Title: Selections and Influential Factors of Interventions for Autism Spectrum Disorder: Caregiver Survey Results

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Introduction: Although research on Autism Spectrum Disorder (ASD) continues to increase, there is no widely accepted course of treatment following diagnosis. As such, caregivers face the challenging task of choosing interventions for their children with ASD. In order to best assist caregivers in this daunting decision-making process, clinicians must understand the selections caregivers make, their sources of information, and influential factors. With this knowledge, professionals may best effect change in caregiver choice by encouraging informed decision-making and use of empirically-based interventions. Thus, the purpose of the current study was to examine the choices that caregivers make in terms of treatment for their children with ASD, the sources from which they obtain information about interventions, and the child and caregiver characteristics that predict evidence-based practice (EBP) versus complementary and alternative medicine use (CAM).

Method: Included participants (N=68) completed a Qualtrics survey consisting of original questions and a validated measure of ASD symptom severity, the Autism Spectrum Disorder – Diagnostic, Child Version (ASD-DC; Matson & González, 2007). Survey respondents were caregivers (62% female; 59% Caucasian) of children with ASD (82% male; 78% Caucasian; mean age=8.8 years).

Results: In terms of rates of current use, high percentages of respondents endorsed EBP and CAM treatment options, with behavioral interventions endorsed by over 50% of caregivers. No respondents endorsed current use of harmful treatments (e.g., chelation). Although endorsement rates were high, actual hours of treatment were not; 25% of the sample endorsed fewer than 10 total hours of treatment per week. In terms of sources of information, websites, other caregivers of children with ASD, and doctors were the top three sources endorsed. To determine whether characteristics of the respondent (caregiver) and the child/adolescent predict hours of CAM treatment versus hours of EBP treatment differentially, two separate exploratory multiple regression analyses were conducted. Child age, child symptom severity of autism, respondent income, and respondent education statistically significantly predicted hours per week of CAM, F(4,45)=3.40, p < .05, adj. R² = .16 and hours per week of EBP, F(4,45)=2.62, p < .05, adj. R² = .12. Only respondent education added statistically significantly to the Hours CAM prediction, p < .05. Respondent education had a significant negative regression coefficient (b = -.32), meaning respondents with higher levels of education endorsed fewer Hours CAM. Only child symptom severity of ASD (as measured by total score on ASD-DC), added statistically significantly to the Hours EBP prediction, p < .05. Child symptom severity of ASD had a significant positive regression coefficient (b = .024), meaning respondents with higher scores on the ASD-DC endorsed more Hours EBP.

Discussion: Rates of current treatment use were fairly consistent with extant research, with more than half of respondents endorsing EBP and CAM treatment options, with behavioral interventions endorsed by over 50% of caregivers. No respondents endorsed current use of harmful treatments (e.g., chelation). Although endorsement rates were high, actual hours of treatment were not; 25% of the sample endorsed fewer than 10 total hours of treatment per week. In terms of sources of information, websites, other caregivers of children with ASD, and doctors were the top three sources endorsed. To determine whether characteristics of the respondent (caregiver) and the child/adolescent predict hours of CAM treatment versus hours of EBP treatment differentially, two separate exploratory multiple regression analyses were conducted. Child age, child symptom severity of autism, respondent income, and respondent education statistically significantly predicted hours per week of CAM, F(4,45)=3.40, p < .05, adj. R² = .16 and hours per week of EBP, F(4,45)=2.62, p < .05, adj. R² = .12. Only respondent education added statistically significantly to the Hours CAM prediction, p < .05. Respondent education had a significant negative regression coefficient (b = -.32), meaning respondents with higher levels of education endorsed fewer Hours CAM. Only child symptom severity of ASD (as measured by total score on ASD-DC), added statistically significantly to the Hours EBP prediction, p < .05. Child symptom severity of ASD had a significant positive regression coefficient (b = .024), meaning respondents with higher scores on the ASD-DC endorsed more Hours EBP.

Discussion: Rates of current treatment use were fairly consistent with extant research, with more than half of respondents endorsing behavioral interventions. While no respondents endorsed current use of harmful CAM options, there were high endorsements of CAM treatments that have not proven dangerous but are not considered effective. Use of CAM treatments that are not harmful may still be problematic in that they siphon off resources (e.g., finances, time) from EBP that is more likely to prove beneficial. Although Hours CAM and Hours EBP regression models were both significant, different variables were statistically significant predictors (respondent education and child symptom severity of ASD, respectively). Further research is needed to determine whether sources of information regarding ASD treatment may also influence use of CAM versus EBP options. As further information is gathered regarding the confluence of factors affecting treatment decisions, professionals will be better able to intervene in caregivers’ selection processes and encourage use of options that have empirical support, which in turn should amplify positive outcomes.

References/Citations: