



**First Steps**

# UTS TRAINING TIMES

**Volume 2 Issue 3**

**September—October 2006**

A closer look inside....

Did you know that the number of children and adults diagnosed with autism is increasing? On page 5, Cathy Pratt, Director of the Indiana Resource Center for Autism (IRCA) at the Indiana Institute for Disabilities in the Community (IIDC), provides an overview of the increasing incidence of autism. In August, Kim Davis, also from the IRCA, presented a very informative training on autism. As a follow up we have focused this edition of the Training Times on autism. We are grateful to the IRCA for allowing us to reprint articles from their website. The IRCA provides information for families and providers; you can visit their website at: <http://www.iidc.indiana.edu/irca/fmain1.html>

We are also pleased to announce a series of telehealth conferences on autism to be presented by Dr. Debra Sokol and a team of therapists from Riley Hospital for Children. The first presentation will be October 12th. It will be telecast from Riley to Ft. Wayne, Evansville and Hammond. See the back cover for additional information.

September is National Early Literacy month. We are excited to be able to assist Ball State University in their research on Early Literacy. You will find a survey on early intervention and literacy on pages 16 and 17. While we encourage all providers to participate in this worthwhile research, it is completely optional and will in no way affect your status as a First Steps provider or your credentialing requirements. The information will be collected anonymously.

Just a reminder, the final edition of the Training Times for 2006 will be published in December. Those of you needing to recredential before the end of the year will need to insure that you complete the self-assessment prior to the December 31st.

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INDIANA'S UNIFIED TRAINING SYSTEM

“Creating Learning Opportunities for Families and Providers Supporting Young Children”

# News from UTS-ProKids

- ◆ Annual Training Fee registration/payment **is not** due and will not be collected until mid November through December 31, 2006. Providers will receive an email notification when the annual training fee registration is available.
- ◆ The Assessment, Evaluation and Programming System (AEPS), will be used as the sole developmental tool for eligibility determination beginning October 1, 2006. AEPS training was required for all ED Team members. Ongoing First Steps providers will have an opportunity to receive AEPS training in the future. Watch your email or check the UTS-ProKids website for additional information.
- ◆ Mindy Dunn, UTS Programmatic Training Coordinator has resigned that position to become a part-time field trainer. Mindy will retain overall responsibility for Orientation, SC Level I and II training and Provider Orientation Follow-Up. Mindy will also provide limited service coordination for the Central Indiana SPOE. This hands-on experience will add to Mindy's extensive knowledge and expertise in Service Coordination.
- ◆ The format for Service Coordinator Level I training has been revised. UTS trainers will continue to provide face-to-face training for all new Intake and Service Coordinators. A three-day face-to-face training is complemented by a self-guided manual and cluster-based observation and activities. UTS believes this combination of face-to-face and self-guided study will enhance Intake and Service Coordinator learning and will insure consistency across all clusters. Questions regarding Service Coordination Level I or II should be directed to Mindy Dunn: [mdunn@utsprokids.org](mailto:mdunn@utsprokids.org)
- ◆ UTS-ProKids is pleased to announce that it has offered the position of Training Coordinator to an experienced adult educator who has provided training courses for Eli Lilly and Methodist Hospital, and who is certified in distance education. We look forward to the further development of distance and self-guided learning opportunities, including webinars, telehealth and pod casts.
- ◆ Renee Nigh has been promoted to Training Manager. Renee will oversee the UTS Programmatic Training and UTS Connect offices. Renee has been with UTS-ProKids for three years and in addition to her many other duties, managed the implementation of the online registration system.
- ◆ UTS-ProKids will soon offer DVD independent study trainings for First Steps providers. Upon registration, the provider will receive a DVD and manual by mail. Providers must complete the training, return the DVD, and successfully complete the training assessment to receive First Steps credential points. Watch your email and the UTS web site for additional information in October. The initial offerings will include:
  - ⇒ Zero To Three: Learning & Growing Together with Families
  - ⇒ Minnesota Low Incidence Projects: Promising Practices, Effective Early Intervention in Autism
  - ⇒ Strategic Teaching & Reinforcement Systems: Teaching Verbal Behavior - An introduction to Parents Teaching Language
- ◆ Upcoming topical trainings:
  - ⇒ October 12, 2006—Education in Early Intervention for Autism (Telehealth) Offered in Indianapolis, Ft. Wayne, Evansville and Hammond. See back cover for more information.

## Indiana First Steps

### UTS Training Times

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**Web Address:** [www.utsprokids.org](http://www.utsprokids.org)

**Email:** Training questions [training@utsprokids.org](mailto:training@utsprokids.org)

**Registration questions:** [registration@utsprokids.org](mailto:registration@utsprokids.org)

# Updates from the Bureau of Child Development Services

1. Families have begun receiving statements for services under the new Cost Participation rules. If families have questions or concerns, they should contact their Service Coordinator or EDS. Member Hotline (Cost Participation); Telephone 317-713-9627 (Indianapolis Area); Telephone 1-800-457-4584, Option 1 - member calls (family).
2. All IFSP services must be billed within 60 days of the date of service. As a provider, you must submit a claim through WebinterChange within 60 days from the date of service with or without the authorization showing on WebinterChange. If you submit a claim within 60 days without an authorization entered into the system, you will receive a denial, stating "No PA on file". However, once the authorization has been entered, you can resubmit the denied claim. If the resubmission is greater than 60 days from the date of service, the claim will initially pend for the filing limit, however; it will be paid IF the original claim was submitted within 60 days from the date of service and there are no other concerns with the claim. All authorizations should be entered within 5 business days after the SPOE receives the authorization with parent and physician signatures. IFSP services will not be authorized by the SPOE until the physician signature is obtained. If the authorization is not available on WebinterChange within 10 working days, you should contact the Service Coordinator to inquire on the status of the authorization.
3. Providers who have billing problems should first check to insure that they billed under the proper authorization code, using the correct taxonomy and CPT modifiers. Providers may contact the EDS Technical Assistance at (317) 488-5160 or (877) 877-5182, option 3. Be sure to have your rendering number, child ID number and ICN ready when you call. If EDS is unable to solve your problem, you should email First Steps at: [FirstStepsWeb@fssa.state.in.us](mailto:FirstStepsWeb@fssa.state.in.us). Please include a description of the problem, your rendering number, child ID# and ICN.
4. All clusters should have ED Teams in place by October 1, 2006. If providers are interested in working on an ED Team, they should notify Janet Ballard at: [janet.ballard@fssa.in.gov](mailto:janet.ballard@fssa.in.gov). Cluster SPOEs are required to maintain a master list of all ED Teams and their members.
5. Effective October 1, 2006, all ED Teams must use the AEPS for eligibility determination. Questions should be directed to Janet Ballard at [janet.ballard@fssa.in.gov](mailto:janet.ballard@fssa.in.gov). Janet is currently meeting with ED Teams in all clusters. The AEPS standard deviation cut off scores will be available on September 21, 2006. All ED Team members will receive a copy of the scoring table.
6. The Personnel Guide contains information and forms for provider credentialing. It can be found at: [https://www.infirststeps.com/matrix/docs/pdfs/TR368\\_PersonnelGuide.pdf](https://www.infirststeps.com/matrix/docs/pdfs/TR368_PersonnelGuide.pdf). EDS should respond to provider credential submissions within 10 days. Providers with enrollment and credentialing questions should contact EDS Provider Enrollment at (877) 707-5750. The link to update provider enrollment information is: [http://www.indianamedicaid.com/ihcp/ProviderServices/provider\\_update.asp](http://www.indianamedicaid.com/ihcp/ProviderServices/provider_update.asp)
7. Provider progress notes are due once per quarter following the initial IFSP. The Service Coordinator should inform providers when their quarterly notes are needed for the 6-month review, annual IFSP and transition meeting. Progress notes for these meetings are required prior to the meeting, even if it does not follow the exact quarter date.
8. Providers must complete a face-to-face form that is signed by the parent/caregiver to support First Steps billing. At a minimum, the face-to-face sheet must contain: child name; date of service; time in and time out; address location of the visit; minutes billed; provider name and contact information; parent/caregiver signature; summary of visit; follow up needed and family education/involvement provided. Canceled sessions should also be addressed. A face-to-face form is available on the Indiana First Steps website at: [http://www.state.in.us/fssa/first\\_step/pdf/facetoface.pdf](http://www.state.in.us/fssa/first_step/pdf/facetoface.pdf). Each quarter random provider billing reviews are performed by the Quality Review Contractors.
9. Indiana recently completed its Office of Special Education Programs (OSEP) validation visit. To illustrate the Quality Review outcomes, Cluster Quality Review Report Cards were developed. They are posted at: [http://www.in.gov/fssa/first\\_step/qcluster.html](http://www.in.gov/fssa/first_step/qcluster.html). Cluster Report Cards will be updated quarterly.
10. Family and provider surveys will soon be sent to gather information on the many cluster transitions that have occurred in the past six months. Please return your survey promptly and encourage your families to participate.

