

COMMUNITY PSYCHIATRIC CENTERS

A Partnership of Dr. Robert A. Lowenstein, M.D. & John Carosso, Psy..D.

THE "ANSWERS" SERIES



AUTISM-SPECTRUM DISORDERS:

- AUTISTIC DISORDER
- PERVASIVE DEVELOPMENTAL DISORDER NOS
- ASPERGER'S DISORDER

The following answers are from excerpts of the writings of Dr. Lowenstein, M.D., Dr. Carosso, Psy.D., latest research findings, the DSM-IV, and from the Autism Society of America. Many of the following training methodologies come from the following researchers and practitioners: Vincent Carbone, Ed.D., BCBA; Mark Sundberg, PhD, BCBA; James Pardington, PhD, Dawson, Osterling, Jack Micheals, Ph.D., BCBA, Christina Burk, M.A., and B.F. Skinner.

What is Autism and PDDNOS?

While understanding of autism has grown tremendously since it was first described by Dr. Leo Kanner in 1943, most of the public, including many professionals in the medical, educational, and vocational fields, are still unaware of how autism affects people and how they can effectively work with individuals with autism. Contrary to popular understanding, many children and adults with autism may make eye contact, show affection, smile and laugh, and demonstrate a variety of other emotions, although in varying degrees. Like other children, they respond to their environment in both positive and negative ways.

What do they mean by a "spectrum disorder"?

Autism is a spectrum disorder. The symptoms and characteristics of autism can present themselves in a wide variety of combinations, from mild to severe. Although autism is defined by a certain set of behaviors, children and adults can

exhibit *any combination* of the behaviors in *any degree of severity*. Two children, both with the same diagnosis, can act very differently from one another and have varying skills.

Parents may hear different terms used to describe children within this spectrum, such as autistic-like, autistic tendencies, autism spectrum, Pervasive Developmental Disorder NOS (PDDNOS), high-functioning or low-functioning autism, more-abled or less-abled. More important than the term used is to understand that, whatever the diagnosis, children with autism and PDDNOS can learn and function productively and show gains with appropriate education and treatment.

Another way of viewing the spectrum is of continuum with Autism at one extreme, Asperger's Disorder at the other, and Pervasive Developmental Disorder NOS (PDDNOS) in the middle. This latter diagnosis is often viewed as a "catch-all" term or "middle-ground" and used as a diagnosis for those children who do not meet full diagnostic criteria for Autism or Asperger's. However, these children demonstrate significant deficiencies in at least two of the three primary diagnostic categories: communication problems, social deficiencies, and evidence of self-stimulatory behaviors.

Every person with autism is an individual, and like all individuals, has a unique personality and combination of characteristics. Some individuals mildly affected may exhibit only slight delays in language and greater challenges with

social interactions. The person may have difficulty initiating and/or maintaining a conversation. Communication is often described as talking at others (for example, monologue on a favorite subject that continues despite attempts by others to interject comments).

How is a diagnosis made?

An evaluation at Community Psychiatric Centers involves an assessment by Dr. Robert A. Lowenstein, M.D., a Board Certified Child Psychiatrist and/or Dr. John Carosso, Psy.D., a Licensed Clinical Child Psychologist. Dr. Lowenstein and Dr. Carosso both have years of experience assessing and diagnosing children functioning within the autistic spectrum.

What are some of the signs of autism and PDDNOS?

People with autism and PDDNOS process and respond to information in unique ways. In some cases, aggressive and/or self-injurious behavior may be present. As described above, the three primary diagnostic domains include profound deficiencies in communication skills, social capacity, and evidence of what is called "self-stimulatory behaviors" such as toe-walking, hand-flapping, or gazing. Persons with autism may also exhibit some of the following traits.

- Insistence on sameness; resistance to change
- Difficulty in expressing needs; uses gestures or pointing instead of words

- Repeating words or phrases in place of normal, responsive language
- Laughing, crying, showing distress for reasons not apparent to others
- Prefers to be alone; aloof manner
- Tantrums
- Difficulty in mixing with others
- May not want to cuddle or be cuddled
- Little or no eye contact
- Unresponsive to normal teaching methods
- Sustained odd play
- Spins objects
- Inappropriate attachments to objects
- Apparent over-sensitivity or under-sensitivity to pain
- No real fears of danger
- Noticeable physical over-activity or extreme under-activity
- Uneven gross/fine motor skills
- Not responsive to verbal cues; acts as if deaf although hearing tests in normal range.

