchers evaluated the effects of caloric intake and supplemental feedings for individuals who engage in ruminative behavior. These antecedent manipulations have shown promising results in decreasing rumination. In 1981, Rast, Johnston, Drum, and Conrin systematically evaluated the effect that food quantity. The researchers manipulated food quantity from regular portions to satiation portions. When the participants were eating satiation portions they were permitted to eat as many "potatoes, cream of wheat, unflavored grits, and/or bread" as they wanted. The authors found that when participants were given satiation portions the duration and frequency of rumination decreased. Other researchers have reported similar results (Johnston, Greene, Rawai, Vazin, and Winston, 1991). Thibadeau, Blew, Reedy, and Luiselli (1999) provided unlimited access to white bread for 1 hour post meal. The authors made the decision to use white bread because this was a preferred food for the participant and the starch content was similar to foods used in other satiation diet programs. This procedure resulted in significantly decreased levels of rumination. In follow-up observations the researchers found that these results were maintained up to 15 months after the conclusion of the study.

Future researchers and clinicians should evaluate different variables that may have similar effects on rumination. These variables include, food type (e.g., meat, starch, fruit), food texture (e.g., smooth versus crunchy), and food preference. For example, it is possible that an individual may be more likely to ruminate after eating a preferred food in comparison to a non-preferred food to gain additional access to its reinforcing qualities (e.g., taste, texture).

Although there are medical diagnoses where rumination is seen as a symptom (e.g., gastro-esophageal reflux), there are times when no medical basis for rumination is apparent. In these cases behavioral interventions, in conjunction with medical recommendations or as a primary treatment, may assist in decreasing or eliminating rumination. Early behavioral strategies emphasized the use of punishment, whereas more recent interventions have utilized reinforcement and antecedent modification. Behavior analysts have much to offer in the treatment of rumination given their adherence to ongoing data collection and the systematic exploration and analysis of variables that might influence rumination.

Jennie England, MA, BCBA, is Clinical Case Manager and James T. Chok, PhD, BCBA-D, is Director of Clinical Services at Melmark. For more information, please visit www.melmark.org.

References

Chial, H. J., Camilleri, M., Williams, D. E., Litzinger, K., Perrault, J. (2003). Rumination syndrome in children and adolescents: Diagnosis, treatment, and prognosis. *Pediatrics, 111,*158-162

Iwata, B. A., Dorsey, M. F., Slifer, K. J., Bauman, K. E., Richman, G. S. (1994). Toward a functional analysis of self-injury. *Journal of Applied Behavior Analysis, 27,* 197-209

Johnston, J. M., Greene, K. S., Rawal, A., Vazin, T., Winston, M. (1991). Effects of caloric level on ruminating. *Journal of Applied Behavior, 24,* 597-603. doi: 10-1901/jaba.1991.24.597

Kliebert, M. L., Tiger, J. H. (2011). Direct and distal effects of noncontingent juice on rumination exhibited by a child with autism. *Journal of Applied Behavior Analysis, 44,*955-959. doi: 10.1901/jaba.2011.44-955

Lang, R., Mulloy, A., Giesbers, S., Pfeiffer, B., Delaune, E., Didden, R., Sigafoos, J., Lancioni, G., O'Reilly, M. (2011). Behavior interventions for rumination and operant vomiting in Individuals with intellectual disabilities: A systematic review. *Research in Developmental Disabilities, 32,* 2193-2205

Lyons, E. A., Rue, H. C., Luiselli, J. K., DiGennaro, F. D. (2007). Brief functional analysis and supplemental feeding for postmeal rumination in children with developmental disabilities. *Journal of Applied Behavior Analysis, 40,* 743-747. doi: 10.1901/jaba.2007.743-747

Rast, J., Johnston, J. M., Drum, C., Conrin, J. (1981). The relation of food quantity to rumination behavior. *Journal of Applied Behavior, 14,* 121-130. doi: 10.1901/jaba.1981.14.121

Rhine, D., Tarbox, J. (2009). Chewing gum as a treatment for rumination in a child with autism. *Journal of Applied Behavior Analysis, 42,* 381-385. doi: 10.1901/jaba.2009.42-381

