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SPECIAL SERIES

Advances in Evidence-Based Intervention and Assessment Practices for Youth With an Autism Spectrum Disorder

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Introduction

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This special series is designed to highlight recent advances in the evidence-based treatment and assessment of youth with autism spectrum disorder (ASD). The seven articles for this special series include novel applications of cognitive-behavioral therapy to address core aspects of ASD, empirical research that provides understanding of ways to assess and intervene with individuals with ASD, and studies that focus on the implementation of evidence-based interventions for youth with ASD. In this introductory paper, we provide an overview of the current state of the field related to the treatment and assessment of youth with ASD and discuss related themes addressed across the papers in the series. We conclude with a brief description of each of the seven papers in the series.

Keywords: autism spectrum disorder; assessment; evidence-based intervention; youth

AUTISM SPECTRUM DISORDER (ASD) is one of the most common neurodevelopmental conditions. Recent estimates suggest as many as 1 out of every 50 youth in the United States may be affected (Blumberg et al., 2013; Kogan et al., 2009). The core ASD symptoms are wide-ranging and can include social-cognitive impairments (e.g., limited theory-of-mind skills), pragmatic language deficits, and repetitive behaviors (e.g., insistence on nonfunctional routines). Youth with ASD often experience significant impairment in adaptive functioning throughout development as a result of the core ASD symptoms (e.g., Howlin, Goode, Hutton, & Rutter, 2004). Most youth with ASD also have comorbid mental health disorders that increase morbidity and stress (e.g., Mannion, Leader, & Healy, 2013; Smith & Matson, 2010; Wood & Gadow, 2010). If untreated, ASD rarely remits over time (Matson & Horovitz, 2010; Matson, Mahan, Hess, Fodstad, & Neal, 2010; Moss, Magiati, Charman, & Howlin, 2008). The great majority of youth diagnosed with ASD in childhood have substantial morbidity in adulthood, such as limited employment, failure to attend or complete postsecondary education, failure to date or marry, and no close friends (Barnhill, 2007; Eaves & Ho, 2008; Marriage, Wolverton, & Marriage, 2009).

Given the impairment caused by ASD, a fundamental goal in the field is identifying interventions that substantially mitigate the morbidity associated

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with ASD. Progress toward achieving this goal is mixed. The intervention literature for ASD has lagged behind that for emotional and behavioral disorders (McLeod, Southam-Gerow, Christon, Archer, & Rodríguez, 2013). Presently, several promising intervention programs exist; however, there are few interventions for ASD that meet American Psychological Association criteria for efficacy or possible efficacy (Danial & Wood, 2013). Moreover, the intervention literature is characterized by methodological limitations that make it difficult to interpret findings (e.g., lack of random assignment, reliance on unblinded rater assessments of outcome; see Rogers & Vismara, 2008). Given the substantial increase in the number of youth identified with ASD over the past decade, an important issue facing the field is how to develop and evaluate effective interventions for youth with ASD (Odom, Collet-Klingenberg, Rogers, & Hatton, 2010; Reichow, Volkmar, & Cicchetti, 2008). Whereas many youth with ASD receive a relatively high dose of treatment in community settings (Ganz, 2006, 2007), descriptive studies document that relatively few of the provided interventions could be classified as evidence based (Bowker, D'Angelo, Hicks, & Wells, 2011; Goin-Kochel, Myers, & Mackintosh, 2007; Green et al., 2006; Heflin & Simpson, 1998; Simpson, 2005; Stahmer, Collings, & Palinkas, 2005), likely limiting their effectiveness.

In moving forward toward more effective intervention for youth with ASD, we believe that researchers will need to address three key issues. These include efficiently measuring the most pressing clinical problems experienced by youth with ASD, given that ASD phenotypes are exceptionally heterogeneous; identifying interventions that are sufficiently promising to justify further development and evaluation; and determining which models of implementation are most likely to promote adoption and adherence to effective practice guidelines for treatment of youth with ASD in community settings. In this special series, we attempt to highlight some ways that these issues may be addressed. In this introductory paper, we discuss these three themes and how they are addressed in the articles in this special series.

Clinical Complexity and the Assessment of Youth With ASD

Youth with ASD can present with strikingly varied levels of clinical features such as perseverative thought and language, poor self-care skills, hyperactivity, motor skills problems, anxiety, peer rejection and friendlessness, failure to work in the classroom, aggression, speech dysfluency, severe rituals and tics, poor conversation skills, and depression (Carr, Taylor, & Robinson, 1991; Farmer & Aman, 2011; Mannion et al., 2013; Shriberg, Paul, McSweeny, Klin, & Cohen, 2001; Smith & Matson, 2010; Stern & Robertson, 1997) among other features. Importantly, youth with ASD often differ from one another on these features to such an extent that one youth's most pressing clinical issues (e.g., aggression) might be completely irrelevant for another youth with ASD (Wing & Attwood, 1987; Wing & Gould, 1979). Resultantly, manualized linear intervention approaches that have a narrow focus on a specific type of symptom or mechanism, such as social skills training, cognitive-behavioral therapy for anxiety, or parent training for disruptive behavior (e.g., Patterson, Smith, & Mirenda, 2012; Rao, Beidel, & Murray, 2008; Rotheram-Fuller & MacMullen, 2011) may or may not be a good fit for a given individual presenting for intervention. The determination of an appropriate intervention focus requires valid and reliable assessment techniques for youth with ASD, and the field is just beginning to recognize that measures developed for youth in the general clinical population do not necessarily have adequate psychometric properties for youth with ASD (e.g., Lecavalier et al., 2014).

Due to the complexity of presentation of clinical needs in ASD, accurate and efficient assessment of intervention targets is a high priority. Identification of intervention targets via assessment could then be used to facilitate a stepped-care or modular approach to intervention that targets the specific issues that are problematic for a specific youth with ASD (Wood, McLeod, Klebanoff, & Brookman-Frazee, 2015-in this issue). Whereas the core symptoms of ASD can be measured accurately with various evidence-based assessment tools, fewer tools exist for measuring the concurrent clinical problems often seen in ASD (e.g., anxiety). Two articles in this special series address the measurement of concurrent anxiety in youth with ASD (Kerns et al., 2015-in this issue; White et al., 2015-in this issue). Both articles represent efforts to ascertain assessment tools that have an empirical basis for characterizing the clinical needs of youth with ASD.

In one of the two papers, Kerns and colleagues (2015-in this issue) examine the concurrent and discriminant validity of anxiety disorders in youth with ASD. Because symptoms of anxiety disorders can phenotypically resemble aspects of ASD, differential diagnosis is needed. For example, the social withdrawal characteristic of some youth with social anxiety disorder may resemble the isolated social behavior of youth with ASD (e.g., Wood & Gadow, 2010). Fortunately, the science of measure development and validation offers clear procedures for testing the distinctiveness of two constructs