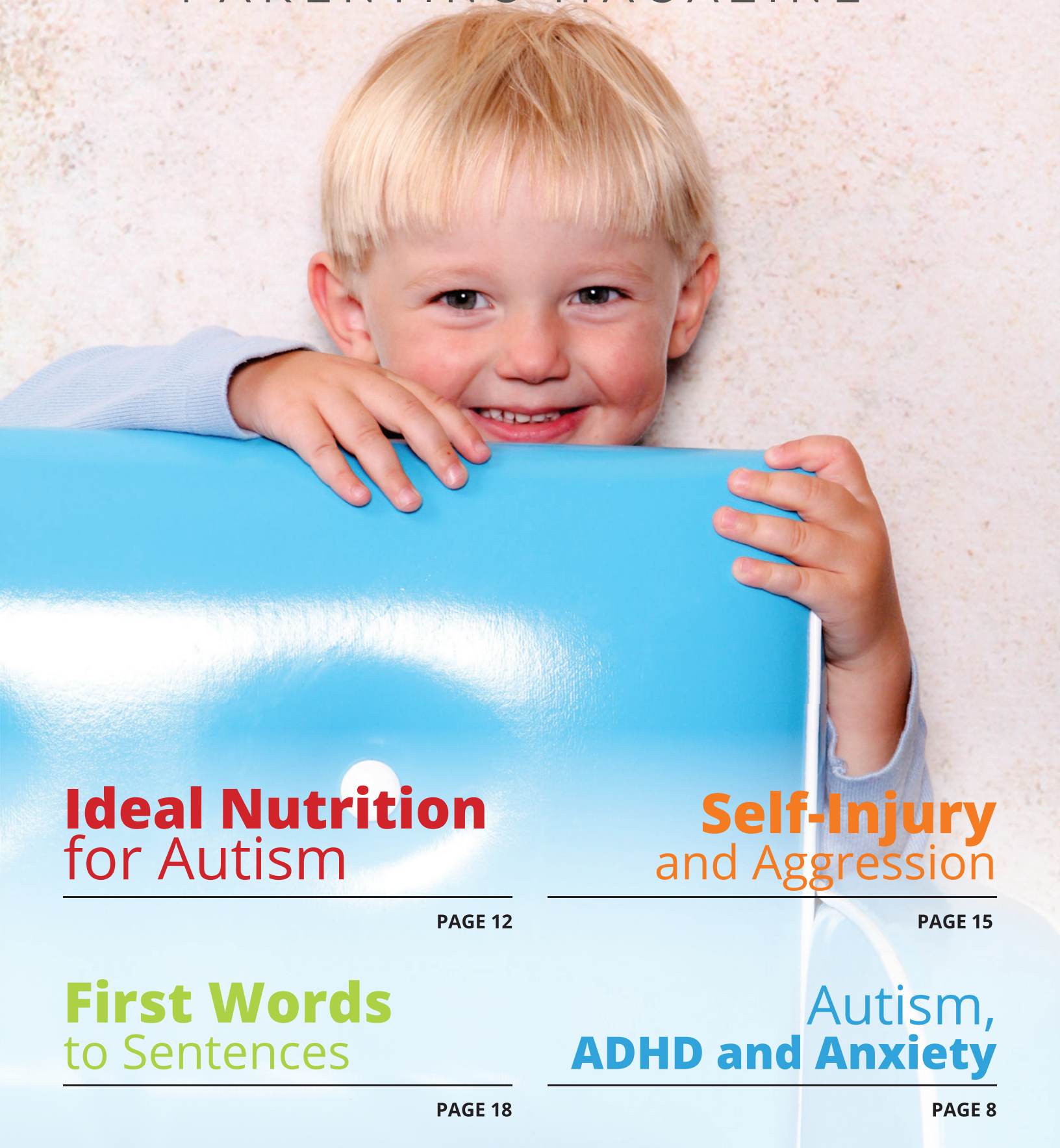
March 2022

AUTISM ADVOCATE

PARENTING MAGAZINE



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And so much more!

