This PowerPoint file is a supplement to the video presentation. Some of the educational content of this program is not available solely through the PowerPoint file. Participants should use all materials to enhance the value of this continuing education program.

Autism Spectrum Disorders

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Goals

- To be familiar with the diagnostic criteria for autism spectrum disorders (ASD)
- To understand common missteps when concerned about ASDs in a pediatric setting
- To know how to appropriately screen and refer families

ASDs – What they are not

- Not ONE thing
  - not ONLY a delay in speech
  - not ONLY disruptive behavior
- Not TWO things
  - not a delay in speech AND disruptive behavior
- NOT morally weighted
  - a diagnosis of ASD is neither “good” nor “bad”
    - indicates a significant QUALITATIVE difference in how a child socially communicates
      - this difference, however, can have significant impact on how EASY or HARD it is for them to navigate in the world

Autism SPECTRUM Disorder

- Change reflects most current findings on ASD
- ASD is not super amenable to categorical cutoffs, spectrum allows us to talk about it more accurately
- CAN have insurance and billing fallout (so be mindful of this)
  - examples: Asperger's and a pervasive developmental disorder not otherwise specified (PDD-NOS)

ASDs – What They Are

- Part 1: "persistent ***deficits*** in **social communication** and social interaction across multiple contexts" as manifested by:
  - 1A - "Deficits in social-emotional reciprocity"
  - 1B - "Deficits in nonverbal communication"
  - 1C - "Deficits in developing, maintaining, and understanding relationships"
- These are **QUALITATIVE** deficits in social communication

“Social Communication”

- If I airdropped you into mainland China (assuming you do not speak Cantonese or Mandarin), you would have a deficit in **VERBAL** communication
- Your social communication would still be intact
  - social-emotional reciprocity
    - you would still be able to share, show people things, and make requests
  - nonverbal communication
    - you would still be able to gesture and make eye contact
      - the cultural norms for which gestures and how much eye contact would vary but would still exist and you could adapt
  - Relationships
    - you would know that different contexts (temple vs. market square) most likely have different social responses (although you may have no idea what the exact responses are) and you could have friends even if you were nonverbal

Presence vs. Absence of Symptoms

- Notice “deficits in social communication” are **ABSENCES**, things that are NOT present (or rarely present)
  - absences may not be noticed as much as presence
    - How do you observe lack of showing?

The thing autism is known for

- Part 2: “Restricted, repetitive patterns of behavior, interests, or activities, as manifested by”:
  - 2A – “Stereotyped or repetitive motor movements, use of objects, or speech”
    - examples: hand flapping or echolalia
  - 2B – “Insistence of sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior”
    - example: same route to school or he/she will start screaming
  - 2C – “Highly restricted, fixated interests that are abnormal in intensity or focus”
    - NOT the 5-year-old who likes SpongeBob a lot
    - example: He/she knows every model of Ford made since 1978

Make your mistakes as quickly as possible

- Mistake #1:
  - confusing a deficit of verbal communication with a deficit of social communication
    - if they cannot talk, they will need speech therapy regardless of if they have autism or not
- Mistake #2:
  - confusing disruptive behavior with autism (even severe disruptive behavior)
    - a severe cough could be anything from bronchitis to tuberculosis to lung cancer (we need to SCREEN)

Make your mistakes as quickly as possible

- Mistake #3:
  - QUALITATIVE deficits in social communication are **NOT** QUANTITATIVE deficits in social communication
    - ADHD can be seen as a QUANTITATIVE deficit in social communication
- Mistake #4: looking ONLY for the presence of symptoms
  - example: the kid lines things up, hates tags on their clothes, and hits . . . but came up and pointed and vocalized to you while making eye contact

Common Mistakes

- BIGGEST mistake:
  - ruling a diagnosis IN, not ruling a diagnosis OUT
    - NEVER look to confirm a diagnosis, look to disconfirm a diagnosis
    - if all you look for is confirmatory evidence, you will always find a concern for autism
- Your job is to screen
  - screenings are PURPOSELY designed to give some false positives
- In regard to diagnosis, the parents I have usually fall in 3 groups:
  - group 1: *"Yup, my child has it. I'd be shocked if you told me s/he didn't have it."*
  - group 2: *"Nope, they absolutely don't have it. I'd be shocked if you told me s/he did have it"*
  - group 3: *"Hmm . . . I don't know. Some things look like [fill in dx], some things don't, so I'm not too sure."*

Screening Tools – M-CHAT

- M-CHAT (Modified Checklist for Autism in Toddlers)
- Age range: 16-30 months
  - kids under 12 months look like they have autism
- Yes or no questionnaire
- low risk = 0-2 → no further action needed
- medium risk = 3-7 → administer follow-up questions
- high risk = 8-20 → send them to us but . . .

