

AUTISM

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SPECIAL SECTION: Problem Behavior



Review of *Punishment on Trial* by Dr. Ennio Cipani

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Promoting enduring behaviour change in children is a complex undertaking, one that is facilitated by use of a full array of consequences. Aptly titled, *Punishment on Trial: A Resource Guide to Child Discipline*, provides a comprehensive review of the myriad issues and considerations parents and professionals face when deciding if and how to use punishment. Dr. Cipani, a frequent author and leader in the field of child behavior therapy, has once again provided his readers with a readable, thought provoking resource to guide them in the arena of child discipline. He is applauded for tackling such a controversial topic in a responsible and thorough manner.

This consumer friendly book is divided into four sections. The first section outlines the downfalls of using a procedural definition of punishment and highlights the effectiveness of modifying child behavior by adopting an outcome-oriented definition of punishment. This emphasis on reducing challenging behavior using an outcome-oriented definition is well articulated and reinforced across the four sections of the book. Consistent with the title, exposing and debunking the many myths that surround punishment comprise the second and most lengthy section of the book. The third section delineates six basic principles of punishment derived from experimental and applied research studies that parents and professionals should incorporate when using punishment procedures. The fourth and final section provides a framework for the responsible use of punishment offering eight questions to ask when planning to use and implement punishment procedures.

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Although a vast amount of literature exists on the subject of punishment, Cipani states that not only is punishment a controversial topic but it is often misunderstood. This is clearly illustrated in section I, where the author answers the question “What is punishment?” by highlighting the difference between a procedural definition of punishment versus an outcome-oriented definition of punishment. Specifically, the procedural definition of punishment evaluates the effectiveness of punishment by looking only at the consequence used. On the other hand the outcome-oriented definition of punishment considers the punisher’s effect on child behavior when evaluating effectiveness. Dr. Cipani advocates for using the outcome-oriented definition of punishment when treating problem behavior for several reasons. First, when the procedural definition is used, and the aversive consequence fails to decrease maladaptive behavior, punishment is deemed to be ineffective. For instance, if a parent uses a procedural definition when implementing punishment and the aversive consequence used fails to reduce problem behavior a parent may conclude that punishment isn’t effective for this child or worse that they are “beyond help”. Second, whereby concluding that punishment was ineffective, a parent’s solution is often to increase the intensity or duration of the punishing event, which unintentionally increases the risk of harm to the child. Clearly the better option, the outcome-oriented definition of punishment helps parents analyze their own discipline procedures by focusing on child behavior when evaluating effectiveness. Specifically, when a parent adopts an outcome-oriented view of punishment when trying to reduce behavior and the punishment fails to reduce problem behavior the parent can conclude that it was the punisher that wasn’t effective, not the fact that the child is beyond help. Importantly, this definition avoids judging the harshness of the consequence. Instead, punishment does not have to evoke pain it only has to decrease behavior. Of utmost importance, the focus is on decreasing behavior not on punishing the child. Many readers will easily see that the concepts resonate to the use of reinforcement and appreciate that the considerations outlined in this section, in particular the distinction between procedural and outcome-oriented definitions, readily apply to behavior strengthening procedures as well.

Myths and misinformation that separate children from effective and timely intervention represent a very serious mental health matter. These myths can be easily tied to misuse, ineffective use, and outright avoidance of punishment procedures. The second section of the book exposes and debunks the myths surrounding the use of punishment and exemplifies the theme of the book, punishment on trial. In section II, 5 myths are discussed in great detail: (1) Punishment does not work; (2) Punishment temporarily suppresses behavior; (3) Punishment causes problems for a child’s emotional development; (4) Punishment is not as effective as reinforcement; and (5) Time-out does not work. For those of us who have been in the field for a number of years, these myths are neither new nor inconsequential. Throughout the section Dr. Cipani reminds parents and professionals alike to “weigh the evidence” when confronted with statements about punishment in order to separate fact from opinion as the field is replete with much misinformation about punishment. More specifically, parents and professionals are advised to consider statements that are based on research and dismiss ones that are based on anecdotal reports, someone’s perceptions or moral positions. The author further asserts that the relative lack of research in the area of punishment leads to speculation, and speculation over time leads to the creation and propagation of myths. Dr. Cipani effectively, and at times comically, exposes these myths to undo the harmful effect they have had on the responsible use of punishment in situations where it is warranted.

The third section describes six basic principles of punishment derived from research studies that parents and professionals should follow when using punishment procedures. The six principles include: (1) There must exist a behavioral contingency; (2) Be consistent; (3) The “even swap” rule; (4) Remove competing consequences; (5) Be specific; and (6) Prove it works. In this section, the author makes great use of research based examples to illustrate the importance and relevance of each principle. There are a few

particularly salient points that are worthy of mention. In keeping with the consumer friendly style of the book the author clarifies the importance of the principle of consistency by stating “when the subject performs the target behavior, the consequence must be inevitable.” “Inevitability” of the consequence is such a powerful way of framing a behavioral contingency and may serve many readers well in how they approach consistency and immediacy. To ensure that parents and professionals also focus on increasing desired behavior, principle #3 outlines the “even swap” rule. Specifically, Cipani maintains that when using punishment to decrease undesired behavior reinforcement must also be used to increase desired behavior. Finally, the inclusion of the final principle is paramount. In an era when countless children are involved in long-standing, ineffective interventions, an appeal to objective determination of efficacy cannot be overstated.

The final section can be used as guidelines to follow to ensure that punishment is being used responsibly. Specifically, Cipani highlights eight questions to ask oneself when planning to use and implement punishment: (1) Am I willing to solve one problem behavior at a time?; (2) Am I willing to deploy that consequence consistently?; (3) Am I willing to sit down and think through a plan before putting anything into action?; (4) Am I willing to complement punishment with reinforcement?; (5) Am I willing to specify precisely the punishing consequence for the target behavior?; (6) Am I willing to evaluate the punisher’s effectiveness on the target behavior?; (7) Am I willing to persist long enough? and, (8) Am I willing to be open to revising the plan when it is ineffective? Dr. Cipani challenges readers to consider that a child’s ability to accept consequences for one’s behavior in part determines a child’s adaptability to the social environment. Specifically, Cipani further states that as children get older, naturally occurring, real world consequences become more unpleasant, therefore, teaching children how to accept unpleasant consequences is an essential part of growing up.

The strengths of this book lie in the excellent use of research studies as well as case studies to further illustrate the important considerations that surround punishment. The clinical case studies reflect a helpful mix of clinical and non-clinical examples across an array of settings. Readers will easily see their own children mirrored in many of the examples. Dr. Cipani skilfully blends vivid examples and reference to published research in a manner that will satisfy professional and savvy consumers, yet not overwhelm a parent who may be picking up a book of this sort for the first time. Striking that balance can be a daunting task, yet the author has succeeded in meeting the needs of diverse readers.

There are two minor criticisms that are worthy of mention. As two individuals who specialize in the treatment of autism, we feel that any book that addresses challenging behaviors should educate its readers about underlying motivation of behavior and the relevance of functional assessment. Secondly, this important resource could have been strengthened with a bit more discussion of the essential similarities and differences between positive and negative punishment procedures.

