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Where it all comes together.

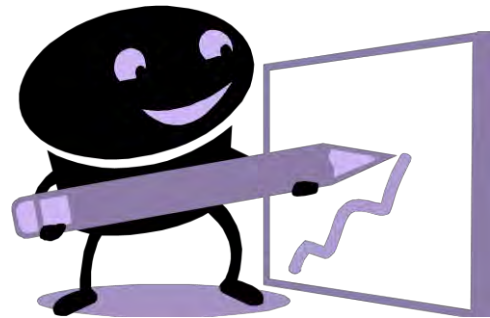
FEATURED TOPIC / DISCIPLINE OF THE MONTH PROACTIVE BEHAVIOR MANAGEMENT

Treatment of Multiply Controlled Problem Behavior With Procedural Variations of Differential Reinforcement

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Abstract:

We describe the assessment and treatment of 2 children with autism spectrum disorder whose problem behaviors (self-injury, aggression, and disruption) were multiply controlled. Results of functional analyses indicated that the children's problem behaviors were maintained by both positive reinforcement (attention) and negative reinforcement (escape from task demands). Subsequently, procedural variations of differential reinforcement and extinction were implemented in different contexts (attention and demand) and were effective in reducing problem behavior, increasing appropriate communication, and increasing compliance.

Introduction:

Although impairments in social interaction and communication are the

primary behavioral characteristics of autism, problem behaviors such as stereotypy and self-injurious behavior (SIB) are also commonly seen (American Psychiatric Association, 1994). In a review of behavioral interventions for children with autism (8 years of age or younger), Homer, Carr, Strain, Todd, and Reed (2002) reported that stereotypy, aggression, SIB, property destruction, and tantrums were the problem behaviors most frequently referred for treatment. These behaviors present a challenge to parents and teachers of children with autism because improvement is unlikely to occur without formal intervention.

Treatment procedures that are effective in decreasing problem behavior while increasing communicative and social behavior are particularly desirable for children with autism. One such class of

interventions is differential reinforcement of alternative behavior (DRA); in one variation of DRA, problem behavior is replaced with some form of communicative response. Often described as functional communication training (FCT), the procedure involves teaching the individual a socially appropriate way to gain access to the reinforcer that currently maintains problem behavior (Carr & Durand, 1985). FCT is commonly combined with extinction (EXT), in which reinforcement for problem behavior is discontinued. In fact, a number of studies have shown that EXT may be a critical component of FCT (Fisher et al., 1993; Kelly, Lerman, & Van Camp, 2002; Shirley, Iwata, Kahng, Mazaleski, & Lerman, 1997).

The successful implementation of both FCT and EXT requires identification of the source of reinforcement for problem behavior, and functional analysis methodology (see Iwata, Kahng, Wallace, & Lindberg, 2000, for a review) has become

Article Summary: “Replacing the Aggressive Behavior of a Child with Autism Toward an Infant Sibling”

David Cox

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Volume 3, Number 1, Winter 2001, pages 28-38

Authors: Barry, L.M., and Singer, G.H.S.

Introduction:

The authors decided to conduct this study as research preceding them had found strong associations between early sibling interactions and later sibling relationships in adulthood. The authors also recognized the increased likelihood that having a sibling with autism posed for potential troubled sibling relationships due to the diagnostic symptoms of autism as well as the elevated stress that having a child with aggressive behaviors has on parents and its subsequent affect on parent implemented treatments.

This article surrounded the case study of a 10 year-old child with autism who was displaying aggressive

behaviors toward a new infant. The aggressive behaviors had gotten to the point where the family had placed physical barriers within the home to separate the child with autism from the infant. The resulting affect on the family led the mother to describe their circumstance “like living in a prison. “I’m locked in that room with the baby and he [the child with autism] always seems to be out there, banging on the door to get at us.”

Following an “initial interview, direct observations, and a functional analysis,” a “clinician-implemented skill training of replacement behaviors and clinician

fading by means of self-management” was hypothesized to lead to increases in learned communication, play, and caregiver skills “similar to those skills observed in the interactions between the 8- and-12-year-old siblings who were typically developing and the infant”. Also hypothesized were decreases in aggression which would result in avoiding the need for out-of-home placement of the child with autism.

Methods:

The family consisted of the mother, the father and the four siblings (ages: 12 years, 8 months; 10 years, 8 months; 8 years, 8 months;

continued on page 5

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the assessment tool of choice because it provides a basis for developing intervention procedures that match the functional characteristics of behavior. For example, teaching a child to request attention from the teacher (positive reinforcement) would not be expected to reduce problem behavior that is maintained by escape from task demands (negative reinforcement). Similarly, withholding attention may extinguish problem behavior maintained by attention but would have little effect on problem behavior maintained by escape. Thus, results of a functional analysis determine which procedural variations of FCT and EXT should be used in a particular case.

Several reports have indicated that problem behaviors occasionally may be maintained by more than one source of reinforcement (Day, Homer, & O’Neill, 1994; Smith, Iwata, Vollmer, & Zarcone, 1993). For example, because both aggression and SIB so often produce a variety of social consequences, individuals who acquire these behaviors because they produce attention may learn that the behaviors also are effective means of escape, and vice versa. When the same behavior serves multiple functions, each function

must be addressed, usually in a different context and with a different treatment. FCT is an attractive option for treating problem behavior having multiple social functions because its procedural variations share common features even though the form of the response being taught and its associated reinforcer differ (e.g., “Play with me” followed by attention vs. “Done” followed by a break from an ongoing task). Results of several studies have indicated that FCT may be an effective treatment for multiply controlled problem behavior (Braithwaite & Richdale, 2000; Day et al., 1994; Hagopian, Wilson, & Wilder, 2001), and the purpose of this study was to evaluate the effectiveness of FCT + EXT both to reduce multiply controlled problem behavior and to increase the communicative skills of two young children with autism spectrum disorders.

Method

Participants and Settings

Two children seen in an outpatient clinic specializing in the assessment and treatment of severe problem behavior participated. Alison was a 3-year-old girl diagnosed with Pervasive

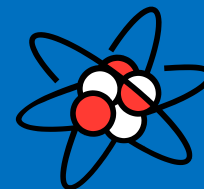


Did you know?

Parrots can produce 500 pounds per square inch of pressure in their beaks.



The average speed of an air molecule is 500 meters per second.



A lion’s roar can be heard for up to 5 miles.



Developmental Disorder Not Otherwise Specified, whose problem behaviors consisted of SIB, aggression, and disruption. Peter was a 4½-year-old boy diagnosed with autism whose problem behaviors consisted of SIB and aggression. Both children had limited verbal repertoires but were able to use one- to two-word phrases and simple gestures and could follow single-step instructions.