Screening Tools – M-CHAT

- *Make SURE that this is a TRUE yes or a TRUE no*
  - example: #8 *"Is your child interested in other children?"*
    - *"No, he isn't; he just hits other kids and takes their toys. He never plays with them."*
  - might be ONLY disruptive behavior
- Make sure to use the follow-up questions if the child scored in medium risk
  - example: #8 follow-up *"Is your child interested in other children?"*
    - *"No, he usually hits other kids"*
    - *"When you are at the playground or supermarket, does your child usually respond to other children?"*
    - *"Yes"*

Screening Tools – M-CHAT

- example: #8 follow-up *“Is your child interested in other children?”*
  - *“How does your child respond?”* (the caregiver picks from a list of 7 which you verbally read)
  - *“Oh ya, he watches them”*
    - this item is now no longer a Fail but a Pass (recode)

Screening Tools - SCQ

- SCQ: Social Communication Questionnaire
- Similar to M-CHAT in terms of yes or no questions
- Fee required
- Can be used on ages 4 and up
- Similar items to the M-CHAT but looking for later developmental milestones a child 4 and older should have: e.g., conversation

Screening Tools - STAT

- STAT: Screening Tool for Autism in Toddlers
- Age range: 24-36 months
  - research attempting to expand age range
- A series of tasks for the child to perform
- VERY similar items on the gold standard test for ASD, the ADOS-2 (Autism Diagnostic Observation Schedule-2)
  - examples:
    - bubbles (ADOS-2, modules 1 and 2)
    - balloon (ADOS-2, modules 1, 2, and toddler)
    - hop dog (ADOS-2, modules 1, 2, and toddler)

Sources

- M-CHAT-R/F
  - for downloads or more information:
    - www.mchatscreen.com
- STAT
  - OUHSC provides training on this and there is an online training here
  - http://stat.vueinnovations.com/
- SCQ (there is a fee)
  - http://www.wpspublish.com/store/p/2954/social-communication-questionnaire-scq
- Good information about screening
  - http://www.cdc.gov/ncbddd/autism/hcp-screening.html

ADOS-2

- The gold-standard test for autism
- 5 modules based on age and language ability
  - toddler: pre-verbal/single words (12-30 months)
  - 1: pre-verbal/single words (31 months or older)
  - 2: phrase speech
    - definition: 3 independent units (“baby no eat”)
  - 3: fluent speech; child/adolescent
  - 4: fluent speech; adolescent/adult

3 Different Kinds of Problems

- Even though we say ASD has NO weight as to “good” or “bad”, this still can be hard for parents

1. A cold
   - *“You take a pill, give it some time, you’re good.”*
2. Stage 4 lymphoma
   - *“All we can do is make you comfortable.”*
3. Diabetes
   - *“You have to MANAGE this.”*
   - *“If it’s not managed well, can have SEVERE consequences.”*
   - *“If managed well, and ESPECIALLY the earlier you catch it, you will do well.”*

Referring – What helps the process?

- Be VERY specific (4 steps)
  1. write the exact BEHAVIORS you see
  2. write the exact ABSENCES you are concerned about
  3. write the exact PRESENCE of symptoms you are concerned about
  4. tell us EXACTLY why you think the child has autism
     - if YOU do not think the child has autism, tell us why you referred and also who thinks they have ASD

Referring – What helps the process?

- Step 5: let us know ANY other contextual factors
  - examples:
    - prenatal alcohol exposure
    - traumatic exposure at any point in the past (such as CPS custody for any reasons)
    - co-occurring medical conditions (e.g., ocular conditions)
    - etc.

Referring

"Billy is 5 years, 2 months. (1) I am concerned about his highly disruptive behaviors such as head banging and daily tantrums. (2) He is entirely nonverbal. (3) He also puts everything in his mouth. (4) I am concerned about autism because of his behavior, his lack of language, and because his eye contact is highly unusual (i.e., he appears to be in a daze). (5) Billy was prenatally exposed to alcohol and was adopted at two years of age. "

If you send this referral, Dr. Gomez will be very happy

"Treatments" NOT Indicated

- NO dietary variable has EVER been shown to impact ASD (either positively or negatively)
- Vaccines do not cause autism
- BEWARE of "facilitated communication"
  - AUGMENTED communication is NOT the same as facilitated communication

Referral Sources

ABA/IBI is the first treatment to recommend

Applied Behavior Analysis (ABA)

An approach to teaching skills based on learning/behavioral principles

Can be used at home, school, community

Can be incorporated into the school and implemented by classroom staff

Provides ongoing framework for skills development

Primarily provided one on one (or in small groups) up to 40 hours per week

Intensive Behavior Intervention (IBI)

Specific intensive format used by MCYS Autism Intervention Program usually delivered by an Autism Intervention Program

Primarily provided one on one (or in small groups) up to 40 hours per week

Delivered by a trained therapist, supervised by a psychologist

Helps with school prep

Includes "learning to learn" behaviors

Referral Sources

- Plan B if you can't get ABA/IBI
  - language problems
    - speech therapy
  - behavior problems
    - parent-child interaction therapy (PCIT) for behavior problems
  - occupational therapy is often used as a "poor man's ABA therapist"
  - genetics referral is now becoming standard
  - private speech and occupational therapists
  - it does not have to be a psychologist or pediatrician who gives a diagnosis of autism (no matter what anyone tells you)

Web Resources

- Autism Speaks
  - www.autismspeaks.org
- Association for Science in Autism Treatment (ASAT)
  - http://www.asatonline.org/research-treatment/
- California Evidence-Based Clearinghouse
  - http://www.cebc4cw.org/
- Autism Society of America
  - http://www.autism-society.org/
- Texas Parents Center (for IEPs)
  - http://prntexas.org

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