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The need of diversifying people with autism and the impact of the autism typology on speech therapy

SUMMARY

It is always a great challenge for a speech therapist and the whole diagnostic team to make a proper diagnosis. This is the key moment of the therapy process. Modern medical diagnostic tools (ICD, DSM) can only show whether the examined person has a pervasive developmental disorder, or not. From the speech therapist - practitioner perspective, this kind of diagnosis is insufficient, because the medical criteria which are the basis of the diagnosis, say very little of the child's functioning level. A huge heterogeneity among persons with this disorder is another issue. This triggered the need for dividing subcategories among this population. The author of the article quotes two classification of autism: first according to L. Wing, second according to O.S. Nikolska. Classifications presented in this work became a starting point to create a more profiled speech therapy intervention. Therapy model presented by the author is based on Applied Behavior Analysis.

Key words: autistic spectrum disorders, pervasive developmental disorders, autism classification, Applied Behavior Analysis, behaviourism, speech therapy, verbal behaviour operants.

The purpose of this work is to analyze the autism typology from the perspective of speech therapy. By shedding light on the issue of classifying autism and characterisation of its particular types, I would like to draw up a more effective, adjusted to a particular group, speech therapy intervention. The methods described and therapeutic techniques, as well as the division of linguistic behaviours, were created on the basis of Applied Behavior Analysis (Bąbel, Ostaszewski 2008; Bąbel, Suchowierska, Ostaszewski 2010) and Behavioural Psychology by B. F. Skinner (1957, 1995, 2013).

LORNA WING'S CLASSIFICATION OF AUTISM AND THE SPEECH THERAPY INTERVENTION

In 1988, on the basis of symptoms of autism's diversified quantity and quality, L. Wing distinguished a whole new group of disorders named 'autistic spectrum disorder' (ASD). After examining a large group of children between the ages of 7 and 14, the researcher singled out persons belonging to the so-called 'autistic continuum' (Pisula 2012: 15). All of those children showed abnormalities in the following areas: 1) engaging into alternating social interactions, 2) communication and 3) usage of imagination during play (Pisula 2005: 14). L. Wing along with G. Gould (1979: 11–29) set apart three types of autistic children: 1) aloof, who are the majority (61%) , 2) passive, 3) odd (Frith 2008: 88). On the basis of this observation B. Prizant and A. L. Schuler presented a more detailed characterisation (Bobkowicz-Lewartowska 2005: 53–54; Pisula 1995):

A. Aloof persons, actively avoiding social contacts are characterised by:

- being cautious and indifferent in most situations (except when they are fulfilling specific needs);
- having little interest in social aspect of relations;
- showing little signs of engaging into verbal or non-verbal interactions;
- showing rare signs of participating with others in any activity;
- having nearly no eye-contact while actively avoiding looking someone in the eyes;
- acting repetitively and stereotypically according to patterns;
- not becoming aware of changes happening in the surroundings by some of these persons, i.e. when someone enters the room;
- cognitive deficits – from moderate to substantial.

B. Passive persons, who passively accept social contacts, but do not engage into them spontaneously. Their main features are:

- limited spontaneity in social situations;
- acceptance of initiating contact by others, both adults and children;
- getting little pleasure from social relations (active rejection occurs rarely);
- a child can communicate verbally or non-verbally;
- direct echolalia occurs more often than the delayed one;
- various level of cognitive deficits.

C. Persons active but peculiar, they present odd forms of participation in social contacts, in which expectations and partner's needs are not satisfied. Those children can ask the same question several times or give long monologues. Here are their features:

• they spontaneously engage in social contacts, more often with adults than with other children ;

• interactions can consist of repetitive, idiosyncratic behavioural patterns (i.e. consistent repetition of questions, verbal rituals;

• interactions may serve as a way to communicate or not, echolalia occurs, both direct and delayed;

• none or little ability to find themselves in a particular role: poor perception of the speaker's needs, no modification of a complex message or its style, difficulties with changing the topic;

• rather routine interest in the interaction than in its content;

• some of those children can be very much aware of the reaction of other persons (especially the extreme ones);

• those persons are less accepted socially-wise than the passive group (because of the active disturbance of culturally determined social conventions).