The verdict is in. In summary, *Punishment on Trial: A Resource Guide to Child Discipline* is written in a consumer friendly manner where the sections follow a coherent sequence to further provide ease of reading. Anyone interested in effectively using punishment procedures will benefit from this book. The field has benefited by such a responsible and thorough analysis of a facet of child discipline that has been sadly neglected and all too often misunderstood.

For more information about this book, please visit the website www.contextpress.com.



**SPECIAL SECTION:
Problem Behavior**

**The Creation of Positive Behavior Support SIG
David Celiberti, Ph.D., BCBA**

**An interview with Matt Tincani, Ph.D., BCBA
President of the PBS SIG
Department of Special Education
University of Nevada, Las Vegas**

What lead up to the development of the Positive Behavior Support SIG?

The SIG was started by a group of ABA members who are proponents of positive behavior support. We thought that a PBS SIG would provide an excellent forum for members interested in PBS to exchange ideas and to collaborate on conference presentations, research, and other activities. The SIG was officially founded in January 2005 after receiving approval from ABA's Executive Council. Since then, the SIG has developed a listserv with over 70 members and has maintained ongoing contact with leadership of the Association for Positive Behavior Support (APBS).

What are the objectives of the SIG?

The objectives of the SIG are to promote and to disseminate positive behavior support within ABA, and to help ensure that PBS is aligned with the science of behavior. Specifically, the SIG hopes to increase the number and visibility of PBS presentations at the ABA conference; to disseminate accurate information about PBS to ABA's membership; to promote methodologically sound, data-based PBS research; and to encourage open dialogue among behavior analysts and proponents of PBS.

What SIG related activities do you have planned for upcoming years?

In the near future, we plan to complete the SIG's website (www.pbsaba.org) and to develop bylaws for the SIG. Our longer term activities include organizing PBS related presentations for the 2006 ABA Conference, developing a SIG newsletter, and conducting collaborative activities with APBS. Regarding the latter, we are currently organizing a symposium on the positive behavior support – behavior analysis connection for the 2006 APBS International Conference in Reno, Nevada (go to www.apbs.org for details).

Sounds like your group has a busy year ahead! Where can the reader find a working definition of PBS?

Several authors have offered excellent definitions of PBS (e.g., Carr et al., 2002; Horner et al., 1990; Anderson & Freeman, 2000). These definitions emphasize a number of common PBS elements, including a focus on prevention, systems change, person-centered values, multi-component intervention, and socially valid outcomes.

How does PBS fit into the broader conceptual and empirical framework of Applied Behavior Analysis?

Fundamentally, PBS involves changing behavior of the individual and the people with whom the individual interacts. Therefore, interventions grounded in the science of behavior are essential to successful PBS. PBS owes much of its foundation to applied behavior analysis (ABA). For example, the technology of functional assessment that emerged from ABA is a critical element of PBS. The field of ABA has much to contribute to PBS. By founding the SIG, we hope that behavior analysts and proponents of PBS will have an open dialogue that benefits both fields. Many in the field of PBS view PBS as a narrower application of the much broader area of ABA. Research in ABA addresses a huge variety of questions, only some of which fit within the rubric of PBS. For example, some research in ABA addresses questions about treatment utility and generality across time and situations; this research might fit within the PBS framework. Other research addresses more theoretical questions that have important applied implications, such as the principles underlying the efficacy of an intervention (e.g., is the efficacy of "noncontingent" reinforcement due to manipulation of establishing operations, extinction, or some other effect). This research does not fit within PBS because it does not immediately address questions about efficacy of methods in real world settings.

As I know you can appreciate, this is a topic that has stirred controversy within the ABA community. In your view, is PBS embedded within ABA or a separate discipline? If the later, what defines PBS as unique or separate from ABA?

PBS and ABA share a similar groundwork in the science of behavior; however, as discussed above, PBS focuses on a more narrow set of issues than does ABA. It is our hope that PBS will result in the field of behavior analysis exploring a variety of issues in a more intensive manner. For example, PBS encourages research demonstrating the utility of interventions implemented by typical care providers in real world settings, durability over time, and strategies for assessing social and ecological validity. Additionally, PBS focuses on developing practices with contextual fit – those that can be embedded and sustained within organizational systems. Even the most effective procedures will be useless if a parent, teacher, or staff person will not or cannot use them.

At the risk of simplifying matters, consider a scenario in which an individual applies all the considerations that you listed above. Does that suggest, in your view, that he or she has stepped *outside* of the discipline of ABA? Or is he or she just practicing ABA in a way that would be consistent with the values of PBS?

No, I don't think that one who practices ABA in the manner described has stepped outside the discipline. Yes, I would agree that one who practices ABA with a focus on prevention, systems change, person-centered values, multi-component intervention, and socially valid outcomes is practicing ABA consistent with the values of PBS. Indeed, a goal of the SIG is to encourage behavior analysts to practice ABA in this manner. We realize that many applied behavior analysts currently practice in this way and simply call it behavior analysis. This is absolutely fine. The goal of the PBS SIG is not to stir up controversy or alienate people. Instead, we hope to provide a forum for focusing more exclusively on these important issues, all of which fit within the broader framework of applied behavior analysis.

I am glad you clarified the distinction in that many of the dimensions emphasized as part of PBS are already embedded within the discipline of ABA as reflected in the ABA literature, the BACB Task List, and the curriculum of graduate training programs. From a research standpoint, what are just a few of the more pressing questions warranting empirical investigation by proponents of PBS?

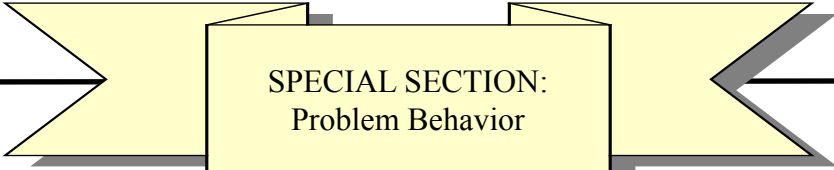
It is important to recognize that PBS is a developing area. Research exploring questions focusing on issues such as the durability of our interventions over time and in multiple settings is critically needed. We also need more research developing and evaluating methods of functional assessment that can be used in schools and other community settings by individuals who do not have extensive training in behavior analysis. A research area that especially interests me is contextual fit. How can we design effective behavioral interventions that will be sustained long after the "behavior experts" have left the picture? Rick Albin and his colleagues at the University of Oregon have done some interesting work in this area. I'm also interested in school-wide PBS and its effects on a number of dependent variables, including placement of students with challenging behavior in more restrictive settings.

Thank you for taking the time to discuss your SIG and its place within the broader discipline of ABA, how can interested parties obtain more information or join your SIG?

For more information about the Positive Behavior Support SIG, contact Matt Tincani, SIG President, at tincanim@unlv.nevada.edu.

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Diagnosis vs. Eligibility: What is the difference?

Robert W. Montgomery, Ph.D.

The issue of Diagnosis vs. Eligibility is a topic that is frequently confusing to parents and professionals working with children in the autism spectrum. It is very frustrating for parents because, in my experience, neither the schools nor the physicians do a particularly good job of explaining either and none do a good job of explaining both. As a professional starting out years ago consulting on school issues the question of Eligibility and all the issues relating to it was very confusing. After having participated in hundreds of IEPs over the past 10+ years and having done many ASD evaluations it appears that most often confusion on this issue arises from miscommunication.