Wilder, D. A., Register, M. Register, S., Bajagic, V., Neidert, P. L., Thompson, R. (2009). Functional analysis and treatment of rumination using fixed-time delivery of flavor spray. *Journal of Applied Behavior Analysis, 42,* 877-882. doi: 10.1901/jaba.2009.42-877

Woods, K. E., Luiselli, J. K., Tomassone, S. (2013). Functional analysis and intervention for chronic rumination. *Journal of Applied Behavior Analysis, 46,* 328-332. doi:10.1901/jaba2007.743-747

Sajwaj, T., Libet, J., Stewart, A. (1974). Lemon-juice therapy: The control of life-threatening Rumination in a six-month-old infant. *Journal of Applied Behavior Analysis, 7,* 557-563. doi: 10.1901/jaba.1974.7.557

Singh, N. N., Manning, P. J., Angell, M. J. (1982). Effects of an oral hygiene punishment procedure on chronic rumination and collateral behaviors in monozygous twins. *Journal of Applied Behavior Analysis, 15,* 309-314. doi: 10.1901/jaba.1982.15-309

Thiabadeau, S., Blew, P., Reedy, P., Luiselli, J. K. (1999). Access to white bread as an Intervention for chronic ruminative vomiting. *Journal of Behavior Therapy and Experimental Psychiatry, 30,* 137-144

Testing from page 33

nature of them at every developmental learning stage; the disregard for different learning abilities (heavens - let's not discriminate) makes monitoring of the yearly mastery of these standards horrendous for our special students with severe emotional disturbances. Our special education students, as part of their IEP, typically have some but not all of the grade level standards in their yearly plans. The question begs to be asked: Why would we presume to test them on a standardized test which measures vast numbers of markers to which they have not been introduced. The CCSS do not prescribe the curriculum, instructional practices, the materials or the texts teachers use to assist students through the learning process. However, our special students don't necessarily (nor do they usually) make those gains within the one year as prescribed. For example, by the end of first grade students should be able "to write an opinion essay in which they introduce the topic or book name they are writing about, state an opinion, supply a reason for the opinion, and provide a sense of closure (CCSS W.1.1)." The adoption of this standard does not usurp the instruction of creatively teaching our students to write in complete sentences or discern the difference between fact and opinion. In fact, providing a focus for learning and a goal, however lofty, and every level throughout our students' education is profoundly necessary.

The manner of assessment, by formative data, however is not promoting the equality that the state is longing for. High standards are now the calling card for college and careers; but once again, what sets the individual apart - the soft skills - is a summative measure. Our students' ability to live and learn independently will not be measured by the Partnership for Assessment of Readiness for College and Careers. According to the Washington Post (June 27, 2014) "… Apparently, the [Department of Education] believes that more testing will help special education students achieve more in school. But since NCLB started, the standardized tests-based 'accountability' era more than a dozen years ago, there has been no evidence to show that standardized tests have improved student achievement…" If we are saying that the standards provide the goals and the curriculum provides the day to day objectives towards reaching those goals, with our students we are continually measuring their mastery of objectives towards goals which they may (or may not) meet. Why are we spending so much time testing the goals themselves? The training program needs to be evaluated and measured and monitored. The objectives measured and maintained and yes, the bar held high.

Today and tomorrow we only want success for our students. Given a dozen educators, parents, students, and politicians you may get quantitatively diverse ideas of how to achieve that for the child. Special education children, especially those with profound disabilities that leave them unable to access the curriculum readily deserve a quality look. The quick answer is alternate assessment. In reality, this occurs with little frequency. That same New Jersey law that provides for a free and appropriate education for our students mandates that "…most be tested in a standardized manner (N.J.A.C. 16A:14-14.1)." In a document that goes on for 165 pages to explain the needs for adjustments and adaptations in the world of special education, with individualized educational plans and specialized accommodations and modifications, standardized testing is something that serves us poorly.

Vicki Ofmani, MEd, LDT-C, is Supervisor/SLE Coordinator at The Forum School, located in Waldwick, NJ. She is also a Member of the Board of Trustees for The Daniel Jordan Fiddle Foundation in Ridgewood, NJ. For more information, please visit www.theforumschool.com or email vicki.ofmani@theforumschool.com.