Every single one of the groups mentioned above presents different repertoire and character of behaviours. The intensity of those behaviours is going to correlate with the level of intellectual functioning of autistic persons. This characterisation shows that particular autistic persons can differ from each other and hence the therapeutic methods should be individually adjusted to each and every child.

By grouping autistic children accordingly to these types, it is possible to sketch the methods of therapeutic conduct in response to needs and characteristics of particular groups. The methods presented were drawn up on the basis of Applied Behavior Analysis.

The beginning of the therapy in each of those groups should consist of building a motivational system, since with no proper motivation the patient is not going to take active part in the therapeutic process.

In the first group we have to arrange situations in which the child is going to be motivated to initiate communication as a result of the need depravation. It is a natural situation, where a child presents the needs by using the language and heading towards satisfying them. Limiting the fulfilment of the child's needs, apart from the situation of verbal communication, is particularly important. It has a strong connection with building the child's motivational system. At the beginning, the therapy should be conducted on the basis of situational training in a properly designed environment [incidental learning (Lovaas, Smith 2006: 366–367; Suchowierska 2005: 66–73; Suchowierska, Ostaszewski, Bąbel 2012: 145–149), order-model procedure (Suchowierska, Ostaszewski, Bąbel 2012: 148–149; Suchowierska 2005: 69–70), delaying the hint (Suchowierska, Ostaszewski, Bąbel 2012: 146–147; Suchowierska 2005: 68–69)]. At the beginning, the speech therapist should concentrate on the functionality of the communication. It means that the form of the message (its full, correct phonetic or syntactic

structure) is not a priority at this stage. During the consolidation of the positive and spontaneous reactions it is important to head towards learning specific behaviours by practising repetitive attempts (Lovaas, Smith 2006: 366–367, 369; Bąbel, Suchowierska, Ostaszewski 2010: 61). This type of training will allow mastery of both the phonetic surface and grammatical statement. The first verbal reactions, according to B. F. Skinner's division, which the therapy should be based on, and which have the communicative value, are natural favours (mand reactions) (Skinner 1957: 35–51; Suchowierska, Ostaszewski, Bąbel 2012: 214–215; Bąbel, Suchowierska, Ostaszewski 2010: 73; Suchowierska, Kawa 2008: 173–174), statements describing reality (tact reactions) (Skinner 1957: 81–148; Suchowierska, Ostaszewski, Bąbel 2012: 215; Bąbel, Suchowierska, Ostaszewski 2010: 74; Suchowierska, Kawa 2008: 174) and dialogue replicas exchanges (intraverbal reactions) (Skinner 1957: 71–78; Suchowierska, Ostaszewski, Bąbel 2012: 215–216; Bąbel, Suchowierska, Ostaszewski 2010: 73; Suchowierska, Kawa 2008: 174). We enrich the verbal behaviours by adding reactions based on repetition (echoic reactions) (Skinner 1957: 55–65; Suchowierska, Ostaszewski, Bąbel 2012: 216–217; Bąbel, Suchowierska, Ostaszewski 2010: 73; Suchowierska, Kawa 2008: 175), thanks to which we can develop the child's phonetic, lexical or even syntactic repertoire. It is important that those behaviours show up spontaneously, in a properly adjusted environment and with the help of persons closest to the child. The therapy's process should be adjusted to the child's age, so that it would not hasten or slow down the child's natural development. As speech therapists we have to look out for the patient's infantalisation and be careful when choosing the goals which are out of reach in the current development stage. During the process of choosing the therapeutic goals, it is worth taking into consideration the sphere of the nearest development and to orientate which of the communication skills the child already possesses. Non-adequate training in this matter can be frustrating and `may lead to adverse reactions.

In the second group both incidental training and repetitive attempt training should be introduced from the very beginning. The child needs to feel that their meeting with the speech therapist is pleasant. This feeling is going to be an indicator of a properly built motivational system. We build a motivational system by using reinforcers (Hall, Hall 2000). It should be strong enough to allow a complete cooperation between the patient and the speech therapist during the repetitive attempts method. It is good to use biological reinforcers at the beginning (moving from continuous to occasional reinforcement) with the help of social reinforcers. During the next stage of the therapy, the biological reinforcers should be gradually withdrawn. It is important to decide whether the reinforcer we use has a proper effect. Selecting the reinforcer should be individually adjusted. The reward, in order to have a reinforcement value, has to be desired by the patient and in the event of surfeiting, a potential reinforcer may become a punishment. It

