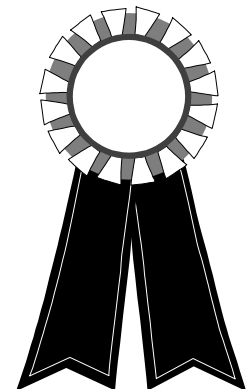
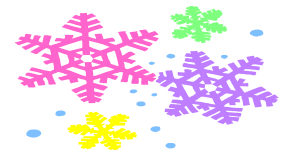


AUTISM

AND RELATED DEVELOPMENTAL DISABILITIES

VOLUME 19, ISSUE 1

WINTER 2003



AABT AUTISM SIG ANNUAL STUDENT RESEARCH WINNER

Treating Social Anxiety Disorder with CBT in the Context of Asperger's Syndrome: A Single-Subject Report

LeeAnn Cardaciotto, James D. Herbert, Brandon A. Gaudiano, Elizabeth M. Nolan, & Kristy L. Dalrymple Drexel University

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ABSTRACT Asperger's Syndrome (AS) is a developmental disorder characterized by social impairment, highly circumscribed interests, repetitive behaviors, and motor clumsiness. The social impairment features of AS are similar to characteristics of social anxiety disorder. However, there is no research examining the comorbidity of these diagnoses or the treatment of social anxiety in the context of AS. The present single-subject report examines the use of cognitive-behavior therapy (CBT) in treating social anxiety disorder in an individual with comorbid AS. The results suggest that a 14-week course of CBT was successful in reducing symptoms of anxiety and comorbid depression. In addition, improvements in social skills were observed (e.g., appropriate eye contact, conversational skills). Limitations and future directions for treatment are discussed.

INTRODUCTION

Asperger's Syndrome (AS) is a relatively new diagnosis, receiving "official" recognition in the DSM-IV in 1994 as a pervasive developmental disorder. Since studies of AS were uncommon until the 1980's, prevalence rates are not established. Beginning in young childhood, AS is a life-long disorder characterized by social impairment, highly circumscribed interests, repetitive behaviors, and motor clumsiness (Volkmar & Klin, 2000). In contrast to autism, there is no significant delay in language or cognitive development. Social impairment is manifested through deficits in the use of non-verbal behaviors, such as idiosyncratic facial expressions, gestures, or posture; the inability to recognize social cues; difficulty behaving according to accepted and implicit social conventions; lack of close peer relationships; and deficits in social or emotional reciprocity (Tantam, 1991). No systematic studies examining the efficacy of treatment for AS have been conducted; only suggestive information from clinician observations has been published.

The social impairment characteristics of AS overlap with associated features of social anxiety disorder (SAD), an anxiety disorder characterized by intense fear of negative evaluation in social situations. The shared social impairments include deficits in social skills and limited social support networks (American Psychiatric Association, 2000). Although AS has been associated with other psychiatric disorders such as Tourette's syndrome (Kereshian & Burd, 1986), obsessive-compulsive disorder (Thomsen, 1994) and schizophrenia (Clarke, D.J. et al., 1989), research has not examined the relationship between SAD and AS.

Cognitive behavioral interventions have been shown to be effective in treating SAD (for recent reviews, see Craske, 1999; Gould & Johnson, 2001). However, there is little research on the use of cognitive behavioral interventions with individuals diagnosed with AS. Since individuals with AS do not have cognitive impairment, cognitive behavioral approaches may be applicable with this population. Given the overlap of some of the symptoms of AS with SAD, the present single-subject study examines the use of cognitive behavior therapy (CBT) for symptoms of social anxiety & impairment in an individual with AS.

METHOD

Client

The client was a 23-year-old male diagnosed with SAD, generalized type and AS according to DSM-IV criteria (American Psychiatric Association, 2000). The SCID-IV (First et al., 1995) was used to make the diagnosis of SAD, and the client met criteria for AS according to The Asperger Syndrome Diagnostic Interview (ASDI; Gillberg et al., 2001). The client reported fearing and avoiding situations including talking to authority figures, speaking in front of a group, interviewing, being assertive, and initiating conversations.