Mealtime** from **page 19

do next can be difficult. Many parents and caregivers are left with the question of “What do I do now?” It is recommended that caregivers begin seeking assistance with primary care providers (Baxter et al., 2014). Primary care providers generally have the skills to help evaluate and decide the first course of treatment. The primary care provider is able to manage the problems in many situations. However, if additional assistance or expertise is needed then the primary care provider is able to make referrals to the correct specialists. These specialists may include allergists, gastroenterologists, psychologists, speech language pathologists, occupational therapists, registered dieticians, and/or behavior analysts. If extra assistance is needed then the caregivers, primary care provider, and additional specialists are able to work together to address the problem.

Not all feeding issues require expert assistance and there are situations where caregivers are able to intervene using simple strategies to correct the problem such as:

Create a schedule and routine: This may include having your child eat at the same time and place. By creating a schedule the child will learn what is expected during meals.

Avoid eating all day: Having food and drink available all day decreases your child’s appetite and may limit how much they want to eat during mealtimes. If you’re full, you’re not going to want to eat anymore!

Limit the amount of distractions during mealtimes: Distractions take the focus off the food and may lead to the child being more focused on the activities rather than eating. Common distractions include television, video games, toys, books, phones, computers, and an excessive number of people.

Model healthy eating behaviors: Children learn many new things by watching and imitating the behaviors of others. So make sure that you model the feeding behaviors you want to see.

Reward behaviors that you want to continue seeing: If the child exhibits a behavior you want to see such as trying new foods or eating all of his/her dinner, reward them for doing this. Rewards may include social attention such as praise or high five’s, getting access to preferred food items, or favorite toys/activities.

Ignore challenging behavior: When possible, do not provide extra attention to a child who is doing things that you do not want them to display. Common challenging feeding behaviors may include spitting, throwing food, or screaming. Limiting the amount of attention may reduce the enjoyment or any “fun” the child may be having by displaying these behaviors. At times, it may not be possible to ignore the behavior due to safety concerns and you may need to consult with an expert for additional advice concerning how to best manage your child’s challenging meal-time behaviors.

Follow the rule of 3: When presenting food to your child it is important to present a combination of preferred and non-preferred food items. The rule of thumb is to offer 3 foods at a time and at least 1-2 of these foods should be items your child already likes. The other food should be an item your child does not like. This will expose your child to non-preferred food items and get used to having those food items near him. Initially, encourage your child to try a small bit and gradually try to get them to eat a little more. Eventually, the goal is for the child to eat a good size portion of the new food.

Presentation of food items: Altering the way you present new foods may increase your child’s willingness to try them. Present new foods in small bites or in fun, familiar ways that make it more likely your child will eat them.

It is important to note that each child is different and these strategies may not be effective for every child. Caregivers should have ongoing dialogue and support from the child’s primary care provider while implementing these basic strategies (Baxter et al., 2014). By using these “caregiver friendly” strategies, caregivers may be able to prevent the need for more specialized interventions (Bachmeyer, 2009).

While there are some simple strategies that families can implement without consultation from a specialist, there are also interventions that have been effective in reducing feeding problems but require a specialist. If your child continues to struggle with mealtimes using some of the simple strategies above, you will want to share these struggles with the primary care provider and perhaps contact a Board Certified Behavior Analyst (BCBA) with experience treating feeding challenges. It is important to highlight that these more complicated interventions should not be done without support and guidance from the appropriate specialist(s).

In summary, it is important to emphasize how challenging and stressful feeding problems can be for parents/caregivers of children with ASD. Feeding problems are often complicated with each child’s problems being unique. In many cases, even with professional guidance, the strategies listed above may result in slow progress marked by small, subtle gains (Baxter et al., 2014) or may be entirely ineffective. Feelings of frustration, sadness, or hopelessness may be overwhelming to caregivers. Thus, it is recommended that caregivers reach out for support and individualized coping techniques from family, friends, professionals, or support groups. By ensuring their own mental health, they may be better able to successfully implement feeding interventions like those above, in collaboration with a physician. Finally, it is recommended that caregivers keep the treatment team informed of the child’s progress and remember to celebrate even the smallest improvements.