is a good idea to limit the child's access to the reward earlier (deprivation should boost the effectiveness). A child, certain of the power of communication and its direct benefits, should spontaneously head towards it. In this group, most of the children are capable of forming questions in order to fulfil their basic needs (mand reactions). Those children accept the interactions initiated by others as well. However, they are reactive and little spontaneous in their reactions. An important step in the therapy is going to be putting the child in a typical peer situation (i.e. in a kindergarten group, in the playground, etc.) and planning communication challenges adequate for them. The child should learn how to begin a conversation by introducing themself, how to politely ask another child to join them in play and how to interact during this time. It will be easier for the child if they plan all of this with the therapist. It will help to avoid stressful situations (autistic children are not too spontaneous, not planning everything before may cause them a lot of stress). Modelling is one way of learning social behaviours. The child imitates particular behaviours, presented earlier by the model[1] (Striefel 2000: 2). At first, every social situation should be very simple, so that the child could easily master it. It can be a request to get some item or do some activity. In social situations dialogue behaviours (intraverbal reactions) have great impact. A child learns to get hints from dialogue and to get information necessary to complete the task given by the therapist.

The repetitive attempts training should cover both speech reception and speech expression exercises. It helps to build a cultural competence, teaching the child the knowledge of the world. Without this competence communication would be impossible. Commenting on the reality (tact reactions) should not be limited to naming the designation (expanding the noun repertoire), but also defining its features, functions and categories (adjective and adverb repertoire). Verbs have a huge impact when it comes to thinking development and language-based reflections[2] (Wygotski 1989: 238), which is why it is so important that the child understands and uses as many expressions of actions and conditions as possible.

Every attempt to initiate an adequate language interaction by the child should be awarded. The lack of developed communication competence may be a huge problem, in effect it may lead to conflicts with people who do not possess enough knowledge about the patient. The patient might not realise these conflicts. A cognitive training should be conducted in this sphere and explanation should be provided about understanding and interpreting the message. Developing a social, situational or pragmatic competence can be a challenge. In order to make the learning process work, there has to be a reinforcement after adequate reactions

[1] The term 'model', used in behavioural terminology, refers to the person (teacher, parent, other child) or to the behaviour, which demonstrates/models in order to teach a particular behaviour.

[2] According to L. S. Wygotski's theory, the outer speech is characterised by its telegraphic style and 'its syntax is almost exclusively predicative'.

(verbal praise, proper gesture, granting a point) (Ayllon 2000). All social situations generate intraverbal reactions, and it is important that the patient is properly motivated to attempt cooperation. A behavioural contact and a meticulous task plan, which the patient is going to carry out in order to gain a reward, can help the speech therapist to build a proper motivation.

The direct echolalia occurring in this group can be used to answer questions according to the pattern presented by an adult (echoic reactions). Automatic repetition is an opportunity to work on the transparency of articulation. Delayed echolalias, despite being rare in this group, can become adequate messages when used in a proper situation. Direct echolalia may develop cultural competence to some degree - the child repeats after the therapist the elements of reality (tact reactions). Also, it makes it easier to build the request repertoire (mands) and exchange repertoire (intraverbal). Automatic repetition may be followed by understanding and cognition with time. First mand and tact reactions should relate to the sphere of basic functioning. The taught verbal behaviours have to fulfil the child's needs by starting with the basic ones. Moving to higher levels requires mastering the basics (Maslow 2006).

Among children who face a difficulty in speaking or they simply do not use verbal speech, first messages can be just slightly similar to the proper messages. It is important that the sounds emitted by them are related, even only symbolically, to reality. They should be meaningful and fulfil basic needs. In the study of speech of the autistic persons the function of the message is always on the first place, not its form. At first the message 'drink' can be expressed by 'dri; or 'i'. It is important that the client learned that there is a particular benefit connected with his message. We are getting to the proper form of a message by using the behaviour shaping procedure in the repetitive attempts training, when the speech therapist teaches the patient the proper shape and the transparent articulation of the message.