And the winner is... LeeAnn Cardaciotto!

There were several wonderful entries this year, but LeeAnn's poster emerged as the strongest of the pack! LeeAnn is currently working on her Ph.D. in Clinical Psychology at Drexel University. Congratulations, LeeAnn!!! Please join us in Boston to see LeeAnn honored at the Autism SIG meeting

Thanks to this year's judges...
Marlene Cohen, Ed.D., Russell Kormann, Ph.D., and Doreen DiDomenico, Ph.D.

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Measures & Assessment

At each assessment after the start of treatment, an independent assessor administered the social phobia section of the SCID-IV to determine whether the client met diagnostic criteria for SAD. In addition, the assessor completed Clinical Global Impression-Severity (CGI-S) ratings at pre-, mid-, post-treatment, and follow-up (two months following the client's last treatment session), and Clinical Global Impression-Improvement (CGI-I) ratings at mid-treatment, post-treatment, and follow-up. A series of questionnaires, including the Social Phobia and Anxiety Inventory (SPAI; Turner et al., 1989), Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987), and the Beck Depression Inventory-II (BDI-II; Beck, 1996), were completed two weeks prior to treatment (baseline), pre-, mid-, post-treatment, and at follow-up. In addition, the LSAS and BDI-II were administered weekly throughout treatment.

Treatment

The client received 14 weeks of individual cognitive behavior therapy (CBT) based on a version of a treatment protocol developed by Heimberg and Becker (2002) and modified by Herbert, Rheingold, and Goldstein (2002). Treatment focused on the reported feared and avoided social situations, including initiating, maintaining, and ending conversations, dating, assertiveness, and job interviewing. Techniques in treatment included cognitive restructuring, role playing, and weekly homework assignments. Homework assignments included performing thought-listing and cognitive restructuring exercises both prior to and immediately after social situations, and in vivo exposure exercises of situations practiced in session. The CBT protocol was modified to include an emphasis on social skills training to attend to the client's deficits in verbal (e.g., introductions, maintaining conversation), non-verbal (e.g., eye-contact, posture), and paralinguistic social skills (e.g., rate of speech, voice volume). Specific social skills were identified and rehearsed during role-play exercises in session, and were applied during the in vivo exercises performed for homework.

RESULTS

Regarding the CGI assessments, at pre-treatment, the client received a CGI-S rating of Severely Ill; at mid-treatment, he received a CGI-S rating of Markedly Ill with a CGI-I rating of Minimal Improvement; and at post-treatment, a CGI-S rating of Moderately Ill with a CGI-I rating of Much Improvement. At follow-up, the client no longer met criteria for social anxiety disorder, as he received a CGI-S rating of Mildly Ill and a CGI-I rating of Very Much Improved. At follow-up, the client reported significantly reduced anxiety in and avoidance of social situations, and increased coping skills for dealing with anxiety-provoking situations.

Questionnaire data show decreases in symptoms of social anxiety and depression though the course of treatment. As seen in Figure 1, there was a steady decline in Social Phobia subscale scores on the SPAI; in the context of clinical significance, the post-treatment SPAI score fell very near the 50th percentile for non-anxious controls, and the follow-up score fell very near the 40th percentile for non-anxious controls. Although Figure 2 depicts an increase in fear ratings decrease in avoidance is shown on the Social Anxiety subscale of the SAS. Lastly, Figure 3 shows a decrease in depression on the BDI-II; at post-treatment and at follow-up, BDI-II scores remained at 4, which is well within the normal range.

Even though there was a decrease in anxiety & depression, minimal changes in social skills were rated from

the behavioral role-play tests. However, improvements in the client's social functioning were noted. Increased appropriate eye contact and conversational skills were observed at post-treatment and follow-up. In addition, by the end of treatment, the client had expanded his social network by joining an arts group.

