



JONATHAN ALDERSON, Ed.M.

# Moving toward a multi-treatment approach to autism:

*The whole is greater than the sum of the parts*

After completing his Masters of Education in Administration, Planning, and Social Policy at Harvard University, Jonathan has a private educational consulting practice in Toronto, Ontario working primarily as an autism treatment specialist training families with special needs children. Combining experience as the Curriculum Specialist Coordinator with Teach For America in Houston, Texas, an internship with the Harvard Family Research Project, and as a coordinator of the Intensive Preparation for the Study of International Education (IPSIE) programme at the Harvard Graduate School of Education, Jonathan's diverse education and work experience provides the inspiration for his focus on bringing innovation to the field of autism treatment.

A young couple sits in a doctor's office. Both of them feel anxiety brewing in their stomachs. They had waited two months for this appointment. The doctor, from behind his desk, confirms their worst fears; with a certain lack of emotion he confers a diagnosis of autism on their 3 year old son. After he negotiates their tears and shock, on the way out he hands them several brochures introducing them to local autism support centres. They have a thousand questions and no answers. At home, without even taking off their shoes or coats, they Google 'Autism' ... over 20 million links ... where do they begin?

Sensory Integration Therapies and the Defeat Autism Now (DAN!) protocol, socialisation, Pamela Wolfburg and playgroups, Auditory Integration Therapy, Lovaas and Applied Behaviour Analysis (ABA), early intervention, home-based, school-based, residential care, TEACCH, Boston's Higashi School, special diets, promises of a cure, vitamin B12, swimming with dolphins, acupuncture, play therapies, The Son-Rise Program, Relationship Development Intervention, Floortime, physical therapy, music therapy, equestrian therapy and Intensive Multi-Treatment Intervention (IMTI) could all possibly play a role: Where should they begin? What is best for their son? Six months later the couple is still spending most of their resources on researching treatments, reading recommended books, making phone calls to get on waiting lists, and feeling as confused and directionless as they had the first moment they heard the doctor say "autism".

The parents learn quickly that the diagnosis is multifactorial: social development delays, language delays and stereotyped repetitious behaviours all impact a wide range of developmental steps. The symptoms manifest across a spectrum. Each child is uniquely complex. The young couple observes their own son's range of ability and disability. In their search for answers, they recognise parts of their child in others' anecdotes, but never fully. As diverse as the explanations and theories of the causes of autism, we can agree that autism has a biological/physiological (body) component, a cognitive (mind) component, and a social/emotional (psychological) component, among others. Current research supports the idea that the factors contributing to the behaviour, communication and learning challenges of people on the autism spectrum are multifaceted; therefore, I believe, treatment should be multifaceted, as well. These days, most parents, professionals, books and reports agree. Yet, unfortunately, many current treatment models operate exclusive of other models and are uni-focused. In other words, treatments haven't been designed to address the multi-dimensional complexity of autism.

Each of the hundreds of treatments available may offer an important piece of 'the puzzle', but it is parents who are left to piece the puzzle together. Which treatment 'pieces' fit their child's special gifts and challenges? How much of each different treatment should a child receive, and how should a family distribute their limited resources among the myriad



choices? A family I recently guided through this decision process explained, “We heard about some great success stories about kids on special diets and supplements; we’ll put all of our money in that direction if you think it will work ... but our doctor is pushing us to go ahead with the IBI training full-time if we can afford it. We’re already stretched with finances and we’re hoping you can help us figure out what we should do ... we just want to do what is best for our son.”

During my sixteen years working in autism treatment, sadly this situation is the most common predicament in which parents find themselves. It’s time the field moved toward more comprehensive and cooperative systems of treatment.

