American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

CLINICAL REPORT

Management of Children With Autism Spectrum Disorders

Guidance for the Clinician in Rendering Pediatric Care

Scott M. Myers, MD, Chris Plauché Johnson, MD, MEd, the Council on Children With Disabilities

ABSTRACT

Pediatricians have an important role not only in early recognition and evaluation of autism spectrum disorders but also in chronic management of these disorders. The primary goals of treatment are to maximize the child's ultimate functional independence and quality of life by minimizing the core autism spectrum disorder features, facilitating development and learning, promoting socialization, reducing maladaptive behaviors, and educating and supporting families. To assist pediatricians in educating families and guiding them toward empirically supported interventions for their children, this report reviews the educational strategies and associated therapies that are the primary treatments for children with autism spectrum disorders. Optimization of health care is likely to have a positive effect on habilitative progress, functional outcome, and quality of life; therefore, important issues, such as management of associated medical problems, pharmacologic and nonpharmacologic intervention for challenging behaviors or coexisting mental health conditions, and use of complementary and alternative medical treatments, are also addressed.

INTRODUCTION

The term autism spectrum disorders (ASDs) has been used to include the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*[1] diagnostic categories autistic disorder, Asperger disorder, and pervasive developmental disorder–not otherwise specified.[2] Recent estimates of the prevalence of ASDs are in the range of 6.5 to 6.6 per 1000, and pediatricians, therefore, are likely to care for children and adolescents with these diagnoses.[3–5] In the companion document to this clinical report,[2] the American Academy of Pediatrics has summarized pertinent background information on ASDs and emphasized the importance of surveillance and screening as well as other potential physician roles in the diagnostic process. However, the role of the primary health care professional extends beyond recognizing signs of ASDs, referring for diagnostic evaluation, conducting an etiologic investigation, providing genetic counseling, and educating caregivers about ASDs and includes ongoing care and management.

ASDs, similar to other neurodevelopmental disabilities, are generally not "curable," and chronic management is required. Although outcomes are variable and specific behavioral characteristics change over time, most children with ASDs remain within the spectrum as adults and, regardless of their intellectual functioning, continue to experience problems with independent living, employment, social relationships, and mental health.[6–8] The primary goals of treatment are to minimize the core features and associated deficits, maximize functional indepen-

www.pediatrics.org/cgi/doi/10.1542/peds.2007-2362

doi:10.1542/peds.2007-2362

All clinical reports from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Key Words
autism, autism spectrum disorders, Asperger syndrome, pervasive developmental disorders, complementary and alternative medicine, early intervention

Abbreviations
ASD—autism spectrum disorder
TEACCH—Treatment and Education of Autistic and Related Communication Handicapped Children
ABA—applied behavior analysis
DTT—discrete trial training
DIR—developmental, individual-difference, relationship-based
RDI—relationship-development intervention
RT—responsive teaching
SI—sensory integration
EEG—electroencephalography
SSRI—selective serotonin-reuptake inhibitor
CAM—complementary and alternative medicine

dence and quality of life, and alleviate family distress. Facilitating development and learning, promoting socialization, reducing maladaptive behaviors, and educating and supporting families can help accomplish these goals. Ideally, interventions should help mitigate the core features of ASDs, which include impairment in social reciprocity, deficits in communication, and restricted, repetitive behavioral repertoire.

Educational interventions, including behavioral strategies and habilitative therapies, are the cornerstones of management of ASDs. These interventions address communication, social skills, daily-living skills, play and leisure skills, academic achievement, and maladaptive behaviors.

Optimization of medical care is also likely to have a positive impact on habilitative progress and quality of life. In addition to routine preventive care and treatment of acute illnesses, management of sleep dysfunction, coexisting challenging behaviors or psychiatric conditions, and associated medical problems, such as seizures, may be particularly important. Medications have not been proven to correct the core deficits of ASDs and are not the primary treatment. However, associated maladaptive behaviors or psychiatric comorbidities may interfere with educational progress, socialization, health or safety, and quality of life. These behaviors may be amenable to psychopharmacologic intervention or, in some cases, treatment of underlying medical conditions that are causing or exacerbating the behaviors. Effective medical management may allow a child with an ASD to benefit more optimally from educational interventions.

EDUCATIONAL INTERVENTIONS

Education has been defined as the fostering of acquisition of skills and knowledge to assist a child to develop independence and personal responsibility; it encompasses not only academic learning but also socialization, adaptive skills, communication, amelioration of interfering behaviors, and generalization of abilities across multiple environments.[9] Physicians and other clinicians are often in a position to guide families to empirically supported practices and help them evaluate the appropriateness of the educational services that are being offered.

Comprehensive Programs for Young Children

In the last 2 decades, research and program development in the area of educational intervention have focused largely on very young children with ASDs because of earlier identification and evidence that early intensive intervention may result in substantially better outcomes.[9,10] Model early childhood educational programs for children with ASDs have been described in thorough reviews.[9,11,12] These model programs are often categorized as behavior analytic, developmental, or structured teaching on the basis of the primary philosophical orientation. Although the approaches have important differences, they also overlap. For example, contemporary comprehensive behavioral curricula borrow from developmental or cognitive approaches (such as addressing joint attention, reciprocal imitation, symbolic play, and theory of mind and using indirect language stimulation and contingent imitation techniques), and some developmental models (eg, the Denver model) and the structured teaching approach of the Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH) program use behavioral techniques to fulfill their curriculum goals.[10,13]

Although programs may differ in philosophy and relative emphasis on particular strategies, they share many common goals, and there is a growing consensus that important principles and components of effective early childhood intervention for children with ASDs include the following[9,10,14–16]:

- entry into intervention as soon as an ASD diagnosis is seriously considered rather than deferring until a definitive diagnosis is made;
- provision of intensive intervention, with active engagement of the child at least 25 hours per week, 12 months per year, in systematically planned, developmentally appropriate educational activities designed to address identified objectives;
- low student-to-teacher ratio to allow sufficient amounts of 1-on-1 time and small-group instruction to meet specific individualized goals;
- inclusion of a family component (including parent training as indicated);
- promotion of opportunities for interaction with typically developing peers to the extent that these opportunities are helpful in addressing specified educational goals;
- ongoing measurement and documentation of the individual child's progress toward educational objectives, resulting in adjustments in programming when indicated;
- incorporation of a high degree of structure through elements such as predictable routine, visual activity schedules, and clear physical boundaries to minimize distractions;
- implementation of strategies to apply learned skills to new environments and situations (generalization) and to maintain functional use of these skills; and
- use of assessment-based curricula that address:
  - functional, spontaneous communication;
  - social skills, including joint attention, imitation, reciprocal interaction, initiation, and self-management;

- functional adaptive skills that prepare the child for increased responsibility and independence;
- reduction of disruptive or maladaptive behavior by using empirically supported strategies, including functional assessment;
- cognitive skills, such as symbolic play and perspective taking; and
- traditional readiness skills and academic skills as developmentally indicated.

Specific Strategies

A variety of specific methodologies are used in educational programs for children with ASDs. Detailed reviews of intervention strategies to enhance communication,[9,17–20] teach social skills,[21–24] and reduce interfering maladaptive behaviors[21,25,26] have been published in recent years. Brief descriptions of selected methodologies are provided below.

Applied Behavior Analysis

Applied behavior analysis (ABA) is the process of applying interventions that are based on the principles of learning derived from experimental psychology research to systematically change behavior and to demonstrate that the interventions used are responsible for the observable improvement in behavior. ABA methods are used to increase and maintain desirable adaptive behaviors, reduce interfering maladaptive behaviors or narrow the conditions under which they occur, teach new skills, and generalize behaviors to new environments or situations. ABA focuses on the reliable measurement and objective evaluation of observable behavior within relevant settings including the home, school, and community. The effectiveness of ABA-based intervention in ASDs has been well documented through 5 decades of research by using single-subject methodology[21,25,27,28] and in controlled studies of comprehensive early intensive behavioral intervention programs in university and community settings.[29–40] Children who receive early intensive behavioral treatment have been shown to make substantial, sustained gains in IQ, language, academic performance, and adaptive behavior as well as some measures of social behavior, and their outcomes have been significantly better than those of children in control groups.[31–40]

Highly structured comprehensive early intervention programs for children with ASDs, such as the Young Autism Project developed by Lovaas[35,41] at the University of California Los Angeles, rely heavily on discrete trial training (DTT) methodology, but this is only one of many techniques used within the realm of ABA. DTT methods are useful in establishing learning readiness by teaching foundation skills such as attention, compliance, imitation, and discrimination learning, as well as a variety of other skills. However, DTT has been criticized because of problems with generalization of learned behaviors to spontaneous use in natural environments and because the highly structured teaching environment is not representative of natural adult-child interactions. Traditional ABA techniques have been modified to address these issues. Naturalistic behavioral interventions, such as incidental teaching and natural language paradigm/pivotal response training, may enhance generalization of skills.[13]

Functional behavior analysis, or functional assessment, is an important aspect of behaviorally based treatment of unwanted behaviors. Most problem behaviors serve an adaptive function of some type and are reinforced by their consequences, such as attainment of (1) adult attention, (2) a desired object, activity, or sensation, or (3) escape from an undesired situation or demand. Functional assessment is a rigorous, empirically based method of gathering information that can be used to maximize the effectiveness and efficiency of behavioral support interventions.[42] It includes formulating a clear description of the problem behavior (including frequency and intensity); identifying the antecedents, consequences, and other environmental factors that maintain the behavior; developing hypotheses that specify the motivating function of the behavior; and collecting direct observational data to test the hypothesis. Functional analysis also is useful in identifying antecedents and consequences that are associated with increased frequency of desirable behaviors so that they can be used to evoke new adaptive behaviors.

Structured Teaching

The TEACCH method, developed by Schopler and colleagues,[43] emphasizes structure and has come to be called "structured teaching." Important elements of structured teaching include organization of the physical environment, predictable sequence of activities, visual schedules, routines with flexibility, structured work/activity systems, and visually structured activities.[43] There is an emphasis on both improving skills of individuals with ASDs and modifying the environment to accommodate their deficits. Several reports have documented progress in children who have received TEACCH services as well as parent satisfaction and improvement in parent teaching skills, but these reports were not from controlled studies of treatment outcomes.[44–49] In a controlled trial, Ozonoff and Cathcart[50] found that children treated with a TEACCH-based home program for 4 months in addition to their local day treatment programs improved significantly more than children in the control group who received local day treatment services only.

Developmental Models

Developmental models are based on use of developmental theory to organize hypotheses regarding the fundamental nature of ASDs and design approaches to address

the deficits. The Denver model, for example, is based largely on remediating key deficits in imitation, emotion sharing, theory of mind, and social perception by using play, interpersonal relationships, and activities to foster symbolic thought and teach the power of communication.[12] This program has shifted from a center-based treatment unit to service delivery in homes and inclusive school environments. Several studies have demonstrated improvements in cognitive, motor, play, and social skills beyond what would be expected on the basis of initial developmental rates in children who are treated according to the Denver model, but controlled trials are lacking.[51–54]

Relationship-focused early intervention models include Greenspan and Wieder's developmental, individual-difference, relationship-based (DIR) model,[55] Gutstein and Sheely's relationship-development intervention (RDI),[56] and the responsive-teaching (RT) curriculum developed by Mahoney et al.[57,58] The DIR approach focuses on (1) "floor-time" play sessions and other strategies that are purported to enhance relationships and emotional and social interactions to facilitate emotional and cognitive growth and development and (2) therapies to remediate "biologically based processing capacities," such as auditory processing and language, motor planning and sequencing, sensory modulation, and visual-spatial processing. Published evidence of the efficacy of the DIR model is limited to an unblinded review of case records (with significant methodologic flaws, including inadequate documentation of the intervention, comparison to a suboptimal control group, and lack of documentation of treatment integrity and how outcomes were assessed by informal procedures[55]) and a descriptive follow-up study of a small subset (8%) of the original group of patients.[59] RDI focuses on activities that elicit interactive behaviors with the goal of engaging the child in a social relationship so that he or she discovers the value of positive interpersonal activity and becomes more motivated to learn the skills necessary to sustain these relationships.[56] Some reviewers have praised the face validity of this model, which targets the core impairment in social reciprocity. However, the evidence of efficacy of RDI is anecdotal; published empirical scientific research is lacking at this time. One study reported beneficial effects of RT on young children with ASDs or other developmental disabilities.[58] Parents were taught to use RT strategies to encourage their children to acquire and use pivotal developmental behaviors (attention, persistence, interest, initiation, cooperation, joint attention, and affect). Children in both groups improved significantly on nonstandardized play-based measures of cognition and communication and standardized parent ratings of socioemotional functioning. Although a control group was lacking and the potential role of concurrent educational services was unclear, the improvements were beyond what the authors expected from maturational factors alone.[58]

Speech and Language Therapy

A variety of approaches have been reported to be effective in producing gains in communication skills in children with ASDs.[9,17,20] Didactic and naturalistic behavioral methodologies (eg, DTT, verbal behavior, natural language paradigm, pivotal response training, milieu teaching) have been studied most thoroughly, but there is also some empirical support for developmental-pragmatic approaches (eg, Social Communication Emotional Regulation Transactional Support, Denver model, RDI, Hanen model).

