Dr. Patricia Manning-Courtney is a developmental pediatrician and is director of the Kelly O’Leary Center for Pervasive Developmental Disorders at Cincinnati Children’s Hospital, a multidisciplinary diagnostic and treatment program for children with Autism Spectrum Disorders. She is a member of the American Academy of Pediatrics Autism Subcommittee.

**Q:** Dr. Manning, what are the most common therapies for children diagnosed with autism?

**Dr. Manning:** Probably the most common therapy is speech therapy because it’s important to focus on building a communication system for a child with autism. I would say that most of the children diagnosed with autism are involved in some form of speech therapy, either privately or through school or both, but there are many others that children with autism participate in. There’s occupational therapy. There are what I refer to as intensive interventions, such as applied behavioral analysis, floor time, relationship development inventory, the Son-Rise Program, and then of course, there are the therapies or the services and supports that children access through their local school districts and local agencies that provide early intervention.

**Q:** Let’s talk a little bit about building a communication system. What does that really mean?

**Dr. Manning:** That means that while talking and using verbal language is important, it’s more important to be able to communicate effectively, and that initially might mean using something besides verbal language, especially in children who are not yet verbal. So that could mean using pictures or signs or some other type of system that allows that child to express a want or need in a more typical manner rather than simply pushing or pulling their parent to what they want or getting it themselves.

What we really want children with autism to understand is the reciprocity of communication. Communication is a give-and-take, a back-and-forth. If I want something, I need to give you something in the form of communication to get that, and it could be, again, a sign or a picture initially. And children with autism and other children with language impairments, in fact, have been found to have a faster rate of true language acquisition when they use initial other communication systems, such as pictures or signs.

**Q:** Now, you talked about applied behavioral analysis. Can you explain what that is?

**Dr. Manning:** Applied behavioral analysis is a very well-known intensive intervention that was described for children with autism back in the 1960s, but actually, behavior analysis has been around for a long time, since even the 1930s, and it’s simply the science of understanding behavior, what motivates behavior, how can we shape behavior, how can we reinforce behavior, and in the 1960s some important psychologists and researchers took those principles of behavior analysis and applied them to teaching children with autism. They took a very structured, adult-directed methodology and showed that children with autism could learn skills in a very
structured one-on-one way with lots of positive reinforcement and through a very specific curriculum, and this was developed into what is now known as applied behavioral analysis.

Q: What could a parent expect if they’re taking their child for this therapy?

Dr. Manning: The goal of ABA is to start as early as possible into a diagnosis or sometimes even before a formal diagnosis of autism and to apply it very intensively, so most ABA providers would hope for at least 20-40 hours a week of one-on-one intervention, which sounds quite intensive, and it is. Families should expect initially to be trained by a very well-educated, knowledgeable behavior analyst. This is usually a psychologist or someone with certification in behavioral analysis. The family and other intervention providers, other therapists or tutors are trained in this methodology so that they’ll learn how to work one-on-one with a child with autism at a table with specific tasks, tasks that are broken down into very, very small segments.

So say for instance we’re trying to teach a child with autism colors. We might put all cards with the color red on them in front of that child and ask that child to touch red, touch red, touch red repeatedly so that they get that concept down, and then we would expand to more colors to help them distinguish.

There are a couple of important principles in ABA, but I think one of the most important is that children learn to imitate. They learn to respond to repeated requests, and they learn that positive reinforcement is a good driver for success, that if you positively reinforce a response, you teach that child that that was the right thing to do, and we want to do that again and again.

Q: So this works pretty well for most children in your experience?

Dr. Manning: In my experience and certainly the research behind ABA -- and it is one of the only if not the only intensive intervention for children with autism that has research behind it -- has demonstrated that about a little less than half of children with autism will benefit significantly from ABA. Early studies that broke children with autism into two groups, one group that got ABA and another group that got different types of intervention, found that the ABA group, that about almost half of that group had significant improvement to the point where they could be in regular school settings. So even though it’s very, very good, you still may only see about 50 percent or so of children who participate in ABA who have significant improvement. Having said that, I would say that the families I’ve worked with who’ve done ABA, even when their children haven’t had significant improvement, they have found it to be a very beneficial strategy and tool for teaching their child and for managing their child’s behavior.