DISCUSSION

The results suggest that cognitive behavior therapy was successful in reducing symptoms of social anxiety, as well as comorbid depression, in an individual diagnosed with comorbid AS and SAD. Two months following treatment, the client no longer met diagnostic criteria for SAD. Evidence for the maintenance of treatment gains were evident, as the client's anxiety symptoms and avoidance of social situations generally decreased two months following treatment, and depressive symptoms remained within the normal range. One interesting finding was that the client's fear rating of social situations seemed to slightly increase from post-treatment to follow-up, while his avoidance rating decreased. This finding was congruent with the client's report of continued anxiety but better ways of coping with the anxiety, as it did not interfere with his daily functioning.

Although there were clinically significant decreases in anxiety and depression symptoms, improvements in the client's social skills were limited, especially with regard to maintenance over time. Since social impairment is a stark characteristic of AS, long-term social skills training may be beneficial for continued development and generalization of social skills, as well as understanding of implicit expectancies and reciprocity embedded in social interaction.

The design of the study precludes definitive statements about the specific benefits of the treatment; however, it seems likely that changes were related to treatment since both AS and SAD are chronic and unremitting without treatment. Further research examining the comorbidity of AS and SAD, as well as the treatment of SAD in the context of AS, is indicated.

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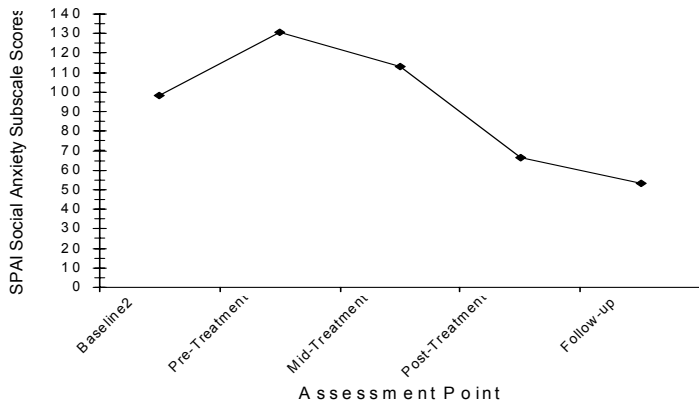


Figure 1. SPAI Social Anxiety Subscale scores by assessment point

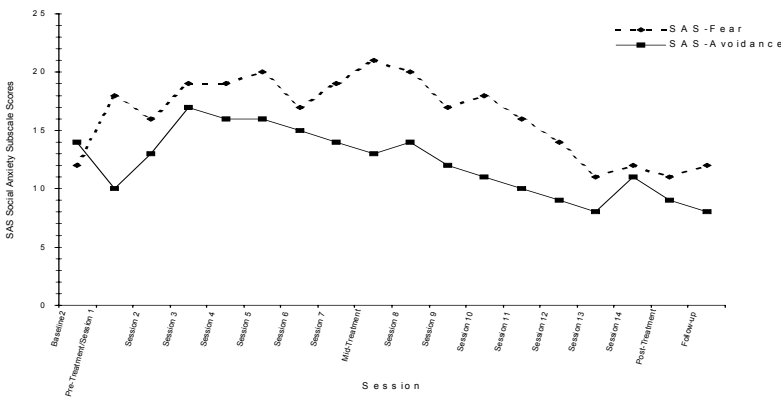


Figure 2. SAS Social Anxiety Subscale Fear and Avoidance Scores by session.