In the third group of her classification, L. Wing placed the so called 'highly functioning' persons. Persons from this group possess rich vocabulary and highly developed language competence/system competence. It means that they can create proper grammatical sentences and distinguish grammatical sentences from the ungrammatical ones (Polański 1999: 305). Language difficulties they face come from improperly developed communication competence. U. Czarnecka (1990: 11) writes that 'communication competence is a skill of choosing the variants of proper sentences in regards to social experiences of communication partners, which is the ability to use the language in an effective and situation-adjusted way, taking into consideration goals and expectations of the speaker and social, conventional rules of language use'. According to S. Grabias (2003: 245–335), 'communication competence' is knowledge of linguistic tools repertoires, which are usually assigned to particular social roles (mother, father, teacher, pupil, student, patient,

supervisor) and about the rules of using these tools in various communication situations. These rules dictate changes in language behaviours depending on:

• who you talk to (differently to a child, differently to a supervisor)

• the situation (differently to one person, differently to a group)

• the purpose, i.e. the intention (differently when taking an action, differently when showing emotions (Grabias 2002: 19).

Building communication competence should be based on training:

a) social competence, which consists of proper recognition and realisation of social ranks of the speakers by the usage of proper linguistic tools adequate to the receivers mental capabilities (i.e. child vs. adult) and their social function (i.e. parent vs. neighbour) (Grabias 2003: 320);

b) situational competence, the ability to use the language in the interactional situations created by the society (i.e. funeral vs. doing shopping) (Grabias 2003: 320–321);

c) pragmatic situation, the ability to achieve a goal given by the speaker (Grabias 2003: 322–323).

A good method to learn the competences presented above turns out to be the drama method, which serves to imitate particular situations that occur in everyday life. A good test for the competences learned this way is fieldwork, where the patient can learn to use these competences under the care of a therapist. For instance, buying products in a shop.

As far as learning of initiating contacts and building messages adequate to situation is considered, scripts may be helpful (the patient receives them written on a paper or recorded on a special device). They help to initiate interaction, because they give a full hint for behaviour adequate to the situation. They can become very useful, i.e. during learning how to introduce oneself or how to express one's needs. Scripts are a type of hint, so they should be eliminated at some point.

Persons from this group usually have a lot of untypical fixations and interests. They are able to develop their knowledge in areas completely inadequate among their peers, for instance, interest in calendars, trains or bus timetables. Such a narrow and untypical sphere of interests prevents the autistic persons from sharing their passions with others, and the constant presence of those passions in their statements makes it hard for them to communicate or start a relationship. A cognitive therapy can help with realising these problems. None or little ability to play a certain role, poor perception of people's needs, difficulties with changing the topic are the challenges for the whole therapeutic team, also for the speech therapist. The speech therapist should motivate people from this group to engage into topics from outside of their interest sphere. It is good to plan, along with the patient, what such an interaction should look like, how to keep the other person focused and how to get to know them better. Group works are a great occasion to practise communication skills.

Dealing with stressful situations is a serious problem. It is very important to teach the autistic persons how to report such situations. Teaching how to communicate emotions properly, also the ones that are not welcome, is the fundamental task for the whole therapeutic team. The patient who can deal with stressful or anger related situations in a socially acceptable way is not going to engage into aggressive or autoaggressive behaviours.

Behaviourists treat an autistic person as a unit which has a learning potential. It has been demonstrated, huge heterogeneity occurs among the group of diagnosed persons. Inside this group a smaller one may generate, and their participants may show characteristic behaviours, have similar needs and abilities, and at the same time they may differ from the people qualified to other groups. By using the rules of the learning and behavioural processes in the therapy, with the particular consideration of conditioning operants, adequately to needs we are able to develop and create a more effective therapy process. Behaviourists point out that in the case of autistic children there are many individual differences. (i.e. some do not talk, some have a very well developed language), which is why they focus on studying individual cases. Their most important goal during studies is to discover the most efficient therapeutic intervention. It gives them the ability to divide children with autism into groups similarly reacting to intervention, not based on their behavioural set. Such a specification has the characteristics of a high functionality (Lovaas, Smith 2006: 366–367).

OLGA SERGIEJEWNA NIKOLSKA'S TYPOLOGY

By describing psychopathological structure of autism, O. Nikolska singles out two features: (1) decreasing the ability of active cooperation with the surroundings, (2) decreasing the level of discomfort during contacts with the world. Both features bring a specific contribution into creating the recurring symptoms: withdrawing from the contacts, stereotypical behaviours and auto-stimulation (Piszczek 2014: 19).