# What Are Autism Spectrum Disorders?

Autism spectrum disorders include Asperger's Syndrome, Autism, and Pervasive Developmental Disorders-Not Otherwise Specified (PDD-NOS). These disorders fall under the global heading of Pervasive Developmental Disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Other Pervasive Developmental Disorders include Rett's Syndrome and Childhood Disintegrative Disorders.

Autism spectrum disorders appear to be genetic and have a neurobiological basis. While characteristics are not always apparent at birth, symptoms appear in the first few years of life. For those diagnosed with Asperger's syndrome or high-functioning autism, an accurate diagnosis may occur later in life. Even though all share a set of behavioral characteristics, each child or adult exhibits symptoms and characteristics very differently. Autism is referred to as a spectrum disorder to signify these differences among a group of people who share a common diagnosis.

An accurate diagnosis is made when an individual displays a certain number of behavioral characteristics related to communication, social skills, and restricted and repetitive interests and behaviors as outlined in the Diagnostic and Statistical Manual of the American Psychiatric Association. For example:

- Some individuals have extensive vocabularies, while others have limited or no speech. Regardless, children and adults have difficulty communicating wants, needs and desires, and understanding communication.
- Engaging in social interactions, as well as play and leisure activities in an appropriate fashion, presents a challenge for most.
- Individuals often demonstrate a narrow range of interests, prefer to repeatedly engage in specific activities, resist changes in routine, and experience difficulties in regulating sensory input from the surrounding environment.
- For some, challenging behaviors such as refusal, physical aggression or self-injurious behavior may occur.

Other disabilities can accompany an autism spectrum disorder. These disabilities include mental retardation, learning disabilities, visual impairments, hearing impairments, attention deficit hyperactivity disorder (ADHD), Tourette Syndrome, epilepsy, Down Syndrome, cerebral palsy, obsessive-compulsive disorders, anxiety disorders, Fragile X and others.

These differences make it difficult for the person to easily negotiate the demands and expectations of society. However, children and adults within the autism spectrum can and do live productive and meaningful lives when provided with appropriate programs and supports. It is estimated that 2 to 6 per 1,000 people in the United States are diagnosed with an autism spectrum disorder, making this one of the most common disabilities and also one of the fastest growing.

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Reprinted from The Indiana Resource Center for Autism (IRCA) at <http://www.iidc.indiana.edu/irca/fwhat.html>.

At IRCA, the staff conduct outreach training and consultations, engage in research, and develop and disseminate information on behalf of individuals across the autism spectrum, including autism, Asperger's syndrome, and other pervasive developmental disorders. Our efforts are focused on providing communities, organizations, agencies, and families with the knowledge and skills to support children and adults in typical early intervention, school, community, work, and home settings.

# Increasing Incidence of Autism Spectrum Disorders Continues in Indiana

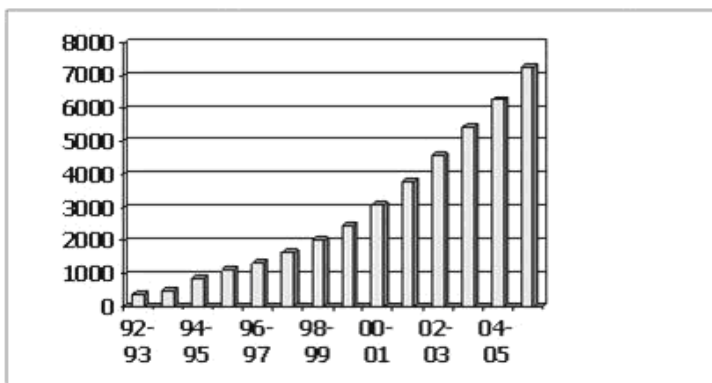
Contributed by [Cathy Pratt, Director](#)

Each year, the IRCA reports on the incidence of autism spectrum disorders in public schools in Indiana. Fifteen years ago, commonly accepted incidence rates ranged from 2 to 5 individuals per 10,000. Today, the Centers for Disease Control believe that the incidence may be as great as 1 in 166 for those diagnosed with autism, Asperger's syndrome, and other pervasive developmental disorders.

So, if the projected incidence rates are accurate, what does this mean for Indiana? Based on the latest census data from 2001, Indiana is home to an estimated 6,114,745 citizens. At an estimated rate of 1 in 166, there are potentially 36,688 individuals with a diagnosis on the autism spectrum. Remember these numbers are projected and only estimate the real occurrence of autism spectrum disorders in Indiana. No database exists of the actual numbers of people with autism spectrum disorders.

Another example of this increase is the 2004-2005 Child Count Data collected by the Indiana Department of Education, Division of Exceptional Learners. The number of students enrolled in Indiana's public schools, during the 2004-2005 school year, was 1,021,244. The number of students between the ages of 3 and 21 identified with an autism spectrum disorder during this same period of time as 6,308.

Number of Students Identified with Autism Spectrum Disorders in Indiana (Source: Indiana DOE)



State ID Rate (2005-06): 1/ 143

This is even more significant when one considers that around 835 more students are being served under this disability category than in 2003-2004. Using these numbers, approximately .006% or 6 in 1,000 students in Indiana have a diagnosis of an autism spectrum disorder. Last year, this number was 5 in 1,000 students.

(Continued on page 6)

## Increasing Incidence of Autism (continued)

Each year, the number of students served under this category increases faster than under any other disability category. And, since parents report that some of these students are served under the labels of Other Health Impairment or Emotionally Disturbed, this number may not be a true reflection of the real incidence.