Sessions were conducted in clinic therapy rooms equipped with one-way observation windows. Rooms were equipped with a table, several chairs, and materials relevant to the specific conditions. Two- to 4-hr clinic appointments were conducted weekly for either 6 months (Alison) or 3 months (Peter). Sessions during each weekly appointment lasted 10 min.

Response Measurement and Reliability

Trained graduate and undergraduate students collected data on the frequency of SIB (head banging, self-biting, self-hitting, or self-scratching), aggression (hitting, kicking, biting, scratching, head butting others, or throwing objects at others), and disruption (property destruction, throwing objects, or knocking over furniture). Data also were collected on the frequency of prompted and unprompted communicative responses (card exchanges by Alison; vocal requests by Peter) during treatment. Frequency data were converted to number of responses per minute for purposes of data analysis. Interobserver agreement was not assessed for Peter's data due to our inability to schedule additional observers during his appointments. Interobserver agreement for Alison's problem and communicative behaviors was assessed during 19% of her sessions by having a second observer simultaneously but independently collect data with the primary observer. Sessions were divided into 10-sec intervals, and data were compared on an interval-by-interval basis. Agreement coefficients were calculated by dividing the smaller number of responses in each interval by the larger number of responses; these fractions were averaged across intervals and multiplied by 100%. Mean agreement scores for problem and communicative behaviors were 98% and 97%, respectively.

Functional Analysis

A functional analysis (Iwata, Dorsey, Slifer, Bauman, & Richman, 1982/1994) was conducted for each child to identify the consequences that maintained problem behavior. The assessment consisted of four conditions arranged in a multielement design. During the attention condition, the child and a therapist were in a room. The therapist asked the child to play independently with toys, then ignored the child except to deliver

attention following occurrences of problem behavior. The purpose of the attention condition was to determine if problem behavior was maintained by positive reinforcement (access to attention). During the demand condition, a therapist presented academic (e.g., imitation, color identification, etc.) and hygienic (e.g., brush hair, wipe table, etc.) tasks to the child using a three-step prompting sequence (verbal, gestural, physical prompts). Compliance produced verbal praise; problem behavior produced a brief break (30 sec) from the task. The purpose of the demand condition was to determine if problem behavior was maintained by negative reinforcement (escape from demands). During the ignore condition, the child and a therapist were in a room; however, the therapist never interacted with the child. The purpose of the ignore condition was to determine if problem behavior was maintained by automatic reinforcement (persisted in the absence of social contingencies). During the play condition, no task demands were presented, and preferred toys and attention were continuously available. No programmed consequences were arranged for problem behavior. The purpose of the play condition was to serve as the control condition, against which the test conditions were compared.

Results of the functional analysis showed that the problem behavior of both children was multiply controlled, maintained by both positive reinforcement (attention) and negative reinforcement (escape). Therefore, each child was taught two functional alternative responses during treatment in different contexts: One response produced attention, and the other response produced escape. A multiple baseline design across behavioral functions was used to evaluate the effectiveness of FCT + EXT on rates of problem and communicative behavior.

Treatment Conditions

Baseline. Two baseline conditions were conducted with each child. One baseline was the same as the attention condition of the functional analysis; the other was the same as the demand condition of the functional analysis.

FCT (attention) + EXT. This intervention was implemented during the attention condition. Problem behavior no longer produced attention (EXT). Instead, communicative responses produced approximately 20 sec of attention. Alison's response was to hand a picture card to the therapist (depicting a photo of Alison playing with an adult). Peter's response was to say, "Play with me." The therapist initially prompted the child to emit the communicative response and then delivered attention. Subsequently, a prompt-delay procedure was used to fade therapist

prompting. Increasingly longer delays between the occurrence of a communicative response and subsequent prompts to communicate were inserted contingent upon the completion of sessions in which rates of problem behavior were low (approximately at or below 10% of baseline rates). The prompt-delay procedure continued until the child exclusively emitted unprompted communicative responses.

FCT (escape) + EXT. This intervention was implemented during the demand condition. Problem behavior no longer produced escape from demands (EXT). Instead, communicative responses produced a 30-sec break from demands. Alison's response was to hand a card to the therapist (depicting a photo of a stop sign). Peter's response was to say, "Break please." The therapist initially prompted the child to request a break immediately following a prompt to complete a task, then gave the child a break. The prompt-delay procedure just described was used to fade prompts to communicate until the child emitted the communicative response independently. An additional, differential reinforcement component was subsequently added to treatment for Alison to increase compliance with demands. Specifically, Alison received a preferred edible contingent upon compliance with demands.

Results

Figure 1 shows the results of Alison's and Peter's functional analysis. Both children exhibited higher rates of problem behavior in the attention and demand conditions relative to the play (control) condition. This pattern of responding suggested that their problem behavior was maintained by both positive and negative reinforcement.

The top two panels of Figure 2 show Alison's treatment results. In the attention condition (upper panel), high rates of problem behavior were observed during baseline. FCT + EXT resulted in immediate and sustained decreases in problem behavior (with the exception of two sessions in which bursts of problem behavior occurred). Independent (unprompted) communication emerged and maintained across sessions. Alison's extended admission to the outpatient clinic allowed additional session time to thin the reinforcement schedule for communication. A graduated multiple schedule arrangement was used, in which signaled periods of reinforcement and extinction for communicative responses were alternated (see Hanley, Iwata, & Thompson, 2001, for details). The thinning procedure initially consisted of a 45-sec period during which all communicative responses were reinforced,

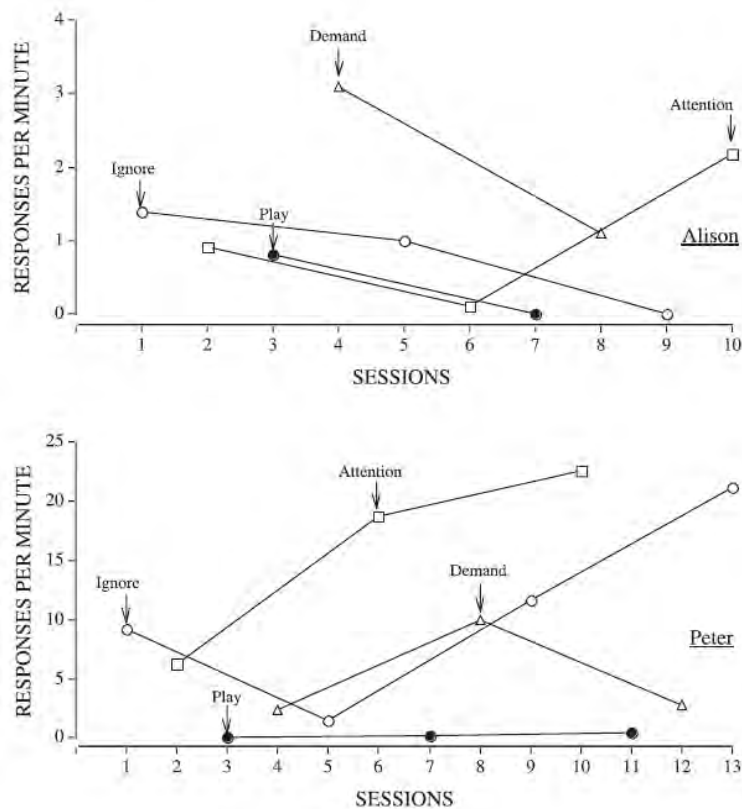


FIGURE 1 Rates of problem behavior exhibited by Alison and Peter during their functional analyses.