Brandon Nichols, MSEd, BCBA, LBA, is Clinical Coordinator and Michelle Myers, BA, BCaBA, is Assistant Clinical Coordinator at The Tom Golisano Center for Autism at Springbrook. For more information please contact Brandon at nicholsb@springbrookny.org or visit the Springbrook website at www.springbrookny.org.

References

Backmeyer, M.H. (2009). Treatment of selective and inadequate food intake in children: a review and practical guide. *Behavior Analysis in Practice, 2*(1), 43 – 50.

Baxter, B., Bellando, J., Pulliam, Watson, J., Powell, P., Srivorakiat, L., & Bing, N. (2014). *Exploring Feeding Behavior in Autism: A Parent’s Guide.* Autism Speaks.

Burklow, K.A., Phelps, A.N., Schultz, J.R., McConnell, K., & Rudolph, C. (1998). Classifying complex feeding disorders. *Journal of Pediatric Gastroenterology and Nutrition, 27*, 143 – 147.

Cornish, E. (1998). A balanced approach towards healthy eating in autism. *Journal of Human Nutrition and Dietetics, 11*, 501 – 509.

Field, D., Garland, M., & Williams, K. (2003). Correlates of specific childhood feeding problems. *Journal of Pediatrics and Child Health, 39*, 299 – 304.

Piazza, C.C., & Carroll-Hernandez, T.A. Assessment and treatment of pediatric feeding disorders. In: Tremblay RE, Barr RG, Peters RDeV, eds. Encyclopedia on Early Childhood Development [online]. Montreal Quebec: Centre of Excellence for Early Childhood Development; 2004: 1-7. Available at: http://www.enfant-encyclopedie.com/Pages/PDF/Piazza-Carroll-HernandezANGxp.pdf. Accessed February 27, 2015.

Piazza, C.C., Fisher, W.W., Brown, K.A., Shore, B.A., Patel, M.R., Katz, R.M. et al. (2003). Functional Analysis of inappropriate mealtime behaviors. *Journal of Applied Behavior Analysis, 36*, 309 – 324.

Schreck, K.A., Williams, K., & Smith, A.F. (2004). A comparison of eating behaviors between children with and without autism. *Journal of Autism and Developmental Disorders, 34*, 433 – 438.

Emotional From page 18

start by describing your own thought process. You can even say the exact opposite of what might be obvious in an attempt to draw your child out of silence. Exercises like these can also be done while watching television. Body language is often more revealing than the spoken word. Shows can even be watched without sound to gauge a child's awareness of social nuance. The difficulties these children (and adults) face tend to be tied to difficulties drawing social inferences, not to a fundamental inability to connect. There are many creative ways for parents to help their children improve their social competencies.

Dr. Jaime Black is a licensed psychologist practicing in New York City at Spectrum Services (spectrumservicesnyc.com) and in Westchester, NY. She works with individuals of all ages with Asperger Syndrome and related conditions, doing psychotherapy, conducting evaluations, and facilitating socialization groups including an improv social skills group. For more information, email JaimeBlackPsyD@gmail.com.

© 2013 AHA Association. Further reproduction of this article is prohibited without express written permission of AHA. This article was reprinted with permission and was originally published in the Fall 2014 issue of AHA Association's On The Spectrum. For more information, visit www.ahany.org.

Best Practices from page 24

Step 1: Precisely define the problem behavior - Behaviors should be identified and described in terms that are specific, observable, and measurable. For example, "calling out" may be defined as "a student speaking during a class discussion without raising his hand and being called on to speak." It would be insufficient to say the child is "impulsive" since that can occur in many different ways. A "tantrum" may be defined as a child "saying 'no,' yelling, and flailing his/her body onto the floor." This is contrasted with labeling the child as having "anger management problems," which is vague. As a rule of thumb, a behavior is sufficiently defined when two objective observers could independently spot it based on the definition provided.

Step 2: Measurement - The purpose of measurement is to determine the frequency, intensity, and duration of a target behavior. For example, "calling out" may occur 3 times in a day or 10 times in a 45-minute class period. Tantrums may occur only twice a day, but may last 60 minutes each and present with strong intensity. The measurement stage provides baseline data. After an intervention is conducted, follow-up data can help determine whether the intervention is effective and can be used to make adjustments to the plan. Although data collection may seem tedious, the rationale is the same used by a physician prescribing medication for cholesterol – assessing initial and follow-up levels ensures that the intervention is working.