Are there also sensory problems?

For most of us, the integration of our senses helps us to understand what we are experiencing. For example, our senses of touch, smell and taste work together in the experience of eating a ripe peach: the feel of the peach fuzz as we pick it up, its sweet smell as we bring it to our mouth, and the juices running down our face as we take a bite. For children with autism, sensory integration problems are common. Their senses may be over-or under-active. The fuzz on the peach may actually be experienced as painful; the

smell may make the child gag. Some children with autism are particularly sensitive to sound, finding even the most ordinary daily noises painful. Many professionals feel that some of the typical autism behaviors are actually a result of sensory integration difficulties.

What can, or can't, a child with autism or PDDNOS do? Can they give eye contact, show affection, and other things?

There are many myths and misconceptions about these disorders. Contrary to popular belief, many autistic children do make eye contact; it just may be less or different from a non-autistic child. Many children with autism can develop good functional language and others can develop some type of communication skills, such as sign language or use of pictures. Children do not "outgrow" autism but symptoms may lessen as the child develops and receives treatment.

One of the most devastating myths about autistic children is that they cannot show affection. While sensory stimulation is processed differently in some children with autism, they can and do give affection. But it may require patience on a parent's part to accept and give love in the child's terms.

What are the causes of autism-spectrum disorders?

There is no known single cause for autism, but it is generally accepted that it is caused by abnormalities in brain

structure or function. Brain scans show differences in the shape and structure of the brain in autistic versus non-autistic children. Researchers are investigating a number of theories, including the link between heredity, genetics and medical problems. In many families, there appears to be a pattern of autism or related disabilities, further supporting a genetic basis to the disorder. While no one gene has been identified as causing autism, researchers are searching for irregular segments of genetic code that autistic children may have inherited. It also appears that some children are born with a susceptibility to autism, but researchers have not yet identified a single "trigger" that causes autism to develop.

Other researchers are investigating the possibility that under certain conditions, a cluster of unstable genes may interfere with brain development resulting in autism. Still other researchers are investigating problems during pregnancy or delivery as well as environmental factors such as viral infections, metabolic imbalances, and exposure to environmental chemicals.

Autism tends to occur more frequently than expected among individuals who have certain medical conditions, including Fragile X syndrome, tuberous sclerosis, congenital rubella syndrome, and untreated phenylketonuria (PKU). Some harmful substances ingested during pregnancy also have been associated with an increased risk of autism. Early in 2002, The Agency for Toxic Substances and Disease Registry (ATSDR) prepared a

literature review of hazardous chemical exposures and autism and found no compelling evidence for an association; however, there was very limited research and more needs to be done.

What about vaccines?

The question of a relationship between vaccines and autism continues to be debated. In a 2001 investigation by the Institute of Medicine, a committee concluded that the "evidence favors rejection of a causal relationship.... between MMR vaccines and autistic spectrum disorders (ASD)." The committee acknowledged, however, that "they could not rule out" the possibility that the MMR vaccine could contribute to ASD in a small number of children. While other researchers agree the data does not support a link between the MMR and autism, more research is clearly needed.

Whatever the cause, it is clear that children with autism and PDD are born with the disorder or born with the potential to develop it. It is not caused by bad parenting. Autism is not a mental illness. Children with autism are not unruly kids who choose not to behave. Furthermore, no known psychological factors in the development of the child have been shown to cause autism.

What are the common treatments?

There are a number of commonly used treatment strategies that are typically based in Applied Behavioral Analysis.

What is Applied Behavioral Analysis?

In 1938, Skinner published *The Behavior Of Organisms*, which described operant conditioning, or the process by which learning occurs as the result of selection by consequences of behavior. Skinner also discussed how antecedent stimuli, when correlated with the function altering effects of consequences, also alter future occurrences of that behavior. This is known as a three-term contingency (A-B-C), the basic unit of analysis of behavior, and was the first description of the discrete trial. In addition to describing the instructional trial, Skinner detailed the basic experimental methodology that led to his findings, which he termed the experimental analysis of behavior (EAB). Later applications of this science to education, and to other matters of socially significant behavior, by behavior analysts led to what is now known as Applied Behavior Analysis (ABA).