AUTISM ADVOCATE
PARENTING MAGAZINE

AAPM strives to foster a broad perspective on all topics regarding autism. To this end, we attempt to be as inclusive as possible with the views we present. These views may or may not reflect our own, but we include them in order to add to the reader's diverse knowledge and education on autism.

Dear Parent Advocate or Reader:

We are excited to share Autism Advocate Parenting Magazine with you! As caring parents, we love our children and want the very best for them. We want to go to bed every night knowing that we have given them the best support and resources possible. Sometimes it can be difficult to know where to start, what therapies are best for our children and what the latest autism research has uncovered. This is where we can help.

Autism Advocate Parenting Magazine's primary purpose is to **empower** parents. We work closely with doctors, therapists, specialists and experts in the field of autism. Their expertise and experiences will give you the ability to **ask** questions, to **advocate** for your child and to **search out** information that can benefit you on your journey.

In our magazine we focus on four key areas that will empower YOU while raising a child on the spectrum:

Current Research

We present the latest research in the field of autism. We share current research in a way that is clear and easy to understand.

Expert Advice

Autism experts from around the world share their knowledge and expertise. They will keep you informed about the latest therapies, treatments, diagnostic tools, nutritional plans and more.

Resources

In every issue we provide FREE printable resources, guides and tools that will help you support your child.

Parent Advocating

Our children are extraordinary and have unlimited potential. We want to join you on your autism journey and share stories of hope, advocacy and inspiration.

EMPOWERING *Parent* ADVOCATES

We are autism parents sharing this journey with you. We know all about the frustrating days, the exciting moments and the long nights. We also know that time and energy are limited, and that seeking out information on autism is challenging and time consuming. We are here to help. If you would like us to find an expert or investigate a topic that can benefit your child, please reach out to us by email: admin@autismadvocateparentingmagazine.com. We want to make your life easier, because we know how hard it can be.

Please note: The articles we provide do not represent the views of Autism Advocate Parenting Magazine. However, we feel it is our obligation to provide you with relevant information so you are informed and can make the best decisions for your child and your family.

Dr. Tom O'Bryan, an autism expert, said it best: "Take one hour a week to learn more about autism and before you know it, you will be an expert in many areas of autism."

We value, embrace and advocate for neurodiversity. We admire each of you — whether you are a seasoned parent advocate or just starting on your autism journey. We love hearing about your success stories, as well as your hopes and dreams. We are honored to be a part of your family's journey, and grateful to have you be a part of ours.

Parent Advocates

Autism Advocate Parenting Magazine

> ***"Take one hour a week to learn more about autism and before you know it, you will be an expert in many areas of autism."***
>
> **- Dr. Tom O'Bryan**

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SOCIAL CAMOUFLAGING

in Girls with ASD

Katharine Figueroa

The Chameleon in the Room

Over five million adults in the United States are autistic, and many are diagnosed later in life.[1] Several factors appear to contribute to a delayed diagnosis for a person with autism, including being female,[2] the absence of co-occurring cognitive impairment, and a lack of resources.[3] A behavior called camouflaging, or "masking," may also contribute to delayed or late autism diagnosis for some individuals.

Camouflaging occurs when a person with autism does not exhibit obvious behaviors or characteristics that are usually associated with autism. For example, an individual may camouflage or hide some repetitive behaviors or restricted interests when in a social setting in order to fit in or avoid social challenges. The act of hiding or repressing natural traits or behaviors that are commonly associated with autism can result in some people not receiving an autism diagnosis until later in life. In some cases, it prevents them from receiving a diagnosis at all. As a result, many autistic people may miss out on services and supports that could be beneficial to their well-being.

Why Do Some Autistic People Camouflage?

An autistic person may want and need to copy the behaviors of others to be socially included and to be safe from stigmatization. Individuals who camouflage describe the experience as wearing "a mask."[4,5] Camouflaging is a subconsciously and consciously learned coping mechanism to fit in socially, and may be convincing enough to fool acquaintances, social partners, and even clinicians.