followed by a 15-sec period during which reinforcement was unavailable. The terminal schedule was one in which a 1-min reinforcement period was followed by a 2-min EXT period. In the demand condition (lower panel), consistently high rates of problem behavior and low levels of compliance were observed during baseline. FCT + EXT resulted in immediate and sustained decreases in problem behavior and consistent rates of independent communication. In addition, levels of compliance increased as compared to baseline levels with the addition of the differential reinforcement of compliance component.

The bottom two panels of Figure 2 show Peter's treatment results. In the demand condition (upper panel), high rates of problem behavior and low levels of compliance were observed during baseline. FCT + EXT resulted in a gradual decrease in problem behavior. Independent communication emerged during the first session and continued to occur consistently across sessions. In addition, Peter's compliance increased relative to baseline levels without the inclusion of additional interventions. In the attention condition (lower panel), extremely high rates of problem behavior were observed during baseline. FCT + EXT resulted in immediate and sustained decreases in problem

behavior. Independent communication emerged during the first session and was maintained across sessions. Due to the short duration of Peter's clinic admission, reinforcement schedule thinning was not evaluated.

The parents of both children were trained to implement the treatment procedures initially during role-play sessions and subsequently during in vivo treatment sessions with their children. Both caregivers demonstrated a high degree of accuracy implementing treatment sessions. Parental reports following the completion of outpatient treatment indicated that both children continued to communicate for attention and escape from demands and engaged in little problem behavior both at home and at school. Alison's mother also reported that Alison began to *vocally* request (rather than exchanging picture cards) attention, breaks from demands, and various other preferred items and activities.

Discussion

Results of this study illustrate the use of procedural variations of differential reinforcement as treatment for multiply controlled problem behavior. Results of functional analyses indicated that the two children's problem behaviors were maintained by both positive and negative

reinforcement. Subsequently, FCT + EXT interventions for each function were implemented in different contexts and were associated with decreases in problem behavior, increases in appropriate communicative behavior, and increases in compliance.

The assessment results add to a growing body of literature indicating that the same problem behavior in the same individual may be maintained by different sources of reinforcement. In the case illustrated here, both children's assessment data suggested that a single intervention was unlikely to be very effective in managing their behavior across situational contexts. Although the data showed some variability, suggesting that assessment should have continued longer, the time constraints imposed by weekly outpatient appointments prevented lengthy assessment. Nevertheless, results for both children were relatively clear and are representative of outcomes obtained from brief functional analyses (Northup et al., 1991; Wacker et al., 1994; Wallace & Knights, 2003).

Two types of interventions were designed to address the multiple functions identified through assessment. One intervention (implemented in the attention context) involved teaching an alternative attention-seeking response while ignoring problem behavior; the other (implemented in the demand context) involved teaching an alternative escape response while not allowing problem behavior to produce escape from ongoing tasks. Although the interventions were procedurally different, they were derived from the same general approach to treatment in that they included both differential reinforcement and extinction components. These characteristics of the intervention process illustrate two important points: (a) Different types of treatment may be required for the same behavior depending on the source of reinforcement that maintains it, and (b) differential reinforcement procedures are very flexible in accommodating a wide range of variation.

A limitation of our research is that the necessity of varying interventions across contexts was not shown. For example, Carr and Durand (1985) showed that FCT appropriate for attention-maintained problem behavior had little effect on children whose problem behavior was maintained by escape. Given the limitations imposed by the setting in which this study was conducted, we deemed this strategy infeasible. Nevertheless, a stronger demonstration of the need to match treatment with function would have been provided by alternating both interventions in both contexts and showing that FCT + EXT for attention-maintained behavior was ineffective when applied to escape maintained behavior and vice versa.