In 1957, as applied behavior analysis was developing and research on ABA was being published, Skinner published *Verbal Behavior*, which detailed a functional analysis of verbal behavior. What Skinner's text did was to extend operant conditioning to verbal behavior in order to fully account for the range of human behavior. Since the publication of *Verbal Behavior*, many applied behavior analysts, including Jack Michael, Mark Sundberg, Jim Partington, and Vince Carbone, have conducted and published research on verbal behavior, much of which can be found in *The Analysis of Verbal Behavior* journal. This body of research serves as

the basic and applied foundation of teaching VB as part of an ABA program, or what is now sometimes referred to as AVB, as discussed above. The science of applied behavior analysis now has a solid empirical foundation to support it, due largely in part to Skinner and Ivan Lovaas.

What is Discrete Trial Therapy?

Discrete Trial Teaching

There is much discussion of what prompting strategies are most effective for children with autism. The two most-discussed prompting procedures are errorless learning and no-no-prompting. This is my take on errorless learning (EL), which will make the most sense if it's discussed in the context of no-no-prompting (NNP).

Prompting procedures differ across programs; while some DTT programs use NNP, others use EL; many use EL for acquisition skills and NNP for mastered skills; others use some combination of the two.

NNP is intended, and used by those who do it correctly, to work on skills that are considered mastered, or (as some have said) for skills that have been in acquisition for a while, i.e., in random rotation. Unfortunately, this is not always done correctly; some begin teaching acquisition skills with NNP, which is not supported by anyone as an effective way to teach.

With NNP, the teacher delivers an antecedent (i.e., "Point to the dog") and

waits for the child to respond. Assuming the child in this example responds incorrectly, the teacher's consequence is to say "No," often also turning her head to the side. The antecedent is then delivered again and, assuming the child again responds incorrectly, the teacher again consequences with "No." The antecedent is then delivered again and the child is prompted to give the correct response, which is then praised. It's important to point out that most folks doing NNP use what's termed an "informational no," or "no equivalents" (such as "nope," "try again," etc.) meaning that it's not harsh, just neutral.

With EL, in contrast, the teacher delivers an antecedent and either prompts immediately (zero-second time delay) or waits a beat to see what the child will do. If the child begins to move to an incorrect response, or doesn't respond, the teacher immediately prompts the correct response and praises. The same antecedent is then presented again, this time as a transfer trial (meaning it's an attempt to have the child respond correctly without the prompt or with less of a prompt). If the child is correct independently, the teacher reinforces more strongly (differentially reinforcing the independent response) and moves on. If the child again begins to respond incorrectly, the teacher prompts again, then usually moves on for a few trials to other targets. However, she soon returns to the missed target to try for an independent response, again prompting and trying for a transfer trial as necessary.

NNP is a system that uses least to most prompting, which (as the name implies) involves starting with less prompting and gradually increasing that prompt in response to errors. EL is a system of most to least prompting, which initially involves prompting with a 0 second time delay (meaning immediately) and gradually fading the prompts to foster independence. There are many errorless learning strategies, i.e., progressive time delay, intrastimulus prompting, etc., but the goal (to minimize or eliminate errors) is the same regardless of technique. While NNP may seem like it fosters independence, and may in some cases do so, in my opinion it can also teach a chain of errors, thin the reinforcement schedule such that learning can become aversive, slow the rate of teaching, make kids prompt dependent, and misuse the child's learning time. EL done correctly can and likely will prevent these teaching problems.

