

From Eligibility Assessment to Intervention for Students With Autism Spectrum Disorder



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1

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Relevant Disclosure

- Co-author of the Autism Spectrum Rating Scales (MHS, 2009).
- Co-author of Assessment of Autism Spectrum Disorders 1st and 2nd Editions (Guilford, 2009, 2018).
- Co-author/presenter Assessment of Autism Spectrum Disorders CEU (APA, 2009).
- Co-author of Raising a Resilient Child With Autism Spectrum Disorders (2011, McGraw Hill).
- Co-author of Treatment of Autism Spectrum Disorders (2012, Springer).
- Co-author of the Autism Spectrum Evaluation Scales (in development, MHS).
- Compensated speaker.



2

We Are Social Beings



3

What Benefits Do We Derive From Socialization?



- Support
- Survival
- Affiliation
- Pleasure
- Procreation
- Knowledge
- Friendship

4

The social development of children with ASD is qualitatively different from other children.



5

In normal developing children perceptual, affective and neuroregulatory mechanisms predispose young infants to engage in social interaction from very early on in their lives. They must in order to maximize chances of survival.



6

Socialization Begins
Early:
Reina and Her Mother



7

When we look at babies
our brain responds
uniquely.



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Adrian, my seatmate
on a recent flight.



9

Adrian, my seatmate
on a recent flight.



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Adrian, my seatmate
on a recent flight.



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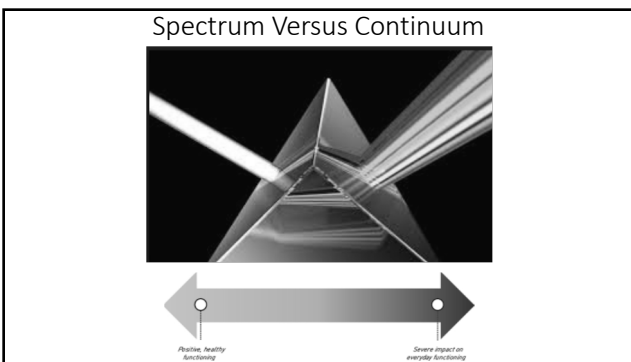
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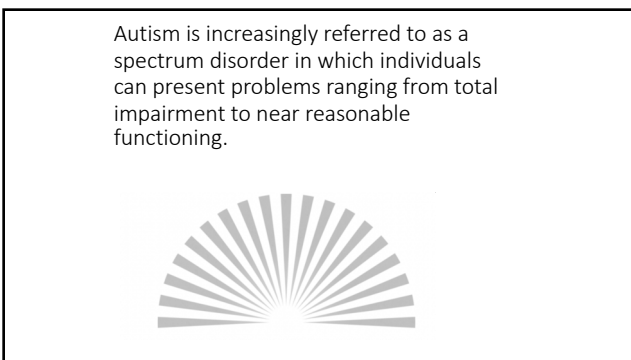
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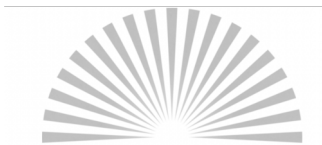
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In a Spectrum Disorder genetic and phenotypic factors predispose certain individuals to express certain Central Nervous System vulnerabilities leading to poorly adapted variations in development and behavior.



16

In a Spectrum Disorder all symptoms are considered relevant to the extent they present in each disorder. Thus a symptom is not exclusive to a disorder.



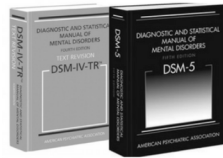
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The form that a Spectrum Disorder assumes is determined by its composite symptoms. These symptoms often have complex relationships.



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The DSM 5 Criteria



19

DSM 5

- Combined social and communication categories.
- Tightened required criteria reducing the number of symptom combinations leading to a diagnosis.
- Omitted Retts and Childhood Disintegrative Disorder.
- Clarified co-morbidity issues
- Eliminated PDD NOS and Aspergers in favor of Autism Spectrum Disorder.

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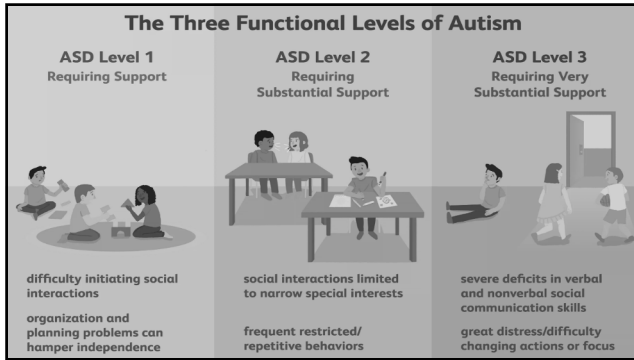
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DSM 5

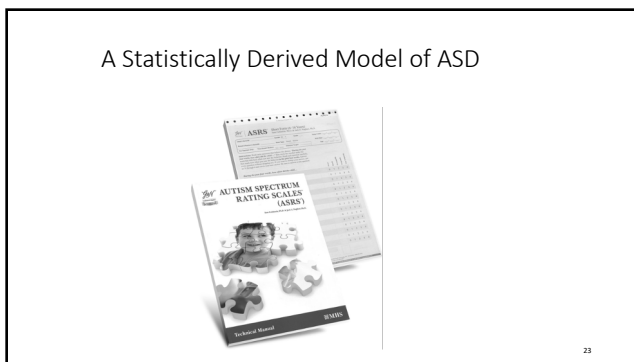
- Five criteria.
- Seven sets of symptoms in the first two criteria – Social/Communication and Restrictive/Repetitive behaviors, interests or activities.
- All three symptoms are required to meet the first criteria (although a typo omits this).
- Two out of four are needed for the second criteria.
- Some symptoms have been combined. Sensory sensitivity has been added.