While there is a general belief and awareness that autism spectrum disorders are on the rise, it is unclear why. Some believe that more children are being identified because the medical community and other professionals have a better understanding of autism spectrum disorders, and because the definition of autism has been expanded to encompass more individuals. Others believe that the increase is real and are advocating for research to investigate the potential causes of autism. Whether we believe the growth is fact or fiction, the reality is that more Indiana citizens are being diagnosed with autism, pervasive developmental disorders, or Asperger's syndrome.

Reference:

Pratt, C. (2006). Increasing incidence of autism spectrum disorders continues in Indiana. *The Reporter*, 11(3), 1, 9.

Dr. Cathy Pratt is the Director of the Indiana Resource Center for Autism at the Indiana Institute on Disability and Community located at Indiana University. Dr. Pratt is on faculty at Indiana University, and presents internationally at conferences and workshops. Dr. Pratt serves on numerous Advisory Boards, including the Advisory Boards of Maap Services, Inc., and the Autism Society of Indiana. She currently serves as Chairman of the Board for the National Autism Society of America and is Co-Chair of the Conference Committee, and a Member of the Government Relations Committee. Dr. Pratt was recently invited to join the Panel of Professional Advisors for the Autism Society of America. She serves on the Advisory Board for the Autism Spectrum Quarterly and is a guest editor for the Journal on Autism and Developmental Disorders. Dr. Pratt served on the Steering Committee for Training and Dissemination for the National Research and Training Center on Positive Behavioral Support. Recently, Dr. Pratt has been involved with the Institute on Rehabilitation Issues focused on Autism, and with the Interagency Autism Coordinating Committee as a member of the Expert Working Group on Services. She has written articles and presents on the following topics: autism spectrum disorders, functional behavior assessment/positive behavior supports, instructional approaches, systems change, and policy. Prior to pursuing her doctorate at Indiana University, Dr. Pratt worked as a classroom teacher for students across the autism spectrum and with other disabilities.

### UTS Training Times On-Line Assessment

**Don't forget to log on to the UTS web site to take the on-line assessment for this issue of the Training Times. Completion of the assessment is a mandatory training requirement for all First Steps providers. Providers are given 2 hours or 0.2 credential points for successfully completing the on-line assessment. The deadline to complete this assessment is November 15, 2006. After that date, a make up assessment will be available, BUT no credential points will be awarded for the make up.**

**The UTS website is located at: <http://www.utsprokids.org>**

# Opportunity to Communicate: A Crucial Aspect of Fostering Communication Development

Contributed by [Beverly Vicker](#)

Communication has long been recognized as an important skill for children to develop. For children who have limited skills, some basic elements are necessary for a child to develop an adequate communication system. The child has to have a need to communicate, a means by which he or she can communicate, opportunities to communicate, and supportive communication partners (Beukelman & Mirenda, 1998). Often the emphasis of a program is on the development of a means of communication whether it be oral speech, sign language, or some other form of augmentative communication. This article will only focus on one element, the need for opportunity to experience communicative exchanges, and to acquire and practice communication skills.

It is not easy to discuss the issue of opportunity because to increase opportunity requires more time investment from the adults in the child's life and sometimes changing the comfort zone for the child. This always involves a balancing act between competing goals and recognition of surrounding circumstances. Key elements are illustrated in the following diagram. All of the elements are important so there needs to be adequate opportunities for all to occur each day.

**Independence of the child.**

**Ability of the child to occupy self.**

**Self regulation by the child.**

**Time for adult to meet other daily demands/needs.**



**Interactions by the child with others.**

**Communication exchanges involving the child.**

According to Hart and Risley (1999), there may be up to 338 utterances produced per hour by a typical child 24 months of age and potentially 5,000 utterances in an average day. Not all of the utterances are directed to others and not all are responded to by parents. But, even if a given child only engaged in 700 exchanges per day with an adult, that still represents considerable time during the course of a week, month, and year to potentially practice communication skills. One must ask, how many communicative exchanges take place during the typical day of a child with an autism spectrum disorder (ASD) who is learning to communicate? What proportion are adult initiated? How many take place at school? How many at home? How many, in either situation, are unique exchanges versus a routine exchange? (In highly routinized exchanges, children do not necessarily gain new skills in vocabulary, syntax, functional use, and background knowledge.) If a skill is still new, how many exchanges or practice opportunities have existed to firmly establish the new skill or to promote generalization?

Seven hundred exchanges a day is actually a low figure for a typical child who has verbal skills. Goals for a child with special needs are often lower than an arbitrary 700 exchanges and qualitatively different. For verbal behavior training, an applied behavior analysis program, the goal is usually 500 responses a day. For users of typical augmentative communication systems, 500 utterances a day should be a reasonable target. The Picture Exchange Communication System suggests 80 as a minimum rate. Language and communication skill development can be compromised if a child has an adequate means of communication, but the frequency of use is very low.

## Opportunity to Communicate (continued)

Very few adults, if any, set out to deliberately compromise opportunities for learning language and communication. Sometimes compromise happens because parents are too invested in other goals. The use of a pacifier with children older than 18 months of age is a good example, and it is an illustration that is not restricted to children with ASD. When one is out in the community, one frequently sees children of various ages with pacifiers in their mouths. The pacifier can help with emotional regulation keeping the child calm and relaxed amid the sensory stimulation of the community. This represents a good goal BUT the question remains if this is the best way of achieving emotional regulation once the child is beyond 18 months of age. The use of a pacifier is not a problem from a communication perspective when a child is napping or sleeping at nighttime during the early years. The child is not missing out on interaction during this time period. During awake hours, however, some children seem zoned out with their sucking behavior and the parents often do not talk to the child because he or she is so content. So much language learning opportunities are wasted and the child is less likely to take the initiative with commenting or calling attention to something because of the device in his or her mouth. This article is not saying "Do not use a pacifier." Rather it is saying, "Are you missing language/communication interaction opportunities with your child, particularly when out in the community? Can you provide alternative periods of having the pacifier in and out? Can you talk more to your child, even when it is in and he may need to nod or gesture?" Being in the community can be challenging for a child with ASD but if you can capture his or her attention with something for brief periods of time, the community can also be a memorable and interesting learning environment.

Missed opportunities can also occur at home. Again the objective is to have balance in the child's life. Most parents use time while their child is occupied with TV or video viewing to get some necessary household chores done or to have a moment to one's self. This is necessary BUT sitting alone with the TV or computer does not improve your child's language or interaction skills. A parent would seem to need several strategies for the child who favors excessive viewing and limited interaction. The first strategy will take time and effort. Attempt to sit down with your child and intermittently interact about the content. If you're lucky, you will be able to direct his or her attention to some aspect of what is happening by using a directional point. ("Oh, look, Tigger is jumping again. Boing-boing-boing"). If it is hard to direct his or her attention, you might want to build a well padded finger on the end of a dowel and use that to point to what you want your child to notice. You could ask him or her a simple question such as is "Is Pooh there too? Where is he?" and encourage your child to point. Keep the intrusions limited to a few the first time, and maybe this activity can grow into some nice interaction over time.