People with ASDs have deficits in social communication, and treatment by a speech-language pathologist usually is appropriate. Most children with ASDs can develop useful speech, and chronologic age, lack of typical prerequisite skills, failure to benefit from previous language intervention, and lack of discrepancy between language and IQ scores should not exclude a child from receiving speech-language services.[60] However, traditional, low-intensity pull-out service delivery models often are ineffective, and speech-language pathologists are likely to be most effective when they train and work in close collaboration with teachers, support personnel, families, and the child's peers to promote functional communication in natural settings throughout the day.[60]

The use of augmentative and alternative communication modalities, including gestures, sign language, and picture communication programs, often is effective in enhancing communication.[17,20,61] The Picture Exchange Communication System (PECS)[62,63] is used widely. The PECS method incorporates ABA and developmental-pragmatic principles, and the child is taught to initiate a picture request and persist with the communication until the partner responds. Some nonverbal people with ASDs may benefit from the use of voice-output communication aids, but published evidence for these aids is scant.[20,64] Introduction of augmentative and alternative communication systems to nonverbal children with ASDs does not keep them from learning to talk, and there is some evidence that they may be more stimulated to learn speech if they already understand something about symbolic communication.[61,62,65]

Social Skills Instruction

There is some objective evidence to support traditional and newer naturalistic behavioral strategies and other approaches to teaching social skills.[22–24,66–68] Joint attention training may be especially beneficial in young, preverbal children with ASDs, because joint attention behaviors precede and predict social language development.[69,70] A recent randomized, controlled trial demonstrated that joint attention and symbolic play skills can be taught and that these skills generalize to different

settings and people.[71] Families can facilitate joint attention and other reciprocal social interaction experiences throughout the day in the child's regular activities. Examples of these techniques are described in the American Academy of Pediatrics parent booklet "*Understanding Autism Spectrum Disorders*."[72]

A social skills curriculum should target responding to the social overtures of other children and adults, initiating social behavior, minimizing stereotyped perseverative behavior while using a flexible and varied repertoire of responses, and self-managing new and established skills.[10] Social skills groups, social stories, visual cueing, social games, video modeling, scripts, peer-mediated techniques, and play and leisure curricula are supported primarily by descriptive and anecdotal literature, but the quantity and quality of research is increasing.[10,15,73] A number of social skills curricula and guidelines are available for use in school programs and at home.[10,66,74,75]

Occupational Therapy and Sensory Integration Therapy

Traditional occupational therapy often is provided to promote development of self-care skills (eg, dressing, manipulating fasteners, using utensils, personal hygiene) and academic skills (eg, cutting with scissors, writing). Occupational therapists also may assist in promoting development of play skills, modifying classroom materials and routines to improve attention and organization, and providing prevocational training. However, research regarding the efficacy of occupational therapy in ASDs is lacking. Sensory integration (SI) therapy often is used alone or as part of a broader program of occupational therapy for children with ASDs. The goal of SI therapy is not to teach specific skills or behaviors but to remediate deficits in neurologic processing and integration of sensory information to allow the child to interact with the environment in a more adaptive fashion. Unusual sensory responses are common in children with ASDs, but there is not good evidence that these symptoms differentiate ASDs from other developmental disorders, and the efficacy of SI therapy has not been demonstrated objectively.[76–78] Available studies are plagued by methodologic limitations, but proponents of SI note that higher-quality SI research is forthcoming.[79] "Sensory" activities may be helpful as part of an overall program that uses desired sensory experiences to calm the child, reinforce a desired behavior, or help with transitions between activities.

Comparative Efficacy of Educational Interventions for Young Children

All treatments, including educational interventions, should be based on sound theoretical constructs, rigorous methodologies, and empirical studies of efficacy.[15] Proponents of behavior analytic approaches have been the most active in using scientific methods to evaluate their work, and most studies of comprehensive treatment programs that meet minimal scientific standards involve treatment of preschoolers using behavioral approaches.[16,38] However, there is still a need for additional research, including large controlled studies with randomization and assessment of treatment fidelity. Empirical scientific support for developmental models and other interventions is more limited, and well-controlled systematic studies of efficacy are needed.

Most educational programs available to young children with ASDs are based in their communities, and often, an "eclectic" treatment approach is used, which draws on a combination of methods including applied behavior analytic methods such as DTT; structured teaching procedures; speech-language therapy, with or without picture communication or related augmentative or alternative communication strategies; SI therapy; and typical preschool activities. Three studies that compared intensive ABA programs (25–40 hours/week) to equally intensive eclectic approaches have suggested that ABA programs were significantly more effective.[31,32,34] Another study that involved children with ASDs and global developmental delay/mental retardation retrospectively compared a less intensive ABA program (mean: 12 hours) to a comparably intensive eclectic approach and found statistically significant but clinically modest outcomes that favored those in the ABA group.[33] Although the groups of children were similar on key dependent measures before treatment began, these studies were limited because of parent-determined rather than random assignment to treatment group. Additional studies to evaluate and compare educational treatment approaches are warranted.

Programs for Older Children and Adolescents

Some model programs provide programming throughout childhood and into adulthood.[11] More commonly, the focus of specialized programs is on early childhood, and published research evaluating comprehensive educational programs for older children and adolescents with ASDs is lacking. However, there is empirical support for the use of certain educational strategies, particularly those that are based on ABA, across all age groups to increase and maintain desirable adaptive behaviors, reduce interfering maladaptive behaviors or narrow the conditions under which they occur, teach new skills, and generalize behaviors to new environments or situations.[13,21,28]

When children with ASDs move beyond preschool and early elementary programs, educational intervention continues to involve assessment of existing skills, formulation of individualized goals and objectives, selection and implementation of appropriate intervention strategies and supports, assessment of progress, and adaptation of teaching strategies as necessary to enable students to acquire target skills. The focus on achieving social communication competence, emotional and be-

havioral regulation, and functional adaptive skills necessary for independence continues. Educational programs should be individualized to address the specific impairments and needed supports while capitalizing on the child's assets rather than being based on a particular diagnostic label.

Specific goals and objectives and the supports that are required to achieve them are listed in a child's individualized education plan and should be the driving force behind decisions regarding the most appropriate, least restrictive classroom placement. Appropriate settings may range from self-contained special education classrooms to full inclusion in regular classrooms. Often, a mix of specialized and inclusive experience is appropriate. Even highly functioning students with ASDs often require accommodations and other supports such as provision of explicit directions, modification of classroom and homework assignments, organizational supports, access to a computer and word-processing software for writing tasks, and social communication skills training. When a paraprofessional aide is assigned, it is important that there be an infrastructure of expertise and support for the child beyond the immediate presence of the aide.[80] The specific duties of the aide should be outlined, the strategies to be used should be defined, and the aide should receive adequate training.

In adolescence, the term "transition" is used to describe the movement from child-centered activities to adult-oriented activities. The major transitions are from the school environment to the workplace and from home to community living. In schools, transition-planning activities may begin at as early as 14 years of age, and by 16 years of age, the individualized education plan should include an individualized transition plan. The emphasis may shift from academic to vocational services and from remediating deficits to fostering abilities. A vocational assessment is often conducted to evaluate the adolescent's interests and strengths and to determine the services and supports needed to promote independence in the workplace and in the community. Comprehensive transition planning involves the student, parents, teachers, the medical home, and representatives from all concerned community agencies. Depending on the individual's cognitive level, social skills, health condition, work habits, and behavioral challenges, preparation for competitive, supported, or sheltered employment is targeted. Regardless of the type of employment, attention to skill development should never stop. Skills necessary for independent living should be taught to the degree possible given the abilities of the person. Sexuality education instruction should be included, and there is a growing body of literature that has addressed the topic.[81–83]

MEDICAL MANAGEMENT

Children with ASDs have the same basic health care needs as children without disabilities and benefit from the same health-promotion and disease-prevention activities, including immunizations. In addition, they may have unique health care needs that relate to underlying etiologic conditions, such as fragile X syndrome or tuberous sclerosis, or to other conditions, such as epilepsy, that often are associated with ASDs. Those with pica or persistent mouthing of fingers or objects should be monitored for elevated blood lead concentrations, particularly if the history suggests potential for environmental exposure.[84] These health care needs are most appropriately met within the context of a medical home.[85,86]

To deliver appropriate and effective medical care, the history, approach to the patient, physical evaluation, and treatment options must be considered in the context of the patient's ASD.[87,88] Familiarizing the patient with the office setting and staff, allowing ample time while talking before touching the patient, allowing the child to manipulate instruments and materials, keeping instructions simple, using visual cues and supports, slowing down the pace, exaggerating social cues, and having family and/or familiar staff available may be helpful in reducing the obstacles to health care provision presented by patients' difficulties with social interaction, communication, and accepting novelty.[88] Often, more time is required for outpatient appointments. In a nationally representative sample, it was found that children with ASDs spent twice as much time with the physician per outpatient visit compared with children in control groups.[89]

Associated Morbidity and Mortality

Health care utilization and costs are substantially higher for children and adolescents with ASDs compared with children without ASDs,[89–91] and available data suggest that mortality is increased as well (standardized mortality ratio: 2.4–2.6).[92,93] The increased mortality in ASDs is thought to be largely, but not completely, accounted for by the increased mortality associated with mental retardation and epilepsy. Cases of suicide in higher-functioning individuals have been reported.[6]

Seizures

The reported prevalence of epilepsy among people with ASDs ranges from 11% to 39%.[94] Comorbid severe global developmental delay/mental retardation and motor deficits are associated with a high prevalence of seizures (42%),[95] whereas the prevalence of seizures is only 6% to 8% in children with ASDs without severe mental retardation, a motor deficit, an associated etiologic medical disorder, or a positive family history of epilepsy.[95,96] The prevalence of epilepsy also was higher in studies that included adolescents and young adults, because the onset of epilepsy in ASDs has 2 peaks: 1 before 5 years of age and another in adolescence.[97] Anticonvulsant treatment in children with ASDs is based on the same criteria that are used for other children with

epilepsy, including accurate diagnosis of the particular seizure type.[98]

Epileptiform abnormalities on electroencephalography (EEG) are common in children with ASDs, with reported frequencies ranging from 10% to 72%.[99] Some studies have suggested that epileptiform abnormalities on EEG[100] and/or epilepsy[101] are more common in the subgroup of children with ASDs who have a history of regression, whereas other studies have not demonstrated this association.[102,103] Autistic regression with epileptiform abnormalities on EEG has been compared by analogy with Landau-Kleffner syndrome and electrical status epilepticus in sleep, but there are important differences between these conditions, and the treatment implications are unclear.[94,104] Whether subclinical seizures have adverse effects on language, cognition, and behavior is debated, and there is no evidence-based recommendation for the treatment of children with ASDs and epileptiform abnormalities on EEG, with or without regression.[104] Universal screening of patients with ASDs by EEG in the absence of a clinical indication is not currently supported.[2,99] However, because of the increased prevalence of seizures in this population, a high index of clinical suspicion should be maintained, and EEG should be considered when there are clinical spells that might represent seizures.

Gastrointestinal Problems

The relationship between gastrointestinal problems and ASDs is unclear, because most studies have not examined representative groups of children with ASDs compared with appropriate controls.[105,106] Surveys published in the gastroenterology literature have stated that gastrointestinal problems, such as chronic constipation or diarrhea, occur in 46% to 85% of children with ASDs.[107–109] Lower rates in the range of 17% to 24% have been reported in other population-based studies,[110–112] and a nested case-control study in the United Kingdom found that only 9% of children with ASDs and the same percentage of controls had a history of gastrointestinal complaints.[113] However, in a recent cross-sectional study that used structured interviews and matched control groups, a lifetime history of gastrointestinal symptoms (including abnormal stool pattern, frequent constipation, frequent vomiting, and frequent abdominal pain) was elicited in 70% of the children with ASDs, compared with 42% of the children with other developmental disabilities ($P = .03$) and 28% of the children without developmental disabilities ($P < .001$).[114]

In children with ASDs undergoing endoscopy, who may or may not be representative of the general population of children with ASDs, high rates of lymphoid nodular hyperplasia and, often, histologically subtle esophagitis, gastritis, duodenitis, and colitis have been described, and preliminary evidence suggests that some immunohistochemical features may be unique to inflammation associated with ASDs.[105,115,116] The existing literature does not support routine specialized gastroenterological testing for asymptomatic children with ASDs.[105] However, if a child with an ASD presents with symptoms such as chronic or recurrent abdominal pain, vomiting, diarrhea, or constipation, it is reasonable to evaluate the gastrointestinal tract. Occult gastrointestinal discomfort also should be considered in a child who presents with a change in behavior, such as outbursts of aggression or self-injury. Radiographic evidence of constipation has been found to be more common in children with ASDs than in controls with abdominal pain (36% vs 10%),[117] and effective management may provide global benefit.