21

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22



23

Exploratory Factor Analysis for 2-5 Years

- A two-factor solution was best for parent and teacher raters
 - **Factor I:** included primarily items related to both socialization and communication (e.g., keep a conversation going, understand how someone else felt) - **Social/Communication**
 - **Factor II:** included items related to behavioral rigidity (e.g., insist on doing things the same way each time), stereotypical behaviors (e.g., flap his/her hands when excited), and overreactions to sensory stimulation (e.g., overreact to common smells) - **Unusual Behaviors**

24

24

Exploratory Factor Analysis for 6-18 Years

- A three-factor solution was best for both parent and teachers versions of the ASRS
 - **Factor I:** included primarily items related to both socialization and communication - **Social/Communication**
 - **Factor II:** included items related to behavioral rigidity, stereotypical behaviors and overreactions to sensory stimuli - **Unusual Behaviors**
 - **Factor III:** included items related to attention problems (e.g., become distracted), impulsivity (e.g., have problems waiting his/her turn), and compliance (e.g., get into trouble with adults, argue and fight with other children) - **Self-Regulation**.

25

25

Factor Consistency

- The consistency of the ASRS scale structure across several demographic groups (gender, age group, race, and clinical status) was studied
- The factor loadings for the groups were correlated using the coefficient of congruence
 - results revealed a very high degree of consistency between all groups
 - indicating that the factor structure of the forms generalized across the demographic groups

26

26

Current View of ASD In ASRS

- Based on the factor analysis, we suggest that ASD is best described as having two clusters of behaviors for children ages 2-5 and three for those aged 6 to 18 years of age.
 - Ages 2 – 5 years
 - Social / Communication
 - Unusual Behaviors
 - Ages 6 – 18 years
 - Social / Communication
 - Unusual Behaviors
 - Self-Regulation
- This is the organizational form of the ASRS.



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DSM IV TR Autism and Asperger Syndrome

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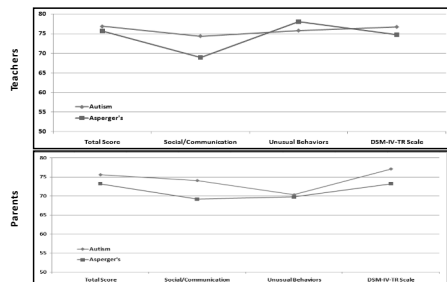
DSM IV TR Autism vs Asperger

- ASRS means for ages 2-5 years were typically somewhat higher for children with Autism than those with Asperger's syndrome
 - Exception being Unusual Behaviors where the two groups were similar
- ASRS means for ages 6-18 years were consistently higher for children with Autism than those with Asperger's syndrome

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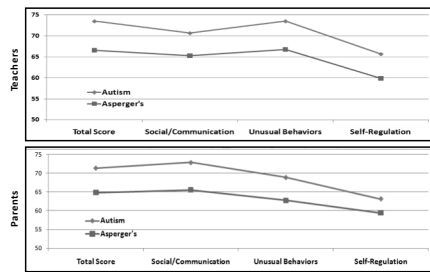
DSM IV TR Autism vs Asperger 2-5 Years



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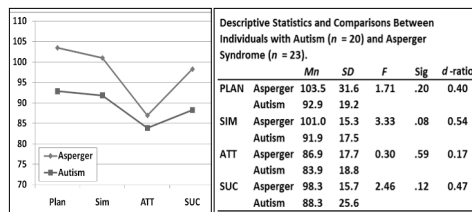
DSM IV TR Autism vs Asperger 6-18 Years



31

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DSM IV TR Autism vs Asperger 6-18 Years



32

32

Diagnosis Versus Eligibility

When the DSM, ICD and IDEIA Collide

33

Students that have a DSM or ICD diagnosis are not automatically eligible for special education services, according to the Individuals with Disabilities Education Improvement Act (IDEIA).

34

34

Educational eligibility and subsequent services are determined by conducting assessments and testing performed by a school's multidisciplinary team and not that of medical diagnostic tests.

These can include observations, history, developmental information, behavior information and a documented prevalence over a period of time.

35

35

Federal Guidelines For Autism Eligibility

(a) General.

(1) Child with a disability means a child evaluated in accordance with §§ 300.304 through 300.311 as having mental retardation, a hearing impairment (including deafness), a speech or language impairment, a visual impairment (including blindness), a serious emotional disturbance (referred to in this part as "emotional disturbance"), an orthopedic impairment, autism, traumatic brain injury, an other health impairment, a specific learning disability, deaf-blindness, or multiple disabilities, and who, by reason thereof, needs special education and related services.

(2)

(i) Subject to paragraph (a)(2)(i) of this section, if it is determined, through an appropriate evaluation under §§ 300.304 through 300.311, that a child has one of the disabilities identified in paragraph (a)(1) of this section, but only needs a related service and not special education, the child is not a child with a disability under this part.

(ii) If, consistent with § 300.39(a)(2), the related service required by the child is considered special education rather than a related service under State standards, the child would be determined to be a child with a disability under paragraph (a)(1) of this section.