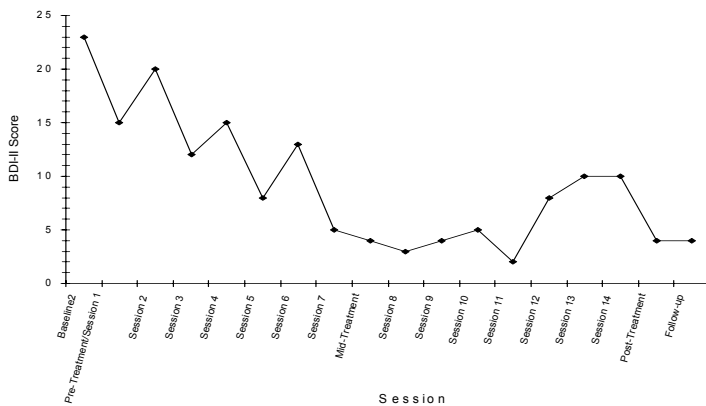


Figure 3. BDI-II scores by session.

Article Synopsis

The following represents an installment of an ongoing series of article synopses drawn from the pool of behaviorally oriented articles published within the last year. This article synopsis was authored by a doctoral student from the Department of Psychology who is also affiliated with the Douglass Developmental Disabilities Center.

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

Anderson and Long (2002) evaluate the utility of the structured descriptive assessment (SDA), a recently developed functional assessment strategy. Anderson and Long describe the potential advantages of this structured descriptive assessment over more traditional analogue and descriptive methodologies and compare its effectiveness with analogue functional analysis. Further, interventions based upon results obtained from an SDA are evaluated.

A traditional analogue functional analysis systematically manipulates both antecedents and consequences for a problem behavior in order to identify what has reinforced the behavior in the natural environment. The literature has repeatedly demonstrated the effectiveness of this methodology for identifying the function of a problem behavior. In contrast to other methods of functional assessment, an analogue functional analysis allows a greater amount of control over environmental events and more direct conclusions. However, if the functional events occur rarely during the assessment, it is difficult to find the maintaining variables and may lead to false conclusions. Descriptive assessments utilize direct observation of behavior in the natural environment and involve less control over environmental events. These assessments are useful in determining natural consequences of behavior and can reveal idiosyncratic variables that might be affecting behavior. However, they only provide correlational information about relationships between events and behavior and thus cannot be used to make causal statements. The authors present the structured descriptive assessment as a potential solution to the challenges associated with descriptive assessments. The SDA systematically manipulates antecedent variables, as in an analogue functional analysis, yet allows for observation of naturally occurring consequences. Further, an SDA is conducted in the individual's natural environment by typical care providers.

Anderson and Long (2002) compared results obtained from an SDA and an analogue functional analysis in four school-aged children diagnosed with autism or mental retardation. The participants had been referred for assessment and treatment of problem behavior. Operational definitions for problem behaviors were developed based upon interview with parents or teachers and were the same in both assessments. The analogue functional analysis was conducted prior to the SDA for all but one participant, whose assessments were conducted simultaneously.

Structured descriptive assessment (SDA). The SDA consisted of repeated exposure to four experimental conditions: attention, task, tangible, and play. In each condition, antecedent variables were manipulated while allowing consequences to naturally occur. Each session was conducted during periods in which the variables associated with each condition naturally occurred. For example, the attention deprivation condition occurred during a period of time in which the staff member working with the student had to work with another student. Prior to each condition, the staff were given instructions in order

to manipulate antecedent variables and were told to respond to the target behavior as they would normally respond.

Attention: The purpose of the attention condition is to create deprivation of attention. After interacting with the student without giving demands for two minutes, the staff are instructed to pretend that they could not interact with the student. Further, they are asked to keep tangible items out of sight and reach of the student. Staff were asked to respond to the problem behavior as they typically would.

Task: In the task condition, staff are asked to work with the student on tasks specified in their individualized education plans. The task condition is designed to create antecedents of demands. There is no removal of tangible items within two minutes of beginning the condition. Staff were asked to respond to the problem behavior as they typically would.