The researcher divides the population of the autistic children into four groups. Every group has its own behavioural patterns. Based on these patterns, the child is provided with the active contact measures with the social environment and with the form of defence and auto-stimulation. Children from particular groups differ in character and the escalation level of primary disorders and recurrent disorders resulting from them (it applies to overcompensation as well) (Piszczek 2014: 21)

Children from particular groups differ in the availability of effective regulation, awareness organisation and behaviour, which requires the therapist to work on various forms and ways of engaging contact and cooperation (Piszczek 2014: 21).

The characteristics of particular groups of autistic children, along with hints about therapeutic intervention, according to O. Nikolska:

I. First Group – children are completely separated from reality, features:

– autistic symptoms are very intensified;
– behaviour conditioned by the sensor stimulus, often stereotypical, based on auto-stimulation;
– lack of emotional contact and speech;
– lack of basic self-service skills, addiction to therapists' permanent help;
– poor repertoire of behaviours and positive sensory experiences;
– limited interests;
– problems with sight fixation and focusing attention;
– lack of reaction to their own name;
– the child is not capable of carrying out the simplest requests;

Therapy: by using sensory experiences pleasant to the child, we reinforce all of the satisfaction states and we try to use a voice tone that is pleasant for the child. We try to interest the child with ourselves and try to achieve primitive cooperation. Enabling them to choose and provoking them to act by themself (experiencing with them something they like and awaiting their reaction), is going to help them realise their role during joint activities. Introducing alternation in activities.

II. Second group – children who reject everything, features:

– many sensory auto-stimulations and movement stereotypes occur;
– the feeling of discomfort, anxiety and above normal mental tonus, triggered by the stimulus from the environment;
– mannerisms, stereotypes and impulsiveness in movement;
– specific intonation;
– untypical way of walking;
– despite emotional relation with their mother, they have a significant difficulty with engaging into interpersonal relations;
– good speech reception with a limited expression;
– echolalia;
– movement stereotypes;
– stiffness of behaviours, no tolerance towards changes;
– they possess a huge learning potential;
– usually independent;
– they engage into contact with persons they know well;
– they have problems with understanding other persons' emotional states and experiences;
– they may try to omit the first attempts of an eye contact;
– they are timid and frightened;
– limited behavioural repertoire;

– they react positively to movement exercises (swinging, running off the hill, climbing);

The therapy should concentrate on maximally expanding the amount of persons with whom the child engages into contact and expanding the repertoire of behavioural interactions. It is important to develop the theories of mind, cognition and emotional relations with others and to learn about different forms of engaging into contact (social and situational competence). The beginning of therapy should create a sense of security in the child. The speech therapist should carefully observe the child's reactions with a special consideration of aggressive behaviours towards themself and others, movement uncertainty, tension and stereotypical behaviours. The goal of the therapy is to limit this kind of behaviours by replacing them with the desired behaviours. The child should take interest in us at the beginning of the therapy, at some point he should aspire to engage into contact. As a first type of contact we should choose eye contact. Especially at the beginning we should slowly introduce the eye contact, we should not rush it, because the child may try to avoid it. The child should develop self-confidence. The speech therapist should be associated with pleasant sensory experiences. In order to attract the child's attention, we can use the direct activities related to the child's behaviour: the therapist sings or taps out the rhythm of child's movement, starts to swing along with them or jump in the tact of their activities. The integrity of the therapist's and the child's behaviours bring interest and enjoyment to the child. We can add verbal reactions into movement activities which please the child, (repetition, naming, describing). Imitation behaviours repertoire develops in these activities and while using fun we employ imagination. All of the desired behaviours should be reinforced. When more complex behaviours show up, the child should engage into everyday activities (preparing a meal, cleaning). We develop the tact behaviour repertoire by teaching features, functions and subject categories. All new skills should be taught gradually. The important part of the therapy is developing the child's patience and teaching them how to overcome everyday obstacles.