(b) Children aged three through nine experiencing developmental delays. *Child with a disability* for children aged three through nine (or any subset of that age range, including ages three through five), may, subject to the conditions described in § 300.111(d), include a child -

(1) Who is experiencing developmental delays, as defined by the State and as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas: Physical development, cognitive development, communication development, social or emotional development; or adaptive development; and

(2) Who, by reason thereof, needs special education and related services.

(Authority: 20 U.S.C. 1401(3); 1401(30))

[71 FR 46753, Aug. 14, 2006, as amended at 72 FR 61306, Oct. 30, 2007]

36

36

Federal Guidelines For Autism Eligibility

(i) Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects a child's educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences.

(ii) Autism does not apply if a child's educational performance is adversely affected primarily because the child has an emotional disturbance, as defined in paragraph (c)(4) of this section.

(iii) A child who manifests the characteristics of autism after age three could be identified as having autism if the criteria in paragraph (c)(1)(i) of this section are satisfied.

(Authority: 20 U.S.C. 1401(3); 1401(30))
[71 FR 46753, Aug. 14, 2006, as amended at 72 FR 61306, Oct. 30, 2007]

37

37

Determining Eligibility for Autism Under IDEIA

- Administering a measure of neuropsychological functioning examining planning, sequencing, critical thinking and behaviors related to executive functioning.
- Administering a basic academic battery.
- Administering observational narrow band questionnaires to Teachers (and Parents?).
- Interviewing and observing the student.
- With verbal students, administering self-report measures assessing self-concept, resilience, worry, camouflage behaviors and unhappiness.
- With teens, administering a brief personality measure specifically focused on the development of schizoid personality traits.

38

Determining Eligibility for Autism Under IDEIA

- Many school districts now require the administration of quasi standardized, interactive tools to determine Autism eligibility.
- However, based on these IDEIA criteria and the fact that eligibility determination *is not* the equivalent of a diagnosis, is the administration of such instruments needed?
- Do they add to the accuracy of eligibility determination? Do they add to IEP goal setting?
- It's undetermined at this time. Such tools may provide a practical and convenient framework to interview the student, but are they a necessity as mandated by some school districts?

39

Considering Co-morbidity

- Considerable overlap exists between autism spectrum disorder (ASD) and mental health disorders.
- High rates of overlap are significant because they affect the nature and type of problems displayed by persons with ASD and how the disorders are assessed.
- ADHD, anxiety disorders and depression are among the disorders most commonly associated with ASD.
- Symptom presentation is similar whether ASD occurs alone or with other conditions.
- Multiple assessments after initial diagnosis of ASD are frequently necessary.
- ASD can be diagnosed very early, while symptoms of other disorders emerge at different points in human development.

40



Educational Care and Treatment

41


Educational Care and Treatment

- Despite strong claims no curative treatment has been vigorously studied.
- "In the absence of a definitive cure there are a thousand treatments" (Klin).
- Behavior modification, educational intervention and pharmacology have been studied.



42

<http://autismpdfc.fpg.unc.edu/content/briefs>



THE NATIONAL PROFESSIONAL DEVELOPMENT CENTER ON
AUTISM SPECTRUM DISORDERS

A multi-institutional center to promote the use of evidence-based practice for children and adolescents with autism spectrum disorders

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Evidence-Based Practice Briefs

Evidence-based practice (EBP) briefs have been developed for at 24 identified evidence-based practices. Select a practice below to access the overview of the practice and downloadable PDF files for the EBP brief and the individual components. An evidence-based practice brief consists of the following core components:

EBP BRIEF COMPONENTS

Overview:
A general description of the practice and how it can be used with learners with autism spectrum disorders.
Step-by-Step Directions for Implementation:
Explicit step-by-step directions detailing exactly how to implement a practice, based on the research articles identified in the evidence base.
Implementation Checklist:
The implementation checklist offers a way to document the degree to which practitioners are following the step-by-step directions for implementation, which are based on the research articles identified in the evidence base.
Evidence Base:
The list of references that demonstrate that the practice is efficacious and meets the National Professional Development Center's criteria for being identified as an evidence-based practice.
Some practices include supplemental materials such as data collection sheets.

43

43

<http://autismpdfc.fpg.unc.edu/content/briefs>

EVIDENCE-BASED PRACTICES FOR CHILDREN AND YOUTH WITH ASD

Antecedent-Based Interventions (ABI)
Computer-Aided Instruction
Differential Reinforcement
Discrete Trial Training
Extinction
Functional Behavior Assessment
Functional Communication Training
Naturalistic Intervention
Parent-Implemented Interventions
Peer-Mediated Instruction and Intervention
Picture Exchange Communication System (PECS)
Pivotal Response Training
Prompting
Reinforcement
Response Interruption/Redirection
Self-Management
Social Narratives
Social Skills Groups
Speech Generating Devices/VOCA
Structured Work Systems
Task Analysis
Time Delay
Video Modeling
Visual Supports

44

44

Components of an Effective Treatment Program

- Structured behavioral treatment
- Parent involvement
- Treatment at an early age
- Intensive intervention
- Social skill development
- Coping and camouflage skill development
- Focus on generalization of skills
- Appropriate school setting
- Medication?

45

Components of an Educational Treatment Program

- There has been a shift away from treatment within highly controlled clinical settings to more natural contexts with caregivers and teachers acting as agents of change.
- This has allowed for collaborative treatment and opportunities to teach skills within the context of children's daily routines.
- This approach, known as family/school centered intervention, has also been demonstrated to lead to positive outcomes for ASD.
- Intensive community-based interventions based on PBS and positive support strategies have yielded positive outcomes with respect to enhanced language and communication as well as reductions in problem behavior.

