Memorandum: On the Exclusive Use of Discrete Trial Training for Children Diagnosed as Autistic/PDD

In the early 1970s, when behavior modification was first coming into vogue, parents and professionals alike welcomed the positive view that people with disabilities were learners and that families could be effective teachers. Techniques such as discrete trial training were championed as ways to break down complex tasks and teach them in manageable steps. As time went by, an appreciation developed of how and why learning can and should take place in natural environments and of more diverse and effective ways to support the development of communication and social interactions. However, attempts are still made to teach children with autism/PDD using a single, basic behavior modification technique for long hours, often 30-40 hours per week, in settings which are contrived rather than natural and which are oriented to adult trainers rather than children's age-appropriate peers. There are a number of caveats to employing the technique of discrete trial training (for brevity, "DTT") in this way:

1.) Long hours of discrete trial training are emotionally hard on the child with autism/PDD because it teaches the child that he/she is "damaged goods." This self-image is formed very young: the child is reinforced in the belief that he is ill, damaged, or "not good enough" because others are allowed normal, desirable activities while he is required to do therapy. Older children and adults have expressed rage at their families because of the stigma they felt in childhood, and have experienced psychological problems.

2.) Children need to "get a life," not merely or mainly to "get therapy." They need the opportunities and support to succeed in inclusive settings, to participate in the natural life of family and community, to have friends and relationships. Thirty hours or more a week of DTT leaves inadequate time for these natural opportunities for nurturing.

3.) Other family members may suffer due to the intrusion of this intensive, time-consuming approach on typical family life. Siblings in particular may come

to lack the attention they need, while the focus on a sibling's disability may derail the development of more positive sibling relationships.

4.) Child development experts such as Stanley Greenspan, MD, caution that the exclusive use of this training method is likely to increase the very perseveration and rigidity which are symptomatic of the developmental disorder.

5.) Experts like Greenspan have also argued that DTT lends itself to the achievement of developmentally inappropriate goals: that is, DTT works best when applied to simple learning tasks (e.g. do a puzzle, respond to flashcards) in which the child can be drilled. Once mastered, these tend to make up a repertoire of "splinter skills" of no particular use to a child who still needs to work through more complex developmental sequences such as parallel play, give-and-take behaviors, and so forth. (As the old saying goes, "A child's work IS play!")

6.) DTT lends itself to the inappropriate suppression/extinction of behaviors simply because they are deemed "cosmetically" undesirable, and without any understanding and appreciation of their function and purpose in the child's life. For example, DTT therapists used to work on extinguishing echolalia: we now know that this can be an important precursor to the development of more independent communication. DTT therapists still tend to work on extinguishing so-called "self-stim" movements, without any consideration of what those movements may indicate about the nature of the child's sensorimotor disturbances, and without taking into consideration the possibility that the movement may be involuntary, may be a calming device, may be the necessary adjunct to call forth some other movement, and so forth.

7.) Reliance on the formation of an intense one-on-one relationship with a trainer does nothing to enhance the child's ability to cope with the more usual group situations found in everyday life, or to model the appropriate behavior of age peers. This on-on-one dependency has been described as "addictive" for the child who has difficulties with social interactions, and it may inhibit the development of more useful and practical skills and strategies.

8.) As typically practiced, DTT programs tend to rely on untrained or minimally trained personnel to fill the long and repetitive hours of behavior trials and behavior corrections. Potential risks are inherent in any situation in which an implementor, not trained in positive approaches, is called upon to respond to a child's challenging behaviors. Of additional concern is the observed lack of warmth and mutuality which exist between trainer and child in typical DTT environments.

9.) Although many DTT programs now promise that they will not, or no longer, rely on aversive conditioning, the escalation of therapy to the aversive level

may be a logical consequence of the belief that sufficient external force can and will change any behavior.

10.) The expansive salesmanship of DTT as the "cure" for autism and of DTT programs as "recovering" children is unsupported by a body of evidence. Overstatement and exaggerated claims should be treated as "red flags." Enthusiastic testimonials from people who say they have been helped by a treatment are no substitute for evidence, and responsible professionals do not solicit testimonials from their patients.

11.) Information about DTT outcomes is anecdotal in nature. It is normal and expected to see positive changes in any child's development over the lengthy periods of time covered by an approach such as DTT, and we cannot assume that those changes were caused by some particular therapy or activity. It is just as possible that the changes "would have happened anyway," or that they can be ascribed to some simple factor in the child's environment, such as receiving adequate attention or making a friend.

12.) The method of DTT is hardly new. It is necessary to keep up with the ever-emerging new information in the field, and to adjust our methods of support and instruction accordingly. In particular, we need to take advantage of improvements in speech and language therapy, in the application of assistive devices, and in the use of sensorimotor integration therapy to address the sensory processing challenges which, by their very nature and complexity, are entirely beyond the range of behaviors on which discrete trial training might have an effect.

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