To diagnose ASDs in most states one needs to be either a licensed psychologist or a physician. Since nearly none of the school systems around the country employ either it is nearly impossible for them to have diagnosed a child with an ASD (or to offer an alternative diagnosis). What schools do is determine eligibility via the IEP Committee process. Just as the schools can not diagnose legally - physicians and psychologists can not "order" or dictate eligibility to the schools. The two are distinct and have completely different meanings and purposes. A child can hold a legitimate diagnosis of autism, PDD-NOS, or aspergers and not have the autism eligibility. Usually the alternative is SDD – Significantly Developmentally Delayed. While many have expressed their concern with the SDD eligibility category it remains a legitimate federally defined eligibility category that quite often a child with a diagnosis of autism qualifies under according to the regulations. Eliminating SDD as an option is a political issue that I will leave to others. The functional question here is whether or not the child is receiving appropriate services to meet all their identified needs.

The schools charge is to determine a child's needs and place them into an eligibility based on the identification of needs and provide services appropriate to meet those identified needs. Remember, a diagnosis is a label that covers thousands of people none of whom is precisely the same as any other person with the same diagnosis. A diagnosis of autism (or any ASD) alone is never sufficient to determine what combination of services a specific child actually needs. This means that often when given a diagnosis by a pediatrician or other physician the IEP team members have insufficient information in the report (often just a letter) to meet the school's obligation to identify all the child's needs. The schools answer when confronted by insufficient information is often to provide an evaluation by their staff. One issue that arises when this offer is made is that many school staff do a poor job of explaining to the parent that this does NOT mean they are "rejecting" the diagnosis offered by their professional. This lack of a complete explanation often leads to misunderstandings and mistrust. The school asking for additional evaluations can mean that they need a great deal more specific information to provide appropriate services on an ongoing basis than they were provided with by the family's professional. It has been my experience that physicians and psychologists can provide reports with insufficient information. Even behavior analysts have been known to provide less than illuminating reports, but this seems to have occurred less often in my experience - principally because we conduct evaluations focusing on function and write in generally operationally clear language.

The bottom line is that very specific and clear information on the nature of the child's needs, skills, deficits, and strengths is absolutely essential to developing the best IEP possible. By doing so the chances that the child will benefit from the services offered by the school increase dramatically.

If the school conducts their evaluation(s) and makes recommendations this is the point at which clear and penetrating assessment of the nature of the reports is essential. If the parent reviews the reports (which must be provided to them AND the person that wrote the report and conducted the evaluation must offer to explain the contents) and finds it does not adequately reflect the issues that they see in their child they have the absolute right to contest the information and request an Independent Educational Evaluation (IEE). This means that you and the schools must agree on an independent professional who has the appropriate training and the legal right to independently conduct the evaluation that you are asking for on your child. The essential idea is that the person doing the IEE is paid for by the schools (like how your insurance company pays your physicians) but that they are working for your child (not for the parents). Again, the idea here is to provide clear and comprehensive information on the needs of the child so that the adults can agree on what the child needs and how to proceed with providing the indicated services.

It is my hope that this note may help some who are as confused about the differences (very real ones) between diagnoses and eligibility as I was years ago. If I can answer any questions on this topic please contact me.

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Article Reviews

Below are reviews of recently published articles on the assessment and treatment of problem behaviors. Thanks to our reviewers: Megan Atthowe, Tanya Baynham, Kate Fiske, Karen Lenard, & Aurelie Welterlin.

McLaughlin, D. M. & Carr, E.G. (2005). Quality of rapport as a setting event for problem behavior: Assessment and intervention. *Journal of Positive Behavior Interventions*, 7, 68-91.

Reviewed by: Tanya Baynham, University of North Texas

Rapport is a term used frequently in both current practice and the literature of traditional psychology. Practitioners know we need to have it and are beginning to incorporate ways to improve rapport between direct care staff and clients. Unfortunately, the subjective, “know it when we see it,” nature of some definitions inhibits systematic replication and the widespread dissemination of a technology to measure the existence of rapport and the effects of programming for its development. In a recent article, McLaughlin and Carr (2005) systematically assess rapport, and then examine the effects of a treatment package designed to build rapport on the problem behavior of three adults with autism.

McLaughlin and Carr argue that rapport is a social setting event; a variable that determines which particular stimulus-response patterns occur at a given time. For example, the presence of a highly preferred instructor and a task such as math facts may not evoke aggression but the same math facts presented by a less preferred instructor may reliably evoke the problem behavior. Given the prevalence of behaviors that interfere with learning and inclusion in less restrictive environments for many people with autism, research in this area is imperative.

Study 1: Assessment of Rapport

Three adults with autism and a history of problem behavior (i.e., aggression and self-injury) in the presence of specific staff members participated in the study. In addition, eight staff members were selected to become part of either a *poor rapport* or *good rapport* dyad. There were three criteria for staff inclusion. First, each person with autism completed a 2-choice paired-stimulus preference assessment. Each person was included in five trials and staff members that were picked at least four times were eligible for possible inclusion in the good rapport group. Those picked one time or less were assessed further for inclusion in the poor rapport dyad. Second, staff members completed a 6-point Likert scale evaluating relationship satisfaction with the

client. If staff ratings matched client choice, the third criterion was assessed. Fellow staff members ranked relationships with the participant relative to other staff members and ratings above the 50th percentile indicated a *good rapport* dyad while ratings below the 50th percentile indicated a *poor rapport* dyad. Staff members with the highest scores across all three criteria were recruited to be part of *good rapport* dyads while those with the lowest scores were designated as *poor rapport* dyads.

Next, 10-30 min functional analyses sessions were conducted within the natural context of ongoing routines. Four conditions were probed, (a) poor rapport + demand

(PR+D), (b) poor rapport + no-demand (PR+ND), (c) good rapport + demand (GR+D), and (d) good rapport + no-demand (GR+ND). Demand conditions (e.g., vacuuming, eating a meal) were mastered to ensure that the differences across conditions were due to cooperation rather than task acquisition. No-demand conditions activities (e.g., watching TV, relaxing) were chosen by the client and were the same length of time as the previous demand condition.

Latency to the onset of problem behavior or the entire task duration in the no-demand condition was recorded as well as completion of each step within the chore task analysis. Mean inter-rater reliability, collected during 38% of the sessions, was 98%.

During PR+D condition, 28/30 ended early prior to task completion due to problem behavior. During the GR+D condition, only 4/30 sessions ended early. Participants also engaged in the activity for longer periods of time in the latter condition. During both the PR and GR +ND conditions, task termination was low: 3/30 and 1/30 respectively.

Study 2: Intervention

During this phase, 6 of the original 8 staff members (due to staff turnover) formed dyads with the same 3 clients who participated in study 1. The purpose was to provide these dyads with strategies to build or improve rapport. A multiple baseline design was implemented across participants in the three poor rapport dyads. The baseline was identical to the PR+D condition. Intervention consisted of 10-13 weeks of rapport-building staff training. Training had three components; noncontingent positive reinforcer delivery, responsivity, and turn taking/reciprocation training.

For the first 3-4 sessions, staff members were required to provide a *daily reinforcer* (e.g., pretzels, chips, cookies) to the client. They were also encouraged to deliver an *occasional reinforcer* (i.e., harder to deliver reinforcers like swimming trips and car rides). There were no requirements placed on the participant. Then, the staff member moved within a meter of the client. If the client did not approach, a verbal, then gestural cue was provided. Approach at any prompt level received an item and praise. If there was no approach, the staff member approached and delivered the item with praise. Staff gradually faded the distance between themselves and client.