Step 3: Functional assessment - The goal of a functional assessment is to better understand the child's reason for, or function of, the specified behavior. Behavior typically occurs for a reason – gaining attention from adults or peers; escaping or avoiding a demand or request; gaining access to something preferred (or tangible); and trying to obtain or avoid something that is internally or automatically reinforcing (e.g., increasing time listening to pleasant music, decreasing painful headache). Hypotheses about functions are determined based on the data collected about what occurs directly before and after a child exhibits the target behavior, and are often the key to successful intervention. For example, if the function of a child's "calling out" behavior is to gain the teacher's attention, then the teacher's verbal reprimand may be increasing the likelihood of it occurring again. If a child's tantrum behavior serves the function of avoiding a task, sending him to time-out may be giving him exactly what he wants. Thus, indentifying the function of a child's behavior is critical in order to develop an effective intervention and minimize the possibility of responding to the problem behavior in ways that will actually keep it going.

Step 4: Developing the plan - Writing a BIP involves identifying behaviors you would like to see more of (i.e. replacement behaviors) and selecting strategies to facilitate the development of these behaviors. Replacement behaviors can include specific skills, such as social skills or functional communication. In the case of the student calling out in class, a replacement behavior might be for the student to raise his hand and wait to be called on before speaking. In the example of tantrum behavior, replacement behaviors may be verbally expressing emotions in an appropriate way, engaging in an alternative coping strategy to manage anger (such as taking deep breaths) and/or complying with the instructions (e.g., making the bed, doing homework, doing classwork). It is critical for parents and school personnel to help children practice replacement behaviors and reinforce them with praise, as well as to consider additional forms of reinforcement, such as prizes or privileges.

Step 5: Evaluate **-** The evaluation phase involves taking an honest look at whether the procedures are being implemented as designed, reviewing data to determine whether there is a reduction in the problem behavior and an increase in desired replacement behaviors, and making modification to the plan as needed. For example, regarding the "calling out" behavior, we want to see whether the teacher has actually been ignoring the calling out behavior and praising the student for raising his hand, as well as analyzing the data to determine whether this has resulted in an actual decrease in calling out. In the case of the tantrum behavior, we may want to confirm that the child has been practicing his coping skills training and that the specific procedures outlined to occur when the tantrum behavior or use of a desired replacement behavior occurs is actually being carried out as planned.

This 5-step process of conducting an FBA and developing a BIP can be time consuming. Yet, a thoughtful assessment and plan developed by parents and/or school personnel provides the greatest opportunity to achieve behavioral success.

Keys to Putting a BIP into Practice

Conduct a Meeting after the FBA is completed - Set up a convenient time to meet with members of the IEP team, including school personnel, parents, and private professionals who are working with the identified child. If any IEP team members are unable to attend in person, consider having them join by phone or video conference. At the meeting, discuss the results of the FBA in detail. Present definitions of the target behaviors, explain the rationale for the method of data collection that was used, share the results, and discuss the hypothesized functions of behavior. Reviewing the FBA helps ensure that all the participants at the meeting recognize the scope and nature of the problem behaviors. Discussing the FBA provides the foundation for a more meaningful discussion about interventions.

Before closing the meeting, make a plan for monitoring progress. Is the intervention being implemented as prescribed? Are data being collected and graphed? Are there any changes that need to be made? Are the caregivers being updated? These are all important components of a successful plan.

Incorporate antecedent-based interventions - Antecedent-based interventions are critical, yet commonly overlooked. Antecedent interventions refer to strategies that help to prevent the problem behavior from occurring. In other words, they are proactive, rather than reactive. Be sure that antecedent strategies are included in the BIP. Consider a student who is engaged in the problem behavior of flopping out of his chair after completing five math problems. Antecedent-based suggestions may include modifying the instructional task for the student and/or allowing the student access to a preferred task after completing three math problems.

