



# AUTISM NEWS

of Orange County  
& the Rest of the World

Spring 2012

Volume 6, Issue 2



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**COVER FEATURE**

We are pleased to feature one of our local artists, **Jacob Tan**. Read more about Jacob on page 26.

**Mission Statement**

*Autism News of Orange County & the Rest of the World* is a collaborative publication for parents and professionals dedicated to sharing research-based strategies, innovative educational approaches, best practices and experiences in the area of autism.

**Submission Policy**

The Autism News of Orange County–RW is available free of charge. The opinions expressed in the newsletter do not necessarily represent the official view of the agencies involved.

Contributions from teachers, therapists, researchers and relatives/children of/with autism are welcome. The editors select articles and make necessary changes.

Please submit articles in Microsoft Word using font size 12, double spaced, and no more than four pages in length (2600 words). Photos are encouraged and when submitted with articles the permission to include is assumed.

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## Editorial

By Vera Bernard-Opitz

The current issue of the Autism News focuses on Early Assessment and Intervention - a topic which touches not only families, diagnosticians, and interventionists, but also policy makers and service providers. How can we recognize early signs of autism in infants and young children and start intervention as early as possible? Which intervention can help when an infant lacks early communicative and social behaviors, such as looking at his parents, smiling in response to their smiles, sharing his small joys and troubles in social interactions, or pointing to share his experiences? And – if all these normal skills don't develop at the expected time - what exact behavior should be targeted? Or to put it in behavioral terms, what behavior is “pivotal to major developmental progress and behavioral change?” And which method is appropriate and effective for this age group?



*Example of the Early Start Denver Model of autism YouTube: Logan\_PattyFeet.mp4*



*Speech Therapy at 22 months  
<http://www.youtube.be/watch?v=WyQ8a1nqWJk&feature=fwrel>*

Since we are starting something very new we may also need to consider critical questions such as the following:

- Can assessment ever be done too early? How stable is a diagnosis made at the tender age of three to six months?
- Are there possible side effects to well-meant

campaigns for early recognition of autism, such as worrying new parents by exposing them to the “red flags for autism,” sometimes even before their child is born? Flyers with headlines such as “Could it be autism?” surely leave their “worry-traces” not only in pregnant moms, but often also in grandparents, other relatives and

friends. Most of our colleagues assume that the benefits of early assessment outweigh the risks of false alarms – and we hope that this is true.

- It has been shown that ABA and structured teaching have made an enormous difference in the lives of individuals with autism. Do we have sufficient comparison studies, however, to justify early intervention with infants? If so, which method with which behavioral target should be used for how many hours a day?
- Two YouTube examples of interventions before the age of 24 months have been a highlight of my recent workshops in Germany. The video from the Early Start Denver program “Patty Feet” shows a child-initiated sophisticated interplay between an infant and a therapist, while the video “Speech Therapy at 22 months” shows a therapist-directed behavioral interaction using physical prompts and behavioral contingencies. Both demonstrate interventions that have different underlying philosophies but clear positive effects. **Matching the right method to the prerequisites of young children obviously needs more data and research evidence.**

While the current issue of the Autism News cannot answer all the questions involved, it sheds some light on the above discussion points.

- In the first article **Barry Grossman and Ruth Aspy** – authors of the Ziggurat Model - describe

an assessment tool that is designed for children from three months through 72 months. It is laudable that the authors do not focus solely on developmental milestones, but include the child's strengths as well as parental concerns.

- **Rebecca Hernandez** presents Help Me Grow, a joint project of UC Irvine Department of Pediatrics and CHOC (Children's Hospital of Orange County), which is funded by Orange County United Way (OCUW), to provide developmental screening and monitoring to siblings of children diagnosed with an Autism Spectrum Disorder (ASD) from age 2 months to five years.
- Regarding pivotal skills in early intervention, previous research has stressed the crucial role of attention in young children with autism. **Elena Patten and Linda Watson** from the University of North Carolina differentiate various types of attention (such as orienting, sustaining, shifting and joint attention) and summarize specific strategies for enhancing attention. An interesting finding is that regardless of the teaching method (ABA, milieu teaching, pivotal response training) or the interventionists (therapists, parents, grandparents) children benefitted when interventions focused on improving attention.
- **Eva Hegewald** from the Autism Center in Alfeld, Germany, shares impressions from an integrated kindergarten program. Photos of the center show how orientation and interaction for children with autism and other developmental problems can be facilitated through architectural and play equipment design.
- **Christine Arens-Wiebel** from the Autism Center in Bremerhaven, Germany, summarizes four years of early intervention on the development of a child with autism. A comprehensive program emphasizing child training as well as family involvement is presented.
- **Catherine Gutshall** from the CARD Program presents strategies for selective eating – a problem frequently faced by parents of young children with autism. Her intensive interven-

tions demonstrate that behavioral intervention can make a big difference in daily challenges.

- **Bobbie McIntyre** shares her sadness about the limitations her children affected by autism face, and also the joy of finding new opportunities. Her article, "Red Tandem Bike," can be seen as a symbol for exploring different ideas, being ready for the unusual and celebrating the unexpected joys along with our children.
- Last, but not least **Lee Hong Eng** from Singapore shares her son's interest in art. Since I had the opportunity to follow Jacob's development from a young, bouncy child into a talented young man, I specially appreciate the story "I want to become an artist," Thanks Jacob, for your outstanding cover picture!

We thank all our authors for their contributions and our supporters for their generous support, all of which have made ANOC 17 possible. **The next issue of the Autism News will focus on Social Skills Programs, but again depends on your donations.**

Wishing you all the best for the new year.

**Vera Bernard-Opitz, Ph.D.**

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**AUTISM NEWS**  
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January 2004 Vol. 1, Issue 1

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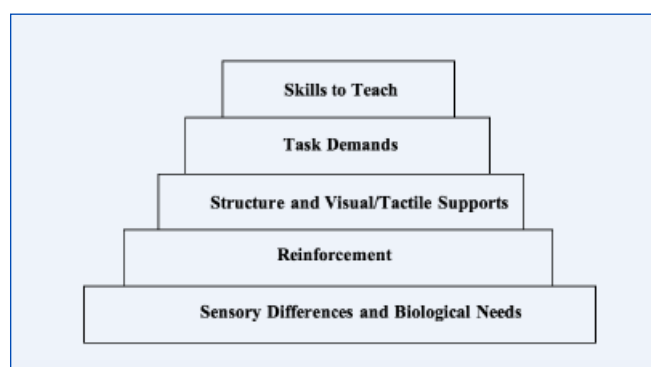
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## Assessment for Early Intervention from Three months through 72 months: The Early Intervention Underlying Characteristics Checklist

By Barry G. Grossman & Ruth Aspy

As educators and parents strive to develop meaningful educational opportunities for individuals with Autism Spectrum Disorders (ASD) it is important to begin with a thorough understanding of the child's needs. This can be accomplished through the use of the Underlying Characteristics Checklist (UCC), a component of the Ziggurat Model (Aspy & Grossman, 2011a). The Ziggurat Model provides a comprehensive framework for designing interventions for individuals of all ages with ASD. This article will focus on its use in early intervention. The premise of this model is that underlying needs and characteristics related to the autism spectrum must be addressed. Therefore, the Ziggurat Model is designed to utilize a child's strengths to address true needs or underlying deficits that result in social, emotional, and behavioral concerns. The Ziggurat Model, whose name is derived from its multi-stepped pyramid shape, centers on a hierarchical system, consisting of five levels that must be addressed for an intervention plan to be effective (see Figure 1).



**Figure 1.** The five levels of the Ziggurat Model.

*The Underlying Characteristics Checklist – Early Intervention (UCC-EI)*

The UCC is an informal tool created to identify characteristics of ASD for the purpose of intervention design. Specifically, it was developed as the first step in linking an individual's ASD to interventions. There are three forms of the UCC for use with indi-

viduals across the lifespan (Aspy & Grossman, 2011b). The high functioning (UCC-HF) and classic (UCC-CL) versions are designed for individuals from six years through adulthood. The newest version is the UCC-Early Intervention (UCC-EI) is designed for individuals from three months through 72 months (Aspy, Grossman, & Quill, 2011).

