White Paper XXXI

The Globally Broadcast Autism Intention Experiment: Part II, Some ATEC Trends And Statistical Data For a Twelve-Month Program

by

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Introduction

This White Paper XXXI, follows on from Part I as Part II of White Paper XXX. It expands the **trends** of the first four months of the ATEC data to provide statistical evaluation of the twelve-month program. Parents and teachers use the ATEC (ATEC autism treatment and evaluation form) to evaluate both progress of the child and the **potential effectiveness** of utilizing a specific intention for this population of children and consists of four subtests: (1) speech/language communication, (2) sociability, (3) sensory/cognitive awareness and (4) health/physical behavior.

ATEC was developed in 1999 by Rimland and Edelson[1] of the Autism Research Institute to measure changes in response to various treatments applied to the children. The internal consistency of the ATEC procedure has been examined[2] by conducting a split-half reliability test on over 1,300 completed ATEC forms and found to be high (0.94 for the total score). The validity of this instrument was validated during the first decade of this century[3-5]. Based on the first 1,358 initial ATEC forms from the Autism Research Institute; the uncorrected, Pearson splif-half coefficient was found to be:

Scale 1: speech, 0.920

Scale II: sociability, 0.836

Scale III: sensory/cognitive awareness, 0.875

Scale IV: health/physical behavior, 0.815 and

Total ATEC score, 0.942 for N=1358.

Method

This study utilized a dedicated IHD (intention host device) as the **sole** treatment modality following the procedures described in White Paper XXX. In this follow-up White Paper, Appendix I outlines the "Global broadcasting technique for the subtle energies concept" so that one can readily evaluate the total treatment dose for each child during the 12-month period (in geometrical units). The specific intention (company confidential) was designed to support the **full-integration** of the children into the physical domain of reality.

The parents of all participants included in this report completed one ATEC baseline survey prior to December 31, 2012 and one survey questionnaire each month thereafter. Initially, 44 subjects had completed all required ATEC forms. Initial questionnaires were emailed[(1)] back and forth creating some logistical difficulties. As of February 2013, the online program "Survey Monkey" was utilized to give parents online access for monthly survey completion which, in turn, streamlined the statistical reporting of results. 39 participants included a monthly survey from December 1, 2012 through November 30, 2013.

Appendix II provides a brief primer to help the reader understand the statistical analysis process. Here, the subjects were 80% male, ranging in age from 3 to 27 years, and residing in North America, Australia, Japan, Canada and Finland. ATEC scores were analyzed using the generalized estimation equation (GEE) while the paired T-test procedure was used to compare data at 3, 6 and 12 months relative to the baseline data.

A supplemental analysis procedure "A generalized linear model, using a generalized linear mixed model (GLMM)", was utilized for each of the questionnaire scores. As might be expected, there are some small numerical differences in the data sets; however, no significant differences appeared between the use of GEE or GLMM.

In this program, two completely different intentions (IHDs) were utilized:

1. To support the **full integration** of the children into the physical domain of reality, and
2. To significantly reduce the daily stress levels of the parents as a consequence of their rearing a child diagnosed with autism.

For this program two uniquely different IHD statements were written by WAT. Next, each of the IHDs was imprinted from separate deep meditative states by four well-qualified meditators. Next, each IHD was placed in its own small room separated from each other by about 100 feet. Each of these rooms also contained a laptop computer used to continuously scroll the appropriate names and addresses into the room with a hold time of one minute for each name and address. Our working hypothesis is that (1) the plugged in IHD synchronizes with the scrolling computer and simultaneously broadcasts the IHD message to the globally distant home of both parent and child and (2) this specific subtle energy

message “conditioned” the bedroom space for both parent and child; then, in turn, these are thought to appropriately transform all important aspects of the appropriate human’s multidimensional body so as to completely manifest and materialize the specific changes needed to realize all aspects of the IHD intention statement.

The specific assessment tools for this program were (a) the autism treatment form checklist (**ATEC**) for the children and (b) the **Zung** self-rating depression scale for the parents.

Each assessment tool that one utilizes has an evaluation scale (1 to 10, say) so that the monthly survey result for each question can be converted to a specific number for that particular month for both the ATEC and the Zung. Thus, for each participant, we convert these numbers into a final score to represent that month’s performance for each questionnaire.

For a meaningful statistic analysis, the **dependent variable** for each category that describes the performance of the child, involved in this program, was the final score summarized each month in each survey questionnaire.

Statistical Analysis

In order to examine the factors associated with the performance of these children, and to evaluate whether their performance improves over time, we used the generalized estimation equation (GEE). GEE is an extension of the generalized linear model for longitudinal, clustered or repeated, measures designs.

The advantage of using a GEE model is that it proves to be a more efficient and unbiased regression parameter relative to an ordinary least squares model. This occurs, in part, because the GEE method allows for specification of a working correlation matrix to account for a, within-subject correlation of responses, upon dependent variables. Since the measurements on each category from the same child should be more similar than such measurements from a different child, the assumption of independence upon the dependent variable may be violated, which necessitates the use of a model that permits correlations within the group of children.

Because of this factor, we employ an autoregressive form **with order one**; this implies that two observations close to each other over time or space are more highly correlated than two observations that are spread further apart. Since the outcome variable is numerical, the normal distribution, along with the identity link, are employed here.

The covariates that we evaluated here, include both a continuous time-term and a gender term. Thus, this study emphasizes investigating whether there is a positive trend-effect on the performance of a child over time and whether there is a gender-effect. A paired T-test is also applied to evaluate whether there is a significant difference on the performance of the children at intermediate time-points of 3, 6 and 12 months relative to the baseline value.

Results

In all of the four categories, we detected a significant positive trend-effect on the performance on all of the children (see Table 1). The boys tended to have a better overall performance on average (a higher score) than girls perhaps because of the 80% to 20% population ratio of boys to girls. But the difference is not significant across all of the categories evaluated. We also noticed that, although there is also a significant trend-effect on the performance averaged over the 4 categories, there is no significant gender-effect.

Table 2 illustrates the contrasts in paired T-tests between intermediate time-points and the baseline values for the four categories plus the average performance. We do detect significant improvements in terms of final score in each of these categories between intermediate time-points at 3, 6 and 12 moths relative to the baseline value except for the 3-month and baseline contrast for sociability.

The 12-month data for all subsets is proved in the following figures with the p-values given in Table 2.

Discussion

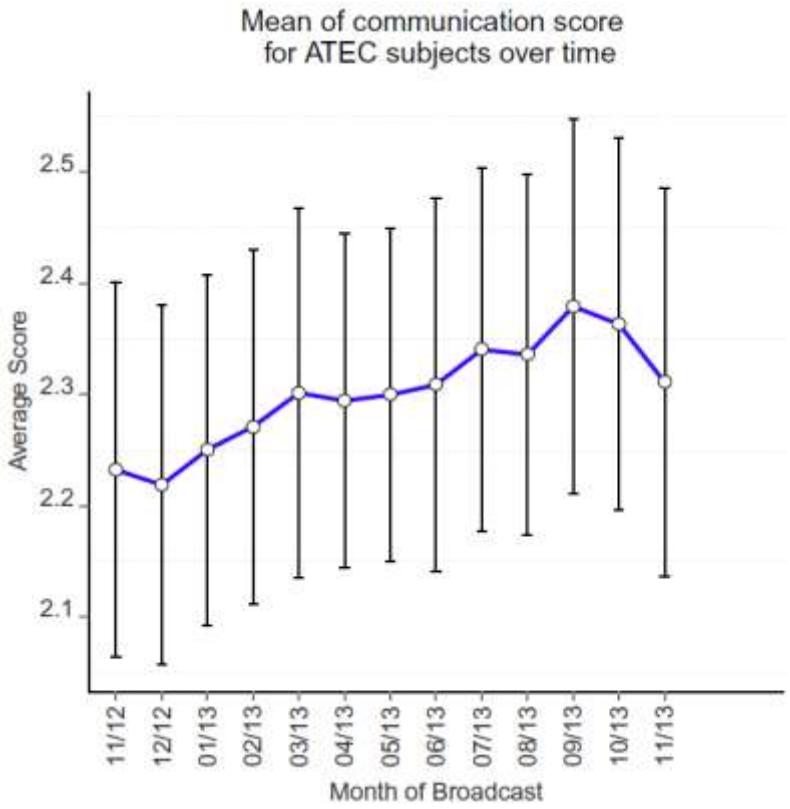
Based upon the foregoing statistical data, the mean p-values of the 39 children indicated a **significant** positive trend overall with a p-value of <0.0001. All subscales improved over the 12-month period, with significant growth between the three interval time-points. It was also noted from the Zung data (see White Paper XXXII), that the parents progressed in direct relationship to their children.

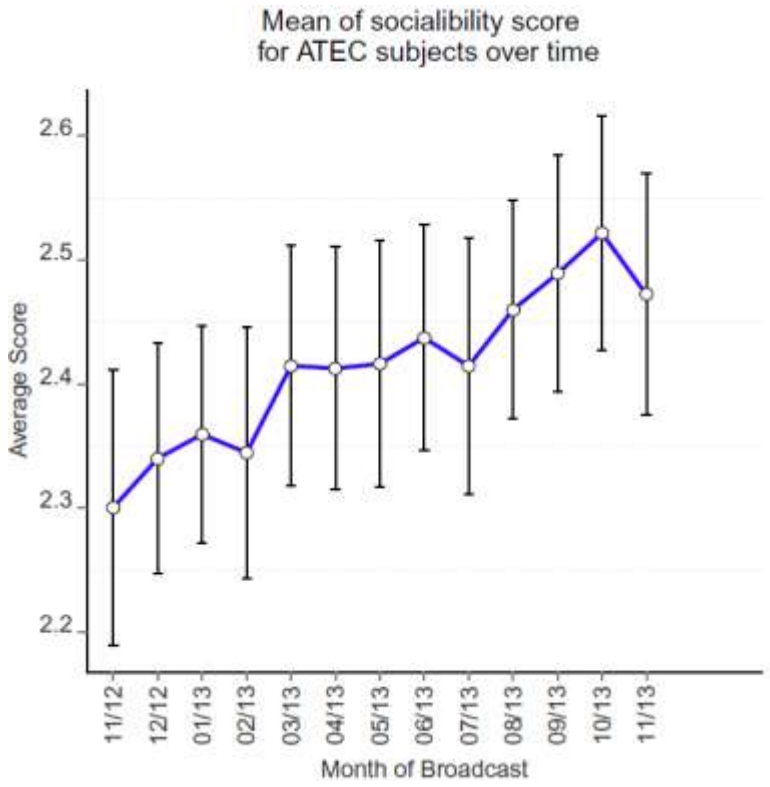
Table 1. Coefficient estimates for each of the categories using GEE.

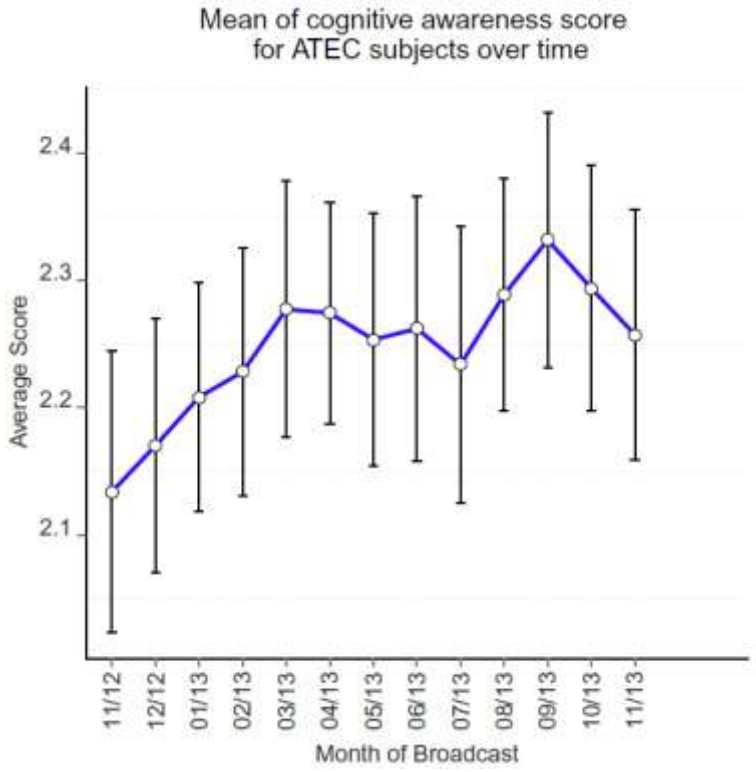
Response	Covariate	Estimate	Confidence Interval	P-value
Communication skill	Time	0.0118	[0.0053, 0.0184]	0.0004
	Female	-0.0516	[-0.4093, 0.3016]	0.7774
Sociability	Time	0.0162	[0.0042, 0.0080]	0.0001
	Female	-0.0812	[-0.3261, 0.1637]	0.5158
Cognitive Awareness	Time	0.0129	[0.0058, 0.0199]	0.0003
	Female	-0.1147	[0.0694, 0.0214]	0.0985
Physical State	Time	0.0202	[0.0104, 0.0300]	<0.0001
	Female	-0.1367	[-0.4682, 0.1948]	0.4189
Average Performance	Time	0.0154	[0.0088, 0.0220]	<0.0001
	Female	-0.0988	[-0.3322, 0.1345]	0.4064

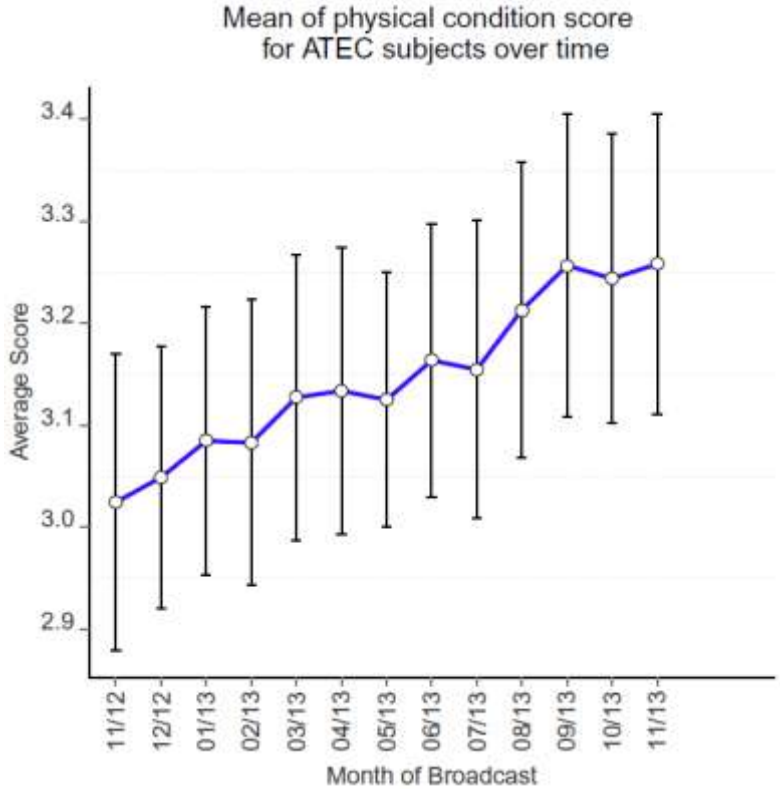
Table 2. Contrasts for each category between intermediate time points and baseline.

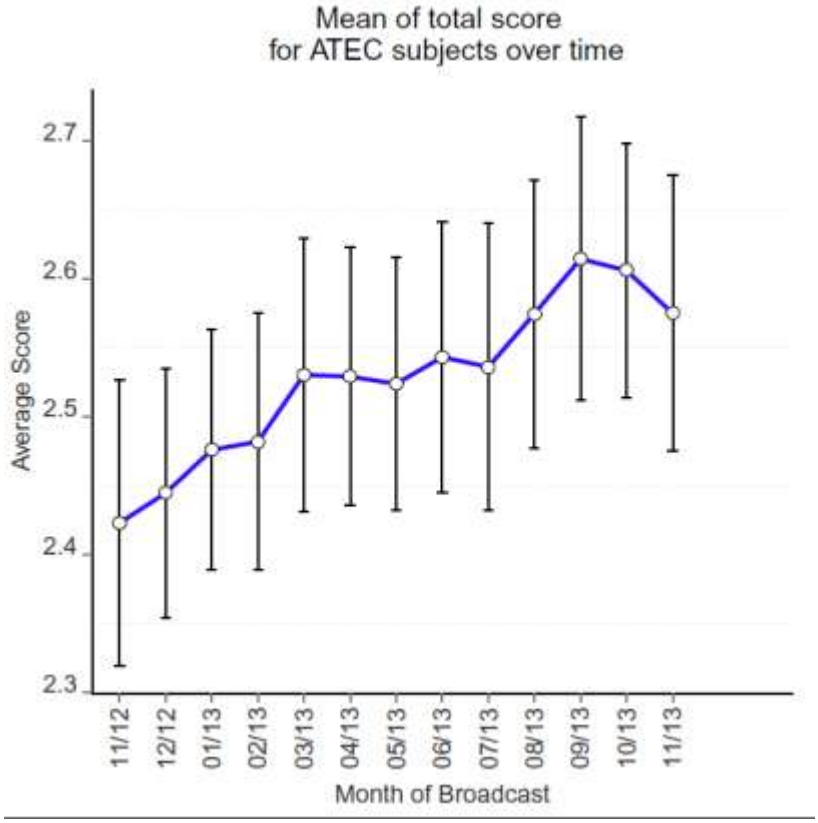
Response	Contrast	Mean Estimate	Confidence Interval	P-value
Communicatin Skill	Time 3 vs Baseline	0.0559	[0.0179, 0.0938]	0.0039
	Time 6 vs Baseline	0.0841	[0.0140, 0.1542]	0.0187
	Time 12 vs Baseline	0.112	[0.0419, 0.1822]	0.00187
Sociability	Time 3 vs Baseline	0.0391	[-0.0288, 0.1071]	0.2593
	Time 6 vs Baseline	0.1139	[0.0293, 0.1985]	0.0083
	Time 12 vs Baseline	0.1642	[0.0745, 0.2538]	0.0003
Cognitive Awareness	Time 3 vs Baseline	0.1151	[0.01616, 0.1687]	<0.0001
	Time 6 vs Baseline	0.1169	[0.0383, 0.1955]	0.0035
	Time 12 vs Baseline	0.1600	[0.0783, 0.2418]	0.0001
Physical State	Time 3 vs Baseline	0.0635	[0.0635, 0.0323]	0.0492
	Time 6 vs Baseline	0.1002	[0.0218, 0.1785]	0.0122
	Time 12 vs Baseline	0.2148	[0.1212, 0.3084]	<0.0001
Average Performance	Time 3 vs Baseline	0.0684	[0.0279, 0.1089]	0.0009
	Time 6 vs Baseline	0.1038	[0.0457, 0.1618]	0.0005
	Time 12 vs Baseline	0.1627	[0.0979, 0.2276]	<0.0001











Anecdotal information suggests that, those parents who participated in a collective support group experienced greater benefit overall than those who did not. The age of the child did not appear to impact progress. ATEC participants aged 3 to 27 made progress unique unto themselves and the physical distance between the Arizona broadcast station site and the participants home address site had no apparent impact on the participant's progress (as noted via the following statements):

As noted in White Paper XXX, **Child #1** is now a 4-year old female who was functionally non-verbal, when the program began 12/03/2012, and lives in Australia. Her mother reports that on 12/04/2012, this daughter spoke about 20 **different words** that day that were in perfect context. The mother indicated the following: "*we all couldn't believe what we were hearing – just amazing*".

Child #2 was a 9 year old male who was completely non-verbal on 12/03/2012 and lives on the East Coast of the US. His mother indicated that he began to use facilitated communication during the first months of the experiment and was able to explain things that she did not even know that he was aware of. On 12/03/2012, he was at best functioning at Grade 1 level. His report card of October 2013 reported that he was satisfactorily functioning at Grade 5 level.

It is interesting that orthodox medicine studying the autism spectrum make two repeated claims: (1) Don't expect any significant changes to occur in children over the age of 7 and (2) cognitive function changes are the last thing to develop in a typical two-year program. In great contrast, our program shows beneficial changes in all age groups from 1 to 4 as well as those in the 20 to 27 age-range and the cognitive function skill set begins to grow in all subjects from day one onward.

This is perhaps understandable because the orthodox medical community conduct their studies at the cellular, neurological and pharmacological levels of the electric atom/molecule aspect of physical reality, whereas, our study deals with the creation of beneficial changes in the participants at higher dimensional levels of integration (emotional, mental and spiritual) as well as at electrical and subtle energy levels with zero intentional use of pharmaceuticals.

Looking at all of the figures, they all have an upward trend but in a somewhat oscillatory, up a step and down a step, format. This is perhaps not surprising if we think of how the actual structural changes might occur at the various levels of the child. First a thermodynamic free energy driving force step for a change must build up in the system, next must come a partial deconstruction of the original structure (a downwards jog), followed by a rearrangement of the primary structural elements into a new configuration amenable to lowering the existing thermodynamic free energy driving force (an upward jog) and such a transforming process is repeated until all the excess thermodynamic free energy driving force (created by the IHD) has been used up).

The easiest analogy to the above is a geological phase transformation called "Oswald's Rule". Here, let us assume that we have a stable geological phase, A, and a thermodynamic free energy, G, driving force (supercooling or supersaturation) for phase change, ΔG_0, is applied to that geological system at time $t = t_1$. Let us also suppose that, although phase, J, is the new thermodynamically most

stable phase at time t_0, there are also phases, B, C, D, ….I, that are now more thermodynamically stable than Phase A so, any one of these phases are allowed to form at time t greater than t_0. Let us assume that Phase C is the fastest to nucleate and grow by transformation of A→C. However, Phase C is also not thermodynamically stable because there is still unused free energy, $\Delta G_,$ smaller than ΔG_0 but larger than zero, available to nucleate and grow any of Phases D, E, F, G, I or J. Thus, one observes something like A→C→D→E→F→G→H→I→J as a successive sequence of phase changes in geological structure slowly over time until $\Delta G=0$ and the thermodynamically stable Phase, J, is formed. Of course, this may take thousands to millions of years to occur. And sometimes the chain of reactions does not even reach J because the kinetics of structural change is too slow!

Finally, returning to the sequence of 5 Figures, one notes the significant downturn in the last two data points (for October and November, 2013). What happened here?

In both August and October, 14 and 7, respectively, new participants were allowed into the ongoing program (in retrospect, not a good idea). Our current working hypothesis for what actually happened to cause this "backsliding" event, was that the children who were previously and collectively focusing on their own integration process, shifted focus to help the new 21 children with their transformation as an act of "loving kindness" and didn't return to their initial focus before the end of the program in December 2013.

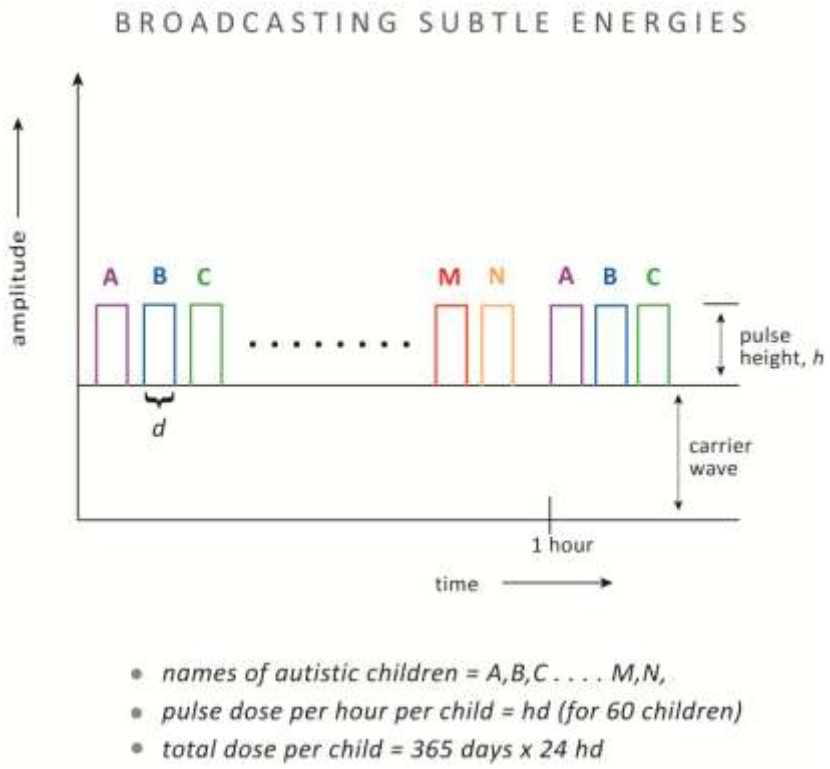
References

1. B. Rimland and S.M. Edelson, online document, www.autism.com/index/atek, "The Autism Treatment Evaluation Checklist (ATEC), Autism Research Institute.
2. www.autism.com/index.php/ind_atek_report.
3. Betty Jarusiewicz (2002). "Efficacy of neurofeedback for children in the autism spectrum: A pilot study", Journal of Neuropathy, Vol. 6 (4) pp 39-49.
4. Derrik Lonsdale, Raymond I. Shamberger, Tapan Audhye (2002). "Treatment of autism spectrum children with thiamine tetrahydrofurfuryl disulfide: A pilot study", Neuroendrocrineology Letters. Vol. 23 (4) pp 303-308.
5. Jorgen Kaveness and Jay Bigam. A study published on the internet showed that the ATEC was able to measure behavioral improvements as a result of the gluten-free/casein-free diet (http://www.gfcfdiet.com/dietsurveysept2.htm).

Appendix I: The Global Broadcasting Procedure for Subtle Energies

The technique used for the Autism Intention Experiment is identical to that used for the earlier "depression and Anxiety" experiment of White paper #XVI. This involves the following ingredients:

(1) A small committed room containing a laptop computer through which sequential slides, with each presenting one name and address for a participant involved in the experiment, are being continuously scrolled through the computer (and thus visible on the computer screen). For a group of 39 participants, a particular name and address is on the screen for one minute in the first cycle. At the end of 39 minutes, the names and addresses are repeated. This process continues, for one full year so the total broadcast dose in minutes for each participant is 365 days times 24 hours per day times 60/39 minutes/hour. This can be visualized as in the figure below for a group of 60 participants with no gap between the pulses of subtle energy on top of a subtle energy carrier wave.



(2) In the same room, the imprinted IHD is running to (a) **condition** that room to the SU(2) Gauge symmetry state level (White Paper XIX) and (b) from that symmetry state simultaneously broadcast to the homes of all the participants named in (1). This is thought to, in turn, **condition** the participant's bedroom in that particular home. It is, then, the specifically **conditioned** home that produces the intended changes in the participant.

Because, what has been created in the home is only a **metastable** thermodynamic free energy state change because of currently unavoidable **leakage** of an essential "coupler" substance in the imprinting IHD system, we re-imprint the particular IHD on a 3-month cycle to maintain the IHD's full functionality over time.

Appendix II: A Brief Primer to Help Understand the Statistical analysis Process

The proper use of modern statistical analysis provides a precise summary of the conclusions that may be drawn from the gathered experimental data under consideration. Also, with some reasonable assumptions or some prior information, one can gain a fairly reliable prediction of the information that can be gained from a proposed experiment.

As definitions, the **population** refers to the whole class about which conclusions are to be drawn, e.g. the C.C.C. (collective consciousness of the children). Whereas, a **sample** or subset of the whole population is often the only realistic opportunity for an experiment (our 39 autistic children). The experimental findings from the sample may then be generalized to draw conclusions about the whole population.

If separate **random** samples are drawn from the whole and compared, two samples are **independent** if the second sample is selected with no reference to the make-up of the first sample. We can speak of two variables as being **independent** when fixing the value of one has no effect on the relative expectation frequency or appearance of the other. When two events are independent, the probability that **both** happen is given by the product of the probabilities of the two event probabilities.

The **population frequency (of appearance) distribution** of a variable, x, is often merely called the distribution of x. The distribution function of x or f(x) is just a plot of f(x) versus x and these are either of the **continuous** type or the **discrete** type. Relative to the central location of the distribution of data points, f(x), the **mean** is the average value while the **median** is the half way point in the readings when they have been arranged in order of size. The **mode** is a peak value of the frequency distribution. The next few diagrams provide some useful illustrations.

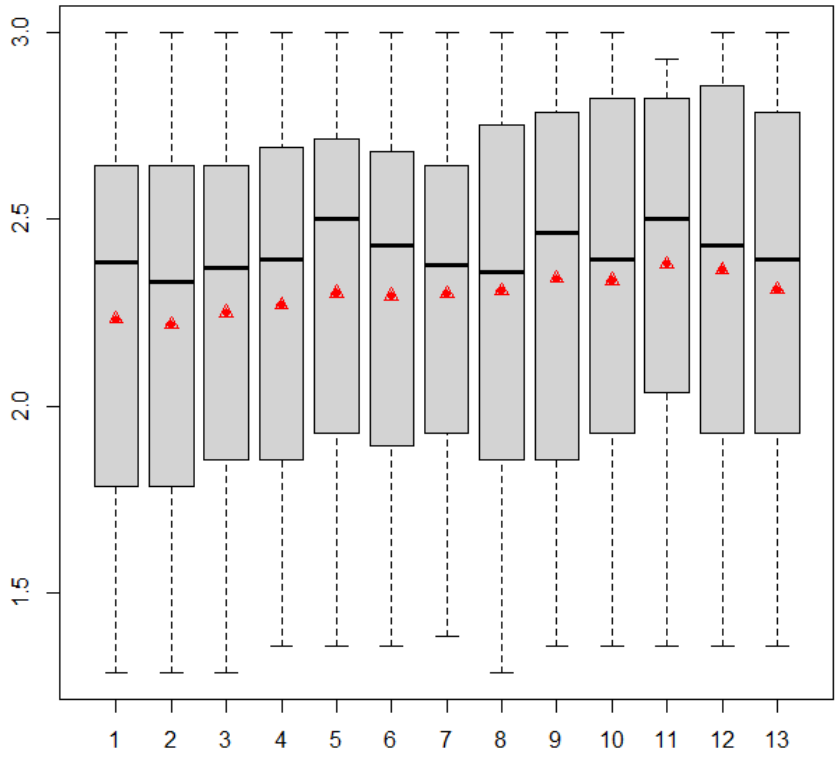


Figure 1. ATEC score vs. month.

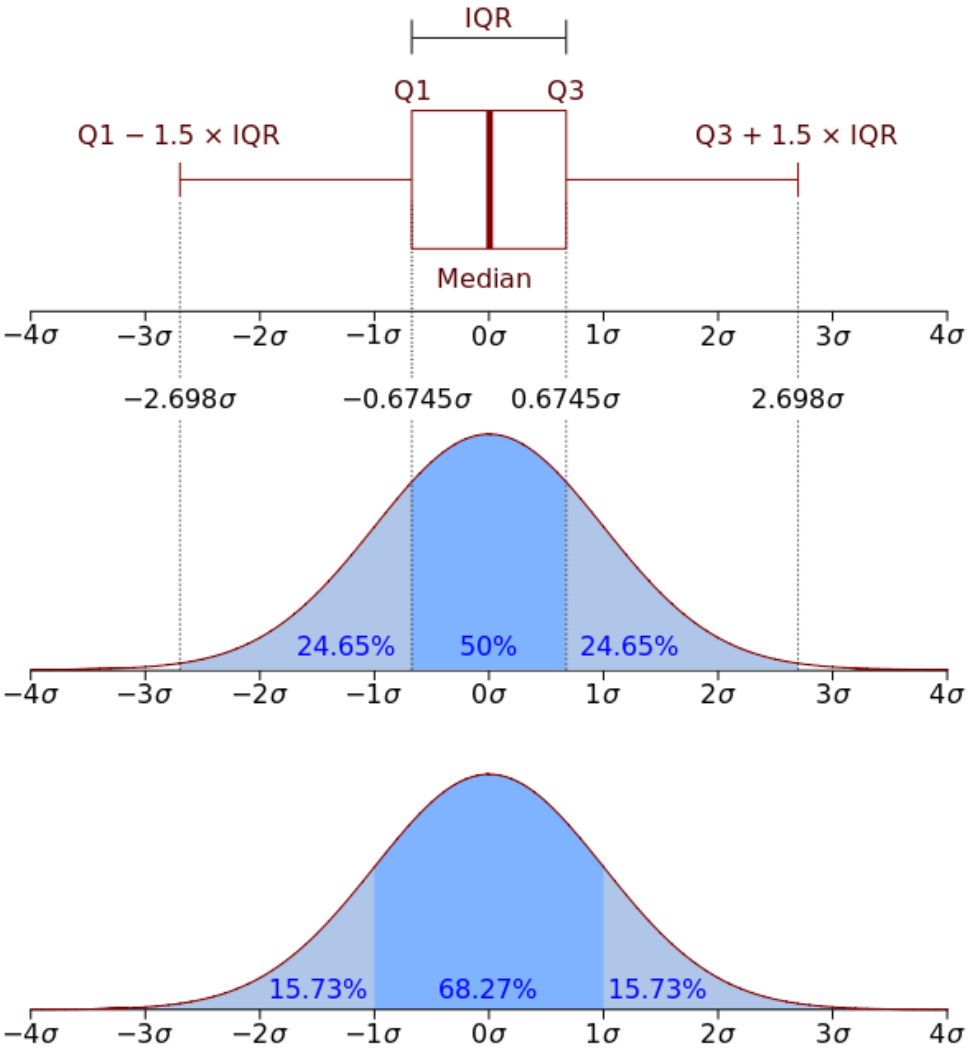


Figure 2. Relation between probability density function and box plot for a symmetrical distribution (Normal Population).

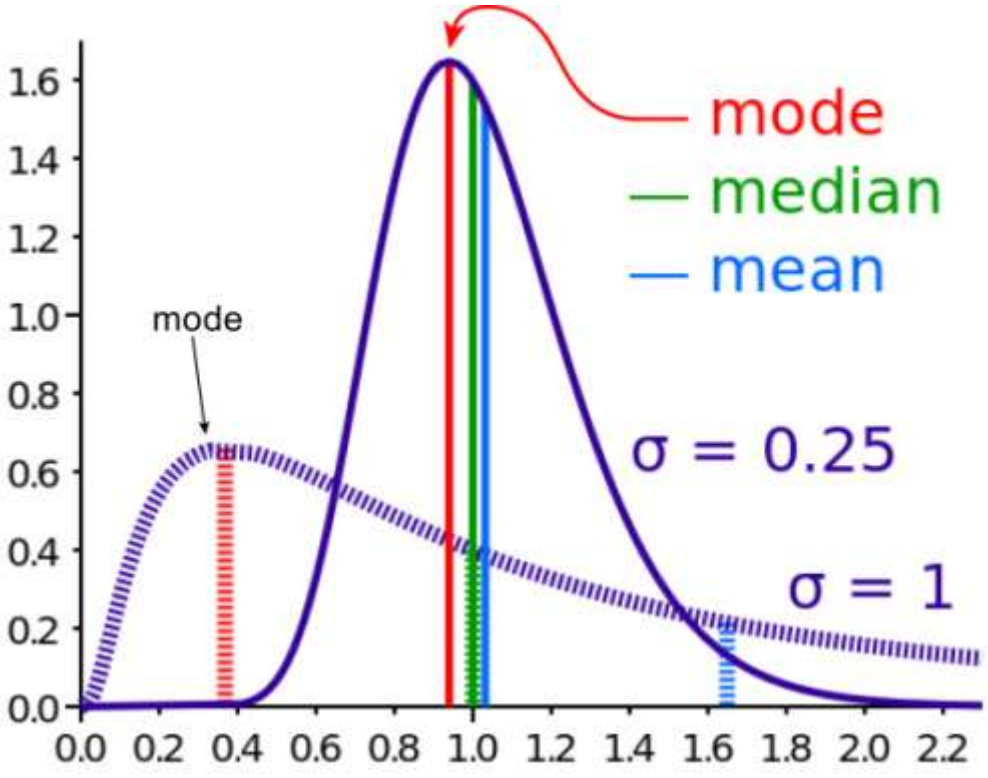


Figure 3. Two log-normal distributions with very different skewness.

Figure 1 is a box plot for the 12-month ATEC data. Here, the shaded boxes represent the interquartile range defined in Figure 2. The black bars represent the median value while the triangles provide the mean of the distribution for any particular month. The "whiskers" represent the whole range of the distribution by month.

In statistics, a **robust measure of scale** is a statistic that quantifies the statistical data spread (statistical dispersion) in a set of numerical data. The most common of such statistics is the interquartile range (IQR – see Figure 2). These are contrasted with conventional measures of scale such as sample variance or sample standard deviation (see σ in Figure 2); they are non-robust, which means that they are greatly influenced by outliers. The IQR is the difference between the 75th percentile value in the sample and the 25th percentile value in the sample, no outliers were detected in the Figure 1 data.

In Figure 3, it is instructive to note the spread between and the mean for a highly skewed distribution (σ=1). Clearly, the significantly higher standard deviation distribution is the one that is most skewed. In the Figure 1 data, all the months are skewed towards higher ATEC scores. The boxes are tall, meaning that the distribution looks more like the σ=1 example than the σ=0.25 example of Figure 3.

The month-to-month variation is quite interesting with skewness and kurtosis changing in possible systematic ways. (The upper end of the 3rd quartile moves upwards with time as does the lower

end of the 2nd quartile). Someone with knowledge of drug trial statistics may be able to comment on some of these variations.

Finally, the normal distribution, which has the probability density function

$$f(x) = \frac{1}{\sqrt{2\pi\sigma}} exp - (z-\mu)^2/2\sigma^2$$

with mean, μ, and standard deviation, σ, is of particular interest in both theoretical and applied statistics. It occurs frequently in practical problems and is easy to use because its properties have been thoroughly investigated. It looks very much like the bell-shaped curve of Figure 2.