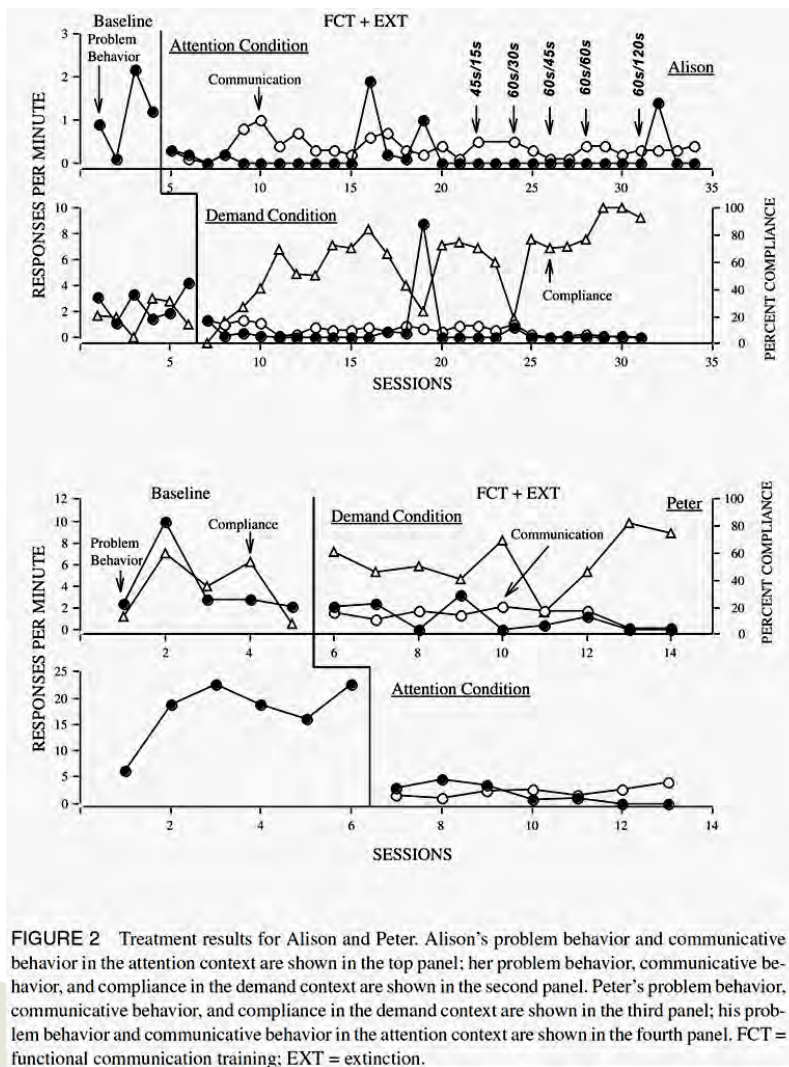


FIGURE 2 Treatment results for Alison and Peter. Alison's problem behavior and communicative behavior in the attention context are shown in the top panel; her problem behavior, communicative behavior, and compliance in the demand context are shown in the second panel. Peter's problem behavior, communicative behavior, and compliance in the demand context are shown in the third panel; his problem behavior and communicative behavior in the attention context are shown in the fourth panel. FCT = functional communication training; EXT = extinction.

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and the infant 3 months). The participants included the child with autism and the infant. The child with autism:

“was able to combine words to form simple sentences (e.g., noun + action, noun + action + place), was toilet trained, and could perform self-help skills, such as dressing himself with minimal assistance. He frequently engaged in solitary self-stimulatory behavior... when not guided in

appropriate activities. The child answered questions with yes/no responses, did not maintain eye contact in social interactions, and did not practice turn taking in conversation.”

The parent's primary concern was with the aggressive behaviors that the child with autism displayed toward the infant. These behaviors included, “smother(ing) the infant”, “shaking and choking the infant, running with and overturning the infant's stroller, and

encouraging the infant...into dangerous situations such as climbing stairs and climbing chairs.”

The setting for the study was the given environments in the house in which each of the respective target behaviors occurred. The design used for the study was a nonconcurrent multiple baseline across behaviors and settings, i.e. baselines of each behavior across each setting were taken at different points in time.*

The sessions in which replacement behaviors were taught were conducted

*NB: “The traditional multiple baseline design in which baselines overlap in time and successively increase in number is not useful when the behaviors evolve sequentially over time and thus do not occur simultaneously. In this study, the design was additionally modified so each behavior was assessed nonconcurrently. The nonconcurrent baseline weakens the study; however, the longitudinal nature of the study required nonconcurrent assessment of behaviors that developed at different times.”

anywhere from two to four times each week during a 26-month period. The replacement behaviors for each of the respective aggressive behaviors were as follows. For smothering the infant, the replacement behaviors “included talking to the infant, speaking in ‘motherese’, showing the infant a toy, bringing the infant a pacifier or bottle, and singing to the infant.” For the dangerous stroller behaviors, replacement behaviors “included walking slowly with the stroller while avoiding obstacles and keeping all four wheels on the ground, talking to the infant, speaking in motherese, and singing to the infant.” With respect to the shaking of the infant, replacement behaviors included “talking to the infant; speaking in motherese; singing songs to the infant; and bringing the infant a toy, pacifier, or bottle”. For the behaviors of attracting the infant to climb stairs, replacement behaviors included “speaking words and making gestures that encouraged the infant to move away from the stairs, closing doors that separated the infant from the stairs, showing the infant toys, and bringing the infant to a room away from the stairs”. In regards to the aggressive behavior of choking the infant, replacement behaviors included “talking to the infant; speaking in motherese; singing songs to the infant; bringing the infant a toy, pacifier, or bottle; rolling on the floor; crawling with the infant; and playing hide-and-seek games with the infant”. Finally, for the behavior of coaxing the infant to climb the chair, “replacement behaviors included talking to the infant; speaking in motherese; singing songs to the infant; bringing the infant a toy, pacifier, or bottle; rolling on the floor; crawling with the infant; playing hide-and-seek games with the infant; sitting in a chair; and reading a book to the infant while seated in a chair”.

The intervention was implemented by a researcher in the family’s home based on the information obtained during baseline and consisted of four components. The first involved a skill training session in which the child was taught the aforementioned replacement behaviors and how to perform them. The second component involved teaching the child to track his use of the replacement behaviors as well as his

aggressive behaviors and to request reinforcement for accurate self-monitoring. The third component was teaching the parents and siblings to use differential reinforcement in responding to the child’s behaviors through modeling and verbal praise of the parents and siblings. The fourth and final component of the intervention aimed at directing the child with autism to notice the positive emotions that the infant was displaying when he engaged in the replacement behaviors.

The reliability of the dependent measures of the occurrence and frequency of replacement and aggressive behaviors was gauged through having independent observers record data during 33% of the sessions. The interrater agreement percentages were then calculated and ranged from “86% to 100% for duration of sessions and from 98% to 100% for the occurrence of replacement behaviors in 15-s percentage intervals...[and]...100% for the occurrence of aggressive behaviors”.

Follow-up sessions were conducted at 1 month following completion of the components and again between 3 and 4½ months following the last independent performance data point that was taken for each of the six behaviors.

Results:

The family decided to keep the child with autism in their home and also recognized their own need for continued behavioral support following the replacement of the first two behaviors. The aggressive behaviors decreased to only two occurrences following the skill training component with no occurrences “during or after the self-management interventions across the six behaviors”. The percentage of replacement behaviors increased throughout the study to 90%-100% following skill training, 95% to 100% following the completion of the four components, and remained in the 84% - 100% range at follow up. Finally, the duration of the appropriate interactions increased from approximately 1-12 seconds for five of the six behaviors during baseline to a range of 23 – 404 seconds following completion of the

four components and again to 105 to 485 seconds at follow-up.

Discussion



“The results of the study indicate that clinician-implemented skill training and clinician fading through self-management may be an effective intervention for families in behavioral crisis in which [mere] parent training is not possible.” The study also suggests the importance of directly observing familial interaction in order to help determine the best manner of approaching the function of the child’s behavior and how best to utilize those interactions to increase appropriate replacement behaviors. This study also highlights the need for more research on the effect of “challenging behavior on changing stimulus conditions in family homes and in family relationships”.

The main shortcoming of this study was its use of a modified design of decreasing and nonconcurrent baselines, “a lack of data regarding the family’s behavior toward their child, and a lack of specific performance criteria for the parent and sibling training that took place”, as well as it being a case-study.

