



Current Trends in Autism Conference Report for SNAC

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Date of Conference:	November 5 th and 6 th , 2013
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Brief Description of Conference:

The Current Trends in Autism Conference was a two day conference designed for professionals, educators and parents; all whose lives are touched by a person with ASD. Today more than 1% of the population is now diagnosed with ASD. This Conference was designed to allow stakeholders to share information and resources by strengthening support networks. Themes included: early screening, new developments in diagnosis, advances in intensive intervention, as well as bullying and mental health in youth with ASDs.

The Miriam Foundation that hosted the conference also used the opportunity to launch their new awareness and fundraising campaign “See Things My Way”.

Presentation Summary by Speaker and Discussion Topic:

Bridget Taylor

Dr. Bridget Taylor is the Executive Director of the Alpine Learning Group in New Jersey. She gave two presentations at the conference on the Tuesday morning: (1) Observational Learning and Children with Autism; and (2) Improving Social Behaviour of Children with Autism. In both presentations, Dr. Taylor used videos to demonstrate the techniques they are using to work with their students with autism.

Observational Learning

Observational learning happens when we observe what others are doing to give us clues as to what we should be doing (we imitate behaviours that bring us positive reinforcement and do not imitate those that bring negative reinforcement). Observational learning does not come naturally to many kids with autism. They are often more interested in objects than people so they don’t learn by watching (observing) others as readily. Observational learning can help...

- kids learn without explicit instructions
- integrate the autistic child in school
- teach social skills

The foundation of observational learning is imitation. Imitation deficits are a core feature of autism. Most intervention for autistic kids ends when they have mastered a certain level of imitation; however Dr. Taylor believes that more is needed to foster observational learning. She explains that many of the things that a child is taught to imitate in a therapy setting are not functional (i.e. “clap your hands”) and that autistic kids would get more out of imitation if it was taught in a functional way—through peer to peer modelling. The first step is having the child learn how to imitate a group of peers. Dr. Taylor used several video examples of kids coming into a group setting and having to

look around them and start doing what the other kids were doing (i.e. all the kids are colouring and have their shoes off; the target child would have to see these details and then do the same thing).

The difference between imitation and observational learning is that imitation does not take into account consequences, whereas observational learning does. The learner has to determine which response they should incorporate in their repertoire and which ones they should not according to the outcome/consequence. In a peer to peer learning environment, an autistic child could learn to observe another child respond to an instruction and be praised “that’s right!” or be corrected “that’s not right”; then they would be able to respond in the correct way after learning from their peer’s example. Her research has shown that after a child is taught these techniques for some time, they then begin to generalize in other areas. One of the best backhanded compliments one of her students received was after they had entered a regular school and the teacher had given Dr. Taylor an update on the child’s progress: “she is doing great in class, but we have noticed that she has been cheating in some of her tests”. This is because the child had learned through observational learning to look for clues from her peers when she didn’t understand what was going on.

Improving Social Behaviour

Social behaviour is very complex. First think of the most social person you know—what is it that makes them that way? Then think of people who have social deficits—do they talk too loud? too close? not enough eye contact? Individuals with autism require specific instruction to improve social skills. The first step is by teaching them to engage in joint attention. Components of joint attention include:

- following an adult’s gaze and point
- checking back with the adult (includes eye contact)
- gaze alternation between object and adult
- reciprocal comment about object

Research has shown that joint attention is often impaired in people with autism. Less eye contact and focus on social interaction leads to less joint attention. Improved joint attention is also linked to better language skills.

Dr. Taylor spent a lot of time going over research about joint attention and the fact that autistic kids can be taught joint attention responses (through prompts, modeling, positive social interactions, tangible rewards). Here are the things to teach an autistic child so they can develop the skill of joint attention:

- eye contact is functional, then teach “spontaneous looking”
- how to follow a point
- teach the child to show an object
- teach the child to make comments and to offer information (can start with rote responses and then move forward from there)

Joint attention skills serve as a foundation for more advanced reciprocal language skills.

Marc Tassé & Nathalie Garcin

Dr. Marc Tassé is the Director of the Ohio State University Nisonger Center, a University Center for Excellence in Developmental Disabilities. Dr. Nathalie Garcin is the Executive Director of the Gold Center (Miriam Foundation) and she was the principal organizer of the *Current Trends in Autism Conference*. Together they spoke about the new DSM-5 (updated in 2013) and how it effects how a child is diagnosed with autism or an intellectual disability today.