Sleep Disturbance

Sleep problems are common in children and adolescents with ASDs at all levels of cognitive functioning.[118–122] Sleep problems correlate with family distress and may have significant effects on daytime functioning and quality of life of children with ASDs.[123–125] In some cases, there may be an identifiable etiology such as obstructive sleep apnea or gastroesophageal reflux; assessment and treatment are guided by history and physical examination. When there is not an identifiable medical cause, behavioral interventions including sleep-hygiene measures, restriction of daytime sleep, positive bedtime routines, and extinction procedures often are effective.[118,126–129]

Relatively little empirical information is available regarding pharmacologic management of sleep problems in children with ASDs or other developmental disabilities. Recommendations typically are based on case reports and open-label trials, extrapolation from the adult literature, and expert consensus (Table 1).[128] There is some evidence of abnormality of melatonin regulation in children with ASDs,[125,130] and melatonin may be effective for improving sleep onset in children with ASDs as well as children with other developmental disabilities[131–134] and otherwise healthy children with sleep/wake disorders.[135] A recent open-label study suggested that controlled-release melatonin improved sleep in a group of 25 children with ASDs and that treatment gains were maintained at 1- and 2-year follow-up,[136] but randomized, double-blind, placebo-controlled studies are needed. Recently, a child and a young adult with ASDs with significant insomnia were reported to have responded well, with no apparent adverse effects, to open-label treatment with the high-affinity melatonin receptor agonist ramelteon.[137] Antihistamines, α_2-agonists, benzodiazepines, chloral hydrate, trazodone, and newer nonbenzodiazepine hypnotic agents, such as zolpidem and zaleplon, sometimes are used to treat pediatric insomnia.[128] In some cases, other conditions or symptoms, such as epilepsy, depression, anxiety, or aggressive outbursts, warrant pharmacologic treatment, and an agent that also may assist with sleep can be chosen.[118]

TABLE 1 **Selected Potential Medication Options for Common Target Symptoms or Coexisting Diagnoses in Children With ASDs**

Target Symptom Cluster	Potential Coexisting Diagnoses	Selected Medication Considerations	Selected References
Repetitive behavior, behavioral rigidity, obsessive-compulsive symptoms	Obsessive-compulsive disorder, stereotypic movement disorder	SSRIs (fluoxetine,[a] fluvoxamine,[a] citalopram, escitalopram, paroxetine, sertraline)	McDougle et al,[158,b] Buchsbaum et al,[180,b] Sugie et al,[159,b] Hollander et al,[157,b] Moore et al,[160,c] Namerow et al,[181,d] Owley et al[182,d]
		Atypical antipsychotic agents (risperidone,[a] aripiprazole, olanzapine, quetiapine, ziprasidone)	McDougle et al[164,b]
		Valproic acid[a]	Hollander et al[183,b]
Hyperactivity, impulsivity, inattention	Attention-deficit/hyperactivity disorder	Stimulants (methylphenidate,[a] dextroamphetamine, mixed amphetamine salts)	Quintana et al,[168,b] Handen et al,[169,b] RUPP Autism Network[170,b]
		α_2-agonists (clonidine,[a] guanfacine)	Fankhauser et al,[172,b] Jaselskis et al,[173,b] Posey et al,[175,d] Scahill et al (RUPP Autism Network)[174,d]
		Atomoxetine[a]	Arnold et al,[178,b] Jou et al,[176,d] Posey et al[177,d]
		Atypical antipsychotic agents (risperidone,[a] aripiprazole, olanzapine,[a] quetiapine, ziprasidone)	McCracken et al,[162,b] Arnold et al,[163,b] Shea et al,[165,b] RUPP Autism Network,[166,b] Troost et al[167,d]
Aggression, explosive outbursts, self-injury	Intermittent explosive disorder	Atypical antipsychotic agents (risperidone,[a] aripiprazole, olanzapine, quetiapine, ziprasidone)	McCracken et al,[162,b] Arnold et al,[163,b] Shea et al,[165,b] RUPP Autism Network,[166,b] Troost et al[167,d]
		α_2-agonists (clonidine,[a] guanfacine)	Fankhauser et al,[172,b] Jaselskis et al,[173,b] Posey et al[175,d]
		Anticonvulsant mood stabilizers (levetiracetam, topiramate, valproic acid)	Hollander et al[184,d], Rugino and Samsock[185,d], Hardan et al[186,d], Myers[148,c], Myers and Challman[149,c]
		SSRIs (fluoxetine,[a] fluvoxamine,[a] citalopram, escitalopram, paroxetine, sertraline)	McDougle et al,[158,b] Moore et al,[160,c] Namerow et al,[181,d] Owley et al[182,d]
		β-blockers (propranolol, nadolol, metoprolol, pindolol)	Connor et al,[187,d] Ratey et al,[188,d] Myers and Challman[149,c]
Sleep dysfunction	Circadian rhythm sleep disorder, dyssomnia–not otherwise specified	Melatonin	Giannotti et al,[136,d] Jan and Freeman,[131,c] Phillips and Appleton,[133,c] Turk,[134,c] Owens et al[128,c]
		Ramelteon	Stigler et al[137,e]
		Antihistamines (diphenhydramine, hydroxyzine)	Reed and Findling,[189,c] Owens et al[128,c]
		α_2-agonists (clonidine, guanfacine)	Mehta et al,[190,d] Ingrassia and Turk,[191,d] Posey et al,[175,d] Owens et al[128,c]
		Mirtazapine	Posey et al[192,d]
Anxiety	Generalized anxiety disorder, anxiety disorder–not otherwise specified	SSRIs (fluoxetine,[a] fluvoxamine,[a] citalopram, escitalopram, paroxetine, sertraline)	McDougle et al,[158,b] Buchsbaum et al,[180,b] Sugie et al,[159,b] Hollander et al,[157,b] Moore et al,[160,c] Namerow et al,[181,d] Owley et al[182,d]
		Buspirone	Buitelaar et al[193,d]
		Mirtazapine	Posey et al[192,d]
Depressive phenotype (marked change from baseline including symptoms such as social withdrawal, irritability, sadness or crying spells, decreased energy, anorexia, weight loss, sleep dysfunction)	Major depressive disorder, depressive disorder–not otherwise specified	SSRIs (fluoxetine,[a] fluvoxamine,[a] citalopram, escitalopram, paroxetine, sertraline)	McDougle et al,[158,b] Moore et al,[160,c] Namerow et al,[181,d] Owley et al[182,d]
		Mirtazapine	Posey et al[192,d]

Evaluation of Challenging Behaviors

Problematic emotional reactions and behaviors such as aggression and self-injury are common in children and adolescents with ASDs. In some cases, medical factors may cause or exacerbate maladaptive behaviors, and recognition and treatment of medical conditions may eliminate the need for psychopharmacologic agents. For example, in the case of an acute onset or exacerbation of aggressive or self-injurious behavior, a source of pain or discomfort may be identified and treated.[138] Sources of discomfort may include otitis media, otitis externa, pharyngitis, sinusitis, dental abscess, constipation, urinary

TABLE 1 **Continued**

Target Symptom Cluster	Potential Coexisting Diagnoses	Selected Medication Considerations	Selected References
Bipolar phenotype (behavioral cycling with rages and euphoria, decreased need for sleep, manic-like hyperactivity, irritability, aggression, self-injury, sexual behaviors)	Bipolar I disorder, bipolar disorder–not otherwise specified	Anticonvulsant mood stabilizers (carbamazepine, gabapentin, lamotrigine, oxcarbazepine, topiramate, valproic acid)	Kowatch and DelBello,[194,c] Myers and Challman[149,c]
		Atypical antipsychotic agents (risperidone, aripiprazole, olanzapine, quetiapine, ziprasidone)	Cheng-Shannon et al,[195,c] Kowatch and DelBello,[194,c] Myers,[148,c] Myers and Challman[149,c]
		Lithium	DeLong,[196,e] Kerbeshian et al,[197,e] Steingard and Biederman,[198,e] Myers,[148,c] Myers and Challman[149,c]

RUPP indicates Research Units on Pediatric Psychopharmacology.

[a] At least 1 published double-blind, placebo-controlled trial supports use in patients with an ASD.

[b] Double-blind, placebo-controlled trial.

[c] Review article.

[d] Open-label trial or retrospective chart study.

[e] Case report.

tract infection, fracture, headache, esophagitis, gastritis, colitis, allergic rhinitis, and others. When behavioral deterioration is temporally related to menstrual cycles in an adolescent female,[139] use of an analgesic or oral or injectable contraceptive may be helpful. Obstructive sleep apnea may contribute to behavioral deterioration and may be amenable to weight reduction, tonsillectomy and adenoidectomy, or continuous positive airway pressure.[140] Extreme food selectivity has the potential to lead to protein-calorie malnutrition or specific vitamin or mineral deficiencies; however, most studies that evaluated nutritional status in children with ASDs have suggested that despite dietary selectivity, malnutrition is uncommon.[105,141] Although the prevalence in children with ASDs is unknown, pica related to iron or zinc deficiency may respond to supplementation with the appropriate mineral. It should be noted that it is not clear how frequently medical factors cause or exacerbate serious maladaptive behaviors in children with ASDs, and the efficacy of these interventions is based on anecdotes, case reports, and conventional clinical practice rather than empirical support from clinical trials.

It is also important to consider environmental factors that may precipitate challenging behaviors. Parents, teachers, or other caregivers may inadvertently reinforce maladaptive behaviors, and in such cases, the most appropriate and effective interventions are behavioral. In some instances, a mismatch between educational or behavioral expectations and cognitive ability of the child is responsible for disruptive behavior (eg, when the diagnosis of mental retardation has not been recognized), and adjustment of expectations is the most appropriate intervention. In both situations, a functional analysis of behavior, completed by a behavior specialist in the settings in which the problems occur, will identify factors in the environment that exacerbate or maintain the problematic behavior. A strategy for intervention through behavioral techniques and environmental manipulations can then be formulated and tested.

Psychopharmacology

Pharmacologic interventions may be considered for maladaptive behaviors such as aggression, self-injurious behavior, repetitive behaviors (eg, perseveration, obsessions, compulsions, and stereotypic movements), sleep disturbance, mood lability, irritability, anxiety, hyperactivity, inattention, destructive behavior, or other disruptive behaviors. After treatable medical causes and modifiable environmental factors have been ruled out, a therapeutic trial of medication may be considered if the behavioral symptoms cause significant impairment in functioning and are suboptimally responsive to behavioral interventions. In some cases, the diagnosis of a comorbid disorder, such as major depression, bipolar disorder, or an anxiety disorder, can be made reasonably and the patient can be treated with medications that are useful for treating these conditions in otherwise typically developing children and adolescents. Modifications of diagnostic criteria may be necessary to account for clinical presentations of psychiatric conditions in individuals with developmental disabilities,[142,143] and tools such as behavior checklists[144] and structured interviews[145] may be helpful. In other cases, clinicians opt to target specific interfering maladaptive behaviors or symptom clusters in the absence of a clear comorbid psychiatric diagnosis (a target-symptom approach).[146–151]

Recent surveys indicate that approximately 45% of children and adolescents[152–154] and up to 75% of adults[8,155] with ASDs are treated with psychotropic medication. Greater age, lower adaptive skills and social competence, and higher levels of challenging behavior are associated with the likelihood of medication use.[154] The evidence regarding the efficacy of psychopharmacologic interventions in patients with ASDs has been de-

tailed in recent reviews.[148,150,151,156] Although most psychotropic medications have been used in children with ASDs, there is currently insufficient literature to establish consensus regarding an evidence-based approach to pharmacologic management. However, in recent years, there has been an increase in publication of randomized, double-blind, placebo-controlled clinical trials to guide clinical practice.

Surveys performed in the United States suggest that selective serotonin-reuptake inhibitors (SSRIs), atypical antipsychotic agents, stimulants, and α_2-adrenergic agonist antihypertensive agents are the most commonly prescribed classes of psychotropic medications for children with ASDs.[152,153] Double-blind, placebo-controlled trials have demonstrated efficacy of the SSRIs fluoxetine[157] and fluvoxamine[158,159] in the treatment of repetitive and other maladaptive behaviors in patients with ASDs, and open-label trials of these and other SSRIs have shown improvements in target symptoms, including repetitive behaviors, irritability, depressive symptoms, tantrums, anxiety, aggression, difficulty with transitions, and aspects of social interaction and language.[157–161] Potential adverse effects of SSRIs include but are not limited to nausea, drowsiness, sexual dysfunction, constipation, abdominal discomfort, fatigue, headache, dizziness, dry mouth, agitation, behavioral activation, hypomania or mania, apathy, suicidal ideation, and alteration of sleep.

Risperidone has become the first medication with US Food and Drug Administration–approved labeling for the symptomatic treatment of irritability (including aggressive behavior, deliberate self-injury, and temper tantrums) in children and adolescents with ASDs. Two large, multisite, randomized, controlled trials have confirmed the short-term efficacy of risperidone for these severe disruptive behaviors in youth with ASDs,[162–165] and 2 open-label studies, each with a double-blind discontinuation component, have suggested long-term benefits and tolerance.[166,167] Potential adverse effects include but are not limited to excessive appetite and weight gain, insulin resistance, dyslipidemia, hyperprolactinemia, extrapyramidal symptoms, tardive dyskinesia, neuroleptic malignant syndrome, QTc prolongation, dry mouth, urinary retention, constipation, seizures, hematologic abnormalities, and sedation.