Conclusion:

In the end, the researcher set out to utilize replacement strategies for aggressive behaviors through sibling and parent interaction with the target child. They were able to demonstrate a decrease in the occurrence of the aggressive behaviors toward the infant child as well as an increase in the occurrence and duration of replacement behaviors. The lack of rigorous experimental conditions combined with its case-study format would suggest that further studies are required involving more precise experimental conditions and a larger sample size before widespread implementation of the exact protocol should be undergone. However, the effectiveness of the protocol combined with the demonstrated importance of familial involvement and interaction with the child helping to cause the changes in negative behaviors seen is of important note.

February 2010: Upcoming Events!

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1 <i>COCAP Meeting</i> 6.00 – 8.00 pm <hr/> ASC: Environ Health Impacts 1.15–4.30 pm	2	3	4	5	6
7	8	9	10 Autism ABC's 6.30 – 8.00 pm	11 Adolescent Clinical Rounds	12	13
14	15	16	17	18 Community Outreach Committee Meeting Molly Strauss Birthday 	19	20
21	22 Missy Perkins & Josh Bond Birthday 	23	24	25 Parents Encouraging Contact David Cox	26 Staff D-Day EC Clinical Rounds Parents Conference	27 Colorado Springs: General Information
28						

March 2010: Upcoming Events!

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1 <i>COCAP Meeting</i> 6.00 – 8.00 pm	2 Young Adult Job Fair at Jefferson County Fairgrounds 1.30-5.30 pm	3 CLE Open House 3.30-5.30 <hr/> ASC Beau Jo's Pizza Night: 5.30-7.30 S. CO and Yale	4	5 Matt Weidner & Shelley Radosevich Birthday 	6
7	8	9	10 Autism ABC's 6.30 – 8.00 pm	11 Adolescent Clinical Rounds	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26 Staff D-Day EC Clinical Rounds	27
28  Shannon Howland Birthday	29	30	31			

FEBRUARY PARENT TRAINING OPPORTUNITIES DENVER METRO AREA, 2010

1. **February 18 (8 week series).** *Mobilizing Families.* 6:00-9:00 p.m. at Arc of Jefferson County. Training, dinner and childcare. For more information, 303-232-1338 X206 or jolynn@arcjc.org. **FREE.**
2. **February 24.** *Components of an IEP.* 6:30-8:00 p.m. at Jeffco Education Center. Sponsored by Arc and Jeffco Public Schools. For more information, lfrankli@jeffco.k12.co.us or 303-982-2520. **FREE.**
3. **February 24.** *Ready or Not, Adolescence is Here: An Overview of Puberty, Sexuality and Relationships.* 5:30-8:30 p.m. at Daniels Fund Building, Denver. To RSVP call Mile High Down Syndrome Association at 303-797-1699. Spanish translation available. **\$.**
4. **February 24.** *Adams 12 Resource Fair.* 5:00-8:00 p.m. For more information, 720-972-4227. **FREE.**
5. **February 25-27.** *Parents Encouraging Parents (PEP).* Colorado Springs. For more information, 303-866-6846 or www.cde.state.co.us/cdesped/PEP.asp. **FREE.**

SCHOOL DISTRICT SPECIAL EDUCATION ADVISORY COMMITTEES

Adams County 12

Special Education Advisory Committee. 720-972-4227.

Boulder Valley

Special Education Advisory Council. anna.stewart@bvsd.org or 720-561-5918.

Brighton 27J

Brighton Parent Resource Group. Caryn Johnson at 303-655-2738 or CJOHNSON@sd27J.org.

Cherry Creek

Special Education Advisory Council. 720-554-4490 or dvenscoyk@cherrycreekschools.org.

Denver

Special Education Advisory Committee. Pam Bisceglia, Parent Liaison, 720-423-3571 or Pamela.bisceglia@dpsk12.org.

Douglas County

Special Education Advisory Council. <http://dcseac.yolasite.com> or dcseac@gmail.com

Jefferson County

Special Education Advisory Council. Lisa Franklin, lfrankli@jeffco.k12.co.us or 303-982-2520.

Littleton

Special Services Advisory Committee (SSAC). jshoup@lps.k12.co.us or 303-347-3471.

COMMUNITY RESOURCES



Creative Perspectives: Family Counseling with Mike Foster, M.S.

Creative Perspectives: Super Group Social Skills Training: Justin Male, M.S.

Therapalooza: Community Based Intervention for Adolescents through Creative Perspectives, Inc.

Autism Society of Colorado: <http://www.autismcolorado.org/>

Autism Society of Boulder County: <http://www.autismboulder.org/>

Center for Disease Control and Prevention Autism Resource:
<http://www.cdc.gov/ncbddd/autism/index.html>

Autism Action: <http://www.autismaction.org/>

Autism Speaks: <http://www.autismspeaks.org/>

Summary of Recent Gastrointestinal Articles from the American Academy of Pediatrics

Meghan Deshais

Recently many media outlets have reported new data related to gastrointestinal disorders in individuals with ASD. The American Academy of Pediatrics recently published two articles addressing this topic. In order to remain as neutral and unbiased as possible I will summarize the findings in both of these articles.

Evaluation, Diagnosis, and Treatment of Gastrointestinal Disorders in Individuals With ASDs: A Consensus Report

The first article was entitled: "Evaluation, Diagnosis, and Treatment of Gastrointestinal Disorders in Individuals With ASDs: A Consensus Report". This article reported findings from a literature review performed by a multitude of experts in the field, including but not limited to developmental pediatrics, epidemiology, medical genetics, immunology, pediatric allergy, and pediatric gastroenterology.

In May of 2008, "a multidisciplinary panel convened in Boston, MA, to review and discuss gastrointestinal aspects of ASDs". The panel reviewed all current medical literature related to gastrointestinal disorders and ASD. They scored the literature using a numerical scale to determine the reliability, and validity of the evidence presented in each article. The expert panel developed 23 "consensus statements" addressing gastrointestinal disorders in individuals with ASD. These statements are reproduced in their entirety (Buie, et al., 2010).

"Statement 1: Individuals with ASDs who present with gastrointestinal symptoms warrant a thorough evaluation, as would be undertaken for individuals without ASDs who have the same symptoms or signs. Evidence-based algorithms for the assessment of abdominal pain, constipation, chronic diarrhea, and

gastroesophageal reflux disease (GERD) should be developed."

"Statement 2: Gastrointestinal conditions that are reported to be common in individuals without ASDs are also encountered in individuals with ASDs."

"Statement 3: The prevalence of gastrointestinal abnormalities in individuals with ASDs is incompletely understood."

"Statement 4: The existence of a gastrointestinal disturbance specific to persons with ASDs (e.g., "autistic enterocolitis") has not been established."

"Statement 5: The evidence for abnormal gastrointestinal permeability in individuals with ASDs is limited. Prospective studies should be performed to determine the role of abnormal permeability in neuropsychiatric manifestations of ASDs."