To add to the overwhelming number of choices a parent has to make, the field of autism is, more than other professional fields, I would argue, particularly proprietary: “Our method works. We have the answers, and others don’t.” As families make their best effort to piece together a mix of treatments to address the many special needs of their child, a majority of therapists continue to believe their ‘unique’ method of treatment is the only real method of treatment and so the burden to choose is placed on the parents. Thousands of mothers of children with autism are left to do the impossible: to play the ultimate negotiator and diplomat communicator between competing therapists. The physical

therapist strongly recommends that the child gets outside on the playground at least once a day, but the intensive behaviour therapist strongly recommends the child works indoors in 1-to-1 training for as many as 40 hours per week. Meanwhile, the local school principal and school psychologist are threatening that the child will suffer from lack of socialisation if they are kept at home and not in school. Parents of children with autism are already challenged to function well above maximum capacity; committed to loving and providing the best for their special child, they shouldn’t be put in the position to also have to navigate through such a polarised field of treatment.

The field of autism treatment is now ready for and would benefit greatly from a next generation of treatment protocol: Multi-Treatment Interventions. There is still much to be learned about how to sew together complementary and also sometimes seemingly diametrically opposed approaches to education and treatment.

Treatments such as Applied Behaviour Analysis (ABA, or Intensive Behaviour Intervention (IBI) in Canada), play therapies such as Floortime and The Son-Rise Program and biomedical protocols such as DAN! each specialise in a narrow yet important range of strategies following particular ideologies of autism and treatment. More importantly, most of the highly specialised programmes

available to families of children with autism either do not interface with other possible complementary treatments or flat out reject and criticize treatments that are different from their own. Some proponents of ABA, for example, have been fairly vocal in rejecting play therapies, biomedical treatments, and any other ‘not scientifically proven’ approach. In the same way, ardent play therapists denounce behavioural methodologies as somehow less humane. Ironically, Dr O Ivar Lovaas himself, considered the pioneer of ABA, wrote in his seminal instruction manual *The ME Book* that “...no one approach will solve all the problems of developmentally disabled persons. Rather, the persons who try to help these individuals need to draw upon a variety of concepts and teaching techniques.” Furthermore, “The ‘teacher-therapist-parent’ has to be flexible, innovative, and able to draw upon a variety of techniques and procedures” (p.3, 1981).

With a nod to Dr Lovaas’s prescient remarks, I believe that the extreme “we’re right, you’re wrong” positions simply aren’t inclusive enough and that a diplomatic meeting in the middle would lead to a multifaceted approach that would be even more appropriate and more effective than any single approach alone.

There is top-tier research underlining the fact that children with autism require a range of supports. A group of America’s leading psychologists and specialists surveyed and studied the field of autism treatment for over a year and concluded, “No single intervention

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has been shown to deal effectively with problem behaviours for all children with autism.” (Educating Children with Autism, National Research Council Report, 2001). For many readers, this idea is neither new nor controversial. Yet, in my practice, I continue to hear on a weekly basis of parents who have been directed by their doctor or local autism information centre to only consider ABA/IBI and to dismiss any other treatments as false hope and junk science. I meet therapists and school officials often who sincerely believe that IBI is the only scientifically ‘proven’ treatment; that special diets are all baseless fads; and that parents who find that massage calms their child down are most likely being taken advantage of by a quack therapist. Just last year, I participated in a funding meeting with an Ontario IBI service provider who has the authority to determine the direction of hundreds of children’s programmes. He leaned over in my direction, nudged me in confidence and claimed that “Sensory Integration Therapy was known and proven to be not helpful, at best, and potentially harmful, at worst.” He explained that he would definitely not approve any home-based programming that included Sensory Integration Therapy.

It is important to note that in the past five years or so, many service providers and professionals have begun to promote what is most often called a multidisciplinary approach to treatment. Teams of professionals from various disciplines usually include an ABA therapist, a physical and/or occupational therapist, a speech and language therapist and a school psychologist, among others. An individualised education/service plan is designed and implemented. While this is a huge step in the right direction, the various different therapies are typically provided separately from one another, often in different and separate locations by different therapists who are often not in daily communication. The design of the education plan is multidisciplinary, but

the actual educational experience of the student is anything but cohesive.