Some children are so "zoned out" on the sensory aspect of viewing video or TV that you will be viewed as an annoyance or distraction while they are waiting for their favorite scene in a video. Try several things to see if you can build this into an interactive situation. First, give your child a warning that you will be sitting next to him or her for awhile. You may need to do some sensory things such as rubbing his or her back to reduce the anxiety/annoyance of you being there. This can build up a positive value for your presence. You may want to mention something about the video or whatever after the event. Once your presence is perceived as an acceptable variation on the usual viewing situation, you can begin to make a comment or ask a question but not at the moment of his or her favorite part. Your speech pathologist can help you make up a topic board for a video and that may help facilitate a few exchanges. A parent can provide good modeling of how the communication support can be used. Look for opportunities to teach new vocabulary and to explain actions.

An alternative strategy is to use the schedule and timer, and limit the time for watching or playing video games or other self absorbing activities. Choose to involve your child in activities where there will be some interaction. Initially it will be important to really tap into your child's interests to counter resistance. Pick something that he or she likes to do and finds satisfying. It may only be a 7-8 out of 10 on a scale of interest and satisfaction, but it has to be of sufficient value to compete with videos, TV, computer, or games. If your child has no other interests, then that is a red flag signal for you to start helping him or her to build interests that will involve him or her with other people. It may take time to broaden interests but there will be a payoff in terms of building better communication skills and social interest.

The last barrier to communication opportunities can be the equally important goal of independence. It is very important for children with autism spectrum disorders to not be cue or prompt dependent, to be able to take the initiative to meet their own needs and to be able to occupy themselves with something of personal interest. BUT, being independent most of the time, means that the child does not need someone to help satisfy his or her needs. By not needing someone, he or she has a legitimate reason to not have to interact. So, some opportunities to communicate and interact are lost by default. This means that parents and teachers will have to create new needs that can only be resolved by interacting with

## Opportunity to Communicate (continued)

another person. The opportunities often need to be planned. As mentioned earlier, one is looking to put some balance into the life of the child with ASD because without adequate opportunities to communicate, the child will have less developed skills. The child will also develop habits that do not include interaction. Different strategies will be needed with the child who has adequate opportunity in school or at home, but who is reluctant or not interested in communicating.

Opportunities to communicate/interact can abound if the child has an adequate means of communication. If the child does not, then the various elements of creating need, providing a means, and providing an opportunity should occur in tandem. If communication partners do not know how to be supportive, then this element must be addressed as well. Opportunity to communicate is not an area that can be ignored within an intervention program.

### References:

Beukelman, D., & Miranda, P. (1998). *Augmentative and alternative communication: Management of severe communication disorders in children and adults (2nd ed.)*. Baltimore, MD: Paul H. Brookes Publishing Company.

Hart, B. & Risley, T. (1999). *The social world of children learning to talk*. Baltimore, MD: Paul Brookes Publishing Co.

Vicker, B. (2006). Opportunity to communicate: A crucial aspect of fostering communication development. *The Reporter*, 11(2), 16-18.

Beverly Vicker is a Speech Language Consultant at the Indiana Resource Center for Autism. Prior to working at IRCA, Beverly worked in public schools, provided services to students with physical challenges, and supervised graduate/undergraduate students in communication disorders. While at the IRCA, she has provided direct service in model programs with students with autism, served on an interdisciplinary assessment team, engaged in training and research, and has produced many written materials. She is the author of a recent screening test that evaluates WH question comprehension. Beverly has presented at state and national level conferences. Besides an interest in autism spectrum disorder and communication disorders, she has an interest in augmentative communication, social pragmatics, literacy, early intervention, and positive behavior support.



### Presenter Proposals Wanted

UTS-Programmatic Training is currently soliciting presenter proposal for UTS topical trainings to be presented in 2006 and 2007. Do you have expertise on a particular topic or treatment that you would like to share with other First Steps providers or families? Have you read a good journal article that would be of interest to First Steps providers or would you like to write an article? UTS pays trainer stipends, reprint costs or original authors for article submissions.

Contact us at [training@utsprokids.org](mailto:training@utsprokids.org) for more information and to request a presenter proposal form.

**Check out the UTS web site for updated training information**

<http://www.utsprokids.org>

## Good Night, Sleep Tight, and Don't Let the Bed Bugs Bite: Establishing Positive Sleep Patterns for Young Children with Autism Spectrum



Contributed by [Marci Wheeler](#)

Most parents have had some experience with a child who has difficulty falling asleep, wakes up frequently during the night, and/or only sleeps a few hours each night. Temporary sleep difficulties are an “expected” phase of child development. Ongoing and persistent sleep disturbances can have an adverse effect on the child, parents and other household members. Children with autism spectrum disorders appear to experience these sleep disturbances more frequently and intensely than typically developing children. A child’s sleeping problems can quickly become a daily parenting challenge.

There are a number of factors to address when establishing a plan to reinforce a positive sleep pattern. First, any underlying medical problems that may be affecting sleep should be assessed. Consider checking for food and/or environmental allergies or intolerances, gastrointestinal disturbances, and seizures. All of these are more common in persons with autism spectrum disorders. Also sleep disturbances can be a side effect of other medications an individual takes and so this should be considered, too.

Sleep disorders that affect the general population should also be ruled out for your child with an autism spectrum disorder. Sleep apnea is a disorder that can affect anyone at any age. It is a disorder in which a person experiences pauses in breathing when the airway becomes obstructed during sleep. The most common cause for blockage is enlarged tonsils or adenoids. Upper respiratory illnesses and/or allergies can also contribute to the development of sleep apnea. Beside pauses in breathing, symptoms of sleep apnea in children include: snoring, mouth breathing, restless sleep, sweating, night waking, and/or frequent coughing or choking while asleep. Other sleep disorders to assess in a child, if appropriate, include sleep terrors and confusional arousals. These both are frequently referred to as parasomnias. Parasomnias are disorders of “partial arousal” that lead to unusual behaviors during sleep. Children with sensory processing difficulties have more problems falling asleep and night waking. An assessment and consultation with an occupational therapist trained in sensory integration may be important to assess relaxation and arousal difficulties, and to help design strategies that address these issues.

After possible medical problems have been addressed, other factors contributing to sleep problems should be considered and strategies for addressing these implemented. Other issues to consider are: environmental variables, bedtime routines and the use of a sleep training method. Each of these three topics is discussed in further detail below.

### Environmental Variables

After examining your child’s sleep environment more closely, there may be some adaptations and modifications needed to assist your child’s ability to relax at bedtime.

1. Consider whether your child is too hot or too cold. Assess the temperature of the room, bedding and sleep clothes to decide what combination is best for your child. Remember that your child’s sense of temperature may be different than your own. Recall what temperature your child seems to prefer and/or seek during the day, and consider when making decisions.
2. Consider tactile sensitivities that may be affecting your child’s ability to sleep. Certain textures can relax or arouse your child. Look at bedding and pajama textures. Your child may prefer his/her feet covered or uncovered with footed pajamas, socks and or even the covers themselves. How tight or loose the clothing fits, and whether or not there is elastic or seams can be an issue for some children. Also bedding should provide the optimum level of pressure, as this too can affect individuals with autism spectrum disorders.
3. Consider noises and how they affect your child. At night, when trying to relax and fall asleep, the noises your child hears may be overpowering and impossible for the child to filter out. These noises, such as water running or an animal scratching may not affect you or other household members but can be disrupting for a child with an autism spectrum disorder. Can certain household noises be monitored for the effect on your child? Sometimes a fan, air filter, TV or soft music in the child’s room can help mask other noises and provide a consistent sound that is comforting and/or soothing for the child.