III. Third group – children with idiosyncratic behaviours and interests, features:

– they possess developed forms of effective defence;
– untypical behaviours and goals occur, even aggressive ones;
– fantasies can have aggressive content;
– intellectual development is enharmonic, but it is rather regular or slightly above regular;
– they master speech early;
– they have a tendency to say monologues and tirades;
– they address the receiver of a statement by mistake, often regrettably;
– they don't pay attention to the other person's reactions, which prevents them from having an effective dialogue;

– often in a symbiotic relationship with mother;
– independent in everyday activities;
– impersonal attitude and emotional coolness towards family and friends;
– they show the need for an emotional contact in a primitive way;
– they avoid emotional contacts based on cooperation;
– they have difficulties with understanding emotions;
– excessive emotional reactions;
– 'fascination' with emotional reactions (both positive and negative);
– experiences are usually just fantasies;
– they may express their emotions with art (drawing)
– stimulated and euphoric;
– they show interest by affective states;
– they create statements with inadequate intonation, without voice modulation;
– facial expressions and gestures seem non-cohesive;
– difficult behaviours may be the result of frustration;
– they take part in movement activities (i.e. developmental movement activities) and activities based on sight and feeling stimulus;
– they have a tendency to fantasise;
– they deal well with everyday activities;
– they act according to the plan prepared earlier;
– stiffness of behaviours;
– they easily engage into relations based on rivalry;

Therapy: The therapist should engage into therapeutic contact in two stages: The need for emotional contact should be awaken during the first stage. The second stage consists of actions leading to developing various forms of this contact. Therapeutic contact should be safe and based on trust. The child should have positive emotions. We should not force the interpretation of the world on the child, but enable them to come up with real interpretation safely. Gaining the child's sympathy and acceptance is possible due to their fantasy. The therapist should present the readiness to listen and recognise the child's activities and drawings without irritation signs caused by the stereotypical character and repetitiveness. At the moment of engaging into eye contact, the therapist should gradually ask questions, so that the child is taught to conduct a dialogue. The therapist's task is to introduce everyday natural and real elements, which will serve as additions or specifications, not changes or disturbances, into the child's fantasy interests (his messages, activities content or drawings). The therapist should help the child to develop forms of contact that aren't based on rivalry, but on shared goals and fun. Tolerance to failures should also be taught, along with the thought 'I don't have to win every time' and 'sometimes we succeed, sometimes we don't'.

IV. Fourth group – children with interaction and cooperation difficulties, features:

– emotional development closest to normal;
– slight block of motoric development and delayed speech development;
– overall decrease of tonicity and tendency to rapid occurrence of blocking processes;
– attachment to others;
– they subdue to the environment's requirements;
– addiction to acceptance and emotional support of family and friends (especially mother);
– they don't tolerate others interrupting their activities;
– they often fixate on their activities;
– between second and third stage the decrease of development becomes more visible;
– frustration occurs;
– problems with controlling the speech;
– echolalia occurs;
– problems with controlling basic motorical activities;
– problem with learning by imitating;
– they don't cooperate in activities;
– exhausting;
– negativism occurs;
– they accept new challenges with difficulty;
– frustrations may cause apathy and difficult behaviours;
– when they face difficulties, they need hints;
– they can be emotionally oversensitive;
– stiff when it comes to choosing ways of acting;
– they protest against changes and novelties;.

The therapy should show the child how to feel joyful about everyday activities (without the need of direct praising, i.e. from parents). It should bring the child's interest to the closest surrounding. A child from this group is capable of understanding that they perceive the world in a specific way, they should be taught their individual preferences and habits. The child should develop self-esteem and appreciation of his individuality. The child takes up fighting the obstacles, spontaneously or by using incentives – the therapist's task is to reinforce such actions. The child should be explained that such actions lead to success. The child reacts properly when they know clearly the rules of the tasks carried out and the activity plan. Attitude towards the activity plan, at first stiff, can be loosened by gradual enrichment and joint introduction of modifications. The important goal of the therapy is learning the various ways of recognising and lowering the emotional

tension and stabilising their affective processes. Regulating personal emotional states is the beginning of independence. It lowers the affective addiction from friends and family and enables a stable self-esteem to appear.