A typical discrete trial program would address skill development in either a Beginning, Intermediate, or Advanced program as delineated below:

Beginning Program

Attending Skills: Sits independently; eye contact in response to name; eye contact in response to instruction; respond to direction. **Imitation:** Gross motor movements; actions with objects; fine motor; oral motor. **Receptive Language:** One-step instructions; identify body-parts, objects, pictures, familiar people; follow verbal instructions; identify verbs in pictures, objects in the environment; point to pictures in a book; identify

objects by function; identify possession; identify environmental sounds. **Expressive Language:** Points to desired items in response to "what do you want,"; points to desired items spontaneously; imitates sounds and words; labels objects; labels pictures; verbally requests desired items; states or gestures yes and no; labels familiar people; makes a choice; reciprocates greetings; answers social questions; labels verbs in pictures, others, and self; labels objects by function; labels possession. **Pre-academic Skills:** Matches identical objects, identical pictures, objects to pictures, pictures to objects, colors, shapes, letters, numbers, nonidentical objects, objects by association; completes simple activities independently, identifies colors, shapes, letters, numbers; counts by rote to 10; counts objects. **Self-help:** Drinks from a cup; uses fork and spoon; removes shoes, socks, pants, shirt, uses napkin, is toilet trained for urination

Intermediate Program

Attending Skills: Sustains eye contact for five seconds in response to name; makes eye contact in response to name while playing; makes eye contact in response to name from a distance; asks "what" when name is called. **Imitation Skills:** Imitates gross motor movements from a standing position; imitates sequenced gross motor movements; sequenced actions with objects, actions paired with sounds, block patterns, simple drawings. **Receptive Language Skills:** Identifies rooms, emotions, places; follows two-step directions; gives two objects; retrieves objects out of view; identifies attributes, community helpers;

pretends; identifies categories, pronouns; identifies categories, pronouns; follows directions with prepositions; identifies an object in view when it is described; places sequence cards in order; identifies gender, items that is missing; answers wh-questions about objects and pictures, yes/no in response to questions about objects and actions; names an object by touch. **Receptive Language Skills:**

Imitates two and three-word phrases; requests desired item in a sentence in response to "what do you want," desired items spontaneously in a sentence; calls parent from a distance; labels objects based on function, objects; labels and points to body parts according to function; labels function of body parts; labels place, emotions, categories; uses simple sentence; reciprocates information ("I have..."), states "I don't know," asks "wh questions, labels prepositions, pronouns, answers general knowledge questions; labels gender; describes pictures in a sentence, recalls immediate past experiences, names belongings in a room, function of rooms, where and when questions; picture sequencing; delivers a message; role plays; offers assistance.

Pre-academic: Match items from same category; give specified quantity of items; match number to quantity; match uppercase to lowercase numbers; match identical words; identify more and less; sequence numbers/letters; complete simple worksheet; copy letters and numbers; identify written name; draw simple pictures; write name; paste and glue; cut with scissors, color within a boundary. **Self-help Skills:** put in pants, shirt, coat, shoes, socks; wash hands;

toilet trained for bowel movements; self-initiates for bathroom.

Advanced Program

Attending Skills: Makes eye contact during conversation, during group instruction. **Imitation Skills:** Imitates complex sequences, peer play, verbal response of peers. **Receptive Language:** Follows three-step instructions, complex instructions from a distance, names a person, place, or thing when it is described, an object when only partly visible, items that are the same; items that are different, what does not belong in a category, plural vs. singular; answers wh-questions about a short story, about a topic; follows instructions "ask" vs. "tell."; finds hidden object given location clues; discriminates when to ask a question and when to reciprocate information.

Expressive Language Skills: States "I don't know" to unfamiliar questions; labels a category to which an item belongs; names items in a category; retells a story; describes objects not in view; recalls past events; describes topics; tells own story; expresses confusion and asks for clarification; uses correct verb tense; describes how to do something; describes similarities and differences. **Abstract Language:** Answers "why" questions, "if" questions; makes logical completions to sentences; describes irregularities in pictures; predicts outcomes, takes another's perspective; provides explanations; identifies main topic in story. **Academic Skills:** Defines people, places, and things; completes a pattern; matches written words to objects/objects to written words; reads common words; names letter sounds;

names a word beginning with letter sound; names initial, medial, and final consonants, spells simple words; states word meanings; identifies simple synonyms, adds single-digit numbers. **Social Skills:** Imitates actions of peer; follows directions from a peer; answers questions from a peer; responds to peer play-initiation statements; plays board game with peer; initiates play statements to peer; reciprocates information to peer; comments to peer during play; asks peer for assistance; offers assistance to peer.