**Research shows that early intervention of ASD is critical to improved long-term outcomes** (Dawson & Osterling, 1997; Eikeseth, Smith, Jahr, & Eldevik, 2007; Harris & Handleman 2000; Ingersoll, 2011; Lord, 1995; McEachin, Smith, & Lovaas, 1993; Rogers, 1998; and Smith, Groen, & Wynn, 2000). **Thus, early identification of symptoms is essential.** Because early intervention makes a critical difference in the progress of individuals with ASD, delay in identification is a matter of great concern. Unfortunately, there are few instruments available to identify ASD in children at 18 months or younger. Delays in identification are especially common for higher functioning individuals with ASD. Often these individuals do not present with classic symptoms at a young age and therefore may miss opportunities for early intervention. If these children receive services at all, it is often not until the end of the elementary school years or later.

The goal of closing the gap between onset of symptoms and diagnosis presents many challenges. Nadal and Poss (2007, p. 409) state that “early detection of ASD is . . . difficult because symptoms during infancy may be more difficult to detect or may present differently from manifestations of the disorder at later stages (Baranek, 1999).” Because there are no medical tests for ASD, identification is based on observation of behaviors and developmental history. While the use of a system, such as the Diagnostic and Statistical Manual (DSM), has been shown to aid in accurate identification (Klin, Lang, Cicchetti, & Volkmar, 2000), the characteristics of

ASD outlined in the DSM are not as sensitive when applied to children under the age of three (Volkmar, Chawarska, & Klin, 2005) and some of the criteria are not applicable for this young population (Stone, Lee, Ashford, Brissie, Hepburn, et al., 1999). Use of the UCC-EI provides a way to more appropriately serve children at a younger age even when their diagnostic picture remains unclear.

In most early childhood programs, children are identified and served based on evaluation of developmental delays. **Not all disabilities can be detected through examination of milestones alone.** In fact, many young children with ASD, especially those who meet the developmental milestones in communication, are often not identified through this approach. Furthermore, use of milestones alone fails to identify *all* concerns that require intervention. For example, **significant tantrums, obsessive interests, or sensory differences may not be identified through the use of developmental milestones;** however, these concerns should be recognized and addressed. An approach to serving children who are not obviously failing to meet

specific developmental milestones or those whose atypicalities are not included in the traditional developmental curriculum is needed.

The UCC-EI was developed to fill this void by not only taking into consideration the developmental normative data typically used to determine eligibility for early childhood programs, but also atypicalities and concerns that may be characteristic of ASD. A childhood checklist may inquire about the age at which a child started speaking in phrases, whereas the UCC-EI includes multiple items that examine the child's use of phrases as well as the quality of the utterances (e.g., presence of idiosyncratic language, echolalia, and joint attention deficits). A typical screening instrument may include the age at which the child begins parallel play with peers; however, the UCC-EI also takes into account the objects with which the child plays, the quality of the interaction with peers, and the child's ability to transition between play schemes. Atypicalities in these and other areas, such as hyperlexia, are not delays that would be detected through a developmental checklist but are *very* meaningful.

**The UCC is comprised of 104 items in eight areas.** The first three represent the autism spectrum triad, *social, restricted patterns of behavior interests and activities, and communication.* Characteristics often associated with ASD are addressed in the next four areas: *sensory differences, cognitive differences, motor differences, and emotional vulnerability.* The eighth underlying area is *known medical and other biological factors.* Designed to be completed by parents, teachers, or other service providers, individually or as a team, the UCC-EI items describe the behaviors associated with ASD.

A *Notes* column provides a space to describe how a given characteristic is expressed in an individual. Information in this column may include specific examples, frequency of behavior, common antecedents or triggers, and so on. While the UCC provides a snapshot of the autism in an individual, the *Notes* section helps to bring clarity to this picture. Further, this information aids in communicating with others involved in intervention and becomes a basis of comparison for follow-up.

## Good Idea Corner



Bedtime can be made more attractive by turning interests and fascinations into wallpaper and bed-sheets. We appreciate this idea and photo from Arno and Sabine Klemm. ♥



The UCC-EI contains a column entitled, *Age of Concern*. Because some behaviors, such as babbling or mouthing objects, are typical at certain phases of development and of significant concern during other periods of development, it is important to take this into consideration when completing the checklist. This column describes the age at which the specific behavior is of concern. In addition, to understanding the manifestation of an individual child's ASD, it is also essential to have an adequate description of the young child's strengths and emerging skills. The UCC-EI incorporates two ways to document these-- **the Individual Strengths and Skill Inventory and the Description of Mastered or Developing Skills** column. With this knowledge, program planning can include interventions that address needs through strengths.

When Leigh Ann was 22 months old, her parents noticed that she was not interacting with other children at daycare and that she was often distressed by loud sounds. Leigh Ann's parents were worried that her language appeared to be limited compared to that of other children in her class. Also, she did not seem to enjoy games like peek-a-boo and spent most of her time playing alone. Leigh Ann is now 4 years old and attends a public school early childhood program. The school evaluation team identified her with ASD and speech impairment. Leigh Ann's evaluation report describes many characteristics related to ASD. She communicates using 4- to 5-word sentences. She does not seem interested in others and often withdraws from group activities. When she plays near peers, she often takes their toys from them and does not seem to notice when they cry as a result. Eye contact is fleeting. At home, Leigh Ann often prefers solitary activities. When she does initiate social interactions with adults and peers, it is usually in order to have her needs met (e.g., requesting preferred objects or food), to point out sparkly objects, or to get others to join her as she recites the names of the

Area	UCC-EI Item	Age of Concern	Developmental Data According to Source	Health Watch Data According to Source
	1. Appears to be unresponsive to others (e.g., unaware of presence of others)	<b>4 months</b> Mark only if child is at least this age.	<b>3 months</b> – enjoys playing with others and sometimes cries when playing stops; imitates movements, facial expressions, and sounds; <b>7 months</b> – social play and responds to people's expression of emotion; <b>1 year</b> – exhibits preferences for people and toys; <b>24 months</b> – is enthusiastic about the company of other children (CDC, n.d.)	<b>2 months</b> – does not smile at the sound of caretaker's voice; <b>3 months</b> – does not smile at people; does not pay attention to new faces; <b>4 months</b> – does not try to imitate any of caretaker's sounds (AAP, n.d.) <b>3 months</b> – does not smile at people; <b>4 months</b> – does not try to imitate any of caretaker's sounds; <b>7 months</b> – shows no affection for the person who cares for him or her; does not seem to enjoy being around people; does not respond to sounds around him or her; does not try to attract attention through actions; <b>8 months</b> – shows no interest in peek-a-boo (CDC)

**Figure 2.** Sample of UCC-EI item with research

Careful to provide empirically sound information regarding autism and typical developmental milestones, the UCC-EI includes the sources from which all development milestones were derived. A sample of one UCC-item in the Social Domain that addresses responsiveness to others appears in Figure 2.

*Case Study*

A brief case study of a toddler illustrates the use of the UCC-EI.

UCC-EI Items	
1. Appears to be unresponsive to others (e.g., unaware of the presence of others)	33. Becomes upset easily with interruption to routines or unanticipated changes in events (e.g., taking a different route to a destination, moving a familiar object from "its place," using a different color plate for meals)
11. Has difficulty using and perceiving nonverbal communication (e.g., tone of voice, gestures, facial expressions)	53. Does not spontaneously comment or share experiences – may speak only when asked a direct question
14. Isolates self from others or chooses solitary play consistently and across settings	54. Has difficulty with basic rules of conversation (e.g., asks inappropriate questions, makes poor eye contact, has difficulty maintaining conversation, wants to talk about own interests exclusively)
29. Displays difficulty engaging in activities other than intense special interests	60. Often responds in a developmentally unusual manner to sounds (e.g., reacts as if has no hearing, ignores some sounds, turns up volume on TV, bangs toys and objects, or overreacts to noises such as crowds or sirens)
Individual Strengths and Skills Inventory: Social	
<ul style="list-style-type: none"> <li>Leigh Ann initiates some social interaction – she tells others about her princess dolls, points out "sparkly" objects, and prompts others to recite the names of Disney princesses and movie lines.</li> <li>She is able to identify some basic emotions of characters in movies.</li> <li>Leigh Ann will initiate short hugs with familiar people.</li> <li>With prompting and assistance, she will participate in group activities and play with others.</li> <li>She plays with her sisters and responds to parent praise.</li> </ul>	

**Table 1.** Excerpts from Leigh Ann's UCC-EI

Disney princesses.