Identify replacement behaviors - Recommendations to address replacement behaviors should always be included in the BIP and reviewed with the team. Replacement behaviors refer to the set of appropriate behaviors which serve the same function of the problem behavior. For example, if a student runs away or yells "NO" when an instructional task is presented or a demand is made, it may be hypothesized that the function of the student's behavior is to avoid or escape the instructional task or the demand. If the avoidance behavior is the result of the task or demand being too difficult, replacement behaviors may be to teach the child to calmly ask for help. Alternatively, he may be taught to hold up a picture card to request a break, utilize a "break pass," or hand the teacher a card that says "one minute please."

Obtain "Buy-In" - Obtain "buy-in" from all of the team members. First, be sure to clearly explain suggested strategies for intervention, as well the empirical research to support the suggestions. Simply forwarding the FBA/BIP with a note, "Here it is, it is all in the report," will often lead to frustration. Second, be sure that all team members understand the rationale for the strategies that are suggested. If there is clarity about the reason for procedures, school staff and parents are more likely to implement them. For example, for the antecedent-based recommendation of modifying a task, it may be helpful to explain that by reducing the response effort to attain a reward or teaching a functional replacement (e.g., saying "break please"), the student is more likely to change his behavior. Third, solicit feedback about the plan. Questions to consider posing to the team include the following: what do you think about the plan, does the plan make sense to you, how do you see yourself implementing these procedures, and what obstacles do you foresee? With school personnel and caregivers already stressed and pressed for time, it is important to strategize with them in a real and practical way about how the procedures will be implemented.

Train school personnel - Teaching educators and caregivers to implement procedures appropriately and correctly is important for the student's success. Identify which staff requires training, plan when the trainings will take place, and identify who will provide the training. If no personnel at the school are able to provide the training, consideration should be given to bringing in an outside consultant. Training of educators and caregivers should consist of a proven, multi-component process that includes direct instruction, modeling, rehearsal/role play and corrective feedback (Stewart, Carr, and LeBlanc, 2007; Miles and Wilder, 2009). In the example of teaching a student how to request a break, modeling the procedure for the staff, role playing the procedure (i.e. taking turns being the teacher and student), and then providing feedback would help staff adhere to the procedure.

Keep it Simple - Whenever possible, try to keep the plan simple. Overly complicated procedures and data collection methods leads to confusion and may result in lack of adherence and non-compliance to the plan.

Dr. Meir Flancbaum is a licensed psychologist at Behavior Therapy Associates in Somerset, NJ. Ms. Elena Zaklis is a board certified behavior analyst at Behavior Therapy Associates. Dr. Michael Selbst is a licensed psychologist and Director at Behavior Therapy Associates. They provide a variety of services for children and adolescents with autism spectrum disorders and related disorders, including individual and group therapy, school-based consultation, functional behavior assessment and behavior intervention planning, and training workshops for professionals and parents. For more information about Dr. Flancbaum, Ms. Zaklis, and services provided at Behavior Therapy Associates, visit www.BehaviorTherapyAssociates.com. Correspondence can be directed to mflancbaum@BehaviorTherapyAssociates.com.

References

Stewart, K. K., Carr, J. E. & LeBlanc, L. A. Evaluation of Family – Implemented Behavioral Skills Training for Teaching Social Skills to a Child with Asperger's Disorder. (2007). Sage Publications, 6, 252-262.

Miles, N. I. & Wilder, D. A. (2009). The Effects of Behavioral Skills Training on Caregiver Implementation of Guided Compliance. *Journal of Applied Behavior Analysis*, 42, 405-410.

Subscribe to Autism Spectrum News

Yes! **I want to receive each Quarterly Issue by Mail**

☐ Student ($20/year) School/Program ________________

☐ Individual/Family ($40/year)

☐ Professionals ($50/year)

☐ Small Group - 25 Copies Each Issue ($150/year)

☐ Large Group - 50 Copies Each Issue ($300/year)

Name & Title: ______________________________

Address: __________________________________

______________________ Zip: ____________

Phone: ______________ Email: ________________

Mail this form with a check made out to:

Mental Health News Education, Inc.
460 Cascade Drive
Effort, PA 18330

To pay by credit card visit:

www.mhnews-autism.org/subscribe.htm

Phone: (508) 877-0970 Email: dminot@mhnews.org

Advertise in Autism Spectrum News

	1 Issue	**4 Issues (25% discount!)**
☐ Business Card:	N/A	$500
☐ Eighth Page:	$300	$900
☐ Quarter Page:	$500	$1,500
☐ Half Page:	$750	$2,250
☐ Full Page:	$1,000	$3,000
☐ Inside Covers & Back Page (please call)		
☐ Honorary Sponsorship (please call)		

Name & Title: ______________________________

Address: __________________________________

______________________ Zip: ____________

Phone: ______________ Email: ________________

Mail this form with a check made out to:

Mental Health News Education, Inc.
460 Cascade Drive
Effort, PA 18330

To pay by credit card visit:

www.mhnews-autism.org/advertise.htm

Phone: (508) 877-0970 Email: dminot@mhnews.org

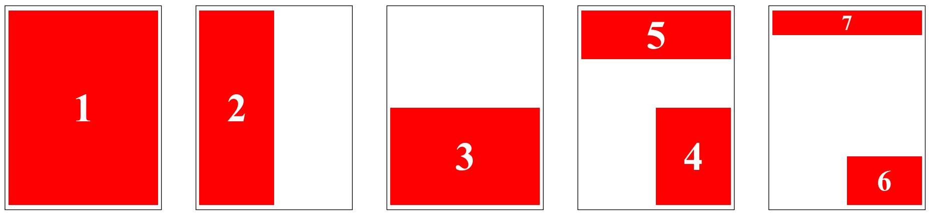
Promote Your Vital Programs, Services, and Events and
Reach Over 100,000 Readers in the Autism Community Across the Nation!

Your Advertisement Will Also Run in Color in Our Online Digital Edition!

Deadline Calendar & Ad Size Specifications

Deadline Dates

Summer 2015 Issue - June 4, 2015
Fall 2015 Issue - September 3, 2015
Winter 2016 Issue - December 3, 2015
Spring 2016 Issue - March 3, 2016



Full Page **Half Vertical** **Half Horizontal** **Quarter V & H** **Eighth V & H**

Ad Sizes - In Inches

	Width	**Height**
Full Page (1)	**10.4**	**12.8**
Half Vertical (2)	**5.1**	**12.8**
Half Horizontal (3)	**10.4**	**6.4**
Quarter Vertical (4)	**5.1**	**6.4**
Quarter Horizontal (5)	**10.4**	**3.1**
Eighth Vertical (6)	**5.1**	**3.1**
Eighth Horizontal (7)	**10.4**	**1.5**
Business Card (not shown)	**5.1**	**1.5**

AUTISM SPECTRUM NEWS™

Your Trusted Source of Science-Based Autism Education,
Information, Advocacy, and Community Resources

www.mhnews-autism.org

For Over 7 Years, Families Have Trusted *Autism Spectrum News* for Answers

What Resources are Available in My Community? • Is This Treatment Safe for My Child?
Where Can I Get Financial Planning Advice? • Where Can I Find Help With IEPs?
What Happens When My Child Grows Up? • What's New in Autism Science?
I Just Want My Child to Have the Best Future Possible....

Subscribe to Autism Spectrum News Today!!

Yes! I Want to Receive Each Quarterly Issue by Mail

☐ Student ($20/year) School: ____________________

☐ Individual/Family ($40/year)

☐ Professionals ($50/year)

☐ Small Group - 25 Copies Each Issue ($150/year)

☐ Large Group - 50 Copies Each Issue ($300/year)

Name & Title: ______________________________________

Address: ______________________________________

______________________ Zip: ______________

Phone: ________________ Email: ____________________

Please make your check out to:
Mental Health News Education, Inc.

Mail in this form and check to:
Mental Health News Education, Inc.
460 Cascade Drive
Effort, PA 18330

To pay by credit card visit:
www.mhnews-autism.org
/subscribe.htm

www.mhnews-autism.org
facebook/AutismSpectrumNews
twitter/AutismSpecNews

Autism Spectrum News is a Quarterly Print and Online Publication
Published by Mental Health News Education, Inc., a 501(c)(3) Nonprofit Organization

For information about advertising, subscriptions, or how to submit an article,
contact David Minot, Publisher at (508) 877-0970 or dminot@mhnews.org