Responsivity training involved reading a communication profile which outlined the participant’s common actions and corresponding communicative functions (e.g., If the client sits down on the floor

following the direction, “Let’s go!” then she is saying, “I want to stay here.”). Through verbal prompting and modeling, the staff were trained to follow *the three A-rule*, (a) acknowledge all communication attempts, (b) use context to assess function of attempt, and (c) address the need/request when possible. Training continued until the staff acknowledged 80% of communicative attempts without trainer prompts.

Part three of the intervention involved training turn-taking skills to dyads while engaging in a mutually preferred activity (e.g., going to Friendly’s). A task analysis was developed and members of the dyad were prompted to share equally in the sequence. Staff members received coaching with scripts, prompts, models and feedback. Each step was rated between 0-2 depending on the amount of interaction. Reliability was scored during over 30% of sessions within each training phase and was always higher than 80%.

Following intervention, staff members who had previously been chosen one time or less during the preference assessment were now chosen on approximately half of the trials. Staff satisfaction, as reported on the 6 point, Likert scale, increased by 1-2 points. Other staff members ranked the staff members approximately 20-percentile points higher than they had prior to intervention. Latency to problem behavior increased in all *poor rapport* dyads. In two of the three dyads, no baseline sessions were ever completed. After intervention, one client completed 6 of 9 sessions and the other completed 4 of 7 sessions.

The inverse relationship between rapport and problem behavior was quite notable in this series of studies. Furthermore, the results demonstrated that the repairing of rapport was attainable despite the fact the members of the poor rapport dyads had known each other for 3-5 years. The data suggest that rapport building, while not eliminating problem behavior, can contribute to the remediation of problem behavior within a multicomponent intervention. The methods described in the study can be extended to the development of rapport in new relationships. Finally, the findings support the use of a multi-method approach to assessing the rapport construct and measuring change over time.

Rapp, J., Vollmer, T., St. Peter, C., Dozier, C., & Cotnoir, N. (2004). Analysis of response allocation in individuals with multiple forms of stereotyped behavior. *Journal of Applied Behavior Analysis*, 37, 481-501.

Reviewed by: Megan Atthowe, BSN, RN, Virginia Institute of Autism

The existence of multiple forms of stereotypic behavior in one individual is common in developmentally disabled populations, yet few studies examine how interventions intended to reduce one topography affect the expression of other topographies. Potentially, several patterns of response reallocation could emerge—the intervention could cause concomitant reductions in untargeted stereotypic behaviors,

could allow an acceleration of previously less frequent stereotypic behaviors, could permit the emergence of desirable behaviors, or could have no systematic impact on other behaviors. Given that stereotypy is a frequent target of behavioral intervention, it behooves the research community to investigate how and why such interventions influence response reallocation. Clearly these data would better guide clinical intervention. Building on previous basic research on response reallocation, the present study examines whether patterns of response reallocation emerge when these common behavioral interventions are applied to the highest probability stereotypic behavior.

Three males and two females ranging in age from five to 14 years, all diagnosed with developmental disabilities, participated in this study. All participants exhibited multiple topographies of stereotypic behaviors. Sessions for three participants were conducted in an inpatient hospital, at school for one participant, and at both school and home for the remaining participant. Four participants’ sessions lasted 10 minutes and occurred 1-3 times per day across 3-4 days per week. Sessions for the fifth participant were 30 minutes long and occurred once per day across 3 days per week. Three experiments were conducted; not all participants were included in each experiment.

The first experiment identified each participant’s most probable stereotypic response (R1) during free-operant (FO) conditions and used a reversal design to examine the effects of R1 restriction on the time allocated to less probable responses. Restriction of the most probable response form resulted in a pattern of response reallocation for 3 of 4 participants, a pattern in which levels of one additional (untargeted) response were reduced while levels of at least one other, lower-probability response were increased. No pattern of response reallocation was evident in the fourth participant’s data.

The second experiment used a reversal design to compare three participants’ response allocation under the FO condition to that under FO plus environmental enrichment (EE). EE for two participants consisted of a variety of stimuli, while the third participant was restricted to one stimulus per EE condition in order to assess stimulus selectivity. Stimuli were chosen based on stimulus preference assessments and/or informal observations and caregiver interviews. No consistent patterns of response allocation were demonstrated across participants. FO + EE showed no effect on responses for one participant, a modest reductive effect on R1 for one participant, and a selective reductive effect for the third participant when the sensory modality of the stimulus was matched to the stereotypic behavior.

In the third experiment, the effects of EE on two participants’ response allocation and object manipulation were compared to EE plus an intervention for R1 using a reversal design. The experimental condition for one participant consisted of EE plus restriction of R1 as in the first experiment. The experimental condition for the second participant consisted of EE plus FR1 reinforcement of toy responses. R1 restriction resulted in increased levels of object manipulation but did not change untargeted stereotypic responses. FR1 reinforcement of object manipulation increased object manipulation and decreased time allocated to both R1 and less probable stereotypic responses.

Several findings are noteworthy. First, levels of R1 were highest after periods of R1 restriction for 3 of 5 participants; second, this effect was not observed after conditions of EE using selective stimuli that provided the same type of stimulation as the stereotypic behavior. This evidence suggests that the increase in R1 in the

reversal condition may have been due to a deprivation effect. If so, interventionists might expect a relative increase in stereotypic behavior when restrictive interventions are discontinued, whereas interventions that incorporate selective EE stimuli may prevent such a rebound effect. Future research should attempt to replicate this effect. Regardless of what pattern stereotypic response allocation may take during intervention, that such reduction or elevation may occur in non-targeted behaviors is important to consider in a risk/benefit analysis prior to implementing any plan.

Hanley, G., Iwata, B., Thompson, R., & Lindberg, J. (2000). A Component Analysis of "Stereotypy as Reinforcement" for Alternative Behavior. *Journal of Applied Behavior Analysis*, 33, 285-297.

Reviewed by: Aurelie Welterlin, B.A., Rutgers University

Stereotypy is one of the defining characteristics of autism. Stereotyped behavior can often be quite stigmatizing and can also interfere with skill acquisition. Research has focused on decreasing stereotypic behavior by increasing more socially acceptable behaviors such as manipulation of leisure materials. Previous studies have used stereotypic behavior itself as a reinforcement for socially acceptable alternative behaviors. The individual components of the interventions used in these studies, however, have not been analyzed separately. The current study assessed the effectiveness of four intervention components: a) continuous access to leisure materials, b) prompts to manipulate leisure materials, c) blocking access to stereotypic behavior, and d) access to stereotypy contingent on the manipulation of leisure materials.

One female and two male adults diagnosed with profound mental retardation participated in the study. Previous to treatment, each participant engaged in little to no manipulation of leisure materials and displayed no preference for leisure materials. Functional analyses indicated that each participant's behavior was maintained by automatic reinforcement.

Treatment sessions lasted for 10 minutes and were conducted four to five days per week at a day-treatment facility. During baseline and treatment sessions, data were collected on stereotypy and object manipulation during continuous 10 second intervals. In the baseline condition, each participant was seated near a table containing leisure materials. The therapists physically guided the participant to touch each leisure material and then left the area. After the baseline condition, each participant was exposed to either two or three additional treatment conditions, each of which was combined with the previous condition in the following additive arrangement: prompting—blocking—contingent access to stereotypy.

