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New and Familiar Roles for Clinical Psychologists in the Effective Treatment for Children With an Autism Spectrum Disorder

Jennifer M. Gillis and Rebecca Beights, *Auburn University*

Alongside the increased prevalence of autism spectrum disorders (ASD), there is a greater likelihood of clinical psychologists having a role in the treatment of children with these disorders. Population heterogeneity with respect to ASD-specific symptomatology, comorbid medical and psychiatric issues, level of cognitive functioning, and presence of adaptive behaviors, all add to the complexity of providing treatment to this population. Consequently, psychologists often find themselves in multiple roles in order to effectively manage treatment for children with ASD and their families. The purpose of this article is to increase awareness of three major roles for clinical psychologists working with this population: assisting families with treatment coordination, identifying and treating comorbid psychopathology, and addressing parental stress.

THE term *autism spectrum disorder* (ASD) refers to individuals who meet the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*; APA, 2000) criteria for either autistic disorder; Asperger's disorder; or pervasive developmental disorder, not otherwise specified. The use of this umbrella term reflects the current conceptualization of these disorders as occurring along a continuum (or spectrum) comprising impairments in communication and social interaction, presence of repetitive or perseverative behaviors, and a restricted range of interests/activities. Given the relatively high prevalence of ASD (i.e., 1 in 150; CDC, 2007), there is an increased likelihood of clinical psychologists coming into contact with families of children with this disorder. Furthermore, although many psychologists specialize in ASD treatment with children, the demand for psychological services from this growing population will likely outpace the current availability of experts in the area.

Importantly, children with an ASD vary tremendously in their presentation across the core areas of impairment described above. Similarly, there is a wide range in intellectual functioning, motor and adaptive living skills, and psychiatric and medical comorbidities across the ASD spectrum (Beglinger & Smith 2001; Bonde 2000; Filipek et al. 1999; Mandell, Cao, Ittenbach, & Pinto-Martin 2006; Mattila et al. 2010). Given this heterogeneity, a comprehensive treatment approach for children with ASD often requires a team of professionals in which the clinical psychologist plays a critical role. Indeed, clinical psychologists possess a broad set of skills, experiences, and expertise that make them uniquely qualified to address many of the myriad needs of this population. Thus, psychologists who are considering opening up their clinical practice to this population can have significant impact on children with an ASD and their families.

There are many roles for psychologists in managing effective treatment for children with an ASD; we have selected three that are perhaps most important and for which the clinical psychologist is aptly trained: (a) assisting families with the process of treatment coordination, (b) identifying and providing treatment for comorbid psychiatric disorders in children with an ASD, and (c) addressing parental stress.[1]

Assisting Families With Treatment Coordination

After receiving the diagnosis of an ASD, families embark upon the challenging road of coordinating care for their child. This can be an overwhelming process for many families, as there are over 400 available interventions that purportedly treat ASD (Romanczyk, Gillis, White, & DiGennaro Reed 2008). A clinical psychologist can assist families with treatment coordination by (a) providing psychoeducation regarding empirically supported

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[1] These three areas are necessary but not sufficient roles in the comprehensive care of children with an ASD and their families. A discussion of the other supports necessary in a comprehensive treatment plan is beyond the scope of this article. There are several excellent resources on this topic (for example, Luiselli, Russo, Christian, & Wilczynski, 2008; Matson, 2008).

treatment options and assisting families with the process of making the complex decisions involved in treatment selection; (b) working with the family and their multidisciplinary team of treatment providers; and (c) monitoring treatment and child progress in the short- and long-term. Clinical psychologists who assist families with these aspects of treatment coordination serve the role of consultant. The degree to which a family seeks consultation from a psychologist largely hinges on the specific treatment needs of the child, family resources, existing systems for children with an ASD (e.g., early intervention, school, etc), and other resources available in the community, region or state.

Treatment Selection

A psychologist working with children with an ASD should be prepared to assist families—and sometimes other stakeholders (e.g., schools, pediatricians, insurance providers)—with guidance in the selection of appropriate treatment by identifying those with empirical support. Making informed decisions regarding treatment options is not an easy task, especially when families come into contact with numerous professionals and other parents that advocate treatments that have not been adequately vetted or only carry anecdotal support. In fact, it appears that most families are spending unnecessary funds for treatments that lack empirical validation. For example, Schechtman (2007) described two different reports indicating many children with an ASD (i.e., between 50% and 92%) receive complementary and alternative medicine treatments, the majority of which have no empirical support. To the extent that these treatments are suboptimal, participation in such services may increase financial and emotional stress for the family and serve to delay more effective intervention.

Provided such concerns, a psychologist assisting with treatment selection should be familiar with current guidelines on treatments with empirical support for children with an ASD. Guidelines have been published to assist with identifying empirically supported treatments for ASD, beginning with the New York State Department of Health Early Intervention Program. (1999), shortly followed by the National Research Council (Committee on Educational Interventions for Children with Autism of the National Research Council [NRC] 2001), and then the report of the American Academy of Pediatrics (Myers & Johnson 2007). All support early intensive behavioral intervention (EIBI), sometimes referred to as applied behavior analysis (ABA). Most recently, the National Autism Center (2009) published a report identifying 11 “Established Treatments” (i.e., well-controlled studies of effective treatments). These include: (a) antecedent packages (e.g., incorporating choice, prompting, familiar stimuli, etc.), (b) behavioral packages (i.e., applied behavior analysis, behavioral therapy, and positive behavior support), (c) comprehensive behavioral treatment for young children (sometimes referred to as ABA or EIBI), (d) joint attention interventions, (e) modeling, (f) naturalistic teaching strategies (e.g., incidental teaching), (g) peer training packages, (h) pivotal response treatment, (i) structured schedules, (j) self-management, and (k) story-based intervention packages (e.g., Social Stories™). Details of these treatments can be obtained without cost from the report of the National Standards Project, which is on the National Autism Center's website (http://www.nationalautismcenter.org). The extant treatment literature recommends starting an EIBI program as early of an age as possible (i.e., less than 3 years of age; Fenske, Zalenski, Krantz, & McClannahan 1985; Filipek et al. 1999; Harris & Handleman 2000; Howlin & Moore 1997). A recent meta-analysis of 14 studies indicated that children who begin EIBI earlier show relatively more gains in language than starting at a later age (Makrygianni & Reed 2010). The meta-analysis also revealed that more intensive intervention (i.e., more hours of intervention per week) yielded greater gains in intellectual abilities and adaptive behavior. Although the National Research Council recommends 25 hours per week of intensive intervention (NRC, 2001), an optimal number of hours per week has yet to be determined. However, Makrygianni and Reed (2010) found that children who received less than 25 hours per week showed more variable outcomes. The combination of treatment intensity and type also appeared influential; better outcomes resulted from more frequent contact hours and the consistent application of empirically supported treatments across settings (e.g., the child's home, clinic, school, etc).

Once families are provided with knowledge about treatments with empirical support, the difficult task of choosing treatment(s) should be addressed. Wilczynski, Christian, and the National Autism Center (2008) recommend choosing treatments that correspond best with a family's value system and priorities. Pituch et al. (2011) surveyed parents’ treatment priorities for their child with ASD using targets that included social, communication, academic, and safety skills. With respect to family values, treatment location may be an important aspect of the treatment selection process. For example, some families might find it intrusive to have therapists in the home, whereas other families might prefer such services as it might decrease family stress in coordinating family schedules. To assist families in making informed decisions, psychologists should be familiar with the types of treatments that are available at varying levels of intensity (number of hours per day and per week), availability of local service providers, existing community resources, and availability of parent support groups. In

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