## Good Night, Sleep Tight (continued)

Also consider visual stimuli that may be causing problems for your child at bedtime. Is your child afraid of the dark? Some children with autism spectrum disorders may seem to prefer dark places during the day but that is different than being expected to sleep in a big room in a bed at night in the dark. Streetlights, the moon, or car lights shining in the room at intermittent intervals may be affecting your child's sleep. Providing a room that is consistently light or dark may be very important, depending on your child's needs.

### Bedtime Routines

Bedtime routines and rituals are very important for most children in establishing positive sleep patterns, but are extremely critical for children with an autism spectrum disorder.

1. Your child will benefit from a set bedtime. Pick a time for bed that is reasonable for your child and which you can consistently provide.
2. Children with an autism spectrum disorder need to know what is going to happen next. Establish a bedtime routine that can provide predictability and a comforting, familiar pattern. For further understanding and structure, a visual bedtime schedule can help. The visual schedule can provide reminders and consistency for the whole family.
3. A good bedtime routine will help teach a child to calm down, relax and get ready to sleep. For example, if bathing is stimulating or frightening for your child, even though you may want him/her to bathe before bed, it may be best to bathe at a completely different time of the day. Likewise, there may be sensory integration activities that have proven to be relaxing to your child during the day that you can also use as part of the bedtime routine.
4. A bedtime routine should be the same everyday and should include activities that are pleasant and relaxing as well as special and individualized to fit your child's needs and interests. A bedtime routine should realistically consist of 4 to 6 steps that do not take more time than is reasonable on a nightly basis.
5. Some activities to consider as part of a bedtime routine or ritual include looking at the same book or story each night, saying good night to favorite objects, toileting, bathing, getting pajamas on, brushing teeth, having a glass of water, singing a favorite song or prayer, listening to calming music that the child enjoys, hugging and kissing family members and/or engaging in a calming sensory integration activity.

On days when you are away from home and/or get home late, it is still important to follow bedtime routines and rituals. You can shorten each step significantly and potentially eliminate nightlong frustrations due to the change. If your child is away from home for a night or two you may see old sleeping patterns emerge. Even in a temporary new environment, routines may help. Upon returning home the bedtime routine will continue to be effective, though the excitement from the change may take a night or more to fade depending on your child and how long you have been away.

### Sleep Training

After addressing medical issues, environmental variables and bedtime routines it is time to tackle the hardest piece in establishing positive sleep patterns: teaching your child to sleep through the night. There are various versions of sleep training methods you may have read or heard about. Basically after the bedtime routine is done and your child is in his bed or crib, leave the room without long drawn out words or further attempts at touching the child in any way.

If the child is upset and obviously not sleeping, wait a few minutes and then go back into the child's room to check on him/her. Checks involve going back into the child's room and briefly (not more than a minute, preferably less) touching, rubbing or maybe giving a "high five", "thumbs up" or hug for an older child who better responds to these gestures. Gently but firmly say, "it's okay, it's bedtime, you are okay" or a similar phrase and then leave the room until it is time for the next check or until the child falls asleep.

Using this technique consistently is generally harder on the parent than it is on the child. It could take a couple of hours the first few nights. It is important to know that it is very likely the child's behavior will get worse for a few days or more before it improves. This is the child testing the change and trying to bring the old routine back. For some children

## Good Night, Sleep Tight (continued)

who are older and not genuinely tired at a reasonable bedtime, a routine of staying in the bed or in the room quietly may be appropriate for these children. Sleep training methods can still be applied in these situations. Also a gate or other barrier may be needed at the bedroom door to remind the child it's bedtime and the expectation is to stay in your room.

If your child is older and never consistently slept through the night, you may be totally sleep deprived yourself. Ask for help from your doctor, a psychologist, social worker or from a case manager if you have applied for Medicaid Waivers. It may not be easy to find a knowledgeable professional but you might start by asking other parents who might know a professional that has helped them in the past. Also if your child seems to regress in their sleeping habits, you may need to consult with knowledgeable professionals. Again, it is best to start with a medical assessment and proceed from there. Sometimes if other medical problems are ruled out, a temporary trial of medication taken under a doctor's care can assist in turning around poor sleep patterns, while working to establish bedtime routines and rituals that work for your child.

Several doctors in the field of autism spectrum disorders have done preliminary research on the short-term use of the over the counter supplement melatonin. Melatonin can help stabilize and promote normal sleep for some children by helping them fall asleep more quickly. The few studies currently available do caution, however, that melatonin sometimes stops working and does not usually help those who frequently wake up during the night. In addition, the long-term effect of taking melatonin has not been established. Some parents have found vitamin supplementation helpful for helping a child get to sleep.

It is extremely common for children with autism spectrum disorders to have difficulty getting to sleep, sleeping for a few hours at a time, and/or staying asleep without frequently waking throughout the night. These poor sleep habits are easily created and can be extremely difficult to change. One issue not yet addressed in this article is the habit of sleeping with the child. This habit may understandably gets started when poor sleeping patterns affect not only the child but the parents and the rest of the family as well.

If the child is in the habit of sleeping with a parent and/or in the parent's bed, the same steps described above should be considered with additional support needed during the examination of the environment and bedtime ritual/routine. For example, a pillow or other item(s) from the parent(s) may help make the environment more comforting to the child as the parent(s) transitions from sleeping with the child. Desensitization to a new bed or room can be added as part of the bedtime routine. Desensitization to a new room or bed can be added as part of a routine done daily for a few days or weeks before also being done as part of the bedtime routine. It can't be stressed enough, the best advice is to avoid creating sleep routines and habits that will have to be broken later, if at all possible.

Checking for medical issues and environmental variables and then planning and consistently as possible following a bedtime routine and a sleep training method can improve the quality of life for the whole family. It can take time to establish positive sleeping patterns particularly if trying to change a long-standing problem. Families frequently have to make sleeping issues a priority until positive sleeping patterns are established. It is a priority that is worth the effort.

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# Mealtime and Children on the Autism Spectrum: Beyond Picky, Fussy, and Fads

Eating and feeding are common topics among parents of young children. First time parents learn and gather information about how and what to feed their children, what to expect during different stages of development, and how to promote positive and healthy eating habits. Many children develop what are described as mild feeding or eating problems at some point in their development. Doctors may take a few minutes at each visit to screen for feeding and diet issues along with measuring growth status. Doctors and nurses will listen and give some guidance for common feeding and nutrition issues. Many problems of picky eating and mealtimes are resolved with a little guidance and some patience. However, parents of children on the autism spectrum often seek further guidance and support for what are frequently much more severe eating problems.