Leigh Ann requires prompting to engage in play and extended social interactions that are not related to her interests. Leigh Ann’s parents say that she has some repetitive and narrow interests. For example, she watches the same Disney princess movies for hours and often recites lines or acts out scenes from the films. She occasionally asks her parents or sisters to join her in reciting lines; however, she becomes upset if they do not recite them exactly as they are in the movie. Leigh Ann has a princess backpack that she insists on carrying with her when she leaves home. It is filled with princess dolls, dress-up clothing, and activity books. She often lines up her princess figures according to clothing color and height. Leigh Ann’s multidisciplinary team, including her parents and teachers, met to develop a new program for her.

The team began by completing the Underlying Characteristics Checklist – Early Intervention (UCC-EI) and Individual Strengths and Skills Inventory (see Table 1). Once priorities were established using steps outlined in the Ziggurat Model, Leigh Ann’s team developed meaningful interventions using the Ziggurat Worksheet. A summary of UCC items and interventions is provided in Table 2.

They began by reviewing interventions currently in place – those that addressed selected UCC items (priorities) were included on the worksheet. Other strategies were considered to be off target and were not included in Leigh Ann’s comprehensive plan. Next, they created new interventions – making sure that each UCC item was well addressed and that sufficient strategies were developed for each level.

**Summary**

Information gathered through use of the UCC-EI helps parents and professionals to plan an individualized comprehensive program using the Ziggurat Model, perhaps even before the child is diagnosed.

Selected Underlying Characteristic	Intervention/Support
1. Appears to be unresponsive to others (e.g., unaware of the presence of others)	<ul style="list-style-type: none"> <li>Parents may set up play dates for Leigh Ann. Select an activity that both children will find enjoyable. Keep the play date brief to help ensure success. Build in reinforcers and make sure that Leigh Ann knows what she is working for. Supervise and narrate during the play to assist. Video the play and review with Leigh Ann.</li> </ul>
11. Has difficulty using and perceiving nonverbal communication (e.g., tone of voice, gestures, facial expressions)	<ul style="list-style-type: none"> <li>Use video, such as clips from Disney princess movies, to teach about emotions and their causes. Emphasize cause and effect – pointing out how the characters feel and what caused them to feel that way. Narrate clips from Disney movies. For example, say, “She is smiling. She is happy because ____.” He is yelling. He is mad because ____.” Help Leigh Ann to generalize to real people in real situations.</li> <li>Exaggerate your own facial expressions for Leigh Ann. Narrate and describe them. For example, say, “I’m smiling because I’m so glad to see you this morning.”</li> </ul>
14. Isolates self from others or chooses solitary play consistently and across settings	<ul style="list-style-type: none"> <li>Structure play activities to include at least one selected/trained peer. Use activities involving Leigh Ann’s interests, such as princess activity books.</li> </ul>

**Table 2.** Excerpts from Leigh Ann’s comprehensive intervention plan

Further, assessment of underlying characteristics provides insight into which skills should be taught and how to design instruction in order to facilitate learning and bring about meaningful and long-lasting change. The UCC-EI offers an effective way to begin program planning by providing a comprehensive perspective.

**Note:** The Underlying Characteristics Checklist – Early Intervention (p.20), by R. Aspy and B. Grossman with K.A. Quill, 2011, Shawnee Mission, KS: Autism Asperger Publishing Company. Copyright 2011 by AAPC. Reprinted with permission. [www.aapcpublishing.net](http://www.aapcpublishing.net)

Dr. Grossman and Dr. Aspy are Licensed Psychologists who have founded the The Ziggurat Group. For further information, please see [www.texasautism.com](http://www.texasautism.com)

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## Strategies to Improve Attention in Children with ASDs

By Elena Patten & Linda R. Watson

What clinician hasn't been excited to implement a new treatment plan only to find that the plan could not be executed because the child's attention was never adequately engaged? Indeed, this can be a common dilemma when working with children with Autism Spectrum Disorders (ASDs). However, once attention is adequately captured, learning can occur perhaps even to an even greater extent than is sometimes expected.

Although research describing features of attention in children with autism is extensive, research describing *interventions* that address attention are not as abundant. Attention can be viewed in many different ways. One commonly accepted way to describe attention is in terms of *orienting* attention (the initial capture of attention that usually results in looking at a stimulus), *sustaining* attention (the ability to maintain focus of attention on a particular stimulus which allows further processing of information), and *shifting* attention (the ability to disengage from one stimulus and reorient attention to another stimulus).

**Orienting attention** is impaired in children and adults with autism (Renner, Klinger, &



*Intuitively, clinicians may address this by hiding items that are not part of the therapeutic activity or removing items that are no longer needed and quickly presenting new items in the child's visual field.*

Klinger, 2006; Townsend, Harris, & Courchesne, 1996). In fact,



research has demonstrated that children as young as eight to 10 months old fail to orient to stimuli that captures the attention of typically developing children (Werner, Dawson, Osterling, & Dinno, 2000). **Difficulty capturing attention directly impacts interventions because if we are unable to draw attention toward stimuli, the child cannot participate in any learning we target.**

**Sustaining attention** is a relative strength in that once attention is adequately captured, individuals with autism can maintain attention to a stimulus while ignoring competing stimuli (Landry & Bryson, 2004; Zwaigenbaum, et al., 2005). It is important to note that this characteristic does not necessarily mean that children with autism have superior processing in terms of what is typically expected. Consider the propensity for children with autism to focus on parts rather than on the whole object. In children with this propensity, superior processing of details may occur but gestalt information may be lost. However, unique characteristics of sustained attention might still be harnessed to create positive learning outcomes.

**Shifting attention is a two-step process: 1) disengaging from one stimulus; and 2) shifting to another stimulus.** Disengaging attention is impaired in autism (Swettenham et al., 1998; Zwaigenbaum et al., 2005) and this supports findings discussed in the previous paragraph describing superior sustained attention, which can extend so far that competing stimuli fail to result in disengagement from the current locus of attention.

A discussion of attention in children with autism is not complete without describing joint attention; shared attention between two individuals and an object or another individual. Attention orienting, sustaining and shifting attention are all included in joint attention.

Joint attention includes both responding to joint attention (i.e., someone else directing your attention to a third entity) and initiating joint attention (i.e., directing someone else's attention to a third entity).

**Joint attention** has been fairly well studied in typically developing children and children with ASDs. Studies demonstrate ties between joint attention skills and later-developing language skills in



both groups with consistent deficits found in children with ASDs (e.g., Dawson et al., 2004; Mundy & Newell, 2007; Sigman & Ruskin, 1999).

**Treatment Targeting Attention in Children with Autism**

Limited empirical evidence exists regarding intervention strategies to address attention when working with children with autism. The National

Standards Project (NSP) report (National Autism Center, 2009) produced a structured systematic analysis of the level of scientific evidence pertaining to treatment of individuals with autism. The project delineated ten treatment targets and graded the quality of evidence. Although “attention” was not specified as a treatment target, attention-gaining strategies were implicit in many of the treatment categories.

For purposes of this article, original research was identified that specifically used attention as an outcome variable (for a more detailed description of search methods and findings, see Patten & Watson 2011). Study goals could be categorized by *therapeutic interventions* (those that sought to habilitate attention in the long term) and accommodations (those that drew attention in the moment quickly and contingently).