"Statement 6: Individuals with ASDs and gastrointestinal symptoms are at risk for problem behaviors. When patients with gastrointestinal disorders present with behavioral manifestations, the diagnostic evaluation can be complex."

"Statement 7: For a person with an ASD who presents for treatment of a problem behavior, the care provider should consider the possibility that a gastrointestinal symptom, particularly pain, is a setting event, that is, a factor that increases the likelihood that serious problem behavior (eg, self-injury, aggression) may be exhibited. Sudden and unexplained behavioral change can be the hallmark of underlying pain or discomfort. Behavioral treatment may be initiated as the possible concurrent medical illness is being investigated, diagnosed (or excluded), and treated, but

the behavioral treatment should not substitute for medical investigation. The behavioral treatment plan should be developed, implemented, and changed as needed in collaboration with the medical caregivers who are leading the medical investigation."

"Statement 8: Education of caregivers and health care providers is necessary to impart knowledge of how to recognize typical and atypical signs and symptoms of gastrointestinal disorders in individuals with ASDs."

"Statement 9: Pediatricians and other primary care providers should be alert to potential nutritional problems in patients with ASDs. Evaluation by a nutritionist who is familiar with nutrition support for individuals with ASDs is recommended if caregivers raise concern about the patient's diet or if the patient exhibits selectivity of intake or is on a restricted diet."

"Statement 10: Primary care nutritional assessment for each person with an ASD should include (1) weight for height or BMI, (2) weight for age, (3) height for age, (4) any marked changes in growth rate."

"Statement 11: Anecdotal reports have suggested that there may be a subgroup of individuals with ASDs who respond to dietary intervention. Additional data are needed before pediatricians and other professionals can recommend specific dietary modifications."

"Statement 12: Available research data do not support the use of a casein-free diet, a gluten-free diet or combined gluten-free, casein-free (GFCF) diet as a primary treatment for individuals with ASDs."

"Statement 13: For patients with ASDs, a detailed history should

be obtained to identify potential associations between allergen exposure and gastrointestinal and/or behavioral symptoms."

"Statement 14: Standardized definitions of adverse reactions to foods would be helpful in discussions with patients/providers. These definitions also should be used in studies of adverse food reactions in individuals with ASDs."

"Statement 15: For patients with ASDs, a detailed history and physical examination should be performed to accurately identify potential comorbid allergic disease."

"Statement 16: Involvement of specialists (allergists, gastroenterologists, dietitians, and feeding therapists) for the management of individuals with ASDs may be beneficial."

"Statement 17: Immunologic aberrations have been reported in individuals with ASDs. However, a direct cause-and-effect relationship between immune dysfunction and ASDs has yet to be proven."

"Statement 18: The role of immune responses in the pathogenesis of gastrointestinal disorders in individuals with ASDs warrants additional investigation."

"Statement 19: The role of gut microflora in the pathogenesis of gastrointestinal disorders in individuals with ASDs is not well understood."

"Statement 20: Given the heterogeneity of persons with ASDs and the many inconsistent research findings regarding ASDs, it is imperative that the phenotype (biological, clinical, and the behavioral features) of future study subjects be well defined. This will help to clarify the underlying pathophysiology

and the clinical aspects of the disorder and guide focused evaluations and treatments.”

“Statement 21: Studies of gastrointestinal disorders in ASDs should include genetic testing for all participants.”

“Statement 22: Prevalence and characterization of specific gastrointestinal symptoms should be examined in well-defined genetic syndromes with high rates of ASDs.”

“Statements 23: Clinical trials of treatment of gastrointestinal symptoms should include banking of DNA samples.”

Overall the expert panel determined that “because of the absence, in general, of high quality clinical research data, evidence based recommendations are not possible at the present time”. (Buie, et al., 2010)

Recommendations for Evaluation and Treatment of Common Gastrointestinal Problems in Children With ASDs

This second article was written in supplement to the above article. “For this article, 8 pediatric gastroenterologists reviewed published guidelines for the management of gastrointestinal symptoms that occur frequently in the general pediatric population. Then, on the basis of their clinical experience, they adapted current best practices to diagnostic evaluation and treatment for children with ASDs.” (Buie, et al., 2010) Four specific gastrointestinal disorders were examined and subsequent recommendations were made by the panel.

1. Chronic Abdominal Pain:

- Differential Diagnosis of Chronic Abdominal Pain: “chronic abdominal pain is defined as intermittent or constant abdominal pain that exceeds 1 or 2 months in duration”
- Evaluation of Chronic Abdominal Pain: Children with ASD often have little

to no verbal communication skills. This makes pain evaluation extremely difficult. Many children will present behaviors that indicate Chronic Abdominal Pain. “These behaviors include pressing on the abdomen and tapping on the areas of distress; changes in state of being include sleep disturbance, self-injurious behavior, and aggression.”

- Treatment Considerations: “In the absence of alarm symptoms, after an unrevealing diagnostic evaluation and failure of empiric treatment to resolve the symptom or behavior, it may be helpful for the practitioner to review with the family the child’s symptoms and explain that although the pain is real, there is no evidence at present of a serious or chronic disease.”

2. Constipation:

- Differential Diagnosis of Constipation: “constipation is the occurrence for 2 weeks or so of a delay or difficulty in defecation”
- Evaluation of Constipation: “The evaluation of all children who present with constipation should include a thorough medical history and physical examination...A history of stool-withholding behavior reduces the likelihood of there being a causative organic condition.”
- Treatment Considerations: “Pharmacotherapy added to behavior management for constipation is often beneficial. Mineral oil, magnesium hydroxide, lactulose, sorbitol, polyethylene glycol (PEG), or a combination of lubricant (mineral oil) and laxative is recommended for the daily management of constipation in children.”

3. Chronic Diarrhea:

- Differential Diagnosis: “chronic diarrhea occurs when loose stools persist for 2 weeks or longer, with or without an increase in stool frequency”

- Evaluation: “Guidelines for the diagnostic evaluation of chronic diarrhea have not yet been developed...A careful history and physical examination are important and include definition of the age of symptom onset and whether symptoms develop abruptly or gradually.”
- Treatment Considerations: “Therapeutic interventions vary depending on the cause of chronic diarrhea; children without ASDs may receive a specific medical/surgical therapy or may be treated symptomatically. Physicians should exercise clinical judgment when considering the appropriate treatment option for children with ASDs.”