Although early studies of the effects of stimulants yielded negative results, recent double-blind, placebo-controlled trials of methylphenidate have demonstrated improvement in hyperactivity, impulsivity, and inattention in children with ASDs.[168–170] Methylphenidate is effective in some children with ASDs, but the response rate is lower than that in children with isolated attention-deficit/hyperactivity disorder, adverse effects are more frequent, and it is unclear whether the results can be generalized to other stimulants.[170,171] Potential adverse effects of stimulant medications include but are not limited to appetite reduction, inhibition of growth, delayed sleep onset, jitteriness, exacerbation of tics, abdominal discomfort, increased blood pressure, increased heart rate, irritability, increased anxiety, and repetitive behaviors.

Two small double-blind, placebo-controlled trials have documented modest benefits of clonidine in reducing hyperarousal symptoms including hyperactivity, irritability and outbursts, impulsivity, and repetitive behaviors in children with ASDs.[172,173] A prospective open-label trial[174] and a retrospective record review[175] have suggested that guanfacine was similarly effective in some patients. Potential adverse effects of these centrally acting α_2-agonists include but are not limited to drowsiness, sedation, dry mouth, decreased blood pressure, dizziness, constipation, and irritability, and these drugs can be dangerous in overdose. Recently, a retrospective study,[176] an open-label trial,[177] and a small double-blind, placebo-controlled crossover trial[178] suggested that atomoxetine may be effective for attention-deficit/hyperactivity disorder–like symptoms in children and adolescents with ASDs, and additional research is warranted. Appetite suppression, nausea, fatigue, mood swings, suicidal ideation, dizziness, and liver injury are among the potential adverse effects of atomoxetine.

A summary of selected target symptoms, potential psychiatric diagnoses, and medication options is provided in Table 1. Pediatricians and other practitioners should only prescribe medications with which they have sufficient expertise, including knowledge of indications and contraindications, dosing, potential adverse effects, drug-drug interactions, and monitoring requirements. It will be important for future research to address the need for more rigorous evaluation of safety and efficacy of psychotropic agents in children with ASDs; the value of combining behavioral and medical interventions; the practice of polypharmacy; delineation of clinical and biological subgroups of patients who may be responsive to particular treatments; the role of drugs in treating deficits in language and nonlanguage cognition, social interaction, and behavioral rigidity; and the potential to alter the neural substrate during early critical periods to affect brain development and future function. Several multisite trials are underway, and others undoubtedly will be forthcoming.[179]

Principles to guide the approach to psychopharmacologic management of ASDs in clinical practice have been proposed by several authors in recent years, and an approach is outlined in Table 2.[148–151] When medications are used, potential benefits and adverse effects should be explained, informed consent should be obtained, baseline data regarding behaviors and somatic complaints should be collected, and potential strategies for dealing with treatment failure or partial response should be reviewed. It is important to have some quantifiable means of assessing the efficacy of the medication and to

TABLE 2 **Clinical Approach to Psychopharmacologic Management**

- Identify and assess target behaviors
  - Parent/caregiver interview
    - Intensity
    - Duration
    - Exacerbating factors/triggers (time, setting/location, demand situations, denials, transitions, etc)
    - Ameliorating factors and response to behavioral interventions
    - Time trends (increasing, decreasing, stable)
    - Degree of interference with functioning
  - Consider baseline behavior-rating scales and/or baseline performance measures/direct observational data
  - Include input from school staff and other caregivers
- Assess existing and available supports
  - Behavioral services and supports
  - Educational program, habilitative therapies
  - Respite care, family psychosocial supports
- Search for medical factors that may be causing or exacerbating target behavior(s)
  - Consider sources of pain or discomfort (infectious, gastrointestinal, dental, allergic, etc)
  - Consider other medical causes or contributors (sleep disorders, seizures, menstrual cycle, etc)
- Complete any medical tests that may have a bearing on treatment choice
- Consider psychotropic medication on the basis of the presence of
  - Evidence that the target symptoms are interfering substantially with learning/academic progress, socialization, health/safety (of the patient and/or others around him or her), or quality of life
  - Suboptimal response to available behavioral interventions and environmental modifications
  - Research evidence that the target behavioral symptoms or coexisting psychiatric diagnoses are amenable to pharmacologic intervention
- Choose a medication on the basis of
  - Likely efficacy for the specific target symptoms
  - Potential adverse effects
  - Practical considerations such as formulations available, dosing schedule, cost, and requirement for laboratory or electrocardiographic monitoring
  - Informed consent (verbal or written) from parent/guardian and, when possible, assent from the patient
- Establish plan for monitoring of effects
  - Identify outcome measures
  - Discuss time course of expected effects
  - Arrange follow-up telephone contact, completion of rating scales, reassessment of behavioral data, and visits accordingly
  - Outline a plan regarding what might be tried next if there is a negative or suboptimal response or to address additional target symptoms
    - Change to a different medication
    - Add another medication to augment a partial or suboptimal therapeutic response to the initial medication (same target symptoms)
    - Add a different medication to address additional target symptoms that remain problematic
  - Obtain baseline laboratory data if necessary for the drug being prescribed and plan appropriate follow-up monitoring
- Explore the reasonable dose range for a single medication for an adequate length of time before changing to or adding a different medication
- Monitor for adverse effects systematically
- Consider careful withdrawal of the medication after 6–12 mo of therapy to determine whether it is still needed

Adapted from Myers SM. The status of pharmacotherapy for autism spectrum disorders. *Expert Opin Pharmacother*. 2007;8:1579–1603; and Myers SM, Challman TD. Psychopharmacology: an approach to management in autism and intellectual disabilities. In: Accardo PJ, ed. *Capute & Accardo's Neurodevelopmental Disabilities in Infancy and Childhood*. 3rd ed. Baltimore, MD: Paul H. Brookes; 2007: In press.

obtain input from a variety of sources, such as parents, teachers, therapists, and aides. Consistent use of validated, treatment-sensitive rating scales and medication adverse-effect scales is desirable. A wide variety of outcome measures have been used in research trials and in clinical practice to measure maladaptive behavior treatment effects.[199] Among the most common are the Clinical Global Impression Scale, Aberrant Behavior Checklist, and Nisonger Child Behavior Rating Form.

Complementary and Alternative Medicine

Complementary and alternative medicine (CAM) is defined by the National Center for Complementary and Alternative Medicine as "a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine."[200] The definition of CAM adopted by the Cochrane Collaboration is "a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health systems of a particular society or culture in a given historical period."[201] Detailed reviews of CAM as related to developmental disabilities and ASD-specific CAM have been published recently.[202–204]

Use of CAM is common in children with ASDs.[152,205–207] Levy et al[206] reported that by the time their clinical population received a formal diagnostic evaluation for a suspected ASD, almost one third of the children already had received a complementary or alternative therapy, and a survey conducted in a predominantly white, middle-to-upper socioeconomic-status private-practice population found that 92% of parents who responded had used CAM therapies for their children with ASDs.[205]

Another recent parent survey found that 52% of the children with an ASD had been treated with at least 1 CAM therapy, compared with 28% of a group of control children without disabilities.[207] Surveys indicate that only 36% to 62% of caregivers who used CAM therapies for their children with ASDs had informed the child's primary care physician,[207,208] although more information on CAM is something that families indicate that they want from their child's primary health care professionals.[209]

It is important that health care professionals understand how to evaluate the evidence used to support all treatments, including CAM, psychopharmacologic, and other interventions. Ideally, the evidence supporting or refuting a treatment should include peer-reviewed studies with appropriately diagnosed, well-defined homogeneous study populations; a randomized, double-blind, placebo-controlled design; an adequate sample size to support the statistical analysis presented; control for confounding factors; and use of appropriate, validated outcome measures. When evaluating the efficacy of studies, it is particularly important to keep in mind confounding factors, such as the placebo effect, and the natural history of the disorder. Participation in a study may alter the way a parent interacts with a child and confound the perceived outcome,[210] and improvements are expected with maturation and educational interventions. Only appropriately controlled studies are helpful in proving that an effect is attributable to the intervention being studied.

The practitioner should encourage families to seek additional information when they encounter the following claims or situations[211]:

- treatments that are based on overly simplified scientific theories;
- therapies that are claimed to be effective for multiple different, unrelated conditions or symptoms;
- claims that children will respond dramatically and some will be cured;
- use of case reports or anecdotal data rather than carefully designed studies to support claims for treatment;
- lack of peer-reviewed references or denial of the need for controlled studies; or
- treatments that are said to have no potential or reported adverse effects.

To help to describe their proposed rationales and mechanisms, CAM therapies used to treat ASDs have been categorized as "nonbiological" or "biological."[204] Examples of nonbiological interventions include treatments such as auditory integration training, behavioral optometry, craniosacral manipulation, dolphin-assisted therapy, music therapy, and facilitated communication. Examples of biological therapies include immunoregulatory interventions (eg, dietary restriction of food allergens or administration of immunoglobulin or antiviral agents), detoxification therapies (eg, chelation), gastrointestinal treatments (eg, digestive enzymes, antifungal agents, probiotics, "yeast-free diet," gluten/casein-free diet, and vancomycin), and dietary supplement regimens that are purported to act by modulating neurotransmission or through immune factors or epigenetic mechanisms (eg, vitamin A, vitamin C, vitamin B_6 and magnesium, folic acid, folinic acid, vitamin B_{12}, dimethylglycine and trimethylglycine, carnosine, omega-3 fatty acids, inositol, various minerals, and others).[203,204]

For most of the aforementioned CAM interventions, there is not enough scientific evidence yet to support or refute their use as treatment for ASDs. However, evaluation of treatments is possible, and a few CAM treatments have been appropriately studied. For example, more than a dozen randomized, double-blind, placebo-controlled trials involving more than 700 patients have demonstrated that secretin (a biological treatment) is not an effective treatment for ASDs.[212,213] Evaluation of nonbiological treatments also is feasible. This has been demonstrated in the case of facilitated communication, a technique that uses a trained facilitator to provide physical support to a nonverbal person's hand or arm while that person uses a computer keyboard or other device to spell. Evidence suggests that the communications produced actually originate from the facilitator[214,215] and that facilitated communication is not a valid treatment for ASDs.[216–218]

Because of methodologic flaws, insufficient numbers of patients, or lack of replication, many CAM therapies have been inadequately evaluated; therefore, evidence-based recommendations for their use are not possible. The most recent and most appropriately designed trials have demonstrated no significant benefit of dimethylglycine,[219,220] vitamin B_6 and magnesium,[221,222] or auditory integration training.[223–225] Both positive[226] and negative[227,228] results have been described for small, methodologically flawed studies of intravenous immunoglobulin. A recent double-blind, placebo-controlled trial revealed no statistically significant differences on Aberrant Behavior Checklist subscale scores between small groups of children with ASDs who were given omega-3 fatty acids and those who were given placebo.[229] However, the investigators noted a trend toward superiority of omega-3 fatty acids over placebo for hyperactivity, which suggests that further investigation may be warranted.[229] The gluten/casein-free diet is based on a hypothesis of abnormal gut permeability and exogenous opiate excess. Although use of the gluten/casein-free diet for children with ASDs is popular, there is little evidence to support or refute this intervention, and reviewers have determined that meaningful conclusions cannot be drawn from the existing literature.[230,231] Subsequent to these reviews, a randomized, double-blind

pilot study demonstrated no significant benefit.[232] Double-blind, placebo-controlled elimination and challenge studies are in progress, and it is anticipated that these studies will provide substantially more useful information regarding the efficacy of the gluten/casein-free diet.[204,230] Measurement of urinary peptides has not been proven to be clinically useful as a marker for ASDs or as a tool to determine if dietary restriction is warranted or would be effective.

Many popular interventions, such as chelation of heavy metals, antifungal agents to decrease presumed yeast overgrowth, and antiviral agents to modulate the immune system, have not yet been studied in people with ASDs; their popularity is based on unproven theories and anecdotes or case reports. None of these interventions can be endorsed as treatment for ASDs outside of well-designed and appropriately monitored clinical trials. Some treatments, such as intravenous chelation, may be particularly dangerous and should be discouraged. One child with autism died as a result of chelation with edetate disodium (Na_2EDTA) despite the facts that a causal association between mercury and ASDs has not been demonstrated, there is no scientific evidence that chelation is an effective treatment for ASDs, and the effectiveness of chelation therapy to improve nervous system symptoms of chronic mercury toxicity has not been established.[233] Unless there is clear evidence of current heavy metal toxicity, chelation by any method is not indicated outside of monitored clinical trials.

In some cases, interesting findings await replication or further investigation. For example, in a double-blind, placebo-controlled trial of vitamin C, improvement was found in total and sensory motor scores on the Ritvo-Freeman Real Life Rating Scale,[234] and several small studies have suggested that music therapy had some short-term benefit on communication skills but not on behavior problems of children with ASDs.[235] Recently, a group of 20 children with ASDs were compared with children without ASDs and found to have an imbalance of methionine and homocysteine metabolism, which was interpreted to represent impaired capacity for methylation and increased oxidative stress.[236] Treatment with trimethylglycine, folinic acid, and methylcobalamin resulted in normalization of laboratory findings. The study did not measure clinical response to the intervention, but anecdotal improvements were noted. Interpretation of these preliminary findings awaits further investigation.

Health care practitioners who diagnose and treat children with ASDs should recognize that many of their patients will use nonstandard therapies. The importance of becoming knowledgeable about CAM therapies, inquiring about current and past CAM use, providing balanced information and advice about treatment options, identifying risks or potential harmful effects, avoiding becoming defensive or dismissing CAM in ways that convey a lack of sensitivity or concern, maintaining open communication, and continuing to work with families even if there is disagreement about treatment choices has been emphasized.[237] It also is essential to critically evaluate the scientific merits of specific therapies and share this information with families, educate families about how to evaluate information and recognize pseudoscience, and insist that studies that examine CAM be held to the same scientific and ethical standards as all clinical research.[202,238]

Parents of children with ASDs will understandably pursue interventions that they believe may present some hope of helping their child, particularly if the therapies are viewed as being unlikely to have any adverse effects. Unfortunately, families are often exposed to unsubstantiated, pseudoscientific theories and related clinical practices that are, at best, ineffective and, at worst, compete with validated treatments or lead to physical, emotional, or financial harm. Time, effort, and financial resources expended on ineffective therapies can create an additional burden on families. Health care professionals can help parents and other caregivers to distinguish empirically validated treatment approaches from treatments that have been proven to be ineffective and those that are unproven and potentially ineffective and/or harmful.

FAMILY SUPPORT

Management should focus not only on the child but also on the family. Although parents once were viewed erroneously as the cause of a child's ASD, it is now recognized that parents play a key role in effective treatment.[9] Having a child with an ASD has a substantial effect on a family. Parents and siblings of children with ASDs experience more stress and depression than those of children who are typically developing or even those who have other disabilities.[239–243] Supporting the family and ensuring its emotional and physical health is an extremely important aspect of overall management of ASDs.

Physicians and other health care professionals can provide support to parents by educating them about ASDs; providing anticipatory guidance; training and involving them as cotherapists; assisting them in obtaining access to resources; providing emotional support through traditional strategies such as empathetic listening and talking through problems; and assisting them in advocating for their child's or sibling's needs.[244] In some cases, referral of parents for counseling or other appropriate mental health services may be required. The need for support is longitudinal, although the specific needs may vary throughout the family life cycle.

One of the chief strategies for helping families raise children with ASDs is helping to provide them with access to needed ongoing supports and additional services during critical periods and/or crises. Natural supports include spouses, extended family members, neigh-

bors, religious institutions, and friends who can help with caregiving and who can provide psychological and emotional support. Informal supports include social networks of other families of children with ASDs and community agencies that provide training, respite, social events, and recreational activities. Formal supports include publicly funded, state-administrated programs such as early intervention, special education, vocational and residential/living services, respite services, Medicaid, in-home and community-based waiver services, Supplemental Security Income benefits, and other financial subsidies. The breadth and depth of services vary, even within the same state or region. Few services exist in many rural areas, and public programs may have long waiting lists.

Sibling support groups offer the opportunity to learn important information and skills while sharing experiences and connecting with other siblings of children with ASDs.[244] Although the research on support groups for siblings of children with disabilities is difficult to interpret because of study-design problems and inconsistent outcome effects on sibling adjustment, these groups generally have been evaluated positively by participating siblings and parents,[244] and there is some evidence of beneficial effects for siblings of children with ASDs.[245]

Because each state has organized its services and access mechanisms differently, physicians and families must learn their own state's unique rules to access supports by contacting the state or county offices of the states' Department of Health and Human Services or Mental Health and Mental Retardation or the state developmental disabilities organization. In addition, local parent advocacy organizations, national autism and related developmental disability organizations, early intervention administrators, and school district special education coordinators often are knowledgeable about various programs and their respective eligibility requirements.

CONCLUSIONS

ASDs are chronic conditions that affect nearly 1 of every 150 children and require ongoing medical and nonmedical intervention. There is a growing body of evidence that supports the efficacy of certain interventions in ameliorating symptoms and enhancing functioning, but much remains to be learned. In addition to their important roles in identifying ASDs through screening and surveillance, establishing the diagnosis, conducting an etiologic evaluation, and providing genetic counseling after a diagnosis is made,[2] pediatricians and other primary health care professionals are in a position to provide important longitudinal medical care and to support and educate families and guide them to empirically supported interventions for their children.

REFERENCES

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR)*. Washington, DC: American Psychiatric Publishing; 2000
2. Johnson CP, Myers SM; American Academy of Pediatrics, Council on Children With Disabilities. Identification and evaluation of children with autism spectrum disorders. *Pediatrics.* 2007;120:1183–1215
3. Fombonne E, Zakarian R, Bennett A, Meng L, McLean-Heywood D. Pervasive developmental disorders in Montreal, Quebec, Canada: prevalence and links with immunizations. *Pediatrics.* 2006;118(1). Available at: www.pediatrics.org/cgi/content/full/118/1/e139
4. Dosreis S, Weiner CL, Johnson L, Newschaffer CJ. Autism spectrum disorder screening and management practices among general pediatric providers. *J Dev Behav Pediatr.* 2006; 27(2 suppl):S88–S94
5. Autism and Developmental Disabilities Monitoring Network Surveillance Year 2002 Principal Investigators; Centers for Disease Control and Prevention. Prevalence of autism spectrum disorders: Autism and Developmental Disabilities Mon-

itoring Network, 14 sites, United States, 2002. *MMWR Surveill Summ.* 2007;56:12–28
6. Howlin P. Outcomes in autism spectrum disorders. In: Volkmar FR, Paul R, Klin A, Cohen D, eds. *Handbook of Autism and Pervasive Developmental Disorders*. 3rd ed. Vol II. Hoboken, NJ: John Wiley & Sons; 2005:201–220
7. Howlin P, Goode S, Hutton J, Rutter M. Adult outcome for children with autism. *J Child Psychol Psychiatry.* 2004;45: 212–229
8. Seltzer MM, Shattuck P, Abbeduto L, Greenberg JS. Trajectory of development in adolescents and adults with autism. *Ment Retard Dev Disabil Res Rev.* 2004;10:234–247
9. National Research Council, Committee on Educational Interventions for Children with Autism. *Educating Children With Autism*. Lord C, McGee JP, eds. Washington, DC: National Academies Press; 2001
10. Olley JG. Curriculum and classroom structure. In: Volkmar FR, Paul R, Klin A, Cohen D, eds. *Handbook of Autism and Pervasive Developmental Disorders*. 3rd ed. Vol II. Hoboken, NJ: John Wiley & Sons; 2005:863–881
11. Handleman JS, Harris SL. *Preschool Education Programs for Children With Autism*. 2nd ed. Austin, TX: Pro-Ed; 2000
12. Harris SL, Handleman JS, Jennett HK. Models of educational intervention for students with autism: home, center, and school-based programming. In: Volkmar FR, Paul R, Klin A, Cohen D, eds. *Handbook of Autism and Pervasive Developmental Disorders*. 3rd ed. Vol II. Hoboken, NJ: John Wiley & Sons; 2005:1043–1054
13. Schreibman L, Ingersoll B. Behavioral interventions to promote learning in individuals with autism. In: Volkmar FR, Paul R, Klin A, Cohen D, eds. *Handbook of Autism and Pervasive Developmental Disorders*. 3rd ed. Vol II. Hoboken, NJ: John Wiley & Sons; 2005:882–896
14. Dawson G, Osterling J. Early intervention in autism. In: Guralnick MJ, ed. *The Effectiveness of Early Intervention: Second Generation Research*. Baltimore, MD: Brookes; 1997:307–326
15. Mastergeorge AM, Rogers SJ, Corbett BA, et al. Nonmedical interventions for autism spectrum disorders. In: Ozonoff S, Rogers SJ, Hendren RL, eds. *Autism Spectrum Disorders: A Research Review for Practitioners*. Washington, DC: American Psychiatric Publishing; 2003:133–160
16. Rogers SJ. Empirically supported comprehensive treatments for young children with autism. *J Clin Child Psychol.* 1998;27: 168–179
17. Goldstein H. Communication intervention for children with autism: a review of treatment efficacy. *J Autism Dev Disord.* 2002;32:373–396
18. Koegel LK. Interventions to facilitate communication in autism. *J Autism Dev Disord.* 2000;30:383–391
19. Marans WD, Rubin E, Laurent A. Addressing social communication skills in individuals with high-functioning autism and Asperger syndrome: critical priorities in educational programming. In: Volkmar FR, Paul R, Klin A, Cohen D, eds. *Handbook of Autism and Pervasive Developmental Disorders*. 3rd ed. Vol II. Hoboken, NJ: John Wiley & Sons; 2005:977–1002
20. Paul R, Sutherland D. Enhancing early language in children with autism spectrum disorders. In: Volkmar FR, Paul R, Klin A, Cohen D, eds. *Handbook of Autism and Pervasive Developmental Disorders*. 3rd ed. Vol II. Hoboken, NJ: John Wiley & Sons; 2005:946–976
21. Bregman JD, Zager D, Gerdtz J. Behavioral interventions. In: Volkmar FR, Paul R, Klin A, Cohen D, eds. *Handbook of Autism and Pervasive Developmental Disorders*. 3rd ed. Vol II. Hoboken NJ: John Wiley & Sons; 2005:897–924
22. Lorimer PA, Simpson RL, Myles BS, et al. The use of social stories as a preventative behavioral intervention in a home setting with a child with autism. *J Posit Behav Interv.* 2002;4: 53–60
23. Taylor BA. Teaching peer social skills to children with autism. In: Maurice C, Green G, Foxx RM, eds. *Making a Difference: Behavioral Intervention for Autism*. Austin, TX: Pro-Ed; 2001: 83–96
24. Weiss MJ, Harris SL. Teaching social skills to people with autism. *Behav Modif.* 2001;25:785–802
25. Campbell JM. Efficacy of behavioral interventions for reducing problem behavior in persons with autism: a quantitative synthesis of single-subject research. *Res Dev Disabil.* 2003;24: 120–138
26. Horner RH, Carr EG, Strain PS, Todd AW, Reed HK. Problem behavior interventions for young children with autism: a research synthesis. *J Autism Dev Disord.* 2002;32:423–446
27. DeMyer MK, Hingtgen JN, Jackson RK. Infantile autism reviewed: a decade of research. *Schizophr Bull.* 1981;7: 388–451
28. Matson JL, Benavidez DA, Compton LS, Paclawskyj T, Baglio C. Behavioral treatment of autistic persons: a review of research from 1980 to the present. *Res Dev Disabil.* 1996;17: 433–465
29. Anderson SR, Avery DL, DiPietro EK, Edwards GL, Christian WP. Intensive home-based intervention with autistic children. *Educ Treat Child.* 1987;10:352–366
30. Birnbrauer JS, Leach DJ. The Murdoch Early Intervention Program after 2 years. *Behav Change.* 1993;10:63–74
31. Cohen H, Amerine-Dickens M, Smith T. Early intensive behavioral treatment: replication of the UCLA model in a community setting. *J Dev Behav Pediatr.* 2006;27(2 suppl): S145–S155
32. Eikeseth S, Smith T, Jahr E, Eldevik S. Intensive behavioral treatment at school for 4- to 7-year-old children with autism: a 1-year comparison controlled study. *Behav Modif.* 2002;26: 49–68
33. Eldevik S, Eikeseth S, Jahr E, Smith T. Effects of low-intensity behavioral treatment for children with autism and mental retardation. *J Autism Dev Disord.* 2006;36:211–224
34. Howard JS, Sparkman CR, Cohen HG, Green G, Stanislaw H. A comparison of intensive behavior analytic and eclectic treatments for young children with autism. *Res Dev Disabil.* 2005;26:359–383
35. Lovaas OI. Behavioral treatment and normal educational and intellectual functioning in young autistic children. *J Consult Clin Psychol.* 1987;55:3–9
36. McEachin JJ, Smith T, Lovaas OI. Long-term outcome for children with autism who received early intensive behavioral treatment. *Am J Ment Retard.* 1993;97:359–372
37. Sallows GO, Graupner TD. Intensive behavioral treatment for children with autism: four-year outcome and predictors. *Am J Ment Retard.* 2005;110:417–438
38. Smith T. Outcome of early intervention for children with autism. *Clin Psychol Sci Pract.* 1999;6:33–49
39. Smith T, Groen AD, Wynne JW. Randomized trial of intensive early intervention for children with pervasive developmental disorder. *Am J Ment Retard.* 2000;105:269–285
40. Weiss M. Differential rates of skill acquisition and outcomes of early intensive behavioral intervention for autism. *Behav Interv.* 1999;14:3–22
41. Lovaas OI, ed. *Teaching Individuals With Developmental Delays: Basic Intervention Techniques*. Austin, TX: Pro-Ed; 2003
42. O'Neill R, Horner R, Albin R, et al. *Functional Assessment and Program Development for Problem Behavior: A Practical Handbook*. Pacific Grove, CA: Brookes/Cole Publishing; 1996
43. Mesibov GB, Shea V, Schopler E. *The TEACCH Approach to Autism Spectrum Disorders*. New York, NY: Kluwer Academic/Plenum; 2005