Therapeutic Interventions. Twelve studies were identified that targeted some form of attention within a larger treatment protocol that was either naturalistic or applied behavioral in nature (e.g., Bernard-Opitz et al., 2004; for more information on each study see Patten & Watson 2011). All of these studies demonstrated that attention improved in children with autism. Joint attention was the outcome vari-

**Strategies Used in Therapeutic Interventions**

Strategy	Studies
<p><i>Child-directed play.</i> The child selected the activity, materials or topic and the adult inserted an intervention within that context. <i>Using child-directed play may be beneficial because children with autism demonstrate difficulty with disengaging and shifting attention, processes which are required more by adult-directed play compared to self-directed play.</i></p>	<p>Gulsrud, Kasari, Freeman, &amp; Paparella, 2007; Ingersol &amp; Schreibman, 2006; Kasari, Freeman, &amp; Paparella, 2006; Salt et al., 2002; Shertz &amp; Odom 2006; Vismara &amp; Lyons, 2007; Whalen &amp; Schreibman, 2003; Yoder &amp; Stone, 2006</p>
<p><i>Reinforcement.</i> Reinforcement included natural reinforcement, such as getting access to a toy after directing another's attention to that toy, or artificial reinforcement, possibly receiving a small food item for directing another's attention to a toy. Other means of reinforcing included allowing the child continued access to preferred toys or providing verbal praise.</p>	<p>Gulsrud et al., 2007; Ingersol &amp; Schreibman, 2006; Kasari et al., 2006; Vismara &amp; Lyons, 2007; Whalen &amp; Schreibman 2003</p>

<p><i>Imitation.</i> Adults imitated the child’s behavior during an intervention, such as imitating facial expressions, actions on objects and motor actions/gestures. <i>This is a simple strategy and somewhat similar to child-directed play in that the child is leading the interaction. The adult imitates the child, typically with the idea that this will result in a turn-taking activity in which the child eventually may imitate the adult.</i></p>	<p>Gulsrud et al., 2007; Ingersol &amp; Schreibman, 2006; Kasari et al., 2006; Salt et al., 2002; Shertz &amp; Odom 2006; Yoder &amp; Stone, 2006</p>
<p><i>Prompting.</i> Cuing or prompting included visual, tactile and auditory cues. <i>Prompting is part of most therapeutic interventions and is logically linked to attention. Prompting can be accomplished in many ways including more direct prompts such as physical touch as well as more subtle prompts such as gestures or single words to support attention. Cuing hierarchies are often employed beginning with the most indirect prompts and moving to more and more obvious prompts until the target behavior is attained. From that point, the goal is to fade prompts to work toward independence.</i></p>	<p>Gulsrud et al., 2007; Kasari et al., 2006; Salt et al., 2002; Shertz &amp; Odom 2006; Whalen &amp; Schreibman 2003; Zercher, Hunt, Schuler &amp; Webster, 2001</p>

able for ten studies while the two remaining studies targeted “attending to parents and therapists” and “off-task behavior.” Specific strategies were often mentioned within designs but unique contributions of strategies were difficult to ascertain due to the global nature of the intervention. However, several strategies emerged across multiple studies that were linked to improvements in attention.

Other strategies targeting attention were also used but with less frequency. Those included: 1) environmental manipulation, such as placing a desired item in a tightly closed jar so that the child would have to request assistance to get the item

(Kasari et al., 2006; McDuffie et al., 2006; Yoder & Stone, 2006); and 2) linguistic mapping, in which the adult talks about what the child is doing (Ingersoll & Schreibman, 2006; Kasari et al., 2006; Salt et al., 2002).

Accommodations. There are often times that gaining attention immediately for the sake of teaching other specific skills is necessary. We can view such strategies as “accommodations” and they are commonplace in educational settings. For example, an accommodation for a child requiring assistance in guiding attention is to provide preferential seating to increase the salience of the lesson being taught. Five

**Strategies Used to Accommodate Interventions**

Strategy	Study
A combination of a verbal cue (the word “look”) plus a gesture (pointing) improved looking to objects upon request.	Leekam et al. (1998)
Child-centered play and imitation improved joint attention (see “therapeutic interventions” above). In this experimental design, adults imitated or expanded the child’s play using an identical set of toys.	Lewy & Dawson (1992)
Using labels when referring to novel objects drew attention to the objects compared to using child-directed speech without labeling.	McDuffie et al. (2006)
Token reinforcement increased attention but returned to baseline when removed. Tokens were stickers used to earn a break.	Tarbox et al. (2006)
Using the child’s perseverative interests as targets improved joint attention.	Vismara & Lyons (2007)

studies were identified that specifically assessed strategies used to accommodate attention. Strategies echoed those mentioned above in the “therapeutic intervention” section but because each accommodation was investigated as a single component, conclu-

evidence-based practice for the treatment of children with ASDs.

This article has been adapted from Patten and Watson, 2011, published in the American Journal of Speech-Language Pathology, an American Speech-

### **In sum, the following empirically-based strategies can be feasibly employed in most broader treatment protocols:**

- 1) **Toys should be chosen that are of interest to the child in order to encourage attention naturally. Parents and teachers are an ideal resource for discovering these. Clinicians should beware of triggering a perseverative behavior, which may cause the child to become over-focused on an object to the exclusion of intervention goals.**
- 2) **Allow the child to select from a small offering of objects and follow up with communication and interventions around the child’s locus of attention.**
- 3) **Imitate the child’s actions on objects in an attempt to elicit reciprocal play. If the child is resistant to releasing objects, try having an identical set of objects to mirror the child and work toward reciprocal imitation.**
- 4) **Use specific labels when talking about the objects in the child’s locus of attention.**
- 5) **Use multimodal prompts, such as combining visual and verbal cues or tactile and visual cues.**
- 6) **Provide natural or artificial reinforcements for attention. Remember that token reinforcement might increase attention in the short term and allow a window of attention during which learning may improve, but attention may wane when token reinforcement is removed.**

sions regarding efficacy can be drawn with more confidence. Specific accommodations that resulted in improvements in attention are in the chart below.

#### **Summary and Clinical Implications**

Although research identifying and testing therapeutic strategies to specifically address features of attention in children with autism is not exhaustive, some empirically validated studies do exist. The available evidence suggests that, regardless of the larger treatment design being used (e.g., ABA, mileu, pivotal response), children with autism benefit from intervention directed at improving attention. Also, children appear to benefit regardless of whether the intervention is provided by parents, clinicians or peers.

Using wisdom gained from their experience while honoring family values and employing empirically-based strategies can help clinicians develop an

Language-Hearing Association publication. Please follow the link for access to full text:

<http://ajslp.asha.org/cgi/content/short/20/1/60>.

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# Environments for Early Intervention

## Impressions from the Autism Center in Alfeld, Germany

By Eva Hegewald

The Autism Center in Alfeld, Germany is a facility of the Lebenshilfe, which offers consultation and therapy for children with Autism Spectrum Disorders (ASD) and their families, childhood educators, and teachers. The center is located in Alfeld, Germany, which a small community with 20,000 residents located near Hannover, Germany. The architecture of the building is adapted to the needs of young individuals with autism or other special needs. The center has three full-time autism consultants, who engage in direct therapy with affected

children, but who also train others involved and organize related workshops. While the close proximity to an integrated kindergarten makes inclusion options easy, specialized treatment rooms allow for distraction-free interventions.

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*Up to eight children can swing together in the beehive.*



*Not all children with ASD enjoy the bright sunshine on the left, so environments can be adapted for different children.*

*Open spaces and retreat options, such as the beehive-swing, offer opportunities for relaxation and cooperative play.*



*Color-coded buildings are easy for young children with autism to find*

*Wall decorations can be used for play and interaction. As a simple example, one child drops a marble into the hole and another other catches it.*



## Intensive Early Intervention in the Autism Therapy Center Bremerhaven

By Christiane Arens-Wiebel

Specialists and parents agree that there is an urgent need for early intervention for children with ASD. Early intervention services have been developed to a greater extent in the U.S. and England, but are also present in Spain, Canada, Norway, Poland and Germany. Since Ivar Lovaas first began using behavioral intervention, the positive effects of Early Intervention Programs have been scientifically documented (Lovaas et al, 1981, 2003; Eldevik et al, 2006). Typically six to eight hours of one-on-one behavioral therapy are conducted per day, providing an average minimum of 30 hours of intensive treatment per week.



Children have a better chance of reducing autistic behavior problems during the first three years of rapid brain development, since their brain is more flexible. Progress tends to depend on the age of the child and the intensity of treatment. Children start to learn in an effective manner when their self-stimulations are replaced by functional activities.