4. Gastroesophageal Reflux Disease (GERD):

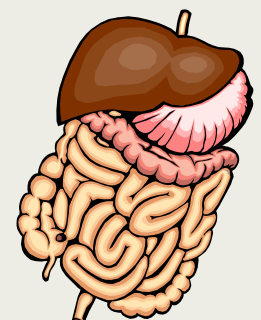
- Differential Diagnosis: “GER, the term for passage of gastric contents into the esophagus, can produce diverse symptoms and complications, called gastroesophageal reflux disease (GERD).”
- Manifestations of GERD/Symptoms: “Recurrent vomiting, weight loss, irritability in infants, regurgitation, heartburn, chest pain, hematemesis (vomiting blood), dysphagia (difficulty swallowing), feeding refusal, apnea (pauses in breathing), wheezing, stridor (high pitched, harsh, vibratory noise caused by partial airway obstruction), hoarseness, cough, abnormal neck positioning, ALTE (apparent life-threatening events).”
- Evaluation: “A diagnostic trial of acid suppression, with an appropriate dose of a proton pump inhibitor (PPI), should be considered before invasive studies.”
- Treatment Considerations: “Treatment of GERD depends on the cause...As in children without ASDs, GERD in children with ASDs can be a chronic problem, with waxing and waning of symptoms. The management

of such children often requires continuity with advancing age and an appreciation by the health care team of the natural history of disorders that underlie GERD.”

This article states that general pediatric gastrointestinal guidelines can be applied to children with ASDs who have or may have a gastrointestinal disorder. Parents and caregivers should be aware of possible behavioral manifestations of gastrointestinal symptoms. Medical procedures and tests that are performed on children without ASDs may be challenging for children with ASDs. “For children who are unable to co-operate, performance of multiple tests during a single examination under anesthesia might be considered.” (Buie, et al., 2010)

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STAFF BIO: ASHLEY GREENHAW

I was born and raised in a small town of 200 people in rural southwest Nebraska. After high school, I moved to Hillsboro, Kansas where I attended a private liberal arts school, Tabor College. In addition to my education, I also played collegiate volleyball at Tabor. I earned my dual degree in Sociology and Communications in May of 2007. My last semester of college was spent in Colorado Springs attending the Focus on the Family Institute and working at an internship in downtown Colorado Springs assisting the homeless and unemployed.

The summer after that, I got married to my wonderful and loving husband, Carson. We then moved to Colorado and began our master's degrees at Denver Seminary. Two years later I completed my degree in Community Counseling. During this time, I gained a lot of experience working with a variety of populations by completing my internship with two different community counseling agencies. I began working with Creative Perspectives in January 2010 as and Therapalooza Interventionist. I was drawn to CP because of my passion for working alongside and equipping children and their families. In addition to my part time work at CP, I also volunteer regularly at Alternatives Pregnancy Center in downtown Denver and grade papers for several of my graduate school professors.

Outside of work, I enjoy reading (mostly Harry Potter), working out, and working on fixing up the older two-story "fixer-upper" house my husband and I purchased in October. This spring will usher in a re-roofing project and lots of landscaping. I enjoy now living within weekend driving distance to my family. I have three precious nieces, one adorable nephew, and a fourth niece that will be arriving in a matter of weeks. My husband and I love our blessed lives here in Colorado.

STAFF BIO: SETH PERELMAN

Seth has been working with children with Autism and other special needs in home, school and community settings for nearly fourteen years. During that time, he has gained experience with a variety of therapeutic modalities, including ABA, RDI, Floortime, and Music Therapy. His future goals include continuing his education in the fields of music, philosophy, and early childhood education.

Four Functions Maintaining Behavior

Molly Strauss

“Evidence from decades of research indicates that both desirable and undesirable behaviors, whether washing hands or screaming and tantruming, are learned and maintained through interaction with the social and physical environment”(Cooper, 501) This statement describes the foundation for functional behavior assessments. In other words, behaviors are strongly tied to what a person “gets” or “gets out of” as a result of practicing the behavior. This is what is called positive or negative reinforcement. There are four generally accepted functions of behavior. They are attention seeking or social reinforcement, tangible reinforcement, sensory or automatic reinforcement, and escape/avoidance. In addition to these four functions, sick or automatic negative reinforcement is also sometimes debated as being a separate category from other types of automatic reinforcement.

Attention seeking behavior, also called social positive reinforcement is defined by the behavior producing a reinforcing response from others (Miltenberger, 80). Social attention can be either positive attention or negative attention. Social attention includes a wide variety of reactions including facial expressions, head turns, laughs, smiles, and physical and verbal praise or reprimand. Examples of attention seeking behavior can include completing a task in order to get the praise of a parent or teacher. It can be dumping out a bucket of blocks or using inappropriate language to get either the positive attention of peers or negative attention of adults. In these cases, the attention of other people serves to maintain or even strengthen a behavior.

Behaviors that are maintained by tangible reinforcement are behaviors that are rewarded by access to preferred materials (Cooper, 501). Tangibles can be anything from food, to toys, or rewarding activities such as

playing in water or watching TV. Examples of behaviors reinforced by tangibles are asking appropriately for a toy and gaining access to that toy, as well as screaming and tantruming until a desired item is presented. Problem behaviors can develop when inappropriate behavior achieves access to preferential items. This can happen inadvertently because providing the desired item to help calm the child temporarily stops the behavior; however this also increases the likelihood that similar behavior can occur in similar situations (Cooper, 501).

A third type of function that maintains behavior is to escape or avoid a non-preferred task or situation. This is the type of behavior that is reinforced by “getting out of something.” There is actually a difference between escape and avoidance behavior even though they are often categorized together. A simple example of an escape behavior is when a person steps barefoot onto hot pavement they immediately jump onto the grass to escape the pain in their feet. Using the same example, avoidance behavior in this situation would be to put on shoes before stepping onto the hot cement (Miltenberger, 81). Problem behaviors such as self-injurious behavior, tantruming, running away etc. can be maintained or strengthened because they often delay demands or uncomfortable situations, or the demands are

taken away as a result of the behavior. This increases the likelihood that the behavior will be seen again in similar circumstances (Cooper, 501).

The fourth type of function that maintains behavior is behavior that is reinforced automatically. These are behaviors that act directly on the environment to produce a reinforcing consequence (Miltenberger, 80). Good examples of automatically reinforced behavior are sensory-seeking behaviors such as thumb-sucking, eating and some self-stimulatory behaviors. Using the example of thumb-sucking, a child may suck his thumb because it feels good and it also makes him feel calm. This behavior is reinforced internally; there is no need for external reinforcement to maintain the behavior. In a functional behavior assessment, the socially-maintained function must be ruled out before a behavior can be assumed to be automatic or sensory (Cooper, 501).

The final category of functions that maintain behavior, which is not always included, is automatic or negative reinforcement. This type of behavior essentially functions to alleviate discomfort when it is not associated with another person, for example physical discomfort. An example of this type of behavior would be putting anti-itch cream on a mosquito bite, also, scratching a bite until it bleeds. Additionally, it has been shown that self-

injurious behavior can function to distract a person from another source of pain (Cooper, 502).