Tangible: The tangible condition occurs during times when access to preferred items is ending. The access to items must be for a duration of two minutes. Once tangible items are removed, staff are instructed to interact as they typically would with the student, without giving demands. Staff were asked to respond to the problem behavior as they typically would.

Play: The play condition is an enriched environment for the student. During this condition, there is access to preferred items, no demands are made of the student, and the staff is instructed to interact with the student and respond to problem behavior as they typically would.

The frequency of problem behavior was recorded in each condition. Further, the natural consequence of each problem behavior were recorded and conditional probabilities for antecedents and consequences were calculated. Based upon conditional probabilities of antecedents, the results indicated that staff implemented the SDA appropriately and relevant establishing operations were produced. In addition to comparing the frequency of the problem behavior across conditions, the authors also used the probability of particular consequences as information to generate hypotheses about what has been maintaining the behavior.

Analogue functional analysis. This analysis consists of repeated exposure to four or five experimental conditions as described by Iwata, Dorsey, Slifer, Bauman, & Richman (1982/1994). Each participant was exposed to the attention, task, and play conditions. Two of the participants were not exposed to the alone condition because they did not exhibit self-injurious behavior. One participant was not exposed to the tangible condition, at the request of a parent. In an analogue functional analysis condition, deprivation of a potential maintaining variable is set up (e.g. deprivation of attention, presentation of demands). Upon the occurrence of the target behavior, the variable is introduced. This systematically creates a condition in which the variable is contingent upon the target behavior (e.g. during the condition, escape becomes contingent upon the problem behavior). The frequency of problem behavior is recorded in each condition and the frequency of problem behavior in each condition is compared to the frequencies in the other conditions.

Results for three of the participants were consistent across both the analogue functional analysis and the SDA and resulted in similar conclusions about the function of the behavior. For one participant, the analogue functional analysis identified as maintained by access to tangible reinforcement while the SDA indicated that the function of the problem behavior was maintained by escape.

In order to examine the extent to which the SDA could lead to effective treatment, the results of the SDA were used to create an intervention for three of the participants. The intervention was matched to the function indicated by the SDA. The frequency of problem behavior for one participant decreased without intervention following assessment and the frequency of problem behavior for that participant no longer warranted treatment. Results indicated that all three interventions resulted in significant reductions in problem behavior. For two of the three participants, the mean reduction was greater than 90% below baseline and reversal indicated functional control. Intervention for the third participant also resulted in significant reductions in problems. However, a reversal was not conducted due to concerns expressed by the student's teacher.

Overall, the results of the SDA resulted in similar conclusions about the function of problem behavior as an analogue functional analysis. Further, information from the SDA resulted in effective interventions for three

of the four participants whose levels of behavior warranted intervention. Since the analogue functional analysis indicated a different function from the SDA, it is possible that the SDA did not reveal a functional relationship that was in effect. As a result, it is suggested that the SDA be used to augment other functional assessment strategies until more research is conducted to demonstrate its effectiveness.

Submitted by: Megan Martins



Services for Families

The following article is an installment in our new series focused on services for families which provides a description of a program for individuals with autism and the family services it provides. If you are interested in submitting information about your program, please contact the editor.

We are starting a new series focused on services for families in which we will provide descriptions of programs for individuals with autism and the family services and programs that they provide. If you are interested in submitting information about your program, please contact the editor.

Behavioral Directions

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Office: 703.855.4032 Fax: 703.317.0292

Written by Jane Barbin, Ph.D.

General Information

Behavioral Directions is a private consulting firm providing services to individuals with autism spectrum disorders and related developmental disabilities. Family services are provided through parent training, advocacy, support groups, and set-up/monitoring of home-based ABA programs. Behavioral Directions was founded by Jane Barbin, Ph.D., the founding director of the Ivymount Autism Program in Rockville, Maryland, a center-based education and treatment program serving children and adolescents with autism utilizing behavioral intervention. Given the vast array of available treatments to address autism spectrum disorders (few of which are based in science), Behavioral Directions was created to promote utilization of strategies with known scientific effectiveness to promote appropriate educational programming, address symptoms of autism (i.e., social and communication deficits) and reduced challenging behaviors that often accompany these disorders. Applied behavior analysis (ABA) methodology is employed for increase and decrease of selected behaviors.