Why do autistic people adopt behaviors that are not natural to them? Contrary to some common misconceptions, many autistic individuals are socially motivated.[6,7] Autistic adults also show a greater desire to have friends than is seen in the general population.[8] A strong desire to have friends and to make connections may prompt camouflaging behavior.

Camouflaging may also be a strategy when an individual faces stigma.[9] It is worth noting that autistic people are more often harassed and bullied when openly autistic than when they are camouflaging.[10] It becomes even more difficult to "unmask" when a person is actively trying to hide differences, both out of a desire to be socially included and the need to be safe from stigmatization.

Gender Differences in Camouflaging and Underdiagnosis

Both camouflaging and underdiagnosis are more common for autistic women than for autistic men.[11,12] Girls' autistic symptoms, while very present, are not as easily seen or recognized, and may never be diagnosed or may even be *misdiagnosed*. Why are females overlooked? Since autistic girls tend to have more friends, their social rejection is harder to see compared to that of their male peers.[13,14]

Autistic girls often experience being "socially overlooked." As a result, they hover in the periphery of a group of peers but do not actually participate. Generally, girls' social relationships also have greater nuance and social rules, which can lead to greater rejection for autistic girls.[14] In comparison, autistic boys typically receive more overt social rejection, which is manifested as physical distance from peers.[13,14]

The experience of autistic girls who have more friends and are seemingly more included could be compared to sunlight that is filtered out by the sunglasses worn by the observer. Since there are no obvious signs of the level of social exclusion that affects autistic boys, the exclusion suffered by girls often goes undetected.

As a child, I was diagnosed with ADHD. At a superficial level, the diagnosis seemed to be a good fit. I had attention issues, was impulsive and forgetful, and I would fidget and fiddle with everything. However, I also had other issues. I was easily overwhelmed by the unfamiliar, had difficulty organizing my thoughts, made seemingly outlandish statements and connections, and consistently committed social errors that were mostly minor. I had friends, though, and could mostly navigate social situations by following the examples of others. I always thought I'd grow out of most of my social awkwardness.

It may be that the social environment of girls makes them better at hiding the usual signs of autism that are most identifiable. Since they do not fit the stereotypes and expectations of what autism looks like, they are never identified as autistic by peers.

The Hidden Cost of Camouflaging

Camouflaging has a significant effect on the mental health of autistic individuals. Neurodivergent individuals who are navigating a neurotypical-dominant society may find the experience too taxing on their mental resources. Camouflaging may lead to additional mental strain and burnout for both autistic men and women.[10,15,16] In fact, camouflaging is associated with depression, anxiety, and stress in autistic women.[15] The negative impacts of camouflaging on mental health could be attributed to confusion about one's true identity under the mask.[17]

As a young adult, my social skills were in a sweet spot of being good enough not to be given a label, but not good enough to pass closer inspection as I tried to make better and long-lasting connections. Meanwhile, social interactions made me more and more exhausted. At the same time, however, I wished I could connect better to others and for longer periods of time. Pretending not to be different seemed to fill me with social anxiety and drained me of energy, particularly when I wasn't successful.

Where to Go from Here

In general, we need a better understanding of how female social culture and an over-reliance on a male autism profile impact camouflaging. Delayed access to supportive services and a lack of knowledge about one's own identity are both detrimental to autistic individuals. There's also a need to better understand the relationship between camouflaging and mental health, and how to support those on the spectrum with mental health challenges.

Individuals who camouflage miss out on significant opportunities to identify with the autism community and to benefit from an inclusive and supportive network.[17] Parents and families should look for supports and services that help their autistic family member connect with others on the spectrum and with those who are well-versed in autism or who can empathize with the family member. It is important for autistic individuals to have places where they do not have to camouflage and where they can be social, while also being true to themselves.