44. Lord C, Schopler E. The role of age at assessment, developmental level, and test in the stability of intelligence scores in young autistic children. *J Autism Dev Disord.* 1989;19:483–499
45. Marcus LM, Lansing M, Andrews CE, Schopler E. Improvement of teaching effectiveness in parents of autistic children. *J Am Acad Child Psychiatry.* 1978;17:625–639
46. Mesibov GB. Formal and informal measures on the effectiveness or the TEACCH programme. *Autism.* 1997;1:25–35
47. Schopler E, Mesibov GB, Baker A. Evaluation of treatment for autistic children and their parents. *J Am Acad Child Psychiatry.* 1982;21:262–267
48. Short AB. Short-term treatment outcome using parents as co-therapists for their own autistic children. *J Child Psychol Psychiatry.* 1984;25:443–458
49. Venter AC, Lord C, Schopler E. A follow-up study of high-functioning autistic children. *J Child Psychol Psychiatry.* 1992; 33:489–507
50. Ozonoff S, Cathcart K. Effectiveness of a home program intervention for young children with autism. *J Autism Dev Disord.* 1998;28:25–32
51. Rogers SJ, Herbison JM, Lewis HC, et al. An approach for enhancing the symbolic, communicative, and interpersonal functioning of young children with autism or severe emotional handicaps. *J Div Early Child.* 1986;10:135–148
52. Rogers SJ, DiLalla DL. A comparative study of the effects of a developmentally based instructional model on young children with autism and young children with other disorders of behavior and development. *Top Early Child Spec Educ.* 1991; 11:29–47
53. Rogers SJ, Lewis H. An effective day treatment model for young children with pervasive developmental disorders. *J Am Acad Child Adolesc Psychiatry.* 1989;28:207–214
54. Rogers SJ, Lewis HC, Reis K. An effective procedure for training early special education teams to implement a model program. *J Div Early Child.* 1987;11:180–188
55. Greenspan SI, Wieder S. Developmental patterns and outcomes in infants and children with disorders in relating and communicating: a chart review of 200 cases of children with autistic spectrum diagnoses. *J Dev Learn Disord.* 1997;1:87–141
56. Gutstein SE, Sheely RK. *Relationship Development Intervention With Children, Adolescents, and Adults*. New York, NY: Jessica Kingsley; 2002
57. Mahoney G, McDonald J. *Responsive Teaching: Parent-Mediated Developmental Intervention*. Baltimore, MD: Paul H. Brookes; 2003
58. Mahoney G, Perales F. Relationship-focused early intervention with children with pervasive developmental disorders and other disabilities: a comparative study. *J Dev Behav Pediatr.* 2005;26:77–85
59. Wieder S, Greenspan SI. Can children with autism master the core deficits and become empathetic, creative, and reflective? A ten to fifteen year follow-up of a subgroup of children with autism spectrum disorders (ASD) who received a comprehensive developmental, individual-difference, relationship-based (DIR) approach. *J Dev Learn Disord.* 2005;9:39–61
60. American Speech-Language-Hearing Association, Ad Hoc Committee on Autism Spectrum Disorders. Principles for speech-language pathologists in diagnosis, assessment, and treatment of autism spectrum disorders across the life span. Available at: www.asha.org/NR/rdonlyres/D0370FEA-98EF-48EE-A9B6-952913FB131B/0/v3TR_autismLSpan.pdf. Accessed February 22, 2007
61. Millar DC, Light JC, Schlosser RW. The impact of augmentative and alternative communication intervention on the speech production of individuals with developmental disabilities: a research review. *J Speech Lang Hear Res.* 2006; 49:248–264
62. Bondy A, Frost L. The picture exchange communication system. *Focus Autistic Behav.* 1994;9:1–19
63. Bondy A, Frost L. The picture exchange communication system. *Semin Speech Lang.* 1998;19:373–388
64. Schepis MM, Reid DH, Behrmann MM, Sutton KA. Increasing communicative interactions of young children with autism using a voice output communication aid and naturalistic teaching. *J Appl Behav Anal.* 1998;31:561–578
65. Layton TL. Language training with autistic children using four different modes of presentation. *J Commun Disord.* 1988;21: 333–350
66. Krasny L, Williams BJ, Provencal S, Ozonoff S. Social skills interventions for the autism spectrum: essential ingredients and a model curriculum. *Child Adolesc Psychiatr Clin N Am.* 2003;12:107–122
67. McConnell S. Interventions to facilitate social interaction for young children with autism: review of available research and recommendations for educational intervention and future research. *J Autism Dev Disord.* 2002;32:351–372
68. Rogers SJ. Interventions that facilitate socialization in children with autism. *J Autism Dev Disord.* 2000;30:399–409
69. Bruinsma Y, Koegel RL, Koegel LK. Joint attention and children with autism: a review of the literature. *Ment Retard Dev Disabil Res Rev.* 2004;10:169–175
70. Whalen C, Schreibman L. Joint attention training for children with autism using behavior modification procedures. *J Child Psychol Psychiatry.* 2003;44:456–468
71. Kasari C, Freeman S, Paparella T. Joint attention and symbolic play in young children with autism: a randomized controlled intervention study. *J Child Psychol Psychiatry.* 2006;47: 611–620
72. American Academy of Pediatrics. *Understanding Autism Spectrum Disorders* [pamphlet]. Elk Grove Village, IL: American Academy of Pediatrics; 2005
73. Reynhout G, Carter M. Social stories for children with disabilities. *J Autism Dev Disord.* 2006;36:445–469
74. Gray C, McAndrew S. *My Social Stories Book*. London, England: Jessica Kingsley; 2002
75. Taylor BA, Jasper S. Teaching programs to increase peer interaction. In: Maurice C, Green G, Foxx RM, eds. *Making a Difference: Behavioral Intervention for Autism*. Austin, TX: Pro-Ed; 2001:97–162
76. Baranek GT. Efficacy of sensory and motor interventions for children with autism. *J Autism Dev Disord.* 2002;32:397–422
77. Dawson G, Watling R. Interventions to facilitate auditory, visual, and motor integration in autism: a review of the evidence. *J Autism Dev Disord.* 2000;30:415–421
78. Rogers SJ, Ozonoff S. Annotation: what do we know about sensory dysfunction in autism? A critical review of the empirical evidence. *J Child Psychol Psychiatry.* 2005;46:1255–1268
79. Schaaf RC, Miller LJ. Occupational therapy using a sensory integrative approach for children with developmental disabilities. *Ment Retard Dev Disabil Res Rev.* 2005;11:143–148
80. Klin A, Volkmar FR. Treatment and intervention guidelines for individuals with Asperger syndrome. In: Klin A, Volkmar FR, Sparrow SS, eds. *Asperger Syndrome*. New York, NY: Guilford Press; 2000:340–366
81. Konstantareas MM, Lunsky YJ. Sociosexual knowledge, experience, attitudes, and interests of individuals with autistic disorder and developmental delay. *J Autism Dev Disord.* 1997; 27:397–413
82. Murphy N. Sexuality in children and adolescents with disabilities. *Dev Med Child Neurol.* 2005;47:640–644
83. Murphy NA, Elias ER; American Academy of Pediatrics, Council on Children With Disabilities. Sexuality of children and adolescents with developmental disabilities. *Pediatrics.* 2006;118:398–403

84. Shannon M, Graef JW. Lead intoxication in children with pervasive developmental disorders. *J Toxicol Clin Toxicol.* 1996; 34:177–181
85. American Academy of Pediatrics, Medical Home Initiatives for Children With Special Needs Project Advisory Committee. The medical home. *Pediatrics.* 2004;113(5 suppl):1545–1547
86. Cooley WC. Redefining primary pediatric care for children with special health care needs: the primary care medical home. *Curr Opin Pediatr.* 2004;16:689–692
87. La Camera RG, La Camera AC. Routine health care. In: Cohen DJ, Volkmar FR, eds. *Handbook of Autism and Pervasive Developmental Disorders*. 2nd ed. New York, NY: John Wiley & Sons; 1997:730–740
88. Volkmar FR, Wiesner LA, Westphal A. Healthcare issues for children on the autism spectrum. *Curr Opin Psychiatry.* 2006; 19:361–366
89. Liptak GS, Stuart T, Auinger P. Health care utilization and expenditures for children with autism: data from U.S. national samples. *J Autism Dev Disord.* 2006;36:871–879
90. Croen LA, Najjar DV, Ray GT, Lotspeich L, Bernal P. A comparison of health care utilization and costs of children with and without autism spectrum disorders in a large group-model health plan. *Pediatrics.* 2006;118(4). Available at: www.pediatrics.org/cgi/content/full/118/4/e1203
91. Mandell DS, Cao J, Ittenbach R, Pinto-Martin J. Medicaid expenditures for children with autistic spectrum disorders: 1994 to 1999. *J Autism Dev Disord.* 2006;36:475–485
92. Shavelle RM, Strauss DJ, Pickett J. Causes of death in autism. *J Autism Dev Disord.* 2001;31:569–576
93. Pickett JA, Paculdo DR, Shavelle RM, Strauss DJ. 1998–2002 update on "Causes of Death in Autism." *J Autism Dev Disord.* 2006;36:287–288
94. Ballaban-Gil K, Tuchman R. Epilepsy and epileptiform EEG: association with autism and language disorders. *Ment Retard Dev Disabil Res Rev.* 2000;6:300–308
95. Tuchman R, Rapin I, Shinnar S. Autistic and dysphasic children II: epilepsy [published correction appears in *Pediatrics.* 1992;90:264]. *Pediatrics.* 1991;88:1219–1225
96. Pavone P, Incorpora G, Fiumara A, Parano E, Trifiletti RR, Ruggieri M. Epilepsy is not a prominent feature of primary autism. *Neuropediatrics.* 2004;35:207–210
97. Volkmar FR, Nelson DS. Seizure disorders in autism. *J Am Acad Child Adolesc Psychiatry.* 1990;29:127–129
98. Sankar E. Initial treatment of epilepsy with antiepileptic drugs: pediatric issues. *Neurology.* 2004;63(10 suppl 4): S30–S39
99. Kagan-Kushnir T, Roberts SW, Snead OC III. Screening electroencephalograms in autism spectrum disorders: evidence-based guideline. *J Child Neurol.* 2005;20:197–206
100. Tuchman RF, Rapin I. Regression in pervasive developmental disorders: seizures and epileptiform electroencephalogram correlates. *Pediatrics.* 1997;99:560–566
101. Hrdlicka M, Komarek V, Propper L, et al. Not EEG abnormalities but epilepsy is associated with autistic regression and mental functioning in childhood autism. *Eur Child Adolesc Psychiatry.* 2004;13:209–213
102. Canitano R, Luchetti A, Zappella M. Epilepsy, electroencephalographic abnormalities, and regression in children with autism. *J Child Neurol.* 2005;20:27–31
103. Chez MG, Chang M, Krasne V, Coughlan C, Kominsky M, Schwartz A. Frequency of epileptiform EEG abnormalities in a sequential screening of autistic patients with no known clinical epilepsy from 1996 to 2005. *Epilepsy Behav.* 2006;8: 267–271
104. Tuchman R, Rapin I. Epilepsy in autism. *Lancet Neurol.* 2002; 1:352–358
105. Erickson CA, Stigler KA, Corkins MR, Posey DJ, Fitzgerald JF, McDougle CJ. Gastrointestinal factors in autistic disorder: a critical review. *J Autism Dev Disord.* 2005;35:713–727
106. Kuddo T, Nelson KB. How common are gastrointestinal disorders in children with autism? *Curr Opin Pediatr.* 2003;15: 339–343
107. Horvath K, Perman JA. Autism and gastrointestinal symptoms. *Curr Gastroenterol Rep.* 2002;4:251–258
108. Lightdale JR, Siegel B, Heyman MB. Gastrointestinal symptoms in autistic children. *Clin Perspect Gastroenterol.* 2001;1: 56–58
109. Melmed RD, Schneider CK, Fabes RA, Philips J, Reichelt K. Metabolic markers and gastrointestinal symptoms in children with autism and related disorders [abstract]. *J Pediatr Gastroenterol Nutr.* 2000;31(suppl 2):S31
110. Fombonne E, Chakrabarti S. No evidence for a new variant of measles-mumps-rubella-induced autism. *Pediatrics.* 2001; 108(4). Available at: www.pediatrics.org/cgi/content/full/108/4/e58
111. Molloy CA, Manning-Courtney P. Prevalence of chronic gastrointestinal symptoms in children with autism and autistic spectrum disorders. *Autism.* 2003;7:165–171
112. Taylor B, Miller E, Lingam R, Andrews N, Simmons A, Stowe J. Measles, mumps, and rubella vaccination and bowel problems or developmental regression in children with autism: population-based study. *BMJ.* 2002;324:393–396
113. Black C, Kaye JA, Jick H. Relation of childhood gastrointestinal disorders to autism: nested case-control study using data from the UK General Practice Research Database. *BMJ.* 2002; 325:419–421
114. Valicenti-McDermott M, McVicar K, Rapin I, Wershil BK, Cohen H, Shinnar S. Frequency of gastrointestinal symptoms in children with autistic spectrum disorders and association with family history of autoimmune disease. *J Dev Behav Pediatr.* 2006;27(2 suppl):S128–S136
115. Horvath K, Papadimitriou JC, Rabsztyn A, Drachenberg C, Tildon JT. Gastrointestinal abnormalities in children with autistic disorder. *J Pediatr.* 1999;135:559–563
116. Torrente F, Anthony A, Heuschkel RB, Thomson MA, Ashwood P, Murch SH. Focal-enhanced gastritis in regressive autism with features distinct from Crohn's and *Helicobacter pylori* gastritis. *Am J Gastroenterol.* 2004;99:598–605
117. Afzal N, Murch S, Thirrupathy K, Berger L, Fagbemi A, Heuschkel R. Constipation with acquired megarectum in children with autism. *Pediatrics.* 2003;112:939–942
118. Malow BA. Sleep disorders, epilepsy, and autism. *Ment Retard Dev Disabil Res Rev.* 2004;10:122–125
119. Oyane NM, Bjorvatn B. Sleep disturbances in adolescents and young adults with autism and Asperger syndrome. *Autism.* 2005;9:83–94
120. Polimeni MA, Richdale AL, Francis AJ. A survey of sleep problems in autism, Asperger's disorder and typically developing children. *J Intellect Disabil Res.* 2005;49:260–268
121. Wiggs L, Stores G. Sleep patterns and sleep disorders in children with autistic spectrum disorders: insights using parent report and actigraphy. *Dev Med Child Neurol.* 2004;46:372–380
122. Williams G, Sears LL, Allaed A. Sleep problems in children with autism. *J Sleep Res.* 2004;13:265–268
123. Patzold LM, Richdale AL, Tonge BJ. An investigation into sleep characteristics of children with autism and Asperger's disorder. *J Paediatr Child Health.* 1998;34:528–533
124. Schreck KA, Mulick JA, Smith AF. Sleep problems as possible predictors of intensified symptoms of autism. *Res Dev Disabil.* 2004;25:57–66
125. Tordjman S, Anderson GM, Pichard N, Charbuy H, Touitou Y. Nocturnal excretion of 6-sulphatoxymelatonin in children and adolescents with autistic disorder. *Biol Psychiatry.* 2005; 57:134–138