Many parents of children on the autism spectrum struggle with their child's severe eating problems with little or no professional help. In part, this is simply due to the limited number of specialists dealing with eating and feeding disorders. Furthermore, within this limited number of specialists there are few that have much understanding and experience with children who have autism spectrum disorders. A frequently suggested strategy for many children with eating and feeding disorders involves withholding food until the child is hungry enough to eat. This approach has been shown to be dangerous and not appropriate for a child on the autism spectrum. Unfortunately, professionals as well as concerned family members and friends mistakenly blame parents of children with autism spectrum disorders for their child's poor eating habits. Sometimes parents' concerns are ignored and they are told not to worry since most children go through stages of picky eating and food fads.

Though no reliable statistics are available on feeding and eating disorders of children on the autism spectrum, it does appear to be relatively common. Families of these children may end up struggling on their own with little understanding from family, friends and the professional community. One British mom, out of loneliness and frustration, attempted a survey that resulted in a sample of 89 questionnaires being filled out and returned. Brenda Legge's (2002), *Can't Eat, Won't Eat: Dietary Difficulties and Autistic Spectrum Disorders*, in which she summarizes feeding and eating problems experienced by families, can undoubtedly serve to assure families that they are not alone. Though each child is unique, information gathered from her survey shows the need for further research on this issue and serves to educate families about some common eating issues.

Medical, behavioral, and environmental factors, including sensory difficulties, must be considered when feeding and eating problems occur. Within the scope of this article, medical and behavioral factors will be addressed briefly. Medical issues and frequently, behavioral issues, need to be assessed and addressed by working with the appropriate professionals. The environmental and sensory related issues will be discussed and outlined in more depth. It is the environmental and sensory related problems that families can often adjust on their own once they better understand their child's needs.

Medical conditions can affect a child's eating habits and eating habits impact health. It is important to assess and address medically related feeding problems first so that the child's health needs can be recognized and managed. After medical problems have been examined, and plans are in place to address these problems, then the behavioral problems, if any remain, are important to address and treat. Occasionally behavioral issues are so severe that medical intervention is needed for these issues also. Environmental issues including sensory difficulties can be considered after medical and behavioral issues have been treated.

## Medical Assessments for Feeding and Eating Skills

Medical assessments can include evaluation of oral motor function including swallowing studies, assessments of food sensitivities and allergies, medications and their effect on eating, and a profile of the child's diet and resulting nutritional issues.

An eating history should be taken. The eating history should include gathering the following information:

- o Details of extensive choking, coughing or gagging when eating;
- o Loss of oxygen (turning blue/purple) while eating;
- o Pattern of liquids or foods that emerge through the child's nostrils when eating; and
- o Reoccurring respiratory difficulties and/or pneumonia.

## Mealtime and Children on the Autism Spectrum (continued)

An occupational therapist, speech and language pathologist, and nutritionist or dietician along with a doctor and a nurse are all involved when a team approach is used for a feeding assessment. Frequently a social worker or child psychologist is also part of a feeding team.

In recent years, an additional aspect of medical assessments for children with autism spectrum disorders related to eating and feeding issues has been suggested. Since the late 1990s, abnormal gastrointestinal functioning of many individuals with autism spectrum disorders has gained increasing recognition and concern. Research by Doctor Andrew Wakefield, and other research by pediatric gastroenterologist Tim Buie and gastroenterologist Arthur Krigsman, suggest that at least half of all children with autism spectrum disorders have clinically significant gastrointestinal symptoms. These researchers have conducted intestinal biopsies and other assessments and have found unique forms of inflammatory bowel disease including enterocolitis, esophagitis, and gastritis in children with autism spectrum disorders. Treatments of these digestive system abnormalities have led to varying degrees of improvements in the core symptoms of autism spectrum disorders, including behavior, communication and social skills. The main treatments for this abnormal inflammatory bowel disease include diet, treatment of gut yeast, and supplemental enzymes. More information can be found about biomedical treatments related to gastrointestinal problems and autism spectrum disorders in books by Jaquelyn McCandless, M.D., William Shaw, Ph.D. and Karen Serrusi. These books are listed at the end of this article. The Autism Research Institute established the Defeat Autism Now! (DAN!) organization in 1995. DAN! sponsors conferences, develops and disseminates written materials, and keeps a database of practitioners who are doing research and treating children with this new biomedical model. You can access this information on their website at [www.autism.com/ari](http://www.autism.com/ari).

Different diets seem to help some people with autism spectrum disorders. A gluten-free, casein-free diet seems to be where many families start when exploring a gastrointestinal connection between their child's behavior and their diet. Families often anecdotally suggest they find their child's self-imposed restricted food choices do expand significantly when they start a gluten-free, casein-free diet. The Specific Carbohydrate Diet (Gottschall, 2002) is also gaining a lot of interest among families of children with autism spectrum disorders. It is best to read the latest research and information, and find a knowledgeable medical professional to work with if you are considering a particular diet, gut healing treatment and/or supplements for your child. This approach certainly does not work for everyone, is very individualized and is a substantial commitment to most families if or when they begin.

When a child is continually refusing food or having other feeding or eating difficulties, it is important to evaluate any possible medical problems and determine factors to be addressed medically that will maximize feeding and eating success. Unfortunately, some children do not seem to have much appetite at all. They may not have the ability to feel or interpret the feeling of hunger. This inability to feel or interpret hunger is confusing and usually means more effort on the part of families to feed their child because s/he will have little or no interest on their own. Food allergies and food intolerance should also be considered as part of medical testing. The lack of ability to detect hunger, food allergies, and/or food intolerance can also impact eating issues and ultimately the child's health.

### Behavioral Problems that Effect Feeding and Eating

Eating disorders are complex and continue to be studied among various populations. Eating disorders such as failure to thrive, rumination, pica, obesity and anorexia nervosa can affect children with autism spectrum disorders. Children experiencing these problems are at risk for serious health and growth problems that can lead to life threatening consequences. It is frequently mentioned in the literature (Kedesdy & Budd, 1998; Macht, 1990; Woolston, 1991) that individuals with disabilities may be at a greater risk for these types of behavioral eating disorders.

Pica, the ingesting of non-nutritious substances, is a behavior that can start at any point in life under various circumstances. If a child is persistently eating non-edible items such as paper, dirt, or craft items and/or chewing on plaster or wood, an evaluation should be done to try and determine the cause. Obviously the child should be closely supervised and kept away from substances related to this pica behavior. There are multiple causes and treatments for pica. A knowledgeable professional can assess and address pica. Nutritional deficiencies, sensory stimulation, lack of ability to discriminate non edible items, and relief of anxiety are all possible factors that can lead to pica. If the pica is not seriously health or life threatening, sometimes substituting edible and/or sensory stimulating alternatives can take care of the problem.

Rumination is the persistent regurgitation, re-chewing, re-swallowing, or occasionally vomiting of previously eaten foods and is a second behavioral problem of eating that can have serious health consequences. The causes of rumination are not clear but are thought to begin due to gastro-intestinal disorders and continue due to the self-stimulatory rewards the individual experiences. Rumination is a relatively rare disorder; the best course of action is an appropriate medical assessment and treatment. Behavioral interventions may be appropriately designed and implemented once

## Mealtime and Children on the Autism Spectrum (continued)

medical issues have been thoroughly addressed. Behavioral issues, when severe, will also need to be assessed and treated medically.