School Readiness: Waits turn, follows group instructions, sings nursery rhymes, answers when called on, raises hand to answer question; listens to story and answers question about the story; shows and tells. **Self-Help Skills:** Brushes teeth, zippers, buttons, snaps.

Some pointers about reinforcement:

- Differentially reinforce - use better or more rewarding reinforcement for higher quality of responses. For example, give a child a better reinforcer for independently responding and a lesser reinforcer for a prompted response.
- Always vary reinforcers so that the child does not know what to expect next.
- Avoid satiation of reinforcers - have a variety of reinforcers so that the reinforcers remain motivating.

- Reinforcement should immediately follow the response so as not to inadvertently reinforce the wrong behavior.
- Pair primary reinforcers with social reinforcement so that primaries can eventually be faded and more natural reinforcement can be used.
- Therapy should be overall reinforcing to the child.

Reinforcement ideas:

- ❖ Snacks the child likes (break into bite size pieces)
- ❖ Tickles
- ❖ Sing a song the child likes
- ❖ Give the child a big squeeze
- ❖ Blow bubbles
- ❖ 5 little piggies
- ❖ use a puppet
- ❖ blow up a balloon and let it go
- ❖ shake child's chair like an earthquake
- ❖ let the child watch a portion of his favorite cartoon or listen to part of his favorite song

How do professional assess language development and progress?

There are a number of assessments, including those used by speech/language pathologists. However, a commonly used comprehensive and intensive assessment used by Behavioral Consultants is known as the 'Assessment of Basic Language and Learning Skills' (ABLLS) is completed at the outset of therapy and re-

administered throughout the therapy process to track progress.

I understand that routine and consistency is very important for children with developmental delays?

Yes, that is true. In fact, it is recommended that routine is maintained and that changes in the routine are well-rehearsed. It helps to post a daily visual schedule with frequent review. It is occasionally helpful to have each part of the schedule on individual Velcro strips that can be removed upon completion.

Do I need to be careful how I give instructions?

Yes, it helps to keep directions short and to the point. Picture-cards of direction can be helpful. Allow ample processing time after a direction. Avoid jargon and figures of speech (e.g. "don't give me any lip..." may only cause confusion).

What is Asperger's Disorder?

Asperger's Disorder is a milder variant of Autistic Disorder. In Asperger's Disorder, affected individuals are characterized by social isolation and eccentric behavior in childhood. There are impairments in two-sided social interaction and non-verbal communication. Though fully able to verbally communicate, their speech is peculiar due to abnormalities of inflection and a repetitive pattern. Clumsiness is prominent both in their articulation and gross motor behavior. They usually have a restricted area of interest that usually

leaves no space for more age appropriate, common interests. Some examples are cars, trains, French Literature, door knobs, hinges, cappuccino, meteorology, astronomy or history. The name "Asperger" comes from Hans Asperger, an Austrian physician who first described the syndrome in 1944.

What tips do you have to help children diagnosed with Asperger's Disorder?

The following is adapted from "Tips for Teaching High-Functioning Persons with Autism" by Carol O'Neal and Susan Moreno of the MAAP Organization:

There tends to be difficulty with organizational skills, regardless of apparent intelligence and/or age. Use: verbal cues, clear visual demonstration, physical cues.

Due to problems with abstract thinking and concepts: avoid abstract ideas when possible; when abstract ideas are necessary, use visual cues as an aid.

An increase in unusual or difficult behaviors may indicate an increase in stress or a feeling of loss of control in a specific situation. Try saying, "do you have something to tell me?" The individual may need to go to a "safe place" and/or a "safe person." Allow for changes in activities. Don't take misbehaviors personally.

There is a tendency to interpret speech literally. Until you know the word processing capabilities of the individual from personal experience, avoid: "cute"

names such as Pal, Buddy, Wise Guy, etc...;
idioms ("save your breath," "jump the gun," "second thoughts," etc.); double meanings (many jokes have double meanings); sarcasm; teasing

Be as concrete as possible: remember that visual social cues are rarely effective; avoid using vague questions with them ("Why did you do that?"); avoid essay-type questions with them.

There is a tendency to not realize when they have said enough or if they are properly addressing the core of the question.

If the individual doesn't seem to be learning the task or concept: break it down into smaller steps; present it in more than one way (visually, verbally, physically).