After working in the field of autism for many years as a therapist, I was frustrated with having to choose to work in either one or another specific methodology. When I had returned to Canada following twelve years of work and studies in the USA, for example, I was offered work with a provincial IBI service provider, but it was made clear to me that I would not be allowed to practice anything but strict IBI methods with the children. Years before, during a year of work abroad consulting for a US-based treatment centre to about seventy five families in the United Kingdom, I was reprimanded for spending too much of the allotted time talking about biomedical treatments rather than the centre’s proprietary treatment. In one particular case, it was painfully evident that the young boy of four years old whom I was hired to help needed medical attention. His bloated stomach, chronic constipation and hypertense repetitive rocking were impeding the child from deriving benefit from the play therapy we were providing. Yet the restrictions of the play therapy centre limited my ability to best help this child and family.

With this as background, I began to piece together a multi-treatment programme called Intensive Multi-Treatment Intervention (IMTI), a programme that, from its inception, has remained committed to being flexible and to evolving as new research and innovation inspires change. Recognising that the population of amazing autistic children with whom I work are, like all children, multidimensional and spectacularly complex, the programme had to be highly customisable. For some children I design a programme that is heavily focused on play therapy and socialisation, while for others the emphasis and majority of time is spent on a more structured curriculum-based IBI approach. Note: It is not as important that the methods themselves are pure and exacting as the order and mix of the



‘best practices’ for any individual child’s unique talents, interests, and challenges. The strength of the ‘IMTI effect’, as I call it, is derived from the interaction between the variety and often diverse elements of an individualised programme. Order and timing of the mix is critical.

Each multi-treatment programme is unique, yet there are some principles that underlie the foundation of any successful multi-treatment programme. The following is a description of some of these principles, further illustrated with anecdotes. It is my hope that many parents and professionals will benefit from adopting these strategies that ultimately could begin to form the bridges between treatments. Put together, I believe that these treatments could create more positive effects combined than they ever can manage apart.

**1 Learning is a biological process therefore physical health must be the priority before behavioural training and education.**

Joshua had already been attending playschool. He was diagnosed with PDD and was verbal, but he often struggled to pay attention. He was hyperactive and sometimes mixed up his words and thoughts. He didn’t interact typically with his peers, and his parents agreed he was not ready for school. After reviewing his physical health history, including nutritional and diet details, I recommended that the amount of processed sugar be reduced and limited in his diet. Along with replacing sugared snacks with fruits, vegetables and natural foods (not without protests from Joshua and animated coaxing from us), Joshua’s mother dramatically reduced his refined

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sugar intake while maintaining his calorie intake with more nutritious foods.

Four weeks later, during their monthly in-home training day, we all agreed that Joshua's overall demeanour had changed positively. Throughout forty minutes of the therapy session, Joshua sat focused and still at the table as he cooperatively took turns at the Jenga building block game. He then followed his father's directions to try some sit ups and push ups for fun, and sat sweetly at his mother's side as they read a story together. Joshua was, without question, calmer and had a greater attention span. His language was less chaotic and he was more cooperative. Joshua still had all of his learning challenges to work through. The dietary changes were not a magic cure and did not resolve most of the issues he faced with his PDD, but by first addressing Joshua's physical health, he was able to attend more readily to the many hours of learning opportunities we would present to him. Using data collected from a medical lab, their family doctor will now take the next step to design and implement a specific protocol to ensure that Joshua will continue to improve his physical health and, consequently, his studentship in the IMTI programme.

We start with considering the physiological health of the child and possible underlying links to autism. Under the supervision and direction of a medical doctor, biological treatment can kick-start a child's development and add momentum to the multi-treatment effect.

