LETTERS TO THE EDITOR

Lovaas Program

To the Editor:

Re Eric Schopler's letter (ARRI 12/2): Yes, more replications of the Lovaas study are needed, but for now this remains the only method with empirically valid research showing that many children it treats achieve normal lives. That is why so many people support it.

Since Lovaas programs offer a reasonable chance of recovery or near-recovery, parents *should* conclude that school districts which offer less well-documented programs are not providing the "free appropriate public education" guaranteed by law. If the parents are forced to sue, that is regrettable; but the blame then falls on the recalcitrant districts and defenders of less effective programs. Though Schopler claims lawsuits will create a backlash against special needs education, even the current conservative Congress re-authorized and strengthened IDEA; and helping children make *big* gains is the best way to strengthen support for our programs. Moreover, parents are winning most of the cases they bring seeking Lovaas programs, even in hearing offices which have been set up by state departments of education.

In saying that Lovaas treatments cost $60-$70,000 per year, Schopler ignores the many cheaper versions (some less than a third that price). Research (e.g., Jacobson, Mulick, and Green, 1996) shows that even full-cost Lovaas programs (under very *unfavorable* assumptions) *save* money in the long run.

The Ozonoff and Cathcart article, which Schopler says "raise[s] serious questions about the details of the Lovaas technique," is not about this at all. It describes a small, unusually intensive, home-based TEACCH program, and the authors specifically say it has no bearing on the Lovaas method. The Gresham and MacMillan article Schopler cites is at least about the subject; it is also full of very basic empirical and methodological errors. (Details available upon request; see below.)

Finally, Schopler cites the Siegel and Sheinkopf article, which has an interesting history. It has been circulating in draft for three years, and contains numerous devastating problems. To cite just one, which Sheinkopf admitted in correspondence with me: while the article purports to show that children receiving roughly 20 hours a week of therapy gained as much as those receiving 30 hours a week, the children who received 20 hours a week received, on average, many more months of therapy. Obviously, this error alone makes isolating the effects of differences in hours per week impossible. The difference in months of treatment was mentioned in the article's first draft, but omitted in the published version; Sheinkopf has said that he knows of no reason, other than perhaps length, why this (fatal) piece of data was deleted.

Schopler seems to think we should not demand effective treatments for children with autism if this irritates defenders of entrenched but less effective methods. Many parents, including this one, disagree.

Kenneth Pomeranz, Ph.D.
Irvine, CA

Copies of the work and correspondence referred to, plus references, can be obtained for $3.00 postage and handling. Write to 34 Schubert Court, Irvine, CA 92612, or klpomera@uci.edu.

Sound Sensitivity

To the Editor:

I am a professional currently working with an autistic child whose mother suspects that he has tinnitus [ringing or other noises in the ear]. Do you have any information on this?

A social worker

Editor's note: It's true that a significant proportion of autistic children seem to have tinnitus, or at least hyperacute hearing. I am aware of several possible treatments, which are:

1. Give the child extra magnesium. Magnesium supplements are readily available at health food and grocery stores, in various forms (e.g., magnesium oxide, magnesium aspartate, chelated magnesium). I would try at least two of these forms for two weeks before giving up on this possibility. Give from 100 mg of magnesium per day, for a small child, to perhaps 500 mg per day for a full-sized adult. These are not "megadoses" of magnesium, but the amount that people would normally be getting as part of their diet if they were eating a really healthful, unrefined diet of foods grown in good soil.

2. Give the person with hyperacute hearing niacinamide (vitamin B3) supplements. Niacinamide is quite bitter and may be difficult to get into a child. I would suggest 100 mg to 200 mg of niacinamide every three hours. (There is no reason why the niacinamide and the magnesium should not both be given.)

3. Auditory integration training (AIT) has been helpful in some cases, although it is difficult to administer properly to an autistic child because it is hard to obtain a proper audiogram—necessary for setting the filters on the AIT device—with a nonspeaking autistic child.

4. Ear plugs. There are a variety of different kinds of ear plugs available at pharmacies and sporting goods stores. Each individual is different and some ear plugs will be much more comfortable and helpful than others.

5. Just possibly, secretin (see page 3).

DMG and Vitamin B6

To the Editor:

Our daughter started taking DMG about five weeks ago. She had been almost completely non-verbal, but within a week she started repeating words. [We used only] DMG for three weeks, then added B6/magnesium. She started spontaneous speech and had improved comprehension. She continues to get better every day.

Lauren Underwood, Ph.D.
Diamondhead, MS

P.S.—She saw two therapists today. Neither one had seen her since the middle of May. They both almost fell out of their chairs. One said it was a miracle. The other couldn't believe how far she had advanced in her speech in such a short period of time.

Letters to the editor are welcome. Letters intended for publication must be signed and should not exceed two pages. Letters may be edited.