### Intensive Early Intervention in Bremen

Since 1984, early intervention has been established in Bremen as a primary service (Cordes, 1985). In comparison to the more common “one therapy hour per week” schedule, more than 40 children below the age of four received between four and twelve sessions per week. In the beginning, the par-

ents and staff of the local preschools were concerned about possible stressors through intensive treatment, but soon found the intensive interventions were helpful for the children.

Since 2000, all children with ASD between the ages of one and three years receive two-hour interventions at least three times per week with a therapist from the Autism Therapy Center Bremen or Bremerhaven. If possible, trained psychology or special education students from the University of Bremen spend an additional two to six hours with the children as part of their practicum. The students have been introduced to autism, behavior therapy, sensory-motor integration and Affolter intervention. Parents and all other co-therapists are regularly supervised.

M-CHAT for Richard, at two years two months  
02/07

- No pretend play
- No proto-declarative pointing
- No response to pointing
- No peek-a-boo game
- No functional play
- Little eye-contact

A team of experienced psychologists and social educators assesses the child before the age of four years using the M-CHAT (*Modified CHECKlist for Autism in Toddlers*) as well as ADOS-R (*Autism Diagnostic Observation Schedule Revised*). After diagnosis, the child is admitted to Early Intervention at the Autism Therapy Center Bremerhaven, where an increasing number of two-year old children are treated.

### Program for Early Intervention

The intervention aims at structuring the day of young children in such a way that constructive activities and play are facilitated. Depending on individual cases, the program aims at 15 to 30 therapy hours per week. Everyday activities are used to enhance fine-motor, communicative and social skills. During the therapy time the child works in a one-to-one sit-



uation with a therapist, a co-therapist or a parent. Intervention at the table usually lasts 15 to 30 minutes with sensory-motor or gross-motor breaks in between. Usually up to three hours of intervention are possible before a longer break is needed. Children also have the opportunity to get involved in “regular” activities, such as walks with their parents, playground or swimming activities.

Before the beginning of therapy intensive observations and testing are conducted. This helps to get an overview of the developmental age, skill profile with its strengths and deficits as well as behavior problems. Based on this and parent information a comprehensive therapy plan is developed. The first therapy sessions focus on communicative events, which are highly motivating. Behavioral intervention methods are systematically introduced with the following **long term aims**:

- *Imitation*
- *Verbal and non-verbal communication*
- *Cognitive skills/attention/concentration*
- *Play and social behavior*
- *Perception*
- *Finemotor/Eye-hand coordination*
- *Self-help*

The first therapy targets tend to be eye *contact and simple imitations*, since attention to social cues and imitation are important prerequisites for the development of communication, social and play skills. Training of gross motor imitation is supple-

mented by tasks for the development of fine-motor, oral-motor and sound imitation as well as the development of speech.

**Observation report of Richard on Language and Communication, June 2007**

*Richard communicates his requests through crying or pulling his interaction partner. His vocalizations vary: he rarely speaks a meaningful word, and if he does, he only says it once. Rare utterances are: “oh,” “there,” “cookie,” “thanks,” “tita” (ticking of clock), “hya, hya” (fire engine). He does not imitate sounds nor words. He sometimes hums – even correct tunes of children’s songs – especially when relaxed. He understands simple instructions, such as: “Give,” “sit down,” and “pick it up.”*

*He does not understand receptive labels, such as everyday objects, animals or bodyparts.*

**Example for therapy targets in Communication in July 2007:**

- *“Want” with sign*
- *Sound imitation*
- *Receptive objects, persons and body-parts*

Children who fail to respond to the above programs are exposed to **object-communication, PECS (Picture Exchange Communicative System) or hand-signs**. Often a combination of various communication systems has been helpful. Some children are able to use signs to communicate basic needs (such as eating, drinking and playing), while requesting specific food or drink items is facilitated through photos or symbols of food (e.g. banana, cookie), drinks (milk, water) or toys (spinner, marbles). Often children start to talk once they are exposed to a non-verbal communication system.

Besides the development of expressive communication, children also are trained in **receptive skills**. Simple instructions, such as “come here,” “sit down,” “get the ball,” “wait for Mom” or “go to the kitchen” are targeted, just as well as understanding of everyday objects and their features. Children also practice comprehension of body parts on themselves,

the therapist, a photo or an animal. All training aims at generalization of learned skills, so that a child knows, that any nose is labeled “nose” and that even short legs of a dog are still called “legs.”

**Cognitive skills, attention and concentration** are improved through a variety of educational toys, such as puzzles, pegboards, or sorting tasks. Children learn to match and sort objects, pictures, colors, shapes or sizes. In recent years TEACCH methods



and materials have been used, such as shoebox or folder tasks.

**Social interaction and play** with children as well as adults are other important therapy targets. Many children with autism often remain at a **basic level of manipulative or combination play**, meaning that they knock objects on the table, wave them in front of their eyes, throw them, insert, stack or line them up. Often they require intensive

training programs to engage in **functional or pretend play**. They may learn to comb the doll’s hair, or pretend that the doll feeds itself; they may also learn different sequences of car or animal play. Through massed drills children in our early intervention have learned to engage in spontaneous pretend and role-play, such as setting the table for the dolls, pretending to pour juice and to feed the doll. Functional reinforcers, such as feeling the car on one’s hands, hearing a car siren or a friction motor are often more useful than artificial consequences, such as gummy bears.

### Parent and social environment

Parents, families and the social environment are highly involved in the above efforts. Parents tend to be receptive about new teaching ideas, training and supervision. Involving parents in early intervention efforts can prevent that behavior problems become fixated and that parents give up because their child is difficult.

### Important components of parent and social environment are

- Basic parent consultation and supervision
- Regular parent training
- Improvement of parent-child interaction
- Team meetings of parents and therapists
- Psychological support to cope with the disability
- Involvement of siblings and grandparents

Parents are introduced to the theory and practice of autism and interventions (e.g. behavior therapy, sensory-motor therapy, communication training). To make support through other parents possible, meetings are arranged as group meetings. Weekly training sessions with children are conducted so that theoretical knowledge is translated into functional training tasks with their own child.

Team meetings are held to exchange information and ideas and to discuss problems and methods. Besides supporting the parents, siblings and grandparents are involved in discussions. They are also





*At the age of four years Richard collected more than 100 buttons and sewed them on a piece of cloth.*

invited to participate in therapy sessions. Since 2002 a sibling support group meets regularly and discusses problems and highlights of living with a brother or sister with a disability.

### **Results of the Early Intervention Program**

Most of the children involved in our Early

Intervention Program have made good progress. About 80% have developed verbal communication; the remaining have developed handsigns or PECS with some being proficient with an electronic talker. Cognitive functioning has also improved. Some few children have even developed to the level of “high functioning autism” and attend regular schools. A comment by a regular school teacher: *“I have noticed that Fabian has been in intensive early intervention. He cooperates well, understands instructions and is highly motivated in class.”*

#### ***Developmental level of Richard after four years of intensive treatment***

- *Talks in complete sentences*
- *Asks and answers questions*
- *Completes tasks independently*
- *Has started to write and read*
- *Is still obsessed with certain rituals, such as taking out and collecting light bulbs.*

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## **Normalization.... A Different Perspective**

**By Vera Bernard-Opitz**

If I could do nothing but feel,  
I would want to feel everything:  
The wind in my hair, the rain on my face,  
the grass under my feet.

If I could do nothing but hear,  
I would want to hear everything:  
The voices of animals and people,  
The words and explanations,  
The music of the world.

If I could do nothing but see,  
I would want to see everything:  
The sun, the moon and the stars and even  
The inside of a car wash.

If I had problems thinking,  
I would hope for some structure:  
Concepts that could organize my perceptions,  
Situations I could understand.

If my hands could not help me,  
I would rely on someone else's hands:  
Hands that would help me to act,  
And would help me to help myself.

If I could not make my needs known,  
I would hope for someone to understand:  
Someone to read my thoughts  
Or someone to understand my handsigns.