Avoid verbal overload. Be clear. Remember that although there is no hearing problem and are paying total attention to what's being said, there may have difficulty in understanding what you feel is important in what you are telling them.

Prepare the child for all changes in his routine and/or his environment.

Behavioral management works, but if incorrectly used or used without keeping the individual's level of ability in mind, it can result in robot-like behavior or be ineffective. Use with creativity.

Consistent treatment and expectations from everyone is vital.

Be aware that auditory and visual input can be extremes of too much or too little, depending on the individual.

If your Asperger's child uses repetitive verbal arguments and/or repetitive verbal questions, try requesting that they write down your reply. If that doesn't work, you write down their repetitive argument and/or statement, and then ask them to write down a logical reply. This serves to distract them from the escalating verbal aspect of the argument or question and sometimes gives them another way of expressing their frustration and/or anxiety.

If your child does not read or write, try role-playing the repetitive verbal question and/or argument with you taking their part and them answering you in a way they think would be logical. This last suggestion should only be used if you think they are still at a point where they will willingly try this. If not, catch their argument and/or question closer to the beginning next time before they work themselves up too much. Remember that logically replying or arguing back with them by itself seldom stops this behavior. This repetitive behavior usually indicates a feeling of loss of control in a situation or uncertainty about someone or something in the environment.

Since there are problems in communication, do not rely on child attempting to relay messages back home about school events, assignments, school rules, etc., unless you try it on an experimental basis with follow-up or

unless you are already certain that the child is capable of relaying the message. Even sending home a note may not work. The child may not remember to deliver the note. A phone call to the parent works best until this skill can be developed.

If an activity involves pairing-off or choosing partners, either draw numbers or use some other means of doing the pairing. A person with autism is often the individual left out. This is a potentially hurtful situation. Another suggestion is to ask someone especially kind if he or she would choose the individual with autism for a partner.

What can I do to promote social skills during interactions for children functioning in the autistic spectrum?

Utilize prompting, encouragement, and redirection during social encounters.

It is recommended that eye contact is prompted, and social engagement is reinforced.

Use social stories, role playing, and rehearsal of social situations.

Utilization of feedback, i.e. videotape or audio recording may also be helpful.

Introduce child to peers, or structure social opportunities, with peers who have similar interests.

Explain why a particular behavior is necessary; don't assume an understanding

of the reasoning behind the pro-social behavior.

Skills that will need to be emphasized include (Attwood & Gray):

Entry: how to join-in with a group of children and how to welcome a child who wants to join-in;

Assistance: recognizing when and how to provide and accept help from others;

Compliments: providing compliments at appropriate times and knowing how to respond to a friend's compliment;

Criticism: knowing when criticism is appropriate and inappropriate, how it is given and the ability to tolerate criticism;

Accepting Suggestions: incorporating the ideas of others in the activity;

Reciprocity and Sharing: a "back and forth" sharing of conversation and resources (toys...);

Conflict Resolution: working through disagreements with compromise, accepting opinion of others;

Monitoring and Listening: learning to observe peer's body language and monitor their contribution to the activity. Monitor one's own body language to reflect interest in peer and activity;

Empathy: recognizing when appropriate comments and actions are required in response to peer's circumstances and the feelings of others;

Avoiding and Ending: teach the appropriate comments and behavior to maintain, end, or avoid an interaction.

Focus on areas such as topic selection; repertoire of interests that can be discussed; ways of marking topic shifts; conversational expectations, i.e. turn taking, listening, building on what is said;

reading of social cues; eye contact; posture; volume; inflection; and generalizing to different settings.

My child with Asperger's Disorder is sometimes teased and rejected. What can I do to help?

To address bullying or child being teased, teach your child any number of simple and easy-to-use diffusing strategies to avoid worsening the situation. In that regard, it tends to be counter-productive for child to become defensive or argumentative when teased but, rather, it's often best for child to respond to the teasing in an unemotional, nonchalant, and agreeable manner. A sense of humor also tends to be quite helpful. Clearly, the child becoming emotional and upset only 'adds fuel to the fire.' It can 'take the wind out of the sails' of the teaser if there is no subsequent argument or emotionality from the would-be "victim" of the teasing. It will also be important to work with school staff to ensure that, while they protect all students from physical danger, they do not take sides when faced with accusations of minor teasing. In that regard, taking sides and punishing only worsens the subsequent teasing given that, after being punished, the "bully" tends to seek revenge on the "victim." However, if the minor teasing is managed effectively by the child and teacher, the situation can be easily diffused and future teasing averted. Please contact this psychologist for more information about specific techniques and/or review the resources listed below.