Q: Would you say that most children with an autism diagnosis go on to get this therapy? Do most have access to these kinds of services?

Dr. Manning: Well, I would say no. I would say that it’s a very intensive intervention. The resources for ABA may be limited depending on where you live, the resources meaning the people who can provide this intervention, and the other resources that may be limited are the finances behind it. It is a costly intervention, as you can imagine, because of the intensity of it,
and funding sources for this intervention vary widely across the country. In some places there may be some state funds for this type of intervention. In some places there’s push for insurance coverage. In some places school districts may cover some of this, but it’s quite inconsistent. In my experience many families have to work very hard to access this type of intervention.

**Q:** If families are having trouble finding a way to pay for these services, what would you suggest?

**Dr. Manning:** I would suggest that they start with their local and state agencies to see if there are different waivers, sometimes the Medicaid waiver, sometimes scholarship funds depending on where a family lives, and their school district may have some resources. My hope would be that they’re close to an agency program that serves children with autism, that they can access resources through that program, as well to resources that can help guide them for funding support because it is challenging.

**Q:** What other therapies have been proven to help with an autism diagnosis?

**Dr. Manning:** To be quite honest, very few other therapies have strong proof or evidence to support their efficacy. Early intervention has been demonstrated for many years to be beneficial in many young children who are identified with developmental disabilities, including autism, but even the therapies that we recommend strongly -- speech therapy, occupational therapy -- we’ve had a hard time proving that they help, so if you get stuck on that word proof, you might be a little challenged to say this intervention specifically has been proven to help children with autism. There are certainly many therapies, as I said, speech therapy, occupational therapy, education therapy that have been shown to be of benefit certainly through observation and through some very limited studies, but proof is a different thing.

**Q:** Can you tell me a little bit more about early intervention? What does that refer to?

**Dr. Manning:** Early intervention is a federally mandated and funded support system for families of children with disabilities under 3 years of age, so in every state in this country, if a child is identified with some type of delay or impairment or disability under 3 years of age, they should be able to access the early intervention system in their region. Now, it’s called different things in different places, even in my region. We’re close to two other states, and in one state it’s called one thing and in another state it’s called First Steps or Early Steps or Early Intervention, so it might be called something different depending on where you live, but you should know that in any place in this country there should be an early intervention system administered through a county or state agency to families of young children with disabilities.

**Q:** Doctor, can autism be cured?

**Dr. Manning:** This is such an important and difficult question, and I think those of us that work with many hundreds and thousands of children with autism would say that we haven’t seen children who are truly cured. We’ve seen children who make lots and lots of progress, so much progress that it’s difficult to distinguish them from their peers. We’ve seen children who change
their diagnosis, so maybe they weren’t correctly diagnosed initially or their diagnosis of autism was somewhat questionable, and they went on to progress and evolve to the point where they really were felt to have a different diagnosis than autism. So I don’t tend to think of autism currently as something that can be cured, particularly because we don’t know what causes autism. We believe that there are probably many, many causes, and until we elucidate those, I don’t think we can talk in terms of a cure.

**Q:** And so would it also be difficult to say why some children seem to lose their autism diagnosis?

**Dr. Manning:** I think there are a couple of phenomena that are occurring when children lose their diagnosis. One could be, as I said earlier, that the initial diagnosis was somewhat questionable. This child might have been very mild within the autism continuum or sort of subtle in their autism diagnosis, and then as time passes, as they get older, as they enter school, we realize you really look more like a child with ADHD or learning disability or anxiety or a language impairment, and you look less like a child with autism, and so technically, that child has lost their diagnosis, but they’ve sort of shifted into a different set of diagnoses.

And then there are a small group of children who are well diagnosed with autism at a young age, and for whatever reason they make tremendous progress, and this is an important area of research that we’re looking at now, who responds to therapy. Why do some children respond more than others? But that small group of children who respond so significantly to the intervention that they’re receiving or just to their own growth and maturation for practical purposes as they get older they may no longer look like they have a diagnosis of autism, and so I guess you could technically say that they lost their diagnosis.

**Q:** So if the goal is not to actually cure a child’s autism, what is the best way for doctors and parents to set goals for these therapies? How should parents approach this?