46

Components of an Effective Educational Program

- Determining the effectiveness of any educational program for students with ASD should be accomplished using methods that reflect specific behaviors as well as a larger conceptualizations of the disorder (e.g., social, communication, and atypical behavior problems). The key questions are:
 How are these behaviors identified?
 How are these behaviors measured?
 How do these behaviors change with intervention?
 What reference point or points will behavior change be calibrated?

47

Medications

- Symptom focused medications: stimulants for attention, anti-depressants for mood, anti-psychotics for "oddities".
- Condition focused medications?



48

New Drug
May Treat
ASD

307 (2012) 491-497 | September 2012
Vol. 4, Issue 152, p. 152n127
So. Trial. Med. DOI: 10.1176/j.atlmed.1004214

RESEARCH ARTICLE

FRAGILE X SYNDROME

Effects of STX209 (Arbaclofen) on Neurobehavioral Function in Children and Adults with Fragile X Syndrome: A Randomized, Controlled, Phase 2 Trial

Elizabeth M. Berry-Kravis¹, David Heuss², Barbara Rothwell³, Peter Zarevich⁴, Maryam Cherubini⁵, Karen Walton-Bowen⁶, Yi Mu⁷, Danh V. Nguyen⁸, Joseph Gonzalez-Heydreich⁹, Paul F. Wang¹⁰, Randall L. Carpenter¹, Mark F. Bear¹⁰ and Randi J. Hagerman²

¹ Author Affiliations

¹⁰To whom correspondence should be addressed. E-mail: pwang@seasidetherapeutics.com

ABSTRACT

Research on animal models of fragile X syndrome suggests that STX209, a γ-aminobutyric acid type B (GABA_B) agonist, might improve neurobehavioral function in affected patients. We evaluated whether STX209 improves behavioral symptoms of fragile X syndrome in a randomized, double-blind, placebo-controlled crossover study in 63 subjects (55 males, ages 6 to 39 years, with a full mutation in the *FMR1* gene (>200 CGG triplet repeats). We found no difference from placebo on the primary endpoint, the Aberrant Behavior Checklist–irritability (ABC–i) subscale. In the other analyses specified in the protocol, improvement was seen on the visual analog scale ratings of parent-nominated problem behaviors, with positive trends on multiple global measures. Post hoc analysis with the ABC–Social Avoidance scale, a newly validated scale for the assessment of fragile X syndrome, showed a significant beneficial treatment effect in the full study population. A post hoc subgroup of 27 subjects with more severe social impairment showed improvements on the Vineland II–Socialization raw score, on the ABC–Social Avoidance scale, and on all global measures. STX209 was well tolerated, with the incidences of sedation and of headache as the most frequent side effects. In this exploratory study, STX209 did not show a benefit on irritability in fragile X syndrome. Nonetheless, our results suggest that GABA_B agonists have potential to improve social function and behavior in patients with fragile X syndrome.

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49

Psychostimulants for ADHD-like symptoms in individuals with autism spectrum disorders.

Cortese S, Castellano P, Morello C, Roux S, Bonnet-Brihault F.

Institute for Pediatric Neuroscience, NYU Child Study Center, Langone Medical Center, 215 Lexington Avenue, 14th Floor, 10016 NY USA. samuel.cortese@nyu.edu.

Expert Rev Neurother. 2012 Apr;12(4):461-73.

We conducted a comprehensive review of studies assessing the efficacy and tolerability of psychostimulants for ADHD-like symptoms in individuals with autism spectrum disorder (encompassing autism disorder, Asperger's syndrome and pervasive developmental disorders not otherwise specified). PubMed, Ovid, EMBASE, Web of Science, ERIC and CINAHL were searched through 3 January 2012. From a pool of 348 potentially relevant references, 12 citations (11 studies) were retained as pertinent. Four of the included studies had a randomized controlled design. Most of the studies assessed methylphenidate immediate release. Despite inter-study heterogeneity, taken together, the results of the selected reports suggest that psychostimulants may be effective for ADHD-like symptoms in autism spectrum disorder individuals. The most common adverse events reported in the included trials were appetite reduction, sleep-onset difficulties, irritability and emotional outbursts. We discuss future directions in the field, including the need for trials assessing more ecological outcomes and combined treatment strategies tailored to the specific individual features.

50

Positive Effects of Methylphenidate on Social Communication and Self-Regulation in Children with Pervasive Developmental Disorders and Hyperactivity

Laudan B. Jahromi, Connie L. Kasari, James T. McCracken, Lisa S-Y. Lee, et. al.

Journal of Autism and Developmental Disorders, 2009)

Drugs that increase serotonin transmission may be useful in reducing interfering repetitive behaviors and aggression as well as improving social relatedness (few controlled studies).

52

Promoting Social Behavior With Oxytocin in High-Functioning Autism Spectrum Disorders

- Published (2/10) online in the Proceedings of the National Academy of Sciences.
- Oxytocin is a hormone known to promote mother-infant bonds.
- A French research group investigated the behavioral effects of oxytocin in 13 subjects with autism.
- Under oxytocin, children with ASD responded more strongly to others and exhibited more appropriate social behavior and affect, suggesting a therapeutic potential of oxytocin through its action on a core dimension of autism.

