

## COMMENTARY

# Growing Pains: How Psychologists Can Help to Meet the Clinical Needs of Clients With Autism Spectrum Disorders

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*The pervasiveness and the prevalence of the autism spectrum disorders (ASD) are now much more recognized than in years past. The treatment needs of higher functioning people with ASD unfortunately often go unmet, and there is tremendous potential for psychologists to help meet these needs. The four articles in this special series provide current, best practice reviews and recommendations for practicing psychologists who work in this area. They highlight commonalities that cut across ASD and other clinical populations, and offer considerations that are unique to working with clients who have ASD. This commentary emphasizes the need for clinicians and applied psychological scientists to consider some of these issues in their own work.*

As a scientist and clinician specializing in autism spectrum disorders (ASD), I have been fortunate to work in both urban communities (hospitals and universities in major metropolitan areas) and in very rural ones (with sheep bleating outside the clinic doors). Two commonalities that have been striking to me across these diverse settings are how similar the needs of families of the clients with ASD have been, and the lack of available and appropriate therapeutic services. I was thrilled when asked to serve as discussant for this *C&BP* special series on treatment for ASD because our field is at a real turning point in the way we view ASD and its treatment. Historically, autism services have been viewed as highly specialized, relegated nearly exclusively to board-certified behavior analysts conducting ABA and special education teachers delivering school-based services. We now appreciate the need for a comprehensive and integrative approach that considers the whole person in treatment, including psychiatric comorbidities, family (including sibling and parent) functioning, and the client's long-term mental health needs to maximize quality of life. No matter the setting in which one practices, there is a substantial clinical need to be met and psychologists are well-equipped to meet this need. The four articles

comprising this special series (Burrell & Borrego, 2012-this issue; Ferraioli, Hansford, & Harris, 2012-this issue; Gillis & Beights, 2012-this issue; Koegel, Matos-Freeden, Lang, & Koegel, 2012-this issue) all speak to the heterogeneity that typifies ASD and the need for psychologists to be informed about the various support roles and evidence-based treatment options available.

Autism and other spectrum conditions (i.e., Asperger's disorder, pervasive developmental disorder—not otherwise specified), up until quite recently, have been considered rare. ASD, especially autistic disorder, was associated with severe intellectual disability and, often, institutionalization. Clearly, this is not the typical client population targeted by most practitioners of cognitive behavioral therapy (CBT). We now appreciate that ASD is not that rare, affecting somewhere between 1 in 38 (Kim et al., 2011) and 1 in 110 (Centers for Disease Control and Prevention [CDC], 2009) children, with varying degrees of severity and impairment. In perspective, this places prevalence of ASD between that for childhood diabetes (Type I and II combined; 0.2%, CDC, 2008) and ADHD (9.0%, Merikangas et al., 2010). ASD is a pervasive and lifelong condition that occurs with nearly boundless demographic and clinical heterogeneity; it does discriminate by ethnicity, race, or socioeconomic status. Perhaps most pertinent to practitioners reading this series is that the fastest growing segment within the ASD population appears to be the “high-functioning” group (i.e., those without co-occurring intellectual disability; Boyd & Shaw, 2010; Honda, Shimizu, Imai, & Nitto, 2005), many of whom go unidentified in their mainstream educational

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settings (Kim et al., 2011) and even into college (White, Ollendick, & Bray, 2011).