### Environmental Problems that Affect Feeding and Eating

Throughout the limited feeding and eating disorders literature (Morris & Klein, 1987; Kedesdy & Budd, 1998; Macht, 1990), environmental factors primarily focus on sensory processing variables. Children with extreme food selectivity issues are frequently dealing with many environmental factors related to sensory modulation and regulation. Selective eating is defined as eating very small amounts of food and/or restricting foods eaten to an extremely narrow selection of sometimes only one or two items. Selective eating can have significant developmental and health consequences. Extreme selective eating problems are often seen paired with strong negative reactions to the introduction of new foods. Mild selective eating is common in all toddlers and young children according to a variety of studies. It cannot be emphasized enough that the issue of concern for a significant number of children on the autism spectrum is extreme food selectivity.

Extreme food selectivity, when related to environmental and sensory issues, can be addressed successfully in many cases. The place to start is to analyze eating habits and then sensory variables. Gathering information about what the child eats successfully, and about how, when and where the child eats best can provide clues for broadening the child's diet. The following questions should be answered: what foods, with whom, where, when and how does the child eat any foods even if it is just a few foods. Frequently, there is a pattern to what foods the child eats or where the child eats successfully.

Parents often discover their child's interest in or avoidance of, particular foods is related to a common sensory experience. A description of common sensory processes related to eating and the various sensory factors are discussed below. Do you know what sensory inputs are motivating to your child? Is your child avoiding certain sensory inputs?

Some children with autism spectrum disorders will eat mostly foods that fit into only one of these four categories; sweet, sour, bitter or salty. It is common, for example, that a child will choose to eat mostly or only foods which are salty and not be interested in sweet foods. Food that is "naturally" salty such as chips, bacon and crackers may make up a majority of a child's diet. This pattern may alarm parents and motivate them to seek information and help.

There are some children who seem to figure out that all food tastes better to them with catsup or occasionally some other condiment. The family and professionals may decide that these toppings are fine as long as it is helping the child get more of the nutrition they need from the foods which they would refuse to eat without their preferred "topping."

The "feel" or touch of the food is commonly a sensory factor for individuals with an autism spectrum disorder. The temperature or texture of foods needs to be just "right." It is common for children to insist on all foods being at room temperature. This may mean that cold foods such as ice cream or popsicles are not tolerated and that foods that are cooked need to be cooled to room temperature before the child will eat them.

It is also common for children with autism spectrum disorders to have a strong preference for one particular texture of foods such as crunchy or smooth. Mashed potatoes must be the same consistency each time for example. When introducing new foods, it is important to consider introducing foods that are of the similar texture or which can be modified to be of similar texture. Some children have a harder time, than typical children, transitioning from foods they can eat with their fingers to foods that are eaten with utensils. The transition from the bottle can also be more problematic for children on the autism spectrum.

Some children with an autism spectrum disorder are much more affected by the smell of food. The smell of foods that are not familiar and comfortable may affect their ability to eat. This may affect their ability to go places outside of their home to eat. Some extremely sensitive individuals may not be able to eat at the same table or in the same room where others are eating a food that has an uncomfortable and/or unfamiliar smell. Be aware that smell could be affecting your child's eating issues.

The way foods "look" is another issue to be aware of when eating and feeding are problems. It is common for parents to share that their child only eats foods of one color such as only white or orange foods. Many children on the autism spectrum will only eat something if it is presented each time in the same type of plate or container. Some extremely selective kids will want "perfect" uniformity of their food and will refuse to eat if they detect even the slightest change.

### Strategies for Addressing Eating and Feeding Problems

When developing a plan for expanding the number and variety of foods a child will eat, it is important to be calm and not controlling. In fact the most successful experiences are when the child is given some control or at least they perceive

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## Early Intervention & Literacy Survey

Researchers at Ball State University, in cooperation with First Steps, are conducting a study on the use of literacy & the early intervention provider. Your participation in this survey is voluntary and will remain anonymous. Please fill out the survey as accurately as possible. Thank you once again for your contribution to this worthwhile project. For one's rights as a research subject, the following persons may be contacted: Karen Thatcher, Ed.D, CCC-SLP; Ball State University; kthatcher@bsu.edu.

**The following survey is included in this edition of the training times to assist Ball State University in its early literacy research. Completion of the survey is completely anonymous and voluntary. It will not affect your status in the First Steps program or the amount of credential points received for reading this edition of the newsletter.**

You may fax your completed survey to (765) 285-5623 or you may take the survey online at <http://www.utsprokids.org>.

1. Your discipline:
  - Occupational
  - Physical
  - Speech
  - Developmental
  - Service Coordinator
  - Other
2. Years as First Steps provider:
  - Less than one year
  - 1-3 years
  - 4-6 years
  - 7-10 years
  - More than 10 years
3. Total number of years practicing (including all work experiences)
  - Less than one year
  - 1-5 years
  - 6-10 years
  - 11-15 years
  - More than 15 years
4. Gender:
  - Male
  - Female
5. Highest level of education completed:
  - High School
  - 2 year degree
  - 4 year degree
  - Master's degree
  - Doctorate degree
6. Average number of children on your caseload:
  - Less than 5
  - 6-10
  - 11-15
  - 16-20
  - More than 20
7. I define literacy as:
  - Reading
  - Reading & writing
  - Reading, writing & oral language
  - Other \_\_\_\_\_
8. Do you utilize books during any of your therapy sessions?
  - Yes
  - No
  - Not Applicable

## Early Intervention & Literacy Survey

9. If **yes**, how many sessions, per week?
- 1-20%
  - 21-50%
  - 51-99%
  - All sessions
10. If **no**, why not?
- Books are not appropriate for my therapy sessions
  - The children I work with do not enjoy books
  - I do not know how to utilize books in my sessions
  - Books are an added expense
  - Books are not accessible
  - Other \_\_\_\_\_
11. Do you utilize nursery rhymes, songs, or finger plays during your therapy sessions?
- Yes
  - No
  - Not applicable
12. If **yes**, how many sessions, per week?
- 1-20%
  - 21-50%
  - 51-99%
  - All sessions
13. How many of the children you service have children's books accessible in their homes?
- None
  - Few (1-25%)
  - Some (26-65%)
  - Most (66-99%)
  - All
14. I feel that the special needs of the children I service affect his/her ability to enjoy literacy.
- Not at all
  - Somewhat
  - Moderately
  - Very much
15. I feel that literacy is related to the therapy service I provide.
- Not at all
  - Somewhat
  - Moderately
  - Very much
16. I discuss the role of literacy with parents during therapy sessions:
- Never
  - Occasionally
  - Frequently
  - Every session
17. At what age is literacy appropriate for children?
- 0-6 months
  - 7 months to 1 year
  - 1 to 2 years
  - 2 to 3 years
  - After 3 years

Fax your completed survey to (765) 285-5623 or you can complete the survey online at <http://www.utsprokids.org>

## Mealtime and Children on the Autism Spectrum (continued)

that they do have some control. Struggles over eating most often make matters worse. Gradual exposure to new foods can be very important. Frequently, in despair, mothers will offer a different array of several new foods each day hoping that by chance the child might try something. The more choices the more chance of success, sounds like it makes sense, but not for a child on the autism spectrum.