53

53

Oxytocin May Have Many Effects

The screenshot shows the journal's website with the article title 'Oxytocin and Human Social Behavior' by Anne Campbell. The abstract discusses the effects of oxytocin on social behavior and the need for more rigorous research designs.

54

54

Medication and Parent Training in Children With Pervasive
Developmental Disorders and Serious Behavior Problems:
Results From a Randomized Clinical Trial

MICHAEL G. AMAN, PH.D., CHRISTOPHER J. MCDUGLE, M.D. et al.

Conclusions: Medication plus PT resulted in greater reduction of serious maladaptive behavior than Medication alone in children with PDDs, with a lower risperidone dose.

J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY,
48:12, DECEMBER 2009).

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**Comorbid ADHD and Anxiety Affect Social Skills Group
Intervention Treatment Efficacy in Children With Autism
Spectrum Disorders**

Kevin M. Antshel, PhD, Carol Polacek, PhD, NP, Michele McMahon, CSW, Karen Dygert, NP, Laura Spenceley, MA, Lindsay Dygert, BS, Laura Miller, BA, Fatima Faisal

ABSTRACT: Objective: To assess the influence of psychiatric comorbidity on social skill treatment outcomes for children with autism spectrum disorders (ASDs). Methods: A community sample of 83 children (74 males, 9 females) with an ASD (mean age = 9.5 yr; SD = 1.2) and common comorbid disorders participated in 10-week social skills training groups. The first 5 weeks of the group focused on conversation skills and the second 5 weeks focused on social problem solving skills. A concurrent parent group was also included in the treatment. Social skills were assessed using the Social Skills Rating System. Ratings were completed by parents at pre- and posttreatment time periods. Results: Children with ASD and children with an ASD and comorbid anxiety disorder improved in their parent reported social skills. Children with ASD and comorbid attention deficit/hyperactivity disorder failed to improve. Conclusion: Psychiatric comorbidity affects social skill treatment gains in the ASD population.

(J Dev Behav Pediatr 32:439-446, 2011) **Index terms:** autism spectrum, social skills, ADHD.

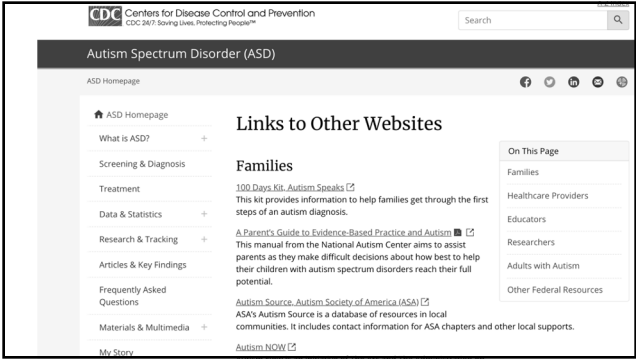
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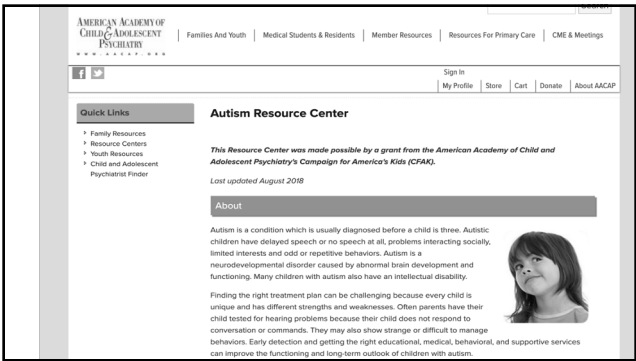
**Some Possible Challenges to Counseling Youth
With ASD**

- Concrete thinkers
- Difficulty with humor
- Problems regulating affect
- Difficulty interpreting other's feelings
- Rule bound
- Diminished empathy
- Decreased desire to please others.

57



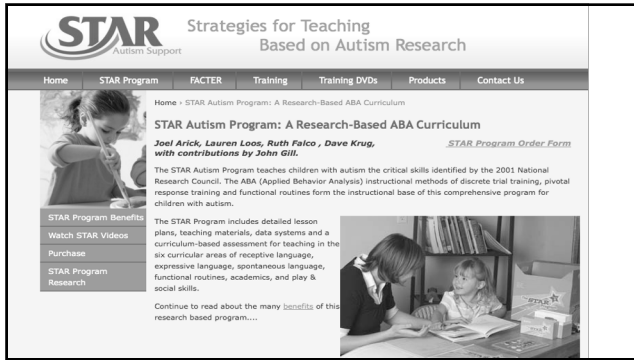
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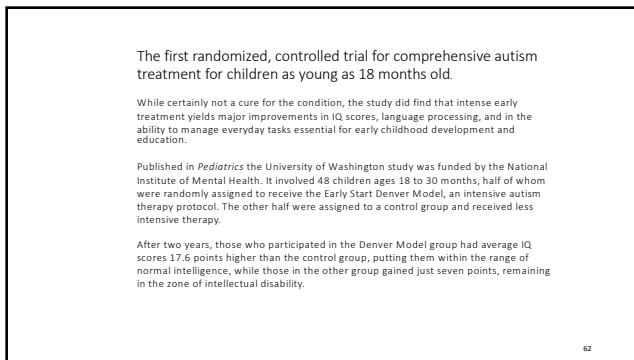
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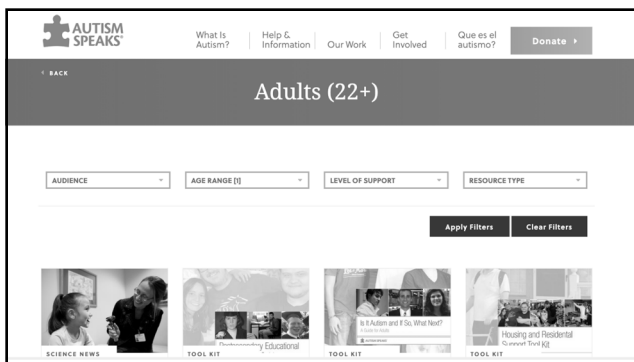