Grooming and hygiene are a challenge. Any Suggestions?

Grooming and hygiene skills can be addressed through a consistent "self-help routine" targeting neglected areas (brushing teeth, combing hair, bathing...).

A daily schedule, or picture schedule, may be helpful.

A reinforcement schedule is advised to increase independence with a decrease in prompts over time.

What about toilet-training?

Toileting issues can be addressed as follows:

Assess readiness (dry for at least two hours, regularity to voiding, pause while wetting or soiling, expresses interest or curiosity about bathroom; comes into bathroom and initiates behavior; can tell difference between clean and dirty diaper; knows when he has to go; can follow simple instructions; is willing to follow simple instructions). However, not that, even in the absences of some of these readiness factors, some steps of the toileting process can be broached.

Use Systematic Toileting Training Approach:

Analysis: maintain elimination record; assess ability to complete various toileting tasks such as enter bathroom, pull down clothes, sit on toilet independently, get toilet paper...)

Goal Training: start with simple, one-step goal, e.g. pull down and up his pants when you first bring him to the toilet. Other simple goals can include flushing, turning on water, squirt hands with soap, rub hands together, rinse hands off, shut off water, dry hands...)

Habit Training: is used when it's difficult to determine clear toileting patterns. Try to establish a toileting time for your child, based on information from elimination record. Child is placed on toilet at regular intervals with reinforcement provided after voiding. You may need to use a visual schedule to help your child adapt to new toileting routine.

Initiation Training: working toward creating an awareness of toileting needs and child initiating trips to bathroom. Notice facial and other cues of need to void, provide verbal prompt/reinforcer.

Night-time training: Last and sometimes most challenging step given that children sleep upwards of 10-12 hours. May decrease liquids before bedtime, wake child up later in the evening/night-time to void (but not optimal if child has trouble going back to sleep), and various moisture alarms. However, all of these strategies have draw-backs that can be discussed with this psychologist.

Chaining and backward chaining techniques may be helpful for skill acquisition. This involves breaking the whole task into small steps and teaching one small step at a time. Sometimes it helps to teach the last step first, and then work backwards ("backward chaining"). For example, drying hands as the last step in toileting process.

Grooming and hygiene skills can be addressed through a consistent "self-help routine" targeting neglected areas (brushing teeth, combing hair, bathing...).

A daily schedule, or *picture schedule*, may be helpful.

SOME HELPFUL RESOURCES THAT CAN BE FOUND AT THE C.P.C. LIBRARY LOCATED AT LOCAL OFFICE:

Addressing Shyness and Social Anxieties

- Talk to Me: Conversation Tips for the Small-Talk Challenged (Honeychurch & Watrous)
- 10 Simple Solutions to Shyness (Antony)

Developing friendships

- Good Friends are Hard to Find: Help Your Child Find, Make and Keep Friends (Wetmore)
- Social Stories and More Social Stories (Gray)
- The New Social Story Book, Illustrated Edition (Gray)

Dealing with Bullies (Avoiding being a "Victim")

- Bullies to Buddies: How to Turn Your Enemies into Friends (Kalman, I)
- www.Bullies2Buddies.com

Sibling issues:

- Siblings Without Rivalry (Faber & Mazlish)
- Bullies to Buddies: How to Turn Your Enemies into Friends (Kalman, I)

- www.Bullies2Buddies.com

Sleep problems

- Solve your Child's Sleep Problems
(Ferber)

Toileting

- Toilet Training Autistic Individuals
in 21 Days: A Guide to Effectively
Potty Training Individuals on the
Autistic Spectrum (Steven, J)

Learning Disabilities

- Learning Disabilities Association
of America
(<http://www.ldanatl.org>)

Additional Internet Resources

- communitypsychiatriccenters.com
(Website provides dozens of links
for information on many childhood
disorders and related resources)