If I could only live,  
Would I be able to live?  
What would normalization be? ♥

## The Issue of Selective Eating Among Children With Autism Spectrum Disorders

By Katharine Gutshall

Eating is a behavior that we often take for granted. It seems so intuitive – we get hungry or something tastes good, so we eat! Unfortunately, enjoying a healthy variety of foods in our diet is not always so easy for children. It has been estimated that up to 25% of all children display some type of feeding problem. Among children with developmental disabilities, that estimate jumps to over 75% of the population. Feeding disorders are incredibly common and can be a huge stressor in the lives of the child and his or her family. Unfortunately effective treatment options are not as wide-spread as the problem, but they do exist.

Traditionally, the term feeding disorders refers to when a child does not consume enough food or liquid to grow adequately, when a child becomes extremely selective in the food he or she will eat based on a specific variable (such as color, texture, temperature, or type), and/or when inappropriate behavior such as tantrums occur during mealtime. Other oral motor issues may also be present, such as the inability to properly manipulate food within the mouth or close the lips around a cup or spoon. All of these issues can be seen in children with Autism Spectrum Disorders (ASD). Additionally, possibly due to hallmark symptoms of autism, children with ASD may show inflexibility around the eating location, utensils used, brand of food eaten, or even how a food is prepared.

**The clear cause(s) of feeding problems is unknown at this time.** It is currently thought that the cause(s) may be complex and interrelated. For some children, **biological (or organic) factors** are known. These can include food intolerances, reflux, gastrointestinal issues, and malformation of the oral cavity and teeth. **Environmental (or non-organic) factors** such as behavioral learning, caregiver responses, and familial eating patterns can also affect a child's feeding. Knowing the etiology of a problem is always helpful in the treatment, however it is not

absolutely necessary before beginning an intervention.

**Within feeding disorders, a vicious cycle can occur and perpetuate.** A

child's refusal to eat may hinder development and practice of proper oral motor skills. This can in turn lead to inadequate nutrition, and, in extreme cases, failure to thrive. Malnourished children might then lack the energy needed to become capable eaters.

It is hard to overestimate the impact one child's issues with food can have on the entire family as they try to ensure that the child is getting enough nutrition. **How many different meals per day is the parent cooking for a child? How far away does the family have to shop to find that one "perfect" brand of food that the child will eat? Is the family able to eat together? Can the child eat out in the community without huge preparation?** We often find that many hours of each day are devoted to the specific eating patterns of the child. By implementing a therapeutic program which produces a healthy feeding pattern that is similar to that of the family, a great deal of stress can be removed from the life of the family.

When looking for advice on treatment, parents turn to doctors, therapists, friends, and family. Lots of differing advice is given! Luckily the literature on feeding disorders is growing. To date, treatments with the most peer-reviewed scientific support are based upon behavioral principles – also known as applied behavior analysis (ABA). Although families may know that ABA is an effective approach to address the deficits and excesses seen in autism, families may not know that ABA can be applied to feed-



ing issues as well! Although not all ABA providers have the background and training in feeding skills, more such highly trained providers are becoming available. Be sure to inquire as to what training and background your child's therapists have had in the field of feeding specifically.

Behavioral intervention has been shown to successfully increase food consumption for children with and without developmental disabilities. Additionally, **ABA has been shown to increase the variety of foods a child will eat, to increase self-feeding and the ability to chew food, and to decrease tantrum behavior during meals.** When working in conjunction with team members from other disciplines, some children with feeding tubes have been able to gain and maintain adequate weight to allow for removal of their feeding tubes.

For the majority of children, intensive, interdisciplinary approaches that use behavior-based treatments are successful both at discharge and during follow-up-studies. However, it has now been shown that less intensive intervention (two to 4 hours per week of therapy rather than four to 5 hours per day) can produce meaningful results as well. Given the long-term benefits of proper treatment and the long-term issues associated with not addressing the issue, it is clear that families need to know that assistance is available for their children's eating problems. Parents need not just "wait for the child to outgrow it." Feeding disorders can be successfully overcome!



**Case Study: Meet Elijah**

*Age at start of services: two years, 11 months*

*Diagnosis: Autism Spectrum Disorder*

*Known food allergies/intolerances: None*

*Caregivers' primary concerns: Food selectivity by type, brand*

Elijah was a child who showed significant food selectivity by food type. His diet was significantly more restricted than is average for a child of his age. He would eat only six foods in addition to three forms of "junk food." **Elijah would tantrum and gag during mealtimes when presented with non-preferred foods.** Elijah also showed inflexibility in his eating patterns as he would only eat certain brands of foods, insisted that food be presented in a specific manner (i.e., each bite of yogurt must have a topping sprinkled on it), insisted on specific utensils and bottle, and consumed foods in certain locations (i.e., grapes while in the cart grocery shopping). Additionally, although Elijah had adequate fine motor skills, he preferred for his mother to feed him.

Services were initiated for Elijah an average of three hours per week at the clinic and his home. With approximately 70 hours of therapy, **Elijah now consumes over 37 new foods while feeding himself.** Elijah finishes age-appropriate portions of foods while sitting independently at the table with his family.

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## Help Me Grow Offers Free Developmental Screening for Siblings of Children with Autism

By Rebecca Hernandez, MEd

Help Me Grow Orange County connects children from birth through age five and their families with developmental services to enhance their development, behavior and learning. By calling the toll free number **1.866.GROW.025**, parents and all providers have a single point of access to resources for all young children living in Orange County. We are a joint project of UC Irvine Department of Pediatrics and CHOC Children's, funded by the Children and Families Commission of Orange County since 2005.

Our mission is to connect young children and their families to existing resources that enhance development and behavior. Our vision is that all children entering school will be healthy and ready to learn. Help Me Grow strives to assist not only those

who would qualify for early intervention and special education services, but also those who would not. Specifically, we attempt to reach those children with milder concerns whose developmental trajectory can be improved. To assist in this goal, we offer developmental screening to target populations in Orange County to identify children at risk for delays and connect them to appropriate resources.

Research conducted by Glascoe & Macias indicates that only 30% of children with developmental or behavioral problems have been identified and referred for services before entering kindergarten. The Center for Disease Control and Prevention estimates that up to 17% of children have developmental delays and/or disabilities. Given these percentages, it is astounding that in Orange County, according to 2006 Regional Center of Orange County data, only 1.6% of children from birth through age four are receiving early intervention or early childhood services. Nationally, only 5.9% of preschool children are receiving special education services.

Currently, Help Me Grow has funding from Orange County United Way (OCUW) to provide developmental screening and monitoring to a specific target population: siblings of children diagnosed with an Autism Spectrum Disorder (ASD) from age two months to five years. These siblings are at risk for ASD and up to 30% may have delays in language, motor and cognition between fourteen months and four and a half years (The Hebrew University of Jerusalem, 2006). It is clear that easily accessible developmental screening is beneficial for early identification and linkage to further evaluation and treatment.

Help Me Grow uses the Ages and Stages Questionnaire-3 (ASQ-3), an evidence-based screening tool that accurately identifies children at risk for developmental delay. This tool measures five areas of development: communication, gross motor, fine motor, problem solving, and personal-social.



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The initial OCUW funding for this focused screening initiative was received in January, 2011, and since that date 58 children have been enrolled to receive an ASQ-3 and 30 of these children also received an ASQ: Social Emotional screening.

Once a child is enrolled, the family will be mailed a packet including an age appropriate questionnaire in the language of their choice, either English or Spanish. Parents are asked to complete the ASQ-3 in a timely fashion and mail it back in the provided business reply envelope. The completed questionnaires are scored, interpreted and results provided. If a child's results indicate cause for concern, our staff with appropriate language skills calls the child's parents to review and discuss the results. Parents are offered care coordination to help them access services for Early Intervention (EI) or Early Childhood Special Education (ECSE), community-based programs or further evaluation. The individualized care coordination continues with the parent's involvement until the child is found eligible for a service under IDEA and/or is connected to community-based services. In all cases, screening results and referral information are sent to the child's family and primary care health provider with consent by the parents. Children not referred or found eligible for EI or ECSE will continue to be rescreened using the ASQ-3 at six-month intervals through age five to ensure identification at the earliest opportunity.