Looking at behavior from a functional perspective is very important because it allows us to understand why people do the things they do. Even when behaviors seem strange or mysterious, in looking at their function we can better understand the person, and also how we should react to the behavior. Function of behaviors can be assessed either formally through a functional behavior assessment (FBA) or casually by investigating possible functions when the behavior is occurring. With difficult behavior it can be challenging to determine the function which is when a formal FBA can give a great deal more information that casual trial and error by a therapist or parent. Especially in the field of autism it is incredibly important to understand the needs of individuals with ASD and how their behavior is fulfilling those needs. It is the responsibility of those surrounding these individuals to figure out how to best allow these needs to be met, while teaching appropriate skills to attain such needs, helping to encourage independence, helping increase social involvement and above all, the safety of the individual and the community.



All done
tokens...time
for table
work.



GFCF Recipes: Pizza, Breadsticks, and Pasta

From the website: <http://allrecipes.com/HowTo/Using-Alternative-Flours/Detail.aspx>



Pizza

- 2 cups rice flour blend
- 2 Tbsp sugar
- 2 tsp xanthan gum
- 2 tsp dry active yeast
- 1/2 tsp salt
- 1 egg
- 1/2 tsp vinegar
- 2 Tbsp vegetable oil
- 1 cup warm milk substitute
- 3/4 cup pizza sauce
- 6 slices tofutti mozzarella

1. In a mixing bowl, combine flour, sugar, xanthan, yeast, and salt.
2. Add egg, vinegar, oil and milk substitute to dry ingredients and mix for 3 minutes on high speed using an electric mixer.
3. Using a rubber spatula, spread dough evenly on a well greased cookie sheet or 14" round pizza pan. Let rise on top of a warm oven for 20 to 30 minutes.
4. Bake crust at 425 F for 10 minutes. Spread on pizza sauce. Add tofutti mozzarella (cut into 1/2 inch pieces), and your choice of pizza toppings.
5. Bake at 425 F for 15 minutes or until cheese bubbles.

Bread Sticks

- 2 cups rice flour blend
- 2 Tbsp sugar
- 2 tsp xanthan
- 2 tsp dry yeast
- 1/2 tsp salt
- 2 eggs
- 2 Tbsp oil
- 1/2 tsp vinegar
- 1/2 cup warm milk substitute

1. Preheat oven to 425 F. Combine flour, sugar, yeast, xanthan, and salt in a medium bowl.
2. Add eggs, oil, vinegar and milk substitute. Stir together and roll out onto a well floured surface. Knead a few times until dough is smooth and uniform.
3. Divide dough into 12 balls and shape into 8 inch long sticks. Place on greased cookie sheet. Cover with a towel and let rise 20-30 minutes on top of the warm oven. Brush tops with oil or gfcf margarine. Bake 8-10 minutes.

Note: For extra flavor, brush with olive oil and sprinkle with garlic powder and Soymage 'Parmesan' before baking.



Spaghetti With Meat Sauce

- 16 oz package Tinkyada Brown Rice Spaghetti Noodles
- 1 pound ground beef
- 1 cup chopped onion
- 2 cloves garlic, minced
- 4 (8 ounce) cans tomato sauce
- 1 (15 ounce) can crushed tomato
- 1 bay leaf
- 2 tsp oregano
- 2 tsp basil
- 1/4 tsp salt

1. Cook spaghetti noodles in a large pot of rapidly boiling hot water following package instructions.
2. In a large saucepan, brown beef with onion, and garlic. Drain off grease.
3. Stir in tomato sauce and seasonings.
4. Bring to a boil. Simmer 15 minutes or more, stirring occasionally.



PROJECT: FREEDOM

RESPITE PROGRAM

MAKE YOUR
RESERVATIONS
NOW!

2010 PROJECT: FREEDOM DATES:

PLEASE RSVP BY THE FIRST OF EACH MONTH

Saturday, January 9, 2010	5 – 9 p.m.
Saturday, February 13, 2010	5 – 9 p.m.
Saturday, March 13, 2010	5 – 9 p.m.
Saturday, April 10, 2010	5 – 9 p.m.
Saturday, May 8, 2010	5 – 9 p.m.

Please contact Missy Perkins for more information
Email: missy.perkins@creativeperspectives.org
Phone: 303.935.5200

INFORMATION

Project: Freedom is an opportunity for parents to have a night out while the kids have fun too!

This respite program is held at CPI's Englewood Center on the second Saturday of the month from 5pm - 9pm.

The evening is filled with fun activities, games, snacks, and a movie! Each night is themed, so come prepared to have fun!

Need a Night Out?



CPI is an approved respite care provider through CES and SLS. Check with your Resource Coordinator to have CPI added to your plan **PRIOR** to making reservations.



Creative
Perspectives Inc.
Autism Centers of Colorado

the **Super Series.**

Social and Life Skills for
Individuals with Asperger's & PDD-NOS



Program Overview & Focus

The **Super Series** has been designed to address a variety of deficits associated with Asperger's and PDD-NOS including challenges in social communication, self-regulation and behavior management, as well as increasing independence, confidence, success, and enjoyment in daily routines and activities.

Who?

Individuals with Asperger's and PDD-NOS from the ages of 6 to adult

Enrollment

Enrollment is ongoing, year-round.
Sessions run in quarters: Fall, Winter, Spring & Summer.

Session

Each session is Center-Based, with the exception of the last week of the month, which is typically utilized for a community outing. Participation in activities within the community provides individuals with the opportunity to socialize with a variety of peers and generalize learned skills across settings.

Ratio?

1:1 initially; with the potential for the formulation of pairs and small groups, based on similar interests, goals, and abilities (upon availability and parent request only).

Cost?

\$45 / per hour

Super Series

Mission:

Be a Friend.

Make a Friend.

SuperSeries Sessions

Commitment to Quality

Programming typically begins with our Super Staff on a 1:1 basis, allowing the individual to work on pre-identified skill sets until it can be determined that there is an appropriate pair, triad, or small group for the individual, based on relevant skill level and interest.

CPI recognizes the challenges that exist for individuals with ASD to establish friendships within their own environment. We work to build individual skill levels and find the best possible matches based on natural factors of friendship, rather than considering only age, diagnosis, and session time.

Ages: Participants are considered on an individual basis; however, age ranges include: 6 – 8, 9 – 11, 12 – 14, and 15 – 18.

Times: Session times are determined per family; groups are subject to interest and availability.

Locations: Sessions are available at both Englewood and Lafayette locations.