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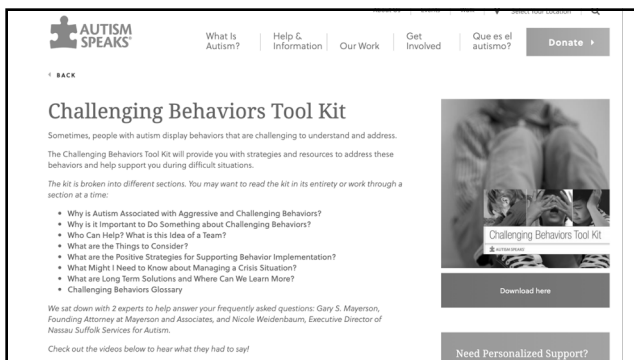
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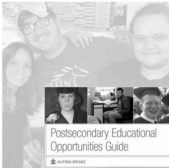
Postsecondary Educational Opportunities Guide

Deciding what to do after high school can be a difficult process. This guide will help you and your family explore the various options available to you.

The guide provides a closer look at four-year universities, community colleges, vocational/technical school, life skills programs and more. The information will help you find the program that is right for you.

The Postsecondary Educational Opportunities Guide is broken up into the following sections:


- Introduction
- Preparing for Postsecondary Education
- Types of Postsecondary Education Programs
- Obtaining Services and Asking for Accommodations
- Life on Campus
- Learning to Live Independently: A Personal Perspective
- Peer-to-Peer Advice
- Advice for Parents
- Alternative Learning for People With Autism: A Personal Perspective
- A Retrospective on Postsecondary Educational Opportunities
- Resources



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70



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Employment Tool Kit


Autism Speaks would like to help you find the right job by providing you with tools and resources, including our Employment Tool Kit.

We have written this kit to help you research, find and keep employment. We compiled job-related stories, tips and information from a collaboration of people, including adults with autism.

Although this guide is written for you, we know that it will also be helpful for family members, service providers, business leaders and anyone who is helping someone with autism find and keep a job.

The Employment Tool Kit is divided into the following sections:


- Introduction
- Self-Advocacy
- What Job is Right For You?
- Benefits and Funding
- Employment Models: What Option is Best For You?
- Your Job Search
- Transportation Options
- Resumes, Cover Letters and Applications
- The Job Interview
- Accommodations and Disclosure
- Soft Skills: Understanding the Social Elements of Your Job
- Success Stories and Lessons Learned



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71



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Autism After Age 21

What happens when my child is no longer in school?
Where will he live when he no longer wants to live with me?
What is going to happen to my child when I'm no longer around, or able to care for him?

These are just a few questions that Easterseals hears from concerned parents of kids with autism. Most children with autism are eligible to receive special education services through the school system until age 21. As the nation's largest provider of services and support for

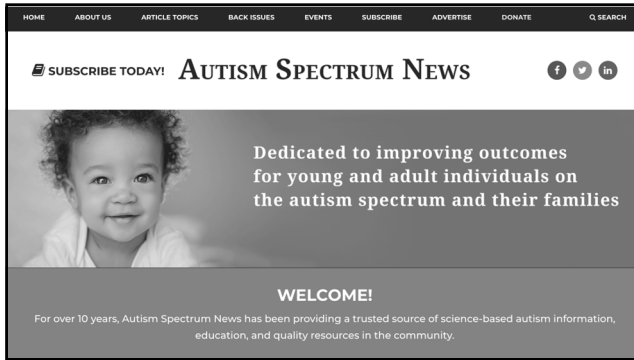
Explore Resources

Living With Autism

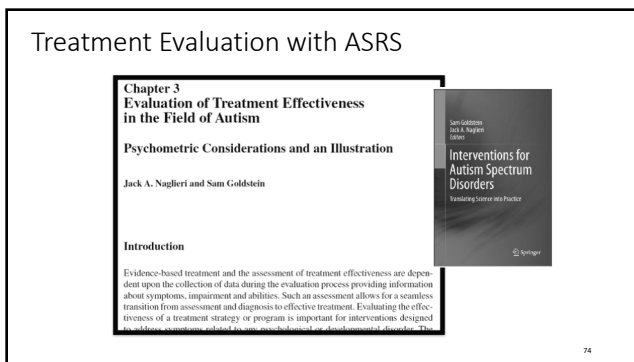
[State Autism Profiles](#)[Autism Signs and Symptoms](#)[Autism Resources](#)[Autism After Age 21](#)