Impact of DSM-5 on Diagnosing Intellectual Disability / Global Developmental Delay

Dr. Marc Tassé addressed more generally the history of the DSM (from its inception in 1952) and how it's been updated every 12 years or so. DSM stands for the Diagnostic and Statistical Manual of Mental Disorders. Its purpose is to facilitate reliable diagnoses of a number of disorders and it's also a tool for collecting public health statistics. Here are some of the primary changes to the new DSM-5:

- The new manual no longer uses the term “mental retardation” and has replaced it with the term “intellectual disability”.
- There is less emphasis on IQ scores since they are insufficient to assess reasoning in real-life situations. (i.e. someone can score high on an IQ test and still have severe adaptive behaviour problems in social judgement or social understanding—sometimes the case with autistic people).
- There is now an emphasis on “adaptive functioning” and how it affects daily life (communication, social participation, independent living, etc.) across multiple environments (home, school, work, recreation, etc.).
- Deficits in adaptive functioning need to be in one or more of 3 domains: conceptual, social and practical.
- Adaptive functioning can be assessed using standardized tests; however these tests need to be adapted to the culture and society in which they are used. Dr. Tassé stressed the importance of having tests specifically designed for the Canadian and Quebec populations (in the past many Francophone Quebecers have scored significantly lower than their Anglo counterparts).
- The DSM-5 no longer looks at sub-types of disorders, but rates things by the severity of symptoms. There are 4 severity levels: mild, moderate, severe and profound. In the US these levels are used for insurance/reimbursement purposes.
- Age has also been included in the updated DSM-5. For autism onset has to be before the age of 18, however this does not affect schooling in Quebec which will continue until the age of 21.

Impact of DSM-5 on Diagnosing Autism Spectrum Disorders

Dr. Nathalie Garcin's presentation focused more specifically on how the DSM-5 affects the diagnosis of autism. Here are her primary points of interest:

- The old category of “Pervasive Developmental Disorders” (which included autism, Rett Syndrome, PDD-NOS and Asperger's) has been replaced “Autism Spectrum Disorders” and it falls under the new

category of “neurodevelopmental disorders”. Therefore the sub-categories of PDD-NOS and Asperger’s are no longer used by the DSM-5. This does not mean that someone no longer has Asperger’s syndrome, but they are under the more general ASD umbrella.

- There are two categories of symptoms for ASD—(1) weaknesses in social communication and social interaction; (2) unusual behaviours, interests or activities that are restrictive and/or repetitive.
- There are 3 levels of severity that someone with ASD will be diagnosed with: (1) requiring support; (2) requiring substantial support; and (3) requiring very substantial support.

More details regarding the categories of ASD symptoms and the level of severity can be obtained from Dr. Garcin’s power point presentation (see links at the end of his report).

The second part of Dr. Garcin’s presentation included a review of current research and theories as to the possible causes of autism, as well as an overview of what the early signs of autism are. Like Dr. Taylor, she is a big advocate of teaching young kids with autism joint attention techniques to provide them with a good foundation for life-long learning.

Jonathan Weiss

Dr. Jonathan Weiss is a clinical psychologist and a psychology professor at Toronto’s York University. He spoke about the importance of providing kids with ASD support so that they can overcome some of the emotional difficulties associated with being on the spectrum—I found this presentation particularly interesting.

Supporting Mental Health in Youth with ASDs

According to Dr. Weiss about 1 in 5 typically developing youth have reported some type of issue (anxiety, hyperactivity, emotional difficulties, and/or behavioural difficulties). In the case of autism, almost all youth on the spectrum have reported at least one of these issues (anxiety being the most common). Often it is not just one problem but a cluster of difficulties. For ASD kids the effects of emotional difficulties is usually social avoidance. But Dr. Weiss doesn’t want us to get caught up in the symptoms (anxiety, sadness, anger); we should look at the underlying causes instead.

Why are the rates so high? Dr. Weiss explains that the answer to this question is very complex, often involving many factors. Below are a few key things to look at:

- biological issues (medical and sensory) – if the child isn’t feeling good or has sensory issues they can have anxiety or anger issues
- psychological issues – a child diagnosed with ASD who has a higher IQ is more likely to have emotional difficulties (sadness, anxiety) than those who are less “aware”
- social stigma – the “R” word is still used a lot with youth and in social media
- bullying – very common (about 77% for kids with ASD and 30% of this group was bullied at least twice a week)
- social disadvantage – kids who came from these types of families (single parent, low-income, unemployment situations, maternal health issues) were more likely to have emotional difficulties (this

includes the presence of negative life events such as death in the family, job loss)

The two main avenues to combat emotional difficulties are through the family unit and peers. Kids who have a supportive and available parents and siblings are shown to be better at emotional regulation. The same is true for friends. And kids who have lots of friends are less likely to be the target of bullying. Getting ASD kids involved with activities that are at their level (i.e. Special Olympics, swimming, acting, dance, chess club) also boosts their self-esteem and allows them to develop friendships. Other things that have helped include:

- mindfulness training – he recommends “Souls of the Feet” program
- social skills groups – he recommends “Secret Agents Society” social skills program (<http://www.sst-institute.net/>)
- early intervention that builds on key individual strengths (don’t focus on weaknesses)
- Cognitive Behaviour Therapy – he recommends the “Facing Your Fears” workbook and the “Exploring Feelings” workbooks for anxiety and anger (Dr. Tony Attwood)

Lonnie Zwaigenbaum

Dr. Lonnie Zwaigenbaum is a professor in the Department of Pediatrics at the University of Alberta and is involved in autism research through his leadership of several different research organizations. Dr. Zwaigenbaum gave a presentation on research into the early detection of ASD and, although very interesting, I will not go into too much detail here since it was not as relevant to school-aged children as some of the other topics covered at the conference.

Advances in Early Detection and Diagnosis of Autism Spectrum Disorders

Early detection of autism does not equal early treatment of autism. Dr. Zwaigenbaum stressed that there needs to be an improvement in the link between getting a diagnosis and the start of treatment. As we all know, the waiting lists for services in Montreal are extremely long.

Some of Dr. Zwaigenbaum findings:

- If a child has autism, the risk that subsequent children would be diagnosed with ASD is 1 in 5 (20%).
- Research is showing that we can now begin to detect autistic tendencies as early as 2 months.
- The 2 most common temperament profiles of babies with autism are: (1) under (re)activity—the kids don’t react and shift attention when you try to get their attention; and (2) emotion (dys)regulation—more crying and less happy interactions.
- “Perfect babies” who don’t cry and you don’t know are in the room can be an early sign of ASD.

Dr. Zwaigenbaum concludes that there is no single method of early ASD detection and that “a spectrum of approaches is needed to identify a spectrum of children”.

Temple Grandin

Dr. Temple Grandin needs very little in the way of introduction. She is one of the most famous ASD ambassadors who has written several books about her experience living with ASD. Through her career in animal research she has redesigned most of North America's livestock facilities. She is currently a professor of animal sciences at Colorado State University.

The Autistic Brain: Thinking Across the Spectrum

In her latest book, Dr. Grandin looks at brain research and what it can tell us about ASD. A portion of her presentation at the conference focussed on looking at various MRI scans of her brain and brain research on other autistic people and how these compare with neurotypical brains. Brain research and genome/DNA research for autism is still in its infancy, but she feels that we have so much to learn from this.

Depending on how the brain has developed, some ASD kids might be stronger in some areas than others. She used to think that all autistics were visual thinkers like herself, but through her research she has discovered 4 types of "thinkers", each with their own strengths. A person may have a mixture of the following strengths:

1. photo realistic visual thinking (aka object visualizer) – poor at algebra but very good at seeing things from different perspectives (Dr. Grandin falls into this category)
2. pattern thinker (aka spatial visualizer) – great at music and math but poor in reading
3. verbal facts – strong in language and translation but poor at drawing and visual thinking
4. auditory thinker – very good at hearing things but has fragmented visual perception

Dr. Grandin feels it is important to focus on the strengths of a person, rather than their weaknesses. The world needs all types of "thinkers" – artists, engineers and outside-the-box thinkers – it would be a dull world if autism didn't exist.

Dr. Grandin highlighted the importance of continually pushing ASD children to do more and more, even if it's out of their comfort zone. Here are some of her main points on how to challenge an ASD child:

- Encourage the kids to learn the art of turn-taking; it is an essential skill in social interactions.
- Do not let these children play video games and/or watch TV too much (she suggests not more than an hour a day).
- Start teaching life skills from a young age to encourage independence (she sees many ASD kids who have been coddled their whole life and are not able to do basic things on their own).
- Have the child learn work skills from a young age that is appropriate for their level of functioning (paper routes, walking dogs, drawing signs, cleaning, helping in church or around the house, etc.).
- She is disappointed that many practical classes have been removed from the curriculum of many schools (wood-working, home-economics, cooking) since these classes are great for some ASD kids.
- Social skills classes eventually need to move out of the classroom and into the real world (have kids go to stores and practice shopping and buying stuff, have them go to a restaurant and order food).
- Adapt the education system to meet the "thinker" (no florescent lights, quiet environment, sensory breaks, print work on different coloured paper and show more images for visual thinkers).



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Web Links to Power Point Presentations:	
1) http://www.goldlearningcentre.com/conference_presentations/ (Nov 5 th presentations)	
2) http://www.goldlearningcentre.com/nov6_conference_presentations/ (Nov 6 th presentations)	