At the completion of treatment sessions, all three participants engaged in low levels of stereotypy and high levels of object manipulation. Each participant, however, differed in the intervention components needed to increase object manipulation. One participant responded to the treatment

condition that included continuous access to leisure materials, prompting, and blocking. During a final probe session, her object manipulation was maintained at 90% while stereotypy remained at zero, suggested that stereotypic behavior was replaced by manipulation of leisure material after a relatively brief history of manipulating leisure materials. The second participant also responded with decreased stereotypy and increased leisure material manipulation during the condition containing continuous access to leisure materials, prompting, and blocking, however, this effect was not maintained after treatment was removed. The final participant needed to be provided with access to stereotypy contingent on object manipulation. Although blocking decreased stereotypy for the participant, the contingency was needed to produce a significant increase in object manipulation.

The current study provides several important intervention strategies for managing stereotypic behaviors. Most importantly, the study suggests that treatment approaches will vary across participants and must be individualized. The data suggest that for some individuals, simply blocking access to one behavior (stereotypy) may increase an alternative behavior (object manipulation). For other individuals, stereotypy may function as a reinforcer for alternative forms of behavior, which could be extremely useful in situations in which few other items are as reinforcing as engaging in stereotypy. Future research should look at extending these findings to examine whether access to aberrant behaviors could lead to longer durations of object manipulation or engagement in more complex forms object manipulation, which may, in turn generate a wider repertoire and stronger sources of reinforcement.

South, L., Ozonoff, S., & McMahon, W. (2005). Repetitive Behavior Profiles in Asperger Syndrome and High Functioning Autism. *Journal of Autism and Developmental Disorders*, 35 (2), 145-158.

Reviewed by: Karen Lenard, Douglass Developmental Disabilities Center

Repetitive behavior is one of the hallmark symptoms of an autistic spectrum disorder (ASD). However, little research has investigated the functional or topographical differences of repetitive behavior in learners with asperger's syndrome (AS) or high functioning autism (HFA). The DSM-IV-TR describes four categories of repetitive behaviors in ASD: "(a) stereotyped motor mannerisms, (b) preoccupation with nonfunctional objects or parts of objects, (c) patterns of interest that are unusual in the narrowness and / or intensity of their pursuit, and (d) extreme rigidity and insistence on sameness." (p. 146). The current study attempted to describe and compare repetitive behaviors in individuals with AS, HFA, and typically developing controls (TD). Specifically, the authors compared frequency, developmental course, and degree of impairment of each category of repetitive behavior between the diagnostic groups to determine whether there are differences between AS from HFA. The authors hypothesized that individuals with AS were more likely to have circumscribed interests and a higher degree of impairment than learners with HFA. The authors also hypothesized that individuals with HFA would be more likely to show the other three types of repetitive behaviors listed in the DSM-IV-TR.

Sixty-one participants were included in the study: 21 participants were diagnosed with HFA, 19 were diagnosed with AS, and 21 were TD control subjects. The HFA group ranged between 8 – 20 years of age, with a mean age of 14.10 years. The AS group ranged between 8 – 19 years of age, with a mean age of 14.28 years. The TD group ranged between 7 – 19 years of age, with a mean age of 13.34 years. The instruments used to diagnose both disorders were the Autism Diagnostic Interview-Revised (ADI-R) and the Autism Diagnostic Observation Schedule-Generic (ADOS-G). All diagnoses were in strict accordance of guidelines outlined in the DSM-IV-TR. Two interviews with parent were conducted to assess repetitive behaviors: the Repetitive Behavior Interview (RBI) and the Yale Special Interests Interview (YSII). Specifically, the Motor Movements and Object Use categories of the RBI were used to examine frequency and duration of repetitive behaviors; the Rigid Routines category of the RBI was used to assess degree of impairment. The YSII was used to determine content, frequency, and duration of circumscribed interests. It was also used to examine the degree of impairment such interests caused individuals, their families, and their peers.

Although individuals with HFA scored higher on the RBI overall than individuals with AS, only two items on the RBI showed significant group differences, both within the Object Use category (lining up objects and spinning/banging/twiddling objects). Using the DSM-IV-TR diagnostic criteria, the authors' primary hypothesis that individuals with AS were more likely to have circumscribed interests was not supported in the current investigation. The authors also investigated whether presence or absence of early language delay, as determined by ADI-R results, predicted whether significant differences between the two groups. Individuals with early language delay showed significantly greater severity of Object Use and Rigid Routines, but no significant group difference in degree of circumscribed interests. In addition, the authors examined developmental change as a factor of severity of repetitive behavior. While lifetime severity was rated as more severe than current severity for both individuals with AS and with HFA for three RBI categories (Object Use, Motor Movement, and Rigid Routines) and parents informally reported preschool years to be the most challenging, no significant correlation of severity with age was determined.

In contrast to these findings, responses to the YSII indicated an increasing impairment due to circumscribed interests in both AS and HFA during the course of development. The authors of this article postulated that this increasing developmental impairment may be a result of the individual with AS or HFA improving in social and communication domains (Facteau, Mottron, Berthiaume, & Burack, 2003; Piven, Harper, Palmer, & Arndt, 1996), thus their circumscribed interests becomes more salient to others.

One limitation of this study is that it was not possible to compare rates of the four classes of repetitive behavior because different scales were used to measure different behaviors. Specifically, Object Use and Motor Movement used frequency and duration measures, while Rigid Routines and Circumscribed Interests infer degrees of impairment using a 4-point Likert scale. Thus, the authors suggested that a future area of research may involve finding comparable measures across behaviors. In addition, the authors of the current study suggested replication with a

larger sample size. Additionally, a longitudinal or cross-sectional experimental design could potentially answer questions about diagnostic differences related to developmental levels. Another limitation to the present study is the overlap of diagnostic criteria for AS and HFA in the DSM-IV-TR, making it inherently difficult to differentiate the two diagnoses. Lastly, three of the four measures used in this study were structured interviews. Miltenberger (1998) cites the major disadvantage of interviews as being relatively inaccurate. Interviews are based on retrospective recall that may be inaccurate or partially accurate due to bias, forgetting and limited access to relevant stimuli. Additionally, Sigafos, et al (1993) found only 43% agreement on structured interview questions when answered by more than one staff person. This finding lends support to the importance of using observational data when measuring behaviors.

Wayne W. Fisher, Iser G. DeLeon, Vanessa Rodriguez-Catter, & Kris M. Keeney (2004). Enhancing the effects of extinction on attention-maintained behavior through noncontingent delivery of attention or stimuli identified via competing stimulus assessment. *Journal of Applied Behavior Analysis*, 37, 171-184.

Reviewed by: Kate Fiske, Rutgers University

One of the advantages of functional analysis is the systematic identification of the maintaining contingency for behavior. Once the contingency has been identified, the behavior analysts, teachers, and families frequently use extinction—the discontinuing of the maintaining contingency—to decrease the behavior. A disadvantage of extinction, however, is that the treatment removes the child's primary means of accessing reinforcement (social, tangible, automatic, or escape) while failing to teach the child a functional alternative. This decrease in reinforcement may produce bursts of the target behavior, extinction-induced aggression, and emotional behavior. As a result, noncontingent reinforcement (NCR, the scheduled delivery of reinforcement on a time schedule or independent of the target behavior) is often paired with extinction to provide the child with access to reinforcement while simultaneously discontinuing the previous maintaining contingency between the target behavior and reinforcement.