There is tremendous diversity in presentation, and of clinical need, posed by people with ASD and their families. As Gillis and Beights (2012-this issue) highlight in their article, there is no doubt that clinicians *will* see more families affected by ASD. It will, therefore, be in clinicians' best interests to be knowledgeable of ASD and appropriate, evidence-based treatment options; this knowledge will also benefit their potential clients. Gillis and Beights provide concrete and practical suggestions for how practitioners can overcome some of the most common obstacles in providing care for people with ASD, addressing issues such as treatment planning, how to monitor change, when to make changes to the treatment plan based on data, and strategies for promoting skill generalization. The need to address the educational and clinical needs of cognitively bright but socially impaired youngsters and young adults with ASD is exemplified in the article by Koegel and colleagues (2012-this issue) in discussing strategies for working with students on the spectrum within inclusive classrooms. Inclusive education is now favored in lieu of segregated special education classrooms for many reasons, including improved clinical recognition of ASD, broadening of the diagnostic criteria (along with less focus on intellectual disability), greater tolerance (if not acceptance) of differences associated with ASD, and perhaps most important, federal legislation mandating education in the least restrictive environment possible. Children with ASD are likely to be educated alongside non-ASD peers in the regular education curriculum, and cognitive and communication abilities are the strongest predictors of inclusive placement (Eaves & Ho, 1997; White, Scahill, Klin, Koenig, & Volkmar, 2006). Unfortunately, there is little evidence of improvement in social functioning or change in diagnostic status, despite interaction with typical peers or improved intellectual performance (Akshoomoff, Stahmer, Corsello, & Mahrer, 2010).

Psychologists can play many roles (e.g., case manager, interventionist, consultant, parental support provider) in the comprehensive care of a client with ASD. Psychologists and counselors often are asked to provide services to those without the disorder who are nonetheless affected by it, such as supporting the parents (e.g., parent training, supportive counseling) or the siblings. ASD is not a disorder of solitude, despite the social interaction deficits that are primary to the disorder. It affects the person's family on multiple levels and requires interdisciplinary care. In this special series, Ferraioli et al. (2012-this issue) summarize research on the benefits of sibling inclusion in the treatment of a child with ASD, while Burrell and Borrego (2012-this issue) provide recommendations for effective ways to involve parents in intervention. Sibling

facilitation is a very understudied area of inquiry, but the research to date is promising. Something most families take for granted—that siblings typically enjoy playing together—can be a major obstacle for families in which one (or more) sibling(s) is (are) affected by ASD. As Ferraioli and colleagues summarize, when intervention can contribute to improved sibling interactions and effective interactive play, the positive impacts can be substantial. Parents experience less stress, the neurotypical sibling feels closer to his or her brother or sister, and some important activities (e.g., family outings and vacations), previously arduous and perhaps avoided if not downright impossible, become feasible. Finally, this article points to several areas of future scientific inquiry, including the need to determine how professionals can best support parents in including siblings in treatment without the sibling feeling pressured or uncomfortable.

Burrell and Borrego (2012-this issue) provide different models of including parents as interventionists in treatment. Most often, board-certified behavior analysts (BCBA) are the primary providers of interventions to target the ASD-related core deficits (e.g., speech and communication), but other types of intervention are often needed, especially for higher-functioning individuals and those who are older. Intensive (e.g., up to 40 hours per week) behavior therapy, begun early (e.g., before the age of 4), is typically recommended for young children upon initial diagnosis (e.g., Eikeseth, Smith, Jahr, & Eldevik, 2007; Harris & Handleman, 2000; National Research Council, 2001). As highlighted in some of the articles in this series (Burrell & Borrego, 2012-this issue; Ferraioli et al., 2012-this issue), with treatment of a young client with ASD, the practitioner may need to include the parents, or other family members, moreso than is typical practice with other client populations because of the pervasiveness of the disabilities, the need for consistency across settings and multiple practice opportunities (e.g., at home, in school), and to enhance skill maintenance posttreatment and generalization of learning to other contexts.

There is great variability in adult outcomes for people with ASD, and long-term outcome is very difficult to predict (Farley et al., 2009). Perhaps particularly relevant to the consumers of *C&BP* is that most families affected by ASD do not go exclusively, perhaps even primarily, to specialty ASD clinics for help. Furthermore, it is emergent problems related to comorbidity that usually prompt the treatment referral, more often than the "core" ASD symptoms (Joshi et al., 2010). Psychiatric comorbidity, especially with anxiety and depressive disorders, is common (deBruin et al., 2007; Joshi et al., 2010; White, Oswald, Ollendick, & Scahill, 2009), and this comorbidity is most apparent among individuals without cognitive impairment (Witwer & Lecavalier, 2010). Clinical research on psychosocial treatments for ASD is developing

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