## **2 Learning happens more easily in cooperation with a teacher that a child trusts, feels respected by and enjoys.**

As obvious as this principle is, surprisingly few models of therapy incorporate or prioritise establishing and maintaining a positive and dynamic therapist-student relationship. With socialisation as a 'core deficit' challenge for people with autism, it is especially crucial that caregivers and therapists engage people with autism in extremely thoughtful and respectful ways that work for the person with autism (regardless of whether or not the mandate of the therapy is achieved). Far too often, I have witnessed a treatment or therapy protocol applied to and imposed upon a child against the child's will, in the face of protest, through struggle and conditional manipulation. The therapist

prioritises completing the treatment protocol over maintaining the quality of the relationship, believing that the target learning objective is somehow more important for the child to learn than the actual learning experience itself. But the experience of struggle and lack of trust pushes the child further from willing participation and further from wanting to learn.

I was once asked to review and provide feedback on a videoed sensory integration therapy session. A state-of-the-art day school for students with autism delivered a video in which one particular student was filmed as he was led through a multi-station activity rotation in the school gymnasium. About ten minutes into the video, I saw the child led to an oral-motor station that, frankly, was painful to watch. The therapist asked the child to lay down on a gym mat, which he did. But within seconds of seeing the therapist pull out the electric toothbrush, the child jumped up and ran across the large gymnasium. The video follows the scene in which two other therapists join in to corral the young student and return him to the mat. However, this time, he was held down and literally rolled up in the gym mat with his arms at his sides so that he was swaddled and not able to avoid the imminent oral-desensitisation treatment. The main therapist then straddled the student-wrap, held the child's head in place and proceeded to push the electric toothbrush in and around the child's mouth. While the oral-motor objective was indeed completed, the damage to the student-therapist relationship far outweighed any sensory integration gains. The school staff had not established trust, rapport or cooperation with this young student. They were stuck in a vicious cycle having to use restraint strategies that just led to more resistance and the consequent need for more restraint.

Today, there are many excellent strategies and programmes that can be effectively used to build rapport and cooperation with students. Play therapies, models of socialisation and communication strategies, when put in place first, help to establish more willing studentship; this way, more structured curriculum-based models such as ABA can be more useful to the child, who is no longer struggling against learning, but is enjoying trying. This example begins to dissolve the debate between choosing either play therapy or ABA toward using them in a complementary way. Invest

a good amount of time to build the student-therapist relationship first and then use structured learning second.

## **3 Multi-treatment should not mean 'all at once'.**

Understandably, with the pressure of early intervention, educators and parents are usually racing to provide as many treatment services as early after the diagnosis as possible. While undoubtedly time is of the essence, timing is equally important. I have spent the past five years studying, experimenting with and specialising in the order and timing of programming within the multi-treatment model. Some treatments are more effective if followed by or preceded by other treatments. For example, my students typically make greater gains and benefit more readily from peer group play after a successful phase of intensive one-to-one adult-directed structured programming (of between three months up to or over one year). If this order is reversed or done concurrently, the children don't seem able to maximally benefit from the peer play. I am currently writing a paper discussing the developmental basis for this.

The effects and benefits of each individual treatment are maximized by carefully considering the order and timing of the various treatments. In contrast, when a multidisciplinary team implements a variety of treatment protocols all at the same time, the child may be subjected to too many different behavioural expectations and different therapist styles at once. For example, in one programme to develop compliance, the child is expected to ask permission to use the bathroom, while in the next class they are encouraged to simply go on their own will to develop independence. The stresses on the child of 'all at once' programming can be compounded when a child is enrolled in diametrically opposed treatments such as half-day ABA/IBI and half-day socialisation play therapy. While a child will indeed make gains in each type of programme, the benefits that each type could provide simply won't be maximized.

There are many complex and interdependent variables to consider with the design of each multi-treatment program. The success of the IMTI programme has been exciting and promising. For more information on IMTI, or to share comments or insight, please visit [www.IMTI.ca](http://www.IMTI.ca).