While the use of noncontingent attention has often been used to decrease behaviors maintained by attention, it can often be difficult to provide, especially for families. A parent with household chores and other children may not be able to provide the noncontingent attention necessary to decrease the behavior. Fisher, DeLeon, Rodriguez-Catter, and Keeney (2004) conducted a multi-phase research project that compared the effectiveness of noncontingent access to competing tangible items paired with extinction (NCT), noncontingent access to attention paired with extinction (NCA), and extinction alone.

Four participants were included in the study, ages 5, 7, 9, and 33 years. Each had been diagnosed with mild to severe mental retardation and exhibited destructive behaviors in the form of aggression, self-injury, and disruptive behavior. A functional analysis of each participant's behavior indicated that it was maintained by access to attention. Following the functional analysis, a competing stimulus assessment was conducted to identify tangible items that competed with the target behavior. The participants were

presented with one item at a time, and researchers recorded the duration of interaction with the item and the frequency of the target behavior while the participant had the item. Two items that promoted both high levels of interaction and low frequency of destructive behavior were identified for each participant.

Fisher et al. (2004) then conducted a treatment analysis of the following treatments: In baseline, the participants were given attention for each occurrence of the target behavior. In the NCT condition, the participants were provided with constant access to competing tangible items and the therapist did not respond to the target behavior. In the NCA condition, the participants were provided with constant attention and the therapist did not respond to the target behavior. Finally, in the extinction condition, the therapist did not interact with the participant and ignored the target behavior.

The results from the study indicate that NCT is as effective as NCA in decreasing problem behavior, and both are more effective than extinction alone. In addition, NCT and NCA seem to be more effective at preventing extinction bursts than extinction alone, though further research in this area is needed. In addition, further research should be conducted on the effectiveness of the NCT in reducing the motivation for attention. While NCT may keep the child engaged for the 5-minute condition, it may not reduce the motivation for attention and the behavior may continue once the competing item has been removed. Research that measures the frequency of behavior once both attention and tangibles have been removed from each condition would better address this possibility.

The results of this study provide useful information for behavior analysts, teachers, and families who are implementing behavior plans in environments where providing noncontingent attention is difficult. If access to competing tangible items can be provided in lieu of attention, the intervention may still prove effective. This will be especially helpful in households and classrooms where parents and teachers are unable to provide one-to-one attention frequently throughout the day. As the authors have suggested, attention could be provided when appropriate, such as at meal times and games), but noncontingent access to competing items could be provided when attention is either inappropriate or unavailable (e.g., parents making dinner, teacher working with another student).

Inclusion of advertisements or announcements in the SIG newsletter does not necessarily indicate endorsement of these items or events by the SIG or SIG newsletter editing staff. The content of this publication has not been reviewed or endorsed by the Association of Cognitive and Behavioral Therapies or the Association for Behavior Analysis.



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FROM ABA SIG

SUMMER 2005

Message from David Celiberti, ABA SIG President

Dear ABA SIG Members:

I hope you all enjoyed Chicago! I am writing to you regarding a number of matters related to the Autism SIG.

Autism SIG Meeting

I received much positive feedback about our panel. I would like to thank Gina Green, Steve Luce, Barbara Wells, and Debra Harris for serving on the panel at our SIG meeting. As you know, we routinely have a brief business meeting followed by a panel discussion or special presentation. We are in the process of assembling the panel for ABA 2006. I will give you more information about the panel in a latter issue of our newsletter.

Although the Autism SIG is ABA's largest special interest group, there are many individuals who work in the area of autism who do not attend our SIG meetings or receive our newsletter. I encourage you to invite your colleagues to join the SIG by contacting Megan Martins, Newsletter Editor, at martinsm@rci.rutgers.edu

SIG Newsletter

Our quarterly newsletter now has four recurring themes (early intervention, challenging behaviors, adults with autism, and family issues). Each newsletter issue will represent one of these themes with the theme for this issue focusing on challenging behaviors. I would like to thank all the individuals who submitted content for this issue. The next issue will focus upon Adults with ASD. If you have suggestions for content please do not hesitate to contact either Megan or myself.

Consumer Guidelines

As you are aware, we are in the process of revising the Autism SIG's Consumer Guidelines. At the SIG meeting in Chicago, we solicited assistance from the SIG membership. A number of SIG members have volunteered and are now part of the Revisions Subcommittee. I am writing to provide you with a bit more

information about the 3 layers of involvement that I envision for this group.

1) Soliciting input from both the ABA and consumer communities about the utility, scope, and relevance of the existing Guidelines. This layer of involvement would largely occur from August through December 2005. This would supplement the general request for input that will occur through an email that you will receive in September.

2) Reviewing input that we collect during the fall and assisting with the revision process. This layer of involvement would commence as feedback arrives but would be most concentrated in January through March.

3) Promoting the accurate dissemination of the existing Guidelines (i.e., new venues for distribution, ensuring that web postings and newsletter exposure contains the guidelines in their entirety with the appropriate placement of the disclaimer). This layer of involvement would occur throughout the year. It will be important that we track the placement of the guidelines so that outdated versions can be pulled and replaced with a revised version of the Guidelines.

I also wanted to provide an overview of the sequence of events that will unfold over the next year. As I stated earlier, we will email the Autism SIG membership in September inviting feedback on the existing Guidelines. Please be on the look out for that correspondence. Your feedback will be considered up until December 1st. My column in the Fall issue of the newsletter will remind you to respond to the email by the December 1st deadline.

By mid December the feedback will be summarized and distributed for review by the Subcommittee. The goal would be to have a final version that will distributed to the SIG membership in early April for a vote (the choices are to accept or not accept; there will be no opportunity for *further* revision at that time). The deadline for voting will precede the May meeting in Atlanta so that the revised Guidelines can be distributed at the conference.

Please visit the following link to view the current Guidelines - <http://www.abainternational.org/sub/membersvcs/sig/contactinfo/Autism.asp>

Please feel free to contact me if you have any questions. I can be reached at dacnys@aol.com

Autism SIG Meeting
Saturday, May 28, 2005, 7:00-8:20 pm
ABA 30th Annual Conference
Chicago, IL

MINUTES

David Celiberti called the meeting to order at 7 pm, beginning with a SIG business meeting. There were 140 members in attendance.

Guidelines Update

David provided an update about the SIG Guidelines for Consumers project. Last year, a revised version of the Guidelines was voted on by the SIG and was accepted by the membership. David announced that the Guidelines will be updated every two years. The next SIG Guidelines will be updated this year and will be voted upon in 2006. David solicited assistance from the SIG membership. A number of SIG members volunteered and are now part of the Revisions Subcommittee.

Student Research Award

David announced that the winner of last year's student research award was Matthew S. Goodwin from the The Groden Center for his poster *Exploring Heart Rate Responses to Stereotypical Behavior in an Individual with Autism*. The award includes a certificate and \$50.00 credit to the ABA bookstore for his winning poster. Congratulations!!

David thanked last year's judges: Corrine Donley, Joanne Gerenser, Gina Green, & Jane Carlson. Judges for this year were then recruited, including: Corrine Donley, Robert La Rue, Peter Gerhardt, & Bobby Newman. Thanks to all for volunteering!