I was finally diagnosed with autism in my early 20s. Since then, I've been put in contact with services that have helped me and that have strengthened my social skills. As I look back now, I realize my ADHD diagnosis did not prepare me for my struggles with emotional regulation, sensory sensitivities, adapting to new situations, and executive function challenges. I've finally been able to address these challenges now that I am equipped with an autism diagnosis. It is important that we "chameleons" get connected sooner to services and opportunities for interaction with the larger autistic community in order to improve our lives.

It is my hope that the future for neurodivergent individuals such as myself will continue to get brighter, and that we can get the help and community support we need through early and accurate diagnosis.

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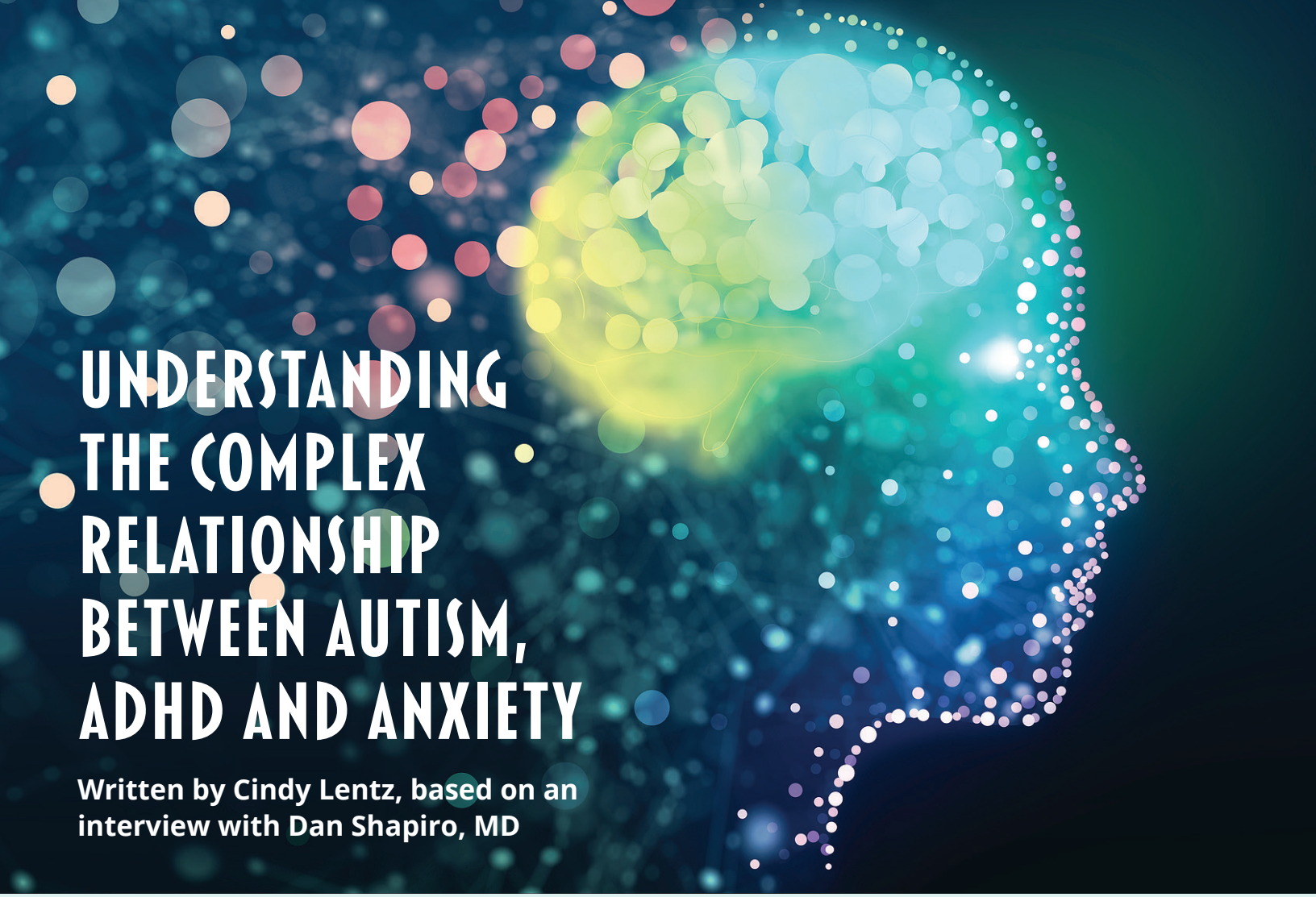
Katharine Figueroa is a research assistant with autism working at the Kasari Lab at UCLA. She contributes to different research projects on autism in a variety of ways, including through her academic writing, data entry, generating visualizations, and by providing expertise from her personal experience as an autism advocate. She is in the process of getting her Associate degree and is a recent graduate at the Evolve Program. Katharine highly values community involvement/representation in research on autism. By increasing awareness of autism as autistic individuals experience it, better understanding can lead to greater inclusivity and normalization of neurodiversity. Reading, writing, and cooking are her favorite activities, along with spending time with animals. One day she would like to publish fiction featuring neurodiverse characters.