126. Christodulu KV, Durand VM. Reducing bedtime disturbance and night waking using positive bedtime routines and sleep restriction. *Focus Autism Other Dev Disabl.* 2004;19:130–139
127. Meltzer LJ, Mindell JA. Nonpharmacologic treatments for pediatric sleeplessness. *Pediatr Clin North Am.* 2004;51: 135–151
128. Owens JA, Babcock D, Blumer J, et al. The use of pharmacotherapy in the treatment of pediatric insomnia in primary care: rational approaches—a consensus meeting summary. *J Clin Sleep Med.* 2005;1:49–59
129. Weiskop S, Richdale A, Matthews J. Behavioural treatment to reduce sleep problems in children with autism or fragile X syndrome. *Dev Med Child Neurol.* 2005;47:94–104
130. Kulman G, Lissoni P, Rovelli F, Roselli MG, Brivio, Sequeri P. Evidence of pineal endocrine hypofunction in autistic children. *Neuro Endocrinol Lett.* 2000;21:31–34
131. Jan JE, Freeman RD. Melatonin therapy for circadian rhythm sleep disorders in children with multiple disabilities: what have we learned in the last decade? *Dev Med Child Neurol.* 2004;46:776–782
132. Paavonen EJ, Nieminen-von Wendt T, Vanhala R, Aronen ET, von Wendt L. Effectiveness of melatonin in the treatment of sleep disturbances in children with Asperger disorder. *J Child Adolesc Psychopharmacol.* 2003;13:83–95
133. Phillips L, Appleton RE. Systematic review of melatonin treatment in children with neurodevelopmental disabilities and sleep impairment. *Dev Med Child Neurol.* 2004;46:771–775
134. Turk J. Melatonin supplementation for severe and intractable sleep disturbance in young people with genetically determined developmental disabilities: short review and commentary. *J Med Genet.* 2003;40:793–796
135. Smits MG, van Stel HF, van der Heijden K, Meijer AM, Coenan AM, Kerkhof GA. Melatonin improves health status and sleep in children with idiopathic chronic sleep-onset insomnia: a randomized placebo-controlled trial. *J Am Acad Child Adolesc Psychiatry.* 2003;42:1286–1293
136. Giannotti F, Cortesi F, Cerquiglini A, Bernabei P. An open-label study of controlled-release melatonin in treatment of sleep disorders in children with autism. *J Autism Dev Disord.* 2006;36:741–752
137. Stigler KA, Posey DJ, McDougle CJ. Ramelteon for insomnia in two youths with autistic disorder. *J Child Adolesc Psychopharmacol.* 2006;16:631–636
138. Bosch J, Van Dyke C, Smith SM, Poulton S. Role of medical conditions in the exacerbation of self-injurious behavior: an exploratory study. *Ment Retard.* 1997;35:124–130
139. Lee DO. Menstrually related self-injurious behavior in adolescents with autism. *J Am Acad Child Adolesc Psychiatry.* 2004; 43:1193
140. Malow BA, McGrew SG, Harvey M, et al. Impact of treating sleep apnea in a child with autism spectrum disorder. *Pediatr Neurol.* 2006;34:325–328
141. Bowers L. An audit of referrals of children with autistic spectrum disorder to the dietetic service. *J Hum Nutr Diet.* 2002; 15:141–144
142. Perry, DW, Marston GM, Hinder SA. The phenomenology of depressive illness in people with a learning disability and autism. *Autism.* 2001;5:265–275
143. Syzmanski LS, King B, Goldberg B, et al. Diagnosis of mental disorders in people with mental retardation. In: Reiss S, Aman MG, eds. *Psychotropic Medications and Developmental Disabilities: The International Consensus Handbook*. Columbus, OH: Ohio State University Nisonger Center; 1998:3–17
144. Brereton AV, Tonge BJ, Einfeld SL. Psychopathology in children and adolescents with autism compared to young people with intellectual disability. *J Autism Dev Disord.* 2006;36: 863–870
145. Leyfer OT, Folstein SE, Bacalman S, et al. Comorbid psychiatric disorders in children with autism: interview development and rates of disorders. *J Autism Dev Disord.* 2006;36: 849–861
146. Bostic JQ, Rho Y. Target-symptom psychopharmacology: between the forest and the trees. *Child Adolesc Psychiatr Clin N Am.* 2006;15:289–302
147. Hollander E, Phillips AT, Yeh CC. Targeted treatments for symptom domains in child and adolescent autism. *Lancet.* 2003;362:732–734
148. Myers SM. The status of pharmacotherapy for autism spectrum disorders. *Expert Opin Pharmacother.* 2007;8:1579–1603
149. Myers SM, Challman TD. Psychopharmacology: an approach to management in autism and intellectual disabilities. In: Accardo PJ, ed. *Capute & Accardo's Neurodevelopmental Disabilities in Infancy and Childhood: Vol I. Neurodevelopmental Diagnosis and Treatment*. 3rd ed. Baltimore, MD: Paul H. Brookes; 2008: 577–614
150. Steingard RJ, Connor DF, Au T. Approaches to psychopharmacology. In: Bauman ML, Kemper TL, eds. *The Neurobiology of Autism*. 2nd ed. Baltimore, MD: Johns Hopkins University Press; 2005:79–102
151. Towbin KE. Strategies for pharmacologic treatment of high functioning autism and Asperger syndrome. *Child Adolesc Psychiatr Clin N Am.* 2003;12:23–45
152. Aman MG, Lam KS, Collier-Crespin A. Prevalence and patterns of use of psychoactive medicines among individuals with autism in the Autism Society of Ohio. *J Autism Dev Disord.* 2003;33:527–534
153. Langworthy-Lam KS, Aman MG, Van Bourgondien ME. Prevalence and patterns of use of psychoactive medicines in individuals with autism in the autism society of North Carolina. *J Child Adolesc Psychopharmacol.* 2002;12:311–321
154. Witwer A, Lecavalier L. Treatment incidence and patterns in children and adolescents with autism spectrum disorders. *J Child Adolesc Psychopharmacol.* 2005;15:671–681
155. Tsakanikos E, Costello H, Holt G, et al. Psychopathology in adults with autism and intellectual disability. *J Autism Dev Disord.* 2006;36:1123–1129
156. Posey DJ, McDougle CJ. The pharmacotherapy of target symptoms associated with autistic disorder and other pervasive developmental disorders. *Harv Rev Psychiatry.* 2000;8: 45–63
157. Hollander E, Phillips A, Chaplin W, et al. A placebo controlled crossover trial of liquid fluoxetine on repetitive behaviors in childhood and adolescent autism. *Neuropsychopharmacology.* 2005;30:582–589
158. McDougle CJ, Naylor ST, Cohen DJ, Volkmar FR, Heninger GR, Price LH. A double-blind, placebo-controlled study of fluvoxamine in adults with autistic disorder. *Arch Gen Psychiatry.* 1996;53:1001–1008
159. Sugie Y, Sugie H, Fukuda T, et al. Clinical efficacy of fluvoxamine and functional polymorphism in a serotonin transporter gene on childhood autism. *J Autism Dev Disord.* 2005; 35:377–385
160. Moore ML, Eichner SF, Jones JR. Treating functional impairment of autism with selective serotonin-reuptake inhibitors. *Ann Pharmacother.* 2004;38:1515–1519
161. Posey DJ, Erickson CA, Stigler KA, McDougle CJ. The use of selective serotonin reuptake inhibitors in autism and related disorders. *J Child Adolesc Psychopharmacol.* 2006;16:181–186
162. McCracken JT, McGough J, Shah B, et al. Risperidone in children with autism and serious behavioral problems. *N Engl J Med.* 2002;347:314–321
163. Arnold LE, Vitiello B, McDougle C, et al. Parent-defined target symptoms respond to risperidone in RUPP autism