Newsletter Report

Megan Martins, newsletter editor, gave a description of the newsletter and a request for participation and submissions. The newsletter is published 4 times each year, and consists of regular features, including: upcoming event announcements, job postings for Director level positions, program descriptions, abstracts of recent publications, article synopses, book reviews, innovative clinical interventions, letters to the editor and other feature articles. Megan

also announced that each future Autism SIG newsletter will contain a special section with a different theme. The themes for the newsletters in the coming year will be:

- ✘ Problem Behaviors (Summer 2005)
- ✘ Adult Services (Fall 2005)
- ✘ Early Intervention (Winter 2006)
- ✘ Family Issues (Spring 2006)

Megan encouraged SIG members to submit contributions to the newsletter and stressed the importance of the continuing contributions of the membership. Submission recruitment forms were distributed to the group. Some members of the SIG expressed willingness to submit contributions to the newsletter.

Treasurer's Report

Megan Martins gave a treasury report. At the 2004 SIG meeting in Boston, MA, \$371 was collected and deposited to the Douglass Developmental Disabilities Center at Rutgers University, thanks to generous voluntary donations. The annual donations are used for reimbursement of newsletter printing and postage costs plus the cash prize for the student research award. This year, \$441 was collected from the membership.

Related SIG Updates

Suzanne Buchanan, vice-president of the Parent and Professional Partnership (PPP) SIG was introduced. The PPP SIG aims to address the needs of parents and consumer's attending the conference and facilitating collaboration among the parents and professionals in attendance. Suzanne encouraged Autism SIG members to attend the events of the PPP SIG.

Barbara Esch, chairperson of the Speech Pathology and Applied Behavior Analysis (SPABA) SIG was also introduced. The SPABA SIG promotes collaboration between speech pathologists and behavior analysts in the dissemination of behaviorally oriented speech and language information.

The remainder of the meeting was devoted to a panel discussion, moderated by David Celiberti.

Panel Discussion 7:30-8:20 pm

Panel discussion on the *Revised Guidelines for Consumers of Applied Behavior Analysis Services to Individuals with Autism and Related Disorders* of the Autism Special Interest Group (SIG). Panel moderated by David Celiberti, Autism SIG President. A copy of the Guidelines can be found at: <http://www.abainternational.org/sub/membersvcs/sig/contactinfo/Autism.asp>.

Panelists

- Gina Green (BACB board; Cambridge advisory board; President of CalABA)
- Deb Harris (parent of a 6 year old with autism; co-founder of the Elijah foundation, and board member of NYSABA)
- Steve Luce (vice president of Melmark; Cambridge advisory board; National Autism Center)
- Barbara Wells (parent of a 13 year old with autism; COSAC)

In light of the gap between supply and demand for ABA services, how do we justify the stringent nature of the Guidelines?

DH: I love this question because it is important to understand the problem of supply and demand. The guidelines serve as a measure against individuals who claim that they were trained in ABA but who do not have the adequate skills to be working with our children. Unfortunately, we sometimes have to choose between providers who do not have adequate experience and this document helps us to choose the best that we have. The guidelines are intensive and the ultimate goal for what we would like from therapist. As a parent, I feel fortunate that we have these standards set now.

Previously, I thought having a special educator was the answer but ABA has its own set of technical skills. A therapist needs to have detailed skills (like a surgeon or other service provider) and demanding those skills will help more children get better treatment.

BW: We must raise the bar for the level of service our children receive because that is what they require to succeed. Lowering the standard would only contribute to the problem. For example, would we allow a medical student to independently perform surgery? Parents need assurance that the person responsible for our child's program will possess the necessary skills and be able to individualize programming to promote an effective education. If we accept less, our children will receive less. High standards benefit children and families.

GG: It is great to hear parents saying this. We know if you set low standards, you get low performance. We ought to strive for the best approximation of high standards rather than settle for lower performance. Settling for lower performance leads to a downward spiral.

SL: The Guidelines are an awesome document that outlines in great detail what we should strive for. They are written with the spirit that we ought to approximate these standards. Standards are imperfect; we all know people who meet them and are terrible and we know others that do not meet them are competent. The issue is:

How do we define who is competent? The Guidelines reflect abilities that are not exactly measured using test technology. Let's compare them to standardized tests, which have horrible correlations. If we are epical about tests, we can encourage consumers to use the Guidelines. Further, the guidelines are a tool that may help professional who have not chosen to pursue a BCBA but have a number of skills. This process is bittersweet due to the crisis of availability. We need to have standards and we need them in addition to what we already have but not everyone will meet them.

What other qualities not mentioned in the Guidelines should be considered when selecting a service provider?

BW: (Open-mind) Is the provider aware of your family's cultural needs? Are they open to diversity? Where do they stand on the use of experimental treatments to supplement a behavioral program? Will they work with you to evaluate these other interventions? (Logistics) Does the provider have a support system in case of short-term or long-term absences such as illness? Do they have adequate clinical supervision when they need assistance? Does the provider act professionally? Does he/she wear appropriate attire? Is he/she punctual? Does he/she keep my family's private information confidential? (Rapport) Most importantly, a provider should have a good rapport with my child and my family. There is so much work to be done that all of the people involved should be active and caring participants. The provider often sets the tone for the entire behavioral program. I want someone who can explain the "what" and "why" of their recommendations and who is excited and thoughtful about the process. The ultimate question is, does this provider motivate and connect with my child?

GG: The qualities I mention are based upon discussions with a parent group. They include a position on the use of other procedures outside of the ABA. The BACB states that you must base treatment selection on scientific evidence. It is also important to ask what elsea provider does, how large is their caseload, what type of supervision these receive, and what type of supervision they will provide. A weak link in the BCBA is supervision and it is important to ask the service provider what type of supervision they will be receiving.

How could the Guidelines be used as a professional development tool?

BW: As you all know, some people study behavior analysis for years in graduate school under appropriate supervision. Other people claim to be knowledgeable about how to run behavior analysis services for children with autism after spending one year as a teacher's assistant in an ABA program. There is tremendous variability in the qualifications of the providers who may work with your child. This variability puts parents in the hot seat to be the judge and jury of who is most qualified. The Guidelines set a standard for experience so that parents and professionals themselves can rate their qualifications. For the many professionals who do not have adequate and sequential training, the Guidelines can be a map, a checklist of sorts, to rounding out their experience. If a professional is interested in providing high-quality ABA programming, this document clearly outlines a path.

SL: This is perhaps one of the best aspects of the Guidelines. It is important to cast out net wide to try to attract many more service providers to the field. Rather than ignore those who do not have all the skills, the Guidelines can be used as a training tool.

How can parents and school districts use the Guidelines?

DH: This issue is the reason that I feel strongly about the Guidelines. As a member of a parent group who supports educators, I feel strongly that they should be disseminated because they are not well recognized by special educators. The Guidelines can be used as a tool to force school districts to set up an appropriate ABA classroom and provide the right type of education. They have already begun to help some parents ensure that a BCBA is specified on an IEP and that the BCBA will provide the right type of consulting. Hopefully, districts will begin to be aware of the requirements for a service provider for our children. Certification is not necessarily enough to ensure that the provider is qualified and this document will help get funding for ABA for our children.