O. NIKOLSKA'S TYPOLOGY AND THE SPEECH THERAPY

According to Nikolska, methods of the therapy should be adjusted to the autistic barrier specificity and the child's ability to engage into contact with the real world. The course of the therapy should be diversified on the basis of the child's characteristic symptoms. These symptoms differ in separate groups. 'The course of working on awakening their speech development should also be different' (Piszczek 2014: 21). According to Nikolska, the therapeutic procedure that is effective in work with children of one group will not only be ineffective in the other group, it can be even harmful, because it may cause a situation in which children start to function below the level of their affective regulation.

In a therapeutic procedure, also speech therapy, there are some universal rules regarding the whole population of autistic people. It will not make a difference to which group the child is qualified, during first meetings we should engage into contact and shape the possibilities of cooperation by using the forms of activity that absorb the child. Every socially acceptable form of relation with the child is top priority.

Therapeutic situation and the speech therapist themself should remind the autistic child only of positive things. It is a starting point for building a strong motivational system.

I. Children from the first group are passive and withdrawn. The speech therapist should concentrate entirely on the methods which stimulate interactive activation of these children. Both non-directive and directive methods applied to specific situations will be proper. The child should be activated even at the preparation stage of the actual therapy. It is important to determine what the child does in their free time, i.e. what kind of activities they take up spontaneously. The speech therapist should possess such knowledge and know how to use it according to Premacks's rule (Bąbel, Suchowierska, Ostaszewski 2010: 113). Before starting to learn verbal behaviours, the child should be able to imitate simple gestures, firstly in a big motor skills range, than a smaller one. An important goal for the speech therapist is to reach the child's sight fixation and joint field of attention. We should build a motivational system from the very beginning, basing our work on biological and social reinforcements. When we talk to the child, they should look at our face.

Adequate reacting with proper consequences to all of the child's messages is very important. In verbal speech practices, especially the ones leading towards

mastering the realisation, we rely on the behaviour shaping method. Natural communication situations are reinforced in situational training, and the speech reception and expression development is based on repetitive attempts training.

Children from this group are often mute, which means that they understand the messages but they don't use verbal expression. At first the speech therapist should reinforce every verbal expression. When the child's activity in this aspect increases, referential messages should be reinforced. Echoic reactions, based on imitating, can have a substantial meaning. By mand reactions, the child should experience the power of communication and discover the need to use language, because mands consist of strong and direct reinforcers.

II. Children from the second group actively reject everything that makes them feel uncomfortable. Therapy for this and other groups should begin with building a strong motivational system. The therapist should be discovering, from the very beginning, objects and activities in which the child participates, so that they could be used as natural reinforcer. Working on difficult behaviours is going to be of huge importance in the therapy. While working on difficult behaviours, the therapist should concentrate on non-aversive methods (DRO, DRA, DRI)[3] (Foxx 1999: 28–29) and extinction. Behavioural contacts should be introduced from the very beginning. Work regularity and realisation of the earlier plan by all people from the child's surrounding is going to be significant. In order to establish a relation, especially during the first stage of the therapy, the option method (Kaufman 1994) can be used. If the method turns out to be unsuccessful, the motivational system is built on reinforcers. For activities which develop language behaviours, the speech therapist can use the tendency for movement activity, which characterises this group. In order to establish a better contact and make the therapy more attractive, songs and poems can be added to movement activity. Logorithmic activities may turn out to be effective. It is a good idea to take breaks during activities and wait for the child to ask for continuing the activity.

III. The third group consists of children immersed in their own, often untypical, interests. The therapist's task is to expand the range of interests with the full use of the learning potential. In order for this process to be successful, a strong motivational system is required. All kinds of fixations can be used as rein-

[3] Three reinforcement techniques which can be used to decrease the number of inappropriate behaviours:

DRO Differential Reinforcement of Other Behaviour. We are trying to award other behaviour, not the one we want to decrease or get rid of.

DRA Differential Reinforcement of Appropriate Behaviour.

DRI Differential Reinforcement of Incompatible Behaviour, i.e. a behaviour which cannot exist simultaneously with the inappropriate behaviour.

forcement. The messages of these children often lack prosodic components, voice modulation and are monotone with flat or inadequate intonation. During working with these children, a big pressure should be put on the emotional components of the message. A prosodic competence should be developed in the child. Building prosodic and communicational competence is a top priority in this group. Problems with articulation may occur, which should be solved be the speech therapist by using standard methods for children with dislalia.

The speech therapist should especially consider behavioural deficits and excesses. The work should be based on situational training with the attitude towards full generalisation of behaviours which develop the child's independence. The speech therapist should conduct exercises on voice emission and grammatical exercises on linguistic accuracy. Children from this group can encounter problems with pronouns (pronoun aversion), function words (mainly prepositions) and grammatical accuracy in terms of inflexion and syntax. Development of this elements should be conducted in the repetitive attempts training.

Difficult behaviours in this group are a huge challenge for the whole therapeutic team. Difficult behaviours consist of stereotypical stimulation, but also of aggressive and autoaggressive behaviours. The most dangerous result form disproportion between age and poor speech knowledge. Natural tendency to stimulation can be used by the speech therapist as a form of positive reinforcers, because they provide pleasant perceptual experiences for the child.

IV. Children from the fourth group encounter significant difficulties while establishing interaction and cooperating with other people. Linguistic competence is developed in this group, the problem lies in the communication competence deficit. Speech therapy training should concentrate on developing the following competences: social, situational and pragmatic. Making the child aware of mentalising and brain theory (Młynarska 2008: 164–165; Frith 2008: 109–126) may be a helpful element. Despite all the deficits, children in this group possess the ability to build relations with other people. These relations may be based on interaction and cooperation. Persons from the fourth group differ from others, their emotional development is close to normal and because of that they are less aggressive and autoaggressive. The speech therapist should work on reactive behaviours, initiation and withstanding the interaction. Scripts and introduction of activity plans (McClannahan, Krantz 2002) may be helpful among the children from this group. Therapy should be conducted with the usage of situational methods and repetitive attempts training. Interaction problems can be a result of communication competence deficit with a well mastered linguistic competence (dictionary and grammar). Exercises which develop communication competence can be based on drama or natural situations (i.e. going shopping, ordering a meal at a restaurant).

If the problems with engaging into contact result from a phobia or other anxiety reactions, conducting a desensitising would be a good idea.

According to Nikolska, the methods of the therapy should always be adjusted to the kind of autistic barrier and forms of interaction with the world available for the child. It should be emphasised that the forms and methods of the therapy which are effective for children from the first group (in the autistic children range) can not only be unsuccessful in other groups, but the use of improper methods may cause them to function at a lower level than before (Piszczek 2014: 21).

Conclusions:

1. Division into groups makes it easier to specify the needs, which facilitates the speech therapy intervention.
2. Diagnosis with group assignment would be more functional.
3. Thanks to the division it is possible to create therapeutic groups, which would consist of people with similar features, abilities and needs, not only based on metrical age and level of intelligence.
4. Classification would serve the creation of specialities of therapeutic groups in response to needs.

ENDING

Both L. Wing's and O. Nikolska's classifications divide the groups of autistic people into transparent types. Despite the target group being clearly defined, the reader is going to find it difficult to jump from one classification to other. It is because both classifications were created independently from each other and both of them are based on different research assumptions. Every type distinguished is a separate compilation of features adequate to the population of autistic people. They are not the most common features in the whole autistic population, but features characteristic for the methodological assumption chosen by the authors. O. Nikolska, by choosing L. Wygotski's theory of individual's development, based her classification on the levels of affective regulation and consciousness organisation. Autistic children would differ in the mastering particular levels. First level is called the level of affective plasticity, second – affective stereotypes, third – affective expansion, fourth one – emotional control (Piszczek 2014: 19).

L. Wing chose a different thinking paradigm for her classification. The researcher based her classification of autistic people on diversity in initiation and establishment of social contacts. The characteristic features presented are observed in their behaviour's repertoire. Engaging into particular activities, way and intensity of this involvement and avoiding certain behaviours and social situations showed diversity inside the group of autistic people and became the basis for creating this classification.

Despite the different research assumptions of both authors' classifications, it is possible to juxtapose both typologies. Starting from O. Nikolska's classification to groups:

I. First – children are passive and withdrawn – both (A) aloof and (B) passive children have to be included;

II. Second – children who actively reject everything – partially (A) aloof and (C) odd;

III. Third – children submerged into their own, often untypical interests – (C) odd;

IV. Fourth – children who encounter significant difficulties while establishing interaction and cooperating with other people – (B) passive and (C) odd.

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