Gradually introducing a new food will help the child to become desensitized to the smell, look and possibly feel of an unfamiliar food. If a new food is chosen that has highly desirable sensory qualities to the child, you will have a better chance at success. Start with a food that has the “best” sensory fit. Offer the food on a daily basis by putting it where the child will be able to desensitize to it. Think of how your child might best accept a new item in his/her space. Frequently a small separate bowl or plate in close proximity to the child’s seat will work. Sometimes a child can tolerate the new item on his or her plate as long as they understand that the only expectation is that it will just stay on their plate. Repeated exposure of the identical food item should be offered once or twice a day, at meals, with no expectations attached. Sometimes this technique paired with others in the family, especially a sibling, modeling the enjoyment of eating this new item, can make it easier for the child to try tasting it. You may try the same food item for two or three weeks. For children who respond to Social Stories (Gray, 2000; Gray & White 2003), information can be offered in this format, at times other than mealtime. In the Social Story, focus on the wonderful benefits of trying this new food. Sometimes, in the Social Story, describing a favorite character like Barney or Spiderman eating this particular food gets them interested enough to taste it.

If desensitization, modeling and a social story have not resulted in the new food being tried, the strategy of offering alternating small bites of a highly desirable food with a small bite of the new food is another option. As always, it is important that this technique not be made into a battle. The idea is to make trying a new food as pleasant and successful as possible. This is a common strategy that is used for all children. The information can be made visual (by putting the different bites in view on the plate) along with the instructions “First *favorite food*, then *new/undesired food*, and then *favorite food*.” An example might be “First macaroni, then peas, and then macaroni.” Both of these approaches for introducing new foods are positive and non-threatening to the child. The child can feel like s/he has some control.

Children do not want to be tricked. Tricks such as hiding “extra” vegetables in spaghetti sauce and or supplements in a child’s favorite drink do sometimes work but can also backfire. Sometimes, after detecting “additions” to familiar favorites, the child learns to be suspicious of all foods and will limit his/her diet even further. This strategy probably works best when the sensory characteristic the child is focusing on is the “look” of the food. If a child is more sensitive to the smell, taste or texture of a food, it may be harder to make “additions” because they are usually easier for the child to detect. Be cautious when using this strategy.

The auditory sense is generally not directly related to eating and feeding issues. Indirectly sounds can contribute to the comfort of the actual environment where eating and feeding take place. It is very common for individuals on the autism spectrum to get overwhelmed in noisy and crowded environments such as a school cafeteria or McDonalds on a Saturday afternoon. It is important to accommodate individuals’ needs so that the environment itself is not preventing successful eating because of sensory overload. Some children take longer switching from a bottle to a cup or learning to use utensils. Part of the issue is that change is hard for these children in general. The sensory issues can also be a partial reason for this difficulty. A desensitization plan for using a cup and/or utensils can be developed. If the problem is severe, an occupational therapist with sensory integration training may be helpful in suggesting desensitization techniques. Sometimes adaptations are possible and appropriate such as allowing the use of plastic utensils instead of metal.

In addition to the sensory properties of foods and the sensory stimulus in the environment affecting the child’s ability to eat in a particular environment, a third common issue is the ability to sit at a table and eat a meal with others. There are a number of reasons why this may be difficult. Eating at a table with others is a social activity. Eating may not be a very motivating or rewarding activity in itself. Pair that with the social issues involved in eating with others and you may begin to better understand the situation from your child’s perspective. Additionally, many of our children are active and have a hard time staying still in one place no matter what the activity. There are several possibilities to address when looking at the issue of sitting at the table with others to eat.

Determining the reason your child is not able to sit at the table will help in deciding what to do to address your child’s needs. Some children need to organize their bodies with a little physical activity before they are asked to sit at a table. Sometimes a timer needs to be set to show more concretely that sitting is expected at mealtime, at least for a few minutes until the timer rings. The length of time a child is expected to sit may be gradually lengthened so success is built up slowly. Some children can sit and eat quickly at the table but will not be able to sit and wait for others before being served and/or after they have finished their food. This inability to wait can sometimes be addressed with special waiting

## Mealtime and Children on the Autism Spectrum (continued)

toys or activities. Sometimes items to focus on while waiting are helpful. Even some older children and adults on the autism spectrum have a need to develop waiting strategies to use at mealtime while eating with others. In this situation, bringing something to read or a pocket sized game to focus on while waiting, is a positive coping strategy for older children and adults, too.

Eating and feeding problems can sometimes dominate family life. It is easy to get overwhelmed when eating problems are severe and are so closely tied to your child's health and development. The fact that mealtime occurs at least three times a day, and families and children are not always able to eat at home, adds to the stress. Get help for any biomedical and behavioral concerns. After those areas are addressed, families' can often tackle the environmental factors by calmly working to desensitize the child to new foods with structure and a non-controlling plan for trying a new food. The expectation to sit and eat at the table can be structured in small steps and paced so the child is successful. Patience with this process is also a key to success. Network with other families to share successes and failures, and to gather new tips or resources that can make a difference. Also when you reach out to others you will be reminded that you are not the only one coping with these challenges!

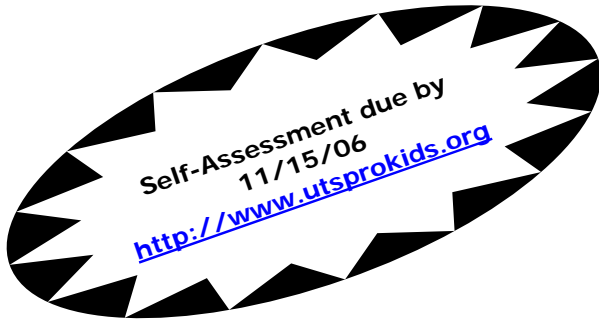
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## Riley TeleHealth Conference Autism: Early Identification and Intervention

**What:** First of **three** conferences on **Autism** for First Step Therapists and early interventionists  
**When:** **Thurs October 12, 2006** 1-3pm CDT (Evansville/Hammond) or 2-4pm EDT (Indy/Ft. Wayne) (Please note local times)  
**Where:** This telehealth conference is offered at four sites statewide.

**Riley Outpatient Center Auditorium-(Ruth Lilly Learning Center-lower level ROC)**

575 West Drive, Indianapolis, IN

**Lutheran Hospital**-7950 West Jefferson Blvd., Fort Wayne, IN 46804

**Deaconess** Riley Children's Specialty Clinic, 4133 Gateway Blvd, Suite 220; Newburgh, Indiana

**Purdue University-Calumet** Porter Hall 117 2200 69th St, Hammond, IN 46323

**Who:** **Deborah K. Sokol**, PhD, MD will speak on prevalence and neurology of autism; **Heike Minnich**, PsyD, HSPP will speak on early clinical signs and behavioral intervention; **Tatia Friet**, M.S. CCC-SLP **Laura Helms**, M.A. CCC-SLP and **Stephanie Cox** will speak on language assessment and early intervention; **Stephanie Nicolini**, MOT, OTR will speak on sensory assessment and early intervention; **Chris Barton** MM, MT-BC, will speak on music therapy in autism; **Jessica Stenz**, MS, will speak on inclusive classroom adaptation for young children with autism; **Maria Cote**, BA will speak on parental advocating

**Special Price:** \$20 Register for the site you wish to attend—space is limited. Register at: <http://www.utsprokids.org/>

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