72

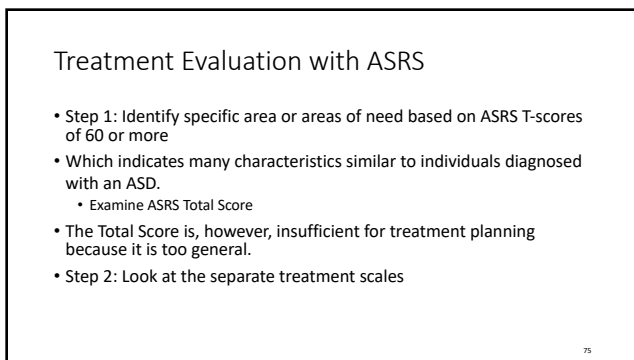
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73



74



75

Treatment Evaluation with ASRS

- Total Score of 73 by Parent & Teacher
- Social Communication scores are high for both raters meaning he has problems with appropriate use of verbal and non-verbal communication requiring him to initiate, engage in, and maintain social contact (Social Communication T-scores of 77 and 78)

Table 3.3 Case of Donny: parent and teacher ASRS T-scores, differences values needed for significance

	Parent	Teacher	Difference
Total score	73	73	0
Social communication	77	78	1
Unusual behavior	60	53	-7
Self-regulation	70	74	4
DSM-IV scale	69	68	-1
Treatment scales			
Peer socialization	70	73	3
Adult socialization	58	63	5
Social/emotional reciprocity	77	76	-1
Atypical language	52	44	-8
Stereotypy	49	54	5
Behavioral rigidity	72	48	-24
Sensory sensitivity	44	48	4
Attention	71	73	2

T-scores greater than 59 appear in *italic text*

*Note Differences needed for significance when comparing Parent and Teacher Table 4.5 of the ASRS Manual

76

76

Treatment Evaluation with ASRS

- ... and he struggles with maintaining control over his behavior (i.e., he is very argumentative) and attending in complex settings (Self-Regulation score of 70)

Table 3.3 Case of Donny: parent and teacher ASRS T-scores, differences values needed for significance

	Parent	Teacher	Difference
Total score	73	73	0
Social communication	77	78	1
Unusual behavior	60	53	-7
Self-regulation	70	74	4
DSM-IV scale	69	68	-1
Treatment scales			
Peer socialization	70	73	3
Adult socialization	58	63	5
Social/emotional reciprocity	77	76	-1
Atypical language	52	44	-8
Stereotypy	49	54	5
Behavioral rigidity	72	48	-24
Sensory sensitivity	44	48	4
Attention	71	73	2

T-scores greater than 59 appear in *italic text*

*Note Differences needed for significance when comparing Parent and Teacher Table 4.5 of the ASRS Manual

77

77

Treatment Evaluation with ASRS

- Raters agree except for Unusual Behavior and Behavioral Rigidity scales.

	Parent	Teacher	Difference	Difference needed ^a
Total score	73	73	0	5 NS
Social communication	77	78	1	6 NS
Unusual behavior	60	53	-7	6 Sig ←
Self-regulation	70	74	4	7 NS
DSM-IV scale	69	68	-1	6 NS
Treatment scales				
Peer socialization	70	73	3	9 NS
Adult socialization	58	63	5	12 NS
Social/emotional reciprocity	77	76	-1	8 NS
Atypical language	52	44	-8	11 NS
Stereotypy	49	54	5	13 NS
Behavioral rigidity	72	48	-24	8 Sig ←
Sensory sensitivity	44	48	4	12 NS
Attention	71	73	2	7 NS

T-scores greater than 59 appear in *italic text*

*Note Differences needed for significance when comparing Parent and Teacher ratings are found in Table 4.5 of the ASRS Manual

78

78

Treatment Evaluation with ASRS

- The difference between Donny's Unusual Behavior scores as rated by his mother (60) and teacher (51) suggests that behaviors in the home and the classroom are different; which implies that the exploration of the environmental impact on his odd behaviors could lead to good intervention options.
- The significant difference between Donny's Behavioral Rigidity scores as rated by his mother (72) and teacher (48), which also warrants further exploration.

79

79

Treatment Evaluation with ASRS

- Consistently high scores on Peer Socialization, Social/Emotional Reciprocity and Attention

	Parent	Teacher	Difference	Difference needed ^a	
Total score	73	73	0	5	NS
Social communication	77	78	1	6	NS
Unusual behavior	60	53	-7	6	Sig
Self-regulation	70	74	4	7	NS
DSM-IV scale	60	68	-1	6	NS
Treatment scales					
Peer socialization	70	73	3	9	NS
Adult socialization	58	63	5	12	NS
Social/emotional reciprocity	77	76	-1	8	NS
Atypical language	52	44	-8	11	NS
Stereotypy	49	54	5	13	NS
Behavioral rigidity	72	48	-24	8	Sig
Sensory sensitivity	44	48	4	12	NS
Attention	71	73	2	7	NS

T-scores greater than 59 appear in italic text

^aNote Differences needed for significance when comparing Parent and Teacher ratings are found in Table 4.5 of the ASRS Manual

80

80

Treatment Evaluation with ASRS

- Item level analysis within Peer Socialization helps clarify the exact nature of the behaviors that led to the high score

3 Evaluation of Treatment Effectiveness in the Field of Autism

51

Fig. A.7 Item level analysis from ASRS interpretive report (shaded items indicate scores that are more than 1 SD from the normative mean)

Peer Socialization	
Item	Score
13. seek the company of other children? (R)	1
14. have trouble talking with other children?	3
19. have social problems with children of the same age?	2
31. play with others? (R)	1
45. understand age-appropriate humor or jokes? (R)	0
50. talk too much about things that other children don't care about?	4
64. choose to play alone?	3
69. show good peer interactions? (R)	2
70. respond when spoken to by other children? (R)	1
Peer Socialization Raw Score = 17	