study: customer approach to clinical trials. *J Am Acad Child Adolesc Psychiatry.* 2003;42:1443–1450
164. McDougle CJ, Scahill L, Aman MG, et al. Risperidone for the core symptom domains of autism: results from the study by the Autism Network of the Research Units on Pediatric Psychopharmacology. *Am J Psychiatry.* 2005;162:1142–1148
165. Shea S, Turgay A, Carroll A, et al. Risperidone in the treatment of disruptive behavioral symptoms in children with autistic and other pervasive developmental disorders. *Pediatrics.* 2004;114(5). Available at: www.pediatrics.org/cgi/content/full/114/5/e634
166. Research Units on Pediatric Psychopharmacology Autism Network. Risperidone treatment of autistic disorder: longer-term benefits and blinded discontinuation after 6 months. *Am J Psychiatry.* 2005;162:1361–1369
167. Troost PW, Lahuis BE, Steenuis MP, et al. Long-term effects of risperidone in children with autism spectrum disorders: a placebo discontinuation study. *J Am Acad Child Adolesc Psychiatry.* 2005;44:1137–1144
168. Quintana H, Birmaher B, Stedge D, et al. Use of methylphenidate in the treatment of children with autistic disorder. *J Autism Dev Disord.* 1995;25:283–294
169. Handen BL, Johnson CR, Lubetsky M. Efficacy of methylphenidate among children with autism and symptoms of attention-deficit hyperactivity disorder. *J Autism Dev Disord.* 2000;30:245–255
170. Research Units on Pediatric Psychopharmacology Autism Network. Randomized, controlled, crossover trial of methylphenidate in pervasive developmental disorders with hyperactivity. *Arch Gen Psychiatry.* 2005;62:1266–1274
171. Aman MG. Management of hyperactivity and other acting-out problems in autism spectrum disorder. *Semin Pediatr Neurol.* 2004;11:225–228
172. Fankhauser MP, Karumanchi VC, German ML, Yates A, Karumanchi SD. A double-blind, placebo-controlled study of the efficacy of transdermal clonidine in autism. *J Clin Psychiatry.* 1992;53:77–82
173. Jaselskis CA, Cook EH, Fletcher E, Leventhal BL. Clonidine treatment of hyperactive and impulsive children with autistic disorder. *J Clin Psychopharmacol.* 1992;12:322–327
174. Scahill L, Aman MG, McDougle CJ, et al. A prospective open trial of guanfacine in children with pervasive developmental disorders. Research Units on Pediatric Psychopharmacology (RUPP) Autism Network. *J Child Adolesc Psychopharmacol.* 2006;16:589–598
175. Posey DJ, Puntney JI, Sasher TM, Kem DL, McDougle CJ. Guanfacine treatment of hyperactivity and inattention in pervasive developmental disorders: a retrospective analysis of 80 cases. *J Child Adolesc Psychopharmacol.* 2004;14:233–241
176. Jou RJ, Handen BL, Hardan AY. Retrospective assessment of atomoxetine in children and adolescents with pervasive developmental disorders. *J Child Adolesc Psychopharmacol.* 2005;15:325–330
177. Posey DJ, Wiegand RE, Wilkerson J, Maynard M, Stigler KA, McDougle CJ. Open-label atomoxetine for attention-deficit/hyperactivity disorder symptoms associated with high-functioning pervasive developmental disorders. *J Child Adolesc Psychopharmacol.* 2006;16:599–610
178. Arnold LE, Aman MG, Cook AM, et al. Atomoxetine for hyperactivity in autism spectrum disorders: placebo-controlled crossover pilot trial. *J Am Acad Child Adolesc Psychiatry.* 2006;45:1196–1205
179. Vitiello B. An update on publicly funded multisite trials in pediatric psychopharmacology. *Child Adolesc Psychiatr Clin N Am.* 2006;15:1–12
180. Buchsbaum MS, Hollander E, Haznedar MM, et al. Effect of fluoxetine on regional cerebral metabolism in autistic spectrum disorders: a pilot study. *Int J Neuropsychopharmacol.* 2001;4:119–125
181. Namerow LB, Thomas P, Bostic JQ, Prince J, Monuteaux MC. Use of citalopram in pervasive developmental disorders. *J Dev Behav Pediatr.* 2003;24:104–108
182. Owley T, Walton L, Salt J, et al. An open-label trial of escitalopram in pervasive developmental disorders. *J Am Acad Child Adolesc Psychiatry.* 2005;44:343–348
183. Hollander E, Soorya L, Wasserman S, Esposito K, Chaplin W, Anagnostou E. Divalproex sodium vs. placebo in the treatment of repetitive behaviours in autism spectrum disorder. *Int J Neuropsychopharmacol.* 2006;9:209–213
184. Hollander E, Dolgoff-Kaspar R, Cartwright C, Rawitt R, Novotny S. An open trial of divalproex sodium in autism spectrum disorders. *J Clin Psychiatry.* 2001;62:530–534
185. Rugino TA, Samsock TC. Levetiracetam in autistic children: an open-label study. *J Dev Behav Pediatr.* 2002;23:225–230
186. Hardan AY, Jou RJ, Handen BL. A retrospective assessment of topiramate in children and adolescents with pervasive developmental disorders. *J Child Adolesc Psychopharmacol.* 2004;14:426–432
187. Connor DF, Ozbayrak KR, Benjamin S, Ma Y, Fletcher KE. A pilot study of nadolol for overt aggression in developmentally delayed individuals. *J Am Acad Child Adolesc Psychiatry.* 1997;36:826–834
188. Ratey JJ, Mikkelsen E, Sorgi P, et al. Autism: the treatment of aggressive behaviors. *J Clin Psychopharmacol.* 1987;7:35–41
189. Reed MD, Findling RL. Overview of current management of sleep disturbances in children: I—pharmacotherapy. *Curr Ther Res.* 2002;63(suppl B):B18–B37
190. Mehta UC, Patel I, Castello FV. EEG sedation for children with autism. *J Dev Behav Pediatr.* 2004;25:102–104
191. Ingrassia A, Turk J. The use of clonidine for severe and intractable sleep problems in children with neurodevelopmental disorders: a case series. *Eur Child Adolesc Psychiatry.* 2005;14:34–40
192. Posey DJ, Guenin KD, Kohn AE, Swiezy NB, McDougle CJ. A naturalistic open-label study of mirtazapine in autistic and other pervasive developmental disorders. *J Child Adolesc Psychopharmacol.* 2001;11:267–277
193. Buitelaar JK, van der Gaag RJ, van der Hoeven J. Buspirone in the management of anxiety and irritability in children with pervasive developmental disorders: results of an open-label study. *J Clin Psychiatry.* 1998;59:56–59
194. Kowatch RA, DelBello MD. Pediatric bipolar disorder: emerging diagnostic and treatment approaches. *Child Adolesc Psychiatr Clin N Am.* 2006;15:73–108
195. Cheng-Shannon J, McGough JJ, Pataki C, McCracken JT. Second-generation antipsychotic medications in children and adolescents. *J Child Adolesc Psychopharmacol.* 2004;14:372–394
196. DeLong R. Children with autistic spectrum disorder and a family history of affective disorder. *Dev Med Child Neurol.* 1994;36:674–687
197. Kerbeshian J, Burd L, Fisher W. Lithium carbonate in the treatment of two patients with infantile autism and atypical bipolar symptomatology. *J Clin Psychopharmacol.* 1987;7:401–405
198. Steingard R, Biederman J. Lithium responsive manic-like symptoms in two individuals with autism and mental retardation. *J Am Acad Child Adolesc Psychiatry.* 1987;26:932–935
199. Aman MG, Novotny S, Samango-Sprouse C, et al. Outcome measures for clinical drug trials in autism. *CNS Spectr.* 2004;9:36–47
200. National Center for Complementary and Alternative Medicine. Expanding horizons of healthcare: five year strategic plan 2001–2005. Washington, DC: US Department of Health and Human Services; 2000

201. Zollman C, Vickers A. What is complementary medicine? *BMJ.* 1999;319:693–696
202. Challman TD, Voigt RG, Myers SM. Nonstandard therapies in developmental disabilities. In: Accardo PJ, ed. *Capute & Accardo's Neurodevelopmental Disabilities in Infancy and Childhood: Vol I. Neurodevelopmental Diagnosis and Treatment*. 3rd ed. Baltimore, MD: Paul H. Brookes; 2008:721–743
203. Gupta VB. Complementary and alternative treatments for autism. In: Gupta VB, ed. *Autistic Spectrum Disorders in Children (Pediatric Habilitation Series Volume 12)*. New York, NY: Marcel Dekker; 2004:239–254
204. Levy SE, Hyman SL. Novel treatments for autistic spectrum disorders. *Ment Retard Dev Disabil Res Rev.* 2005;11:131–142
205. Harrington JW, Rosen L, Garnecho A, Patrick PA. Parental perceptions and use of complementary and alternative medicine practices for children with autistic spectrum disorders in private practice. *J Dev Behav Pediatr.* 2006;27:S156–S161
206. Levy SE, Mandell DS, Merhar S, Ittenbach RF, Pinto-Martin JA. Use of complementary and alternative medicine among children recently diagnosed with autistic spectrum disorder. *J Dev Behav Pediatr.* 2003;24:418–423
207. Wong HHL, Smith RG. Patterns of complementary and alternative medical therapy use in children diagnosed with autism spectrum disorders. *J Autism Dev Disord.* 2006;36:901–909
208. Sibinga EM, Ottolini MC, Duggan AK, Wilson MH. Parent-pediatrician communication about complementary and alternative medicine use for children. *Clin Pediatr (Phila).* 2004;43: 367–373
209. Liptak GS, Orlando M, Yingling JT, et al. Satisfaction with primary health care received by families of children with developmental disabilities. *J Pediatr Health Care.* 2006;20: 245–252
210. Sandler A. Placebo effects in developmental disabilities: implications for research and practice. *Ment Retard Dev Disabil Res Rev.* 2005;11:164–170
211. Nickel R. Controversial therapies for young children with developmental disabilities. *Infants Young Child.* 1996;8:29–40
212. Sturmey P. Secretin is an ineffective treatment for pervasive developmental disabilities: a review of 15 double-blind randomized controlled trials. *Res Dev Disabil.* 2005;26:87–97
213. Williams KW, Wray JJ, Wheeler DM. Intravenous secretin for autism spectrum disorder. *Cochrane Database Syst Rev.* 2005; (3):CD003495
214. Smith MD, Haas PJ, Belcher RG. Facilitated communication: the effects of facilitator knowledge and level of assistance on output. *J Autism Dev Disord.* 1994;24:357–367
215. Cardinal DN, Hanson D, Wakeham J. Investigation of authorship in facilitated communication. *Ment Retard.* 1996;34: 231–242
216. American Academy of Pediatrics, Committee on Children With Disabilities. Auditory integration training and facilitated communication for autism. *Pediatrics.* 1998;102:431–433
217. Jacobson JW, Mulick JA, Schwartz AA. A history of facilitated communication: science, pseudoscience, and antiscience. Science Working Group on Facilitated Communication. *Am Psychol.* 1995;50:750–765
218. Mostert MP. Facilitated communication since 1995: a review of published studies. *J Autism Dev Disord.* 2001;31:287–313
219. Bolman WM, Richmond JA. A double-blind, placebo controlled pilot trial of low dose dimethylglycine in patients with autistic disorder. *J Autism Dev Disord.* 1999;29:191–194
220. Kern JK, Miller VS, Cauller PL, Kendall PR, Mehta PJ, Dodd M. Effectiveness of *N,N*-dimethylglycine in autism and pervasive developmental disorder. *J Child Neurol.* 2001;16: 169–173
221. Findling RL, Maxwell K, Scotese-Wojtila L, Huang J, Yamashita T, Wiznitzer M. High-dose pyridoxine and magnesium administration in children with autistic disorder: an absence of salutary effects in a double-blind, placebo-controlled study. *J Autism Dev Disord.* 1997;27:467–478
222. Nye C, Brice A. Combined vitamin B_6-magnesium treatment in autism spectrum disorder. *Cochrane Database Syst Rev.* 2005; (4):CD003497
223. Mudford OC, Cross BA, Breen S, et al. Auditory integration training for children with autism: no behavioral benefits detected. *Am J Ment Retard.* 2000;105:118–129
224. Sinha Y, Silove N, Wheeler D, Williams K. Auditory integration training and other sound therapies for autism spectrum disorders. *Cochrane Database Syst Rev.* 2004;(1):CD003681
225. Sinha Y, Silove N, Wheeler D, Williams K. Auditory integration training and other sound therapies for autism spectrum disorders: a systematic review. *Arch Dis Child.* 2006;91: 1018–1022
226. Gupta S, Aggarwal S, Heads C. Dysregulated immune system in children with autism: beneficial effects of intravenous immune globulin on autistic characteristics. *J Autism Dev Disord.* 1996;26:439–452
227. DelGiudice-Asch G, Simon L, Schmeidler J, Cunningham-Rundles C, Hollander E. Brief report: a pilot open clinical trial of intravenous immunoglobulin in childhood autism. *J Autism Dev Disord.* 1999;29:157–160
228. Plioplys AV. Intravenous immunoglobulin treatment of children with autism. *J Child Neurol.* 1998;13:79–82
229. Amminger GP, Berger GE, Schafer MR, Klier C, Friedrich MH, Feucht M. Omega-3 fatty acids supplementation in children with autism: a double-blind randomized, placebo-controlled pilot study. *Biol Psychiatry.* 2007;61:551–553
230. Christison GW, Ivany K. Elimination diets in autism spectrum disorders: any wheat amidst the chaff? *J Dev Behav Pediatr.* 2006;27(2 suppl):S162–S171
231. Milward C, Ferriter M, Calver S, et al. Gluten- and casein-free diets for autistic spectrum disorder. *Cochrane Database Syst Rev.* 2004;(2):CD003498
232. Elder JH, Shankar M, Shuster J, Theriaque D, Burns S, Sherill L. The gluten-free, casein-free diet in autism: results of a preliminary double blind clinical trial. *J Autism Dev Disord.* 2006;36:413–420
233. Brown MJ, Willis T, Omalu B, Leiker R. Deaths resulting from hypocalcemia after administration of edetate disodium: 2003–2005. *Pediatrics.* 2006;118(2). Available at: www.pediatrics.org/cgi/content/full/118/2/e534
234. Dolske MC, Spollen J, McKay S, Lancashire E, Tolbert L. A preliminary trial of ascorbic acid as supplemental therapy for autism. *Prog Neuropsychopharmacol Biol Psychiatry.* 1993;17: 765–774
235. Gold C, Wigram T, Elefant C. Music therapy in autistic spectrum disorder. *Cochrane Database Syst Rev.* 2006;(2):CD004381
236. James SJ, Cutler P, Melnyks S, et al. Metabolic biomarkers of increased oxidative stress and impaired methylation capacity in children with autism. *Am J Clin Nutr.* 2004;80:1611–1617
237. American Academy of Pediatrics, Committee on Children With Disabilities. Counseling families who choose complementary and alternative medicine for their child with chronic illness or disability [published correction appears in *Pediatrics.* 2001;108:507]. *Pediatrics.* 2001;107:598–601
238. Hyman SL, Levy SE. Introduction: novel therapies in developmental disabilities—hope, reason, and evidence. *Ment Retard Dev Disabil Res Rev.* 2005;11:107–109
239. Bågenholm A, Gillberg C. Psychosocial effects on siblings of children with autism and mental retardation: a population-based study. *J Ment Defic Res.* 1991;35:291–307
240. Bouma R, Schweitzer R. The impact of chronic childhood illness on family stress: a comparison between autism and cystic fibrosis. *J Clin Psychol.* 1990;46:722–730

241. Dumas JE, Wolf LC, Fisman SN, et al. Parenting stress, child behavior problems, and dysphoria in parents of children with autism, Down syndrome, behavior disorders, and normal development. *Exceptionality.* 1991;2:97–110
242. Gold N. Depression and social adjustment in siblings of boys with autism. *J Autism Dev Disord.* 1993;23:147–163
243. Gray DE. Ten years on: a longitudinal study of families of children with autism. *J Intellect Dev Disabil.* 2002;27:215–222
244. Marcus LM, Kunce LJ, Schopler E. Working with families. In: Volkmar FR, Paul R, Klin A, Cohen D, eds. *Handbook of Autism and Pervasive Developmental Disorders*. 3rd ed. Vol II. Hoboken, NJ: John Wiley & Sons; 2005:1055–1086
245. Smith T, Perry A. A sibling support group for brothers and sisters of children with autism. *J Dev Disabil.* 2005;11:77–88

RESOURCE FOR FAMILIES

American Academy of Pediatrics. *Autism: Caring for Children With Autism Spectrum Disorders: A Resource Toolkit for Clinicians*. Elk Grove Village, IL: American Academy of Pediatrics; 2007