**Dr. Manning:** My hope would be that parents are working closely with a team of providers, a speech therapist, an occupational therapist, school people, and a medical provider, and that these people over the years get to know this child and this family very well and that they help this family set realistic goals because, for example, we have some families whose goal is that their child talk, and I tell families that talking is like the top of Mount Everest, and we have a lot of base camps to get through before we get to that.

We want this child to communicate. We want this child to have a communication system. We want them to use their language in a functional way, so educating a family about how communication typically progresses in a child with autism is a very important part of goal setting, and I think our therapists, particularly our speech therapists, are very helpful with that.

I think it’s important for providers and this team of people around a family to help a family identify common problem areas that we want to prevent if at all possible. So we want behavior to be something that doesn’t get in the way of this child’s progress, and so from a very early age, we want to educate a family about what’s an appropriate behavioral goal. What is appropriate to
be able to expect to go to the store or go to a restaurant or go to church? We might have to work actively towards that behavioral goal, but just because a child has autism doesn’t mean their behavior can be completely out of control and unmanaged because that child doesn’t understand. It means that we just have to work harder to make sure that behavior doesn’t become a major impediment to that child’s progress.

So I feel like setting goals is very much around educating the family about what are common patterns of development in children with autism, what are common problem areas that we want to avoid, and how we proceed stepwise towards goals rather than set really high goals and be frustrated and disappointed, but how we set small, realistic goals that we can achieve over time.

Q: The team surrounding the child and the family that we’ve been talking about, do they provide psychological support to the whole family throughout this process?

Dr. Manning: I have certainly found that to be the case. I have found that our therapists, occupational therapists, school team members, and the medical team members, myself, a nurse practitioner, even our nurses in our clinic, once we get to know a family and follow a child over time, I think we do provide that kind of support because we’re responding in times of crisis.

We’re walking through different phases of life with a family. We’re getting through preschool and going into kindergarten and entering middle school and going into high school. And all of those junctures can bring with them new challenges, new goals, new successes, but also sometimes some moments of grief as well because I think a child with a chronic disability like autism, the family would naturally have times of struggle when that disability becomes a little bit more difficult psychologically to be thinking about. So I think we do, and I think that’s my goal when I meet a family and the child is being diagnosed with autism that they know that we’re going to walk this journey with them, and I hope that every family has a team like that that goes on the journey with them and helps them through that.

Q: For a family who’s just starting on this journey, are there other supports in the community that they might find, other folks going through this similar experience?

Dr. Manning: Absolutely. In fact, I tell families all the time that I’ll never be able to teach them as much as another family will, and I think that I’ve seen some amazing friendships and connections come together because families share this experience. I have a child with autism, and it’s very difficult to sometimes relate to people with children who don’t have autism when you’re dealing with that, especially in a young child, so I think there are some strong connections and some strong support that can come from local support groups, local support agencies, different chapters of the Autism Society or Autism Speaks or other types of support networks have been incredibly helpful.

I also think that’s a very personal issue for families. Some families find a lot of support through those types of entities, and other families find support through their own family, through church, through other systems. It’s quite a personal thing, so I’m very cautious not to tell everyone that
they have to go to a support group, but it’s there if they need it, but that it is important that they identify a small support network for themselves.

Q: Is there anything else you’d like to tell us today about autism therapies?

Dr. Manning: Probably the hardest thing I have found over the years in working with families of children with autism is that there isn’t one single prescription when a child is diagnosed with autism, and that’s very frustrating. It’s almost that there are too many answers. There’s too many options. So families are often left having to make difficult decisions, and they’re doing research, and they’re talking to other people and hearing lots of information about many, many different types of therapies, and it can be very hard for a family to decide what should we do and what’s the right answer because right now there is no right answer.

Many of the interventions that have been described for children with autism have in common some component of intensity, some component of working individually with the child one-on-one. If you can spend 10 minutes on the floor with your child every day, I think that’s a great thing. I think you need to maximize the services you can get through your school district and through your early intervention systems, and you need as a parent to feel confident that the decisions that you’ve made are the right ones.

And I’ve told families that I work with no one knows their child obviously better than the family, and I don’t doubt for a second that a family makes the right decision knowing as much as they know about their child, but I think with so many options out there it can be hard to feel confident about those decisions, so again, going back to your team and rechecking with them, are we on the right path, is an important process to go through.

Q: That’s great advice, Dr. Manning. Thank you so much.

Dr. Manning: You’re welcome.