Behavioral observations and treatment in natural settings (e.g., home, school, and community) are used to enhance effectiveness. Collaboration with related professionals is also conducted as needed. Selection and monitoring of educational and skill acquisition programming is offered in school and home settings, functional assessment/analysis is used to identify functions of difficult behaviors and to provide for function-based treatments. Parent and staff training on designed plans and data-based monitoring and follow-up are also offered. External program evaluations and needs assessments are offered to schools and program evaluations and needs assessments are offered to schools and agencies to assist in program development. agencies to assist in program development.

Advocacy

Family advocacy is provided through attendance at school and agency meetings and collaboration with other professionals in support of effective education and treatment strategies to benefit individuals with autism. Consultation with other colleagues may sometimes take the form of providing educational information to promote a fuller understanding of the client's disability. Expert legal testimony is available when a client has been fully evaluated.

Family Support

Family support is offered through providing referrals and sharing information on local resources in the family's area (e.g., local support groups, legal counsel, neuropsychological testing, related service providers using behavioral strategies, etc.). Professional presentations are done to disseminate science-based assessment and treatment information. Ongoing monitoring of progress, review and analysis of treatment data, and parent training are offered through home and office visits to ensure successful implementation of designed programs. Training of school staff and other personnel also working with the client is offered and is an important component to supporting the family and providing for consistency across settings. A parent support group was offered in 2002 consisting of a series of topics chosen by members along with sharing and problem-solving between group members.

Home-Based Behavioral Programming

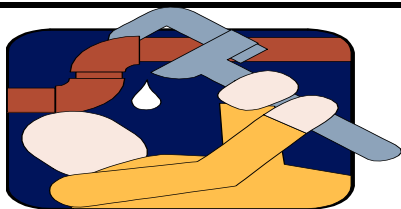
Families who desire to begin home-based behavioral instruction for their child are provided with consultation on what can be expected in the process in regards to family involvement and commitment and potential benefits for their child in comparison with other available education and treatment options. If the family decides to undertake a home-based program, initial evaluation of their child's abilities and prioritized areas for skill acquisition and, as needed, reduction of challenging behaviors are done. Staff members working in the home are trained in applied behavior analysis (ABA) strategies (i.e., chaining, discrete trial, incidental teaching, prompting, shaping, reinforcement, stimulus control, etc.) to carry out a systematic program across the day. Staff members are taught how to conduct data collection and to graphically represent data to allow for data-based decisions to be made. Following initial program selection and training, the program is monitored frequently with on-site visits and data review to make needed adjustments. Collaboration and consultation with local education agencies is provided to guide the family, assist in I.E.P. development, and aid the transition of the student to a school setting when appropriate.

Clinical Training and Experience

In regards to training and experience, Dr. Jane Barbin holds a doctoral degree in Clinical Psychology and is licensed in Virginia and Maryland. The clientele generally served is from the Washington D.C. metropolitan area; however consultation is available in other locations. Dr. Barbin completed an internship in Behavioral Psychology at the Johns Hopkins University School of Medicine and Kennedy Krieger Institute. She currently serves on the Virginia Statewide Autism Council and is president-elect of the Maryland Association for Behavior Analysis (MABA). Dr. Barbin has often been an invited speaker at autism advocacy meetings and professional conferences.

For more information about services offered by Behavioral Directions, please contact Dr. Barbin at the above phone number





PUBLICATION PIPELINE

Listed below are recently published behaviorally-oriented articles focusing on treatment for individuals with autism.