Help Me Grow Orange County continues to seek families who may be interested in participating in this developmental screening opportunity. To participate the child must:

- have a sibling with an Autism Spectrum Disorder,
- be within age two months to five years, and
- live in Orange County, California

If interested in learning more about this developmental screening opportunity for siblings of children with autism, please visit [www.helpmegrowoc.org](http://www.helpmegrowoc.org) or call Help Me Grow at **1.866.GROW.025**. ♥



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## A Red Tandem Bike

By Bobbie McIntyre

My husband is from an active, outdoor family. When I first met Tim, he often kept his father company on long bike rides but soon forsook them to be with me. At the time, I felt I had robbed my future father-in-law of his best friend. Eventually, Tim and I married and had children but our two oldest children were diagnosed with Autism Spectrum Disorder (ASD). Although my husband resumed riding with his dad, the rides were few and far between.

Life with autism is often hard to bear, not only dealing with the disability itself but with the loss of potential opportunities for your child. Several years ago, my sister Kharol invited me to watch her daughter, Kyrie, perform in a color guard competition. As I watched those teenage girls glide and dance across the floor with vibrant flags waving and sabers flashing, I started to cry. I couldn't help but think that my daughter Marisa, who is severely autistic, would never be able to take part in something so thrilling.

**"I couldn't help but think that my daughter Marisa, who is severely autistic, would never be able to take part in something so thrilling."**

Of course, even if she were neuro-typical, she might have no interest in Color Guard. She might become a rebel instead, dying her strawberry-blond hair black, wearing gothic clothes and garish makeup, not to mention plenty of piercings and probably a hidden tattoo. But that girl, most likely standing at the edge of the school parking lot, telling her equally rebellious friends about her latest D's and F's in what class and which teachers she told off today, would be able to make a choice. She would have an opportunity to choose who she became...but Marisa did not have a choice.

Now, my second-oldest child is not as severely



affected by ASD as Marisa. Brendan has lots of abilities, to the delight and consternation of all who know him. He talks all the time, mostly about his own interests. We are repeatedly asked if Dr. Jekyll and Mr. Hyde live in London or if Squidward is cranky and dislikes Spongebob. But Brendan still has many limitations.

When he was younger, Brendan used to walk down the stairs leading with the same foot, left-left-left, until he reached the bottom. Now, I know all young children do this, but kids with disabilities frequently take much longer to overcome these challenges. I knew he understood right and left so I improvised. When he would walk down the steps, I called out like a drill instructor, "left-right-left-right, Brendan!" After a few years, he became successful at it. As we live in a condo, with my voice echoing off the walls and into the courtyard, I often wondered if my neighbors thought I was preparing my son for the armed services.

**"Brendan, my second oldest child, is not as severely affected by ASD as Marisa."**

That would never be a possibility for him to excel, but we tried to make sure Brendan was able to participate to the best of his ability in most activities with his peers. He was fully included during elementary school and he still attends regular elective classes, like art and computers, at his middle school. However, we've never been able to teach Brendan how to ride a bike.

The past few years have gotten relatively easier with Brendan and Marisa so Tim has started riding more regularly with his Dad and his older brother John, who had taken over as his Dad's biking companion. Occasionally their younger brother, Steve, joins them along with his two sons Ryan and Chase. This has become a Saturday morning ritual, biking down the coast to Newport Beach to have breakfast at Charlie's Chili.

Often on a Saturday morning, Brendan, who usually rises early, will be sitting at the computer, perusing YouTube as Tim gets ready to leave for his weekly ride. I'd listen to them from the bedroom, where I would be desperately trying to catch up on sleep.

"Dad, where are you going?" Brendan would ask.

"To ride with Grandpa and Uncle John." The front door would close and I would hear Tim clatter

**"I've often wondered if Brendan cared about being left out."**

down the stairs with his bike. For a while, there would be silence and then eventually I'd hear YouTube start up again. I've often wondered if Brendan cared about being left out.

Sometimes, I'd care.

Last summer, we lost my mother-in-law to a brief and tragic battle with cancer. The Saturday rides have become much more important to the McIntyre men. My husband's youngest brother Kevin, moved home from New York and generally all five men participate on the ride.

**"Eventually, my goal is for Brendan to ride independently on his own bike, and for Marisa to become the second rider on the red tandem bike!"**

One Saturday, after Tim returned from the ride, he received an excited call from Kevin. Kevin said he and John had spotted a used, tandem bike for sale and they had purchased it. Tim rushed out with Brendan in tow.

A few hours later they returned. My husband found Brendan a helmet and they headed out the door. At the bottom of the stairs, was a fire-engine red, tandem bicycle with a little rust around the edges...it was beautiful! They left for the nearest park.

When they returned, I asked Tim, how it went. He said, "Brendan did great!" Especially when he saw some dogs. "Dad, Dad pedal faster," he said Brendan would cry out as they rode. Then my husband told me, he'd lift his feet up, to let Brendan do all the pedaling. He'd do fine until his energy ran out and then my husband would start pedaling with him again. They've ridden several times this week and Brendan loves it!

Tomorrow is Saturday. I hope the weather holds. Because at the bottom of our stairs sits opportunity... in the form of a red tandem bike.

*Postscript:*

*My husband, Tim drove down to Huntington Beach State Park. He and Brendan rode to Charlie's Chili from there, a round trip of about 6 miles. Brendan had breakfast with the "boys." I hope Brendan will be able to make the entire ride. Eventually, my goal is for him to ride independently on his own bike and for Marisa to become the second rider on the red tandem bike!*

**For further information please contact:**

**Bobbie McIntyre**

*E-mail: [bobbiekwm@aol.com](mailto:bobbiekwm@aol.com)* ♥

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## Cover Artist: Jacob Lee

### I WANT TO BE AN ARTIST

Play-Doh, toilet paper, boxes and masking tape: these were my son's first artist tools. From an early age Jacob sculpted mostly weapons and dinosaurs out of various supplies. In addition, the thousands of Lego pieces were put together, taken apart and put together again into mythical beings of his imagination.

Jacob learned to talk within a ten-week Parent-Teacher Training program at the BICC Singapore

Art has always been Jacob's means of communication with the world at large. At school, his teachers noticed very early on that he is good at sculpting. With growing confidence he showed off his finished work to his teachers, who nurtured his interest and talent and exposed him to other forms of art such as batik painting and anime.

Today, he draws mainly mythical creatures like "The Royal Knight" which he selected to be exhibited.

Even though Jacob did not particularly enjoy batik painting, his eye for interesting color combinations surfaced through his paintings. He was chosen to present one of his garment paintings to the President of Singapore.

Jacob was first introduced to anime when he was 15 years old. He and a classmate were selected to join another school's anime club, which had had some of its work published in Japan. His experience over a period of six months sparked a new personal interest, which moved him toward expressing his creativity either on paper or digitally.

The Internet and computer games were Jacob's primary sources of inspiration. As his parents, we had many discussions about whether or not to allow him access to the Internet. In the end, we allowed him access to it, but we carefully explained to him



*Jacob now has a facebook page with more than 500 friends mostly from art. He sure enjoys his life!*

what is appropriate and what he needs to be careful with. Of course, as a growing teenager, we had to take away some of his discoveries. Mostly what he accessed were YouTube guides on Lego assembly and characters from computer games. He also discovered Facebook and now has over 500 friends, mostly people he has met through his art.

Jacob's interest in art has given him the opening conversation piece to engage with others. Most people are amazed at the detail he provides, and encourage him.

His artistic renditions are two dimensional, like the characters he sees on the Internet. Recently, he sees shadows. Unfortunately perspective is something that he does not understand yet.

With his growing interest in drawing, Jacob is now more willing to attend an art class outside school.

He has been accepted into an art enrichment school next year and I am very excited for him, as he furthers his journey to realizing his dream of becoming an artist.

#### For further information, please contact:

**Lee Hong Eng**

*E-mail: hongenglee@gmail.com* ♥

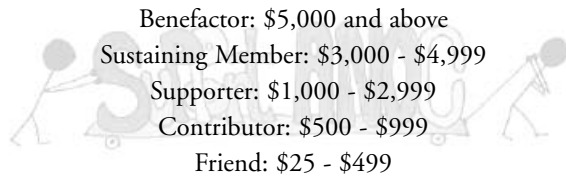




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We are grateful for the  
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### **Job Announcement**

Toufic Jeiroudi

Your support is urgently needed to help  
ANOC continue. Please visit our website at  
[www.autismnewsoc.org](http://www.autismnewsoc.org) for more information.