BW: The Guidelines can be used as a tool to help parents put the responsibility of a child's program where it belongs, with the professional. So often, parents don't know the questions to ask, let alone the answers. When you need to put faith in someone else's expertise and you don't know how to determine if they are qualified, it helps to know what questions to ask. When you hear the word autism for the first time, you're not thinking skill acquisition then skill generalization. You're thinking, will my child talk? What is the next step? The emotional roller coaster has just started up the incline; this document is a level plane. It provides the questions necessary for a parent to ask of the professionals who will be responsible for their child's development. This is a short cut through all the pseudoscience and other people's claims. This is a good night's sleep the night before an IEP meeting because it gives the consumer qualities to look for in the person who will be designing their child's program.

GG: I am constantly running into people who do not know enough about ABA. A document like this is another way to educate people about the field. Having a legitimate professional credential is important to keep others from posing as qualified professionals and protect the consumer.

How do the Guidelines interface with the BACB standards?

GG: Although I cannot speak for the BACB, the board is interested in developing specialty certifications, one of which will certainly be autism. This is a major task and anything that we can do to start putting things down will be helpful. It is important that we eventually get a viable, credible certification in ABA for autism. I think that the Guidelines will be a springboard for the development of that specialty certification.

DH: The concern I have about the BACB is that it is unable to protect our children from harm. It is very important that the therapist have particular skills in a wide range of areas specific to autism and this document is a step in the right direction. Children with autism vary according to age, severity of the disorder, behavior problems etc... Familiarity with "autism" is not enough but it is a critical starting point.



ABCT NEWS

ASSOCIATION OF BEHAVIORAL AND
COGNITIVE THERAPIES
39TH ANNUAL CONVENTION
November 17-20, 2005
Washington DC Hilton

For more information about the convention, check out the ABCT (formally AABT) website at www.aabt.org! Autism related convention events to come in a future issue of the newsletter. Stay tuned!

ATTENTION STUDENTS AND MENTORS!!

A Student Poster Contest at ABCT 2005

If you are a graduate or undergraduate student and the first author on an autism related poster accepted by ABCT, you are eligible to enter the ABCT Autism SIG's student research contest. If you are mentoring a student who may not receive the newsletter, please pass this notice along to them. The winner of the student research contest receives a framed award and gift certificate to the ABA bookstore. Further, the winner's poster will be printed in a later edition of the newsletter (which is received by hundreds of professionals in the field).

Submitting a poster is easy. All you need to do is complete an entry form, attach a copy of the poster, and submit the poster to Megan Martins, Autism SIG Co-Chair. If you have any further questions or would like to request a form, please contact Megan at martinsm@rci.rutgers.edu.

Deadline: December 5, 2005 (two weeks after ABCT)



Poster Session Invitation
Autism and Related Developmental Disabilities SIG
Association for Behavioral and Cognitive Therapies

Dear Colleague,

The Autism and Related Developmental Disabilities Special Interest Group (SIG) of the Association for Behavioral and Cognitive Therapies (ABCT) would like to invite you to participate in the 2005 SIG Exposition at the annual convention of ABCT. The focus of the Autism SIG's poster session is "*Works in Progress*", although all autism related submissions are eligible.

If you are currently working on a research project or have a student who is working on a research project, I enthusiastically encourage you to consider this invitation. The EXPO provides a wonderful opportunity for professionals and students to meet each other and learn more about the work currently being done in our field.

For those of you unfamiliar with ABCT (formerly Association for the Advancement of Behavior Therapy, AABT), the national convention is held in November each year. At the EXPO, each SIG has a certain number of poster slots allowed and we would like to meet this maximum number this year. We had a very successful outcome last year, and we aim to make it even better this year. We are currently involved in an effort to expand the presence of the Autism SIG and autism related events at ABCT and we would especially like to welcome our colleagues from the Association for Behavior Analysis (ABA) as well as other agencies or universities to join us at ABCT this year. If you would like more information about ABCT, their website is www.aabt.org.

The convention this year will take place in Washington DC, from November 17-20, 2005. In order to submit your work, please send the *title of the project, a brief abstract of the project*, and the *names and affiliations of the authors* to Megan Martins, the Autism SIG Co-Chair by Friday, August 26, 2005. You can email your submission to Ms. Martins at martinsm@rci.rutgers.edu or fax a copy to (732) 932-3095. You will receive a response from the SIG about whether your poster was accepted during the first two weeks of September.

If you have any questions regarding the SIG or the Expo please email or call Ms. Martins at (732) 932-3017, ext. 161. Additionally, if you wish to stay informed about other upcoming ABCT Autism SIG events, please email Ms. Martins.

We hope you will join us at ABCT this upcoming November!

Sincerely,

Megan Martins, M.S.
ABCT Autism SIG Co-Chair

Jan S. Handleman, Ed.D.
ABCT Autism SIG Chair

Update from the Developmental Disabilities SIG Association for Behavioral and Cognitive Therapies

DD SIG Meeting
Russell Kormann, SIG Chair

The Developmental Disabilities SIG will be holding our annual meeting on Saturday November 19, from 12:00-1:30 in the Chevy Chase Room. We are extremely pleased to present Dr. Brenda Smith Myles an associate professor in the Department of Special Education at the University of Kansas as this year's keynote speaker. She is a national leader in the area of asperger syndrome and will be making an address entitled "The Cycle of Tantrums, Rage, and Meltdowns in Children and Youth with Asperger Syndrome." The presentation will overview the three-stage cycle of tantrums, rage, and meltdowns: rumbling, rage, and recovery. In addition, interventions that can be used at each stage will be overviewed as will a brief overview of prevention strategies. Emphasis will be placed on strategies applicable across settings.

Dr. Myles co-directs the Autism Spectrum Disorders program at the University of Kansas, a program designed to prepare education and related services professionals to teach children and youth diagnosed with autism, asperger syndrome, and other pervasive developmental disorders. Coursework covers assessment; curriculum, social, communication, and behavior interventions; and sensory issues. Students participate in multiple field-based practica in a variety of school and clinical sites, including the opportunity for field experiences in multicultural settings. Program participants pursue a master's degree in Special Education with an emphasis in autism and asperger syndrome. Dr Myles was the recipient of the 2004 Autism Society of America's Outstanding Professional Award. She has written numerous articles and books on asperger syndrome and autism including *Asperger Syndrome and Difficult Moments: Practical Solutions for Tantrums, Rage, and Meltdowns* (with Southwick) and *Asperger Syndrome and Adolescence: Practical Solutions for School Success*. The DD SIG is proud to provide ABCT with an opportunity to explore the needs of this growing population.

I am also very happy to report that the response to my annual March membership mailing this year was once again excellent. I was able report to AABT's central office that the Developmental Disabilities SIG continues to be alive and well with a confirmed membership list of seventy-one (71) members, a twenty percent increase over just last year. It is also exciting to note that twenty percent of our responding members are students (an eight percent increase over just last year) who will hopefully become full and highly participatory members to both the DD community and ABCT in the very near future. I want to thank everyone that returned the membership inquiry and encourage you to help keep our ranks growing, by dragging one friend/colleague to the convention and obviously to the SIG meeting and asking them to join the merry band by e-mailing their stated interest to me at kormann@rci.rutgers.edu.

Please send your suggestions of topic ideas for possible inclusion in an upcoming issue of the SIG newsletter to:

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