UNDERSTANDING THE COMPLEX RELATIONSHIP BETWEEN AUTISM, ADHD AND ANXIETY

Written by Cindy Lentz, based on an interview with Dan Shapiro, MD

Three of the most common developmental differences in pediatrics are attention deficit hyperactivity disorder (ADHD), anxiety, and autism spectrum disorders (ASD). Research has shown that these conditions have exceptional genetic overlap.[1] In some studies, up to 80 percent of children with autism also have ADHD.[2] In addition, at least 40 percent of children with autism also have anxiety.[3] Individuals with any or all of these conditions may show impairments in self-regulation, which involves knowing when to initiate, sustain and shift activities and thoughts. They may also show other impairments in executive functioning, involving planning, strategizing, and organizing. Although autism, ADHD and anxiety have significant overlap, it is important to understand their differences as these will guide functional and pharmacological treatments.

ADHD

The core features of ADHD are poor impulse control and difficulties with attention. Those with ADHD can generally be divided into two categories. The first category is comprised of hyperactive and impulsive individuals who predominantly exhibit excessive motor activity and talking, and who have difficulty being able to stop and think. The second group is made up of individuals who predominantly have difficulty with attention, are easily distracted, have a short attention span and may have difficulty finishing a task. It is common for children to fall into both groups as they can be hyperactive, impulsive and easily distracted.

ANXIETY

Anxiety is a feeling of fear or apprehension. There are many different subtypes of anxiety, such as specific fears and phobias, separation anxiety, fear of crowds, and post-traumatic stress disorder. The type of anxiety that individuals experience can shift from one type to another as they go through different developmental phases. Anxiety is not always as obvious as other developmental differences because it is an internal challenge. Given this fact, children and adults often present anxiety in less conspicuous ways. Some common symptoms of anxiety are a feeling of internal distress, headaches, throat discomfort, breathing problems, tummy aches, and bowel or bladder changes. The most common symptom of anxiety is avoidance of the anxiety trigger. For example, an individual who is afraid of dogs would avoid dogs at all costs. If the individual is successful in avoiding the trigger, anxiety symptoms may be hidden, but the anxiety is no less real or impairing.

AUTISM

Autism represents a very broad spectrum of developmental differences. The core features include social skill deficits and repetitive or ritualized behaviors. Social skill deficits result in differences with peer interaction, difficulties with shared engagement and differences in play and conversation. Repetitive behaviors include doing the same thing over and over, and inflexibility in thinking, talking and pursuing interests.

The Co-occurrence of ASD, ADHD and Anxiety

ADHD, anxiety and autism have features and characteristics that may just represent normal human variation. We are all different. One person might be scared of spiders, while another might be unable to sit still. The difference between "human variation" and a "disorder" is in the level of impairment. If an individual simply has some hyperactivity, impulsivity, anxiety, social differences or restricted interests but is not *impaired* by