*Thank you!*

# Introducing the new Underlying Characteristics Checklist – Early Intervention (UCC-EI)

Ruth Aspy, Ph.D., Barry G. Grossman, Ph.D., and Kathleen Ann Quill Ed.D.

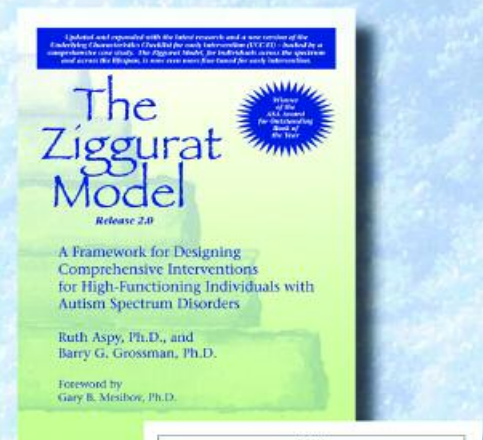
Developed as a component of the Ziggurat Model, the Underlying Characteristics Checklist (UCC) is an informal, non-standardized assessment tool designed to identify characteristics across a number of domains associated with ASD. It is not designed or intended for diagnosis of ASD. The new Underlying Characteristics Checklist-Early Intervention (UCC-EI) is useful for identifying children from infancy through 72 months who could possibly benefit from early intervention services.



Your First Source for Practical Solutions for  
Autism Spectrum and Related Disorders

For more information on the UCC-EI Checklist go  
to [www.aapcpublishing.net](http://www.aapcpublishing.net) and search UCC-EI  
Questions? Call toll free 1-877-277-8254 or  
email [aapcinfo@aapcpublishing.net](mailto:aapcinfo@aapcpublishing.net).

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**UCC-EI  
UNDERLYING CHARACTERISTICS CHECKLIST-EARLY INTERVENTION**  
Ruth Aspy, Ph.D., and Barry G. Grossman, Ph.D. © 2011 AAPC Publishing, Inc. 10/11

NAME: \_\_\_\_\_ SEX: \_\_\_\_\_ RACE: \_\_\_\_\_  
AGE: \_\_\_\_\_ MONTHS: \_\_\_\_\_

DATE: \_\_\_\_\_

**UCC-EI CHECKLIST**

**SECTION 1: UNDERLYING CHARACTERISTICS**

Area / Item	Age of Onset	Notes	Description of Characteristic
1. Responds to the name and other verbal cues in different settings or places	12 months	✓	Child does not respond to name or other verbal cues in different settings or places.
2. Shows non-verbal and physical responses to people	12 months	✓	Child does not show non-verbal or physical responses to people.

**SECTION 2: COMMUNICATIVE AND SOCIAL INTERACTIONS**

Use this checklist to identify characteristics that may be present in children with autism spectrum disorders. This checklist is not intended to be used for diagnosis. It is intended to be used to identify characteristics that may be present in children with autism spectrum disorders. It is not intended to be used to identify characteristics that are not present in children with autism spectrum disorders. It is not intended to be used to identify characteristics that are not present in children with autism spectrum disorders.

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## EVENTS EVENTS EVENTS EVENTS EVENTS.....

March 19, 2012 – “Adolescence, Sexuality, Employment: How do the pieces fit?”  
by Peter Gerhardt., Ed.D. RCOC, 4-8 p.m.

April 25, 2012 – Latest research on Autism by David Amaral, Ph.D. from the  
MIND Institute, RCOC, 4-8 p.m

For information on seminars at Regional Center, contact Kelly Rico at  
(714) 796-5330.

## Infants and Mothers Needed for a Research Study

The UC Irvine Dept. of Psychology and Social Behavior is looking for **mothers with infants younger than 9 months who...**

- 1) Have another child with an Autism Spectrum Disorder
- OR-**
- 2) Have NO family history of any developmental disorders

to participate in a research study evaluating a **training program** for mothers designed to help the **early detection of autism**

Participation involves a developmental assessment, training program or safety video, and questionnaires during a 1.5 hour study visit at home or at the university's family lab, and two online or mailed questionnaires that each take 20 minutes to complete.



All participants will receive a \$20 gift card

### UC Irvine Parent Training Project

Kara Thorsen, M.A.  
kthorsen@uci.edu  
1-949-607-8824

Faculty Sponsor: Wendy Goldberg Ph.D.  
wendy.goldberg@uci.edu



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If you have a comment about our newsletter, we'd love to hear from you. Please send all comments to [verabernard@cox.net](mailto:verabernard@cox.net).

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For further information please contact the Editor at [verabernard@cox.net](mailto:verabernard@cox.net) or Joel Miller at [jdmiller@uci.edu](mailto:jdmiller@uci.edu).

*Announcements are not endorsed by the Editor of ANOC nor the involved companies.*



**For OC Kids Neurodevelopmental Center is proud to be a founding partner and long time supporter of ANOC.**

Since September 2001, For OC Kids, has played a unique and major role in providing comprehensive, medical and support services for Orange County families with children who have Autism, ADHD and other developmental disorders. We have been able to do this with ongoing support from the Children and Families Commission of Orange County.

***For OC Kids entered its 10<sup>th</sup> year with the strategic vision of expanding our program by creating a Center of Excellence that will include comprehensive, multidisciplinary services to all Orange County children with Autism, ADHD and other developmental disorders from birth through 21 years.***

By the end of our tenth year, we will have provided over 6,000 new patient comprehensive evaluations and more than 20,000 follow-up visits. Our strategic vision included providing evidence-based and cutting-edge services with six expansion priorities:

1. Expand services to assist patients up to 22 years of age.
2. Build a multi-disciplinary team that will include experts from key disciplines.
3. Provide a deeper level of family support, education, and advocacy.
4. Provide comprehensive treatment services for children and families.
5. Develop an innovative research team and collaborative opportunities with colleagues.
6. Provide education for professionals now and into the future.

We look forward to the ongoing philanthropic support of our community in achieving this vision!

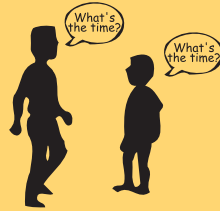
**For more information on our programs, visit us at [www.forockids.org](http://www.forockids.org)**

# SOME EXAMPLES OF AUTISTIC BEHAVIOR

## ALGUNOS EJEMPLOS DEL COMPORTAMIENTO DE PERSONAS CON AUTISMO



Avoids eye contact  
Evita el contacto visual



Copies words like a parrot ("echolalic")  
Repite las palabras como un loro  
("en forma de echo")



Shows preoccupation with only one topic  
Demuestra preocupación/interés en solo un tema/asunto



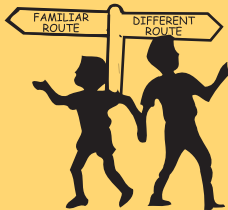
Lacks creative "pretend" play  
Carece el juego creativo



Shows indifference  
Demuestra indiferencia



Displays special abilities in music, art, memory, or manual dexterity  
Demuestra capacidades especiales en musica, arte, memoria or destreza manual



Does not like variety: it's not the spice of life  
No demuestra interés en variedad



Shows fascination with spinning objects  
Demuestra fascinación con objetos que giran



Shows fear of, or fascination with certain sounds  
Demuestra miedo de/ó fascinación con ciertos sonidos



Laughs or giggles inappropriately  
Risa/reír inadecuadamente



Shows one-sided interaction  
Demuestra interacción que es unilateral



Does not play with other children  
No juega con otros niños

### Some Examples of Autistic Behavior Algunos ejemplos del comportamiento de personas con autismo

- Difficulty with social interactions.  
Tienen dificultad para socializar con otras personas.
- Problems with speech.  
Tienen problemas con su lenguaje.
- Disturbed perception.  
Tienen una percepción anormal de los sucesos que acontecen a su alrededor.
- Abnormal play.  
Su forma de jugar es anormal.
- Resistance to change in routine or environment.  
Se resisten a cambios en sus actividad rutinarias ó a su medio ambiente.