Charlop-Christy, M.H., Carpenter, M., Le, L., LeBlanc, L.A., & Kellet, K. (2002). Using the picture exchange communication system (PECS) with children with autism: Assessment of PECS acquisition, speech, social-communicative behavior and problem behavior. Journal of Applied Behavior Analysis, 35 (3), 213-231.

Durand, V.M. (2002). Treating sleep terrors in children with autism. Journal of Positive Behavior Interventions, 4(2), 66-72.

Grindle, C.F., & Remington, B. (2002). Discrete-trial training for autistic children when reward is delayed: A comparison of conditional cue value and response marking. Journal of Applied Behavior Analysis, 35(2), 187-190.

Hoch, H., McComas, J.J., Johnson, L., Faranda, N., & Guenther, S. (2002). The effects of magnitude and quality of reinforcement on choice responding during play activities. Journal of Applied Behavior Analysis, 35(2), 155-169.

Koegel, R.L., Symon, J.B., & Koegel, L.K. (2002). Parent education for families of children with autism living in geographically distant areas. Journal of Positive Behavior Interventions, 4(2), 88-103.

LaBelle, C.A., & Charlop-Christy, M.H. (2002). Individualizing functional analysis to assess multiple and changing functions of severe behavior problems in children with autism. Journal of Positive Behavior Interventions, 4(4), 231-241.

Lorimer, P.A., Simpson, R.L., Myles, B.S., & Ganz, J.B. (2002). The use of social stories as a preventative behavioral intervention in a home setting with a child with autism. Journal of Positive Behavior Interventions, 4(1), 53-60.

Nuzzolo-Gomez, R., Leonard, M.A., Ortiz, E., Rivera, C.M., & Greer, R.D. (2002). Teaching children with autism to prefer books or toys over stereotypy or passivity. Journal of Positive Behavior Interventions, 4(2), 73-79.

Shipley-Benamou, R., Lutzker, J.R., & Taubman, M. (2002). Teaching daily living skills to children with autism through instructional video modeling. Journal of Positive Behavior Interventions, 4 (3), 165-175

Winborn, L., Wacker, D.P., Richman, D.M., Asmus, J., & Geier, D. (2002). Assessment of mand selection for functional communication training packages. Journal of Applied Behavior Analysis, 35(3), 295-298.

Worsdell, A.S., Iwata, B.A., Wallace, M.D. (2002). Duration-based measure of preference for vocational tasks. Journal of Applied Behavior Analysis, 35(3), 287-290.

CONFERENCE CORNER



CALL FOR PAPERS

A Association for the Advancement of Behavior Therapy
A 37TH ANNUAL CONVENTION
B NOVEMBER 20-23, 2003
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Don't forget to make your submissions to AABT!! The deadline for submission of symposia, clinical roundtables, panel discussions, and posters is March 3, 2003. Submissions can be made online. Please go to www.aabt.org to submit your abstract or for more information.

Special attention to student researchers: Submit your poster and be eligible to enter the AABT Autism SIG Student Research Contest!!

ASSOCIATION FOR BEHAVIOR ANALYSIS
29TH ANNUAL CONVENTION
MAY 23-27, 2002
SAN FRANCISCO

The convention program is now online! Check it out at www.abainternational.org. Autism related convention events to come in a future issue of the newsletter. Stay tuned!

Works in Progress

The Autism SIG of the Association for Behavior Analysis is currently working on the following projects:

1. A subcommittee is working on revising the Guidelines for Consumers that were initially put forth in 1998.
2. A subcommittee is establishing a set of links for SIG webpage that provide ABA resources an information



ADVERTISEMENTS & ANNOUNCEMENTS



SpeechTeach

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Douglass Developmental Disabilities Center

The DDDC at Rutgers, The State University of New Jersey is a center for the study and treatment of autism. **There are currently positions open.** Please send resume or inquire about possible openings to:

Norine Haines
Douglass Developmental Disabilities Center
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Please send your suggestions of topic ideas for possible inclusion in an upcoming issue of the SIG newsletter to:

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