81

81

Treatment Evaluation with ASRS

Quick Solution Finder

Peer Socialization

Increase ability to seek out other children	51
Initiate conversation with other children	51
Increase ability to play appropriately with other children	51
Increase ability to understand humor	227
Improve ability to carry on normal conversation with peers	174
Respond appropriately when other children initiate	159

Peer Socialization	
Item	Score
14. have trouble talking with other children?	3 NS
50. talk too much about things that other children don't care about?	4
64. choose to play alone?	3
69. show good peer interactions? (R)	2

82

82

Treatment Evaluation with ASRS

- The Quick Solution Guide provides the correspondence of behaviors associated with ASD and specific interventions provided by authors in the chapters that appear in the book.
- For example, Donny had a high ASRS T-score on the Social/Emotional Reciprocity scale and one of the items that addressed "looking at others when spoken to" was very high. Interventions for this behavior can be found on pages

83

83

Treatment Evaluation with ASRS

Table 3.4 Parent T-scores for ASRS scales obtained over three time periods

	Time 1	Time 2	Time 3	Progress monitoring (Time 2 - 1)	Progress monitoring (Time 3 - 1)
Total score	73	70	63	-3 NS	10 Sig
Social communication	77	77	66	0 NS	11 Sig
Unusual behavior	60	58	58	-2 NS	2 NS
Self-regulation	70	67	62	-3 NS	8 NS
DSM-IV scale	69	68	63	-1 NS	6 NS
Treatment scales					
Peer socialization	70	69	68	-1 NS	2 NS
Adult socialization	58	58	58	0 NS	0 NS
Social/emotional reciprocity	77	77	63	0 NS	14 Sig
Atypical language	52	52	52	0 NS	0 NS
Stereotypy	49	49	49	0 NS	0 NS
Behavioral rigidity	72	67	67	-5 NS	5 NS
Sensory sensitivity	44	44	44	0 NS	0 NS
Attention	71	68	58	-3 NS	13 Sig

T-scores greater than 59 appear in *italic text*
 Note Differences needed for significance when comparing scores over time for Parent and Teacher ratings are found in Table 4.11 of the ASRS Manual ($p = 0.10$ with Bonferroni correction)

84

84

The “Prime Directive” is Independence

- Reduce reliance on prompts.
- Help individual’s predict and control. environment and behavior.
- Increase self-esteem and self-efficacy.
- Develop independence through a “learning to swim” mindset.

85

Theater as a Medium to Develop Social Skills

- Theater arts offer an opportunity for individuals with ASD to venture into the community in a win-win relationship.
- EPIC’s performances help the general community better understand the nature of having ASD.
- At the same time, actors with ASD have the opportunity to interact in a medium that we believe will foster not only the development of self-esteem, but appropriate social interaction—the latter very clearly being the primary hurdle to successful adult transition for those with ASD.
- EPIC hopes to quantify our initial experiences of the benefits of theater for those with ASD through a long-term, qualitative study measuring the associative effects of theater arts, training on social skills, sense of purpose and independence in daily life activities.

86

EPIC Players



87

Conclusions



- The determination of eligibility and the integration of specialized educational programs as part of comprehensive treatment for students with ASD continues to evolve.
- It is still the case that there is at times a confusing relationship between clinical/medical diagnosis and care, and eligibility determination and specialized educational processes.
- Over the last twenty years school psychologists have become very knowledgeable about the evaluation and treatment of ASD. The process by which eligibility as Autism under IDEIA is determined continues to vary significantly between states and school districts.
- We need to adopt a reasoned and reasonable set of guidelines for school psychologists charged not only with determining eligibility under IDEIA for a student to be served as OHI/Autism but also gather statistically viable information about a student's cognitive, neuropsychological, social, emotional, academic and behavioral presentation and competence so as to seamlessly integrate assessment data into measurable IEP goals.

88

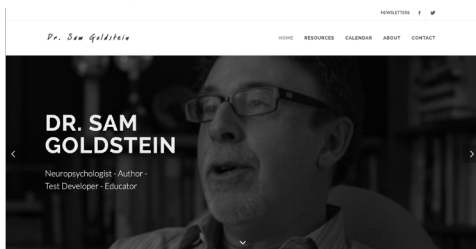
Continuing Education

CEFI® (Manual Quiz: 3 CE Credits)
The Comprehensive Executive Function Inventory™ is a comprehensive evaluation of executive function strengths and weaknesses in youth aged 5 to 18 years.

ASRS® (Manual Quiz: 4 CE Credits)
The Autism Spectrum Rating Scales™ identifies symptoms, behaviors, and associated features of Autism Spectrum Disorders in youth.

89

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90

Devin Teichert
 Song of Myself
 December 16, 2008


Were They but There at Night

There is a bolder field where every stone
 Is a glazed, glittering gem, like stars fallen from the sky
 All except one, a plain grey rock alone in the center
 Feeling excluded and shunned

People come, tourists, painters, photographers, collectors
 To view each shining boulder, a pleasure to the beholder
 Ooh! Ahh! Look at this one! Come quick!
 Pedestals bulge with fingernails and paint once run dry

But the grey rock remains ignored
 An ugly blotch on a sweeping mural

The sun sets, everyone leaves
 And they miss the outcrop of the field
 For when night falls, the grey rock in the center
 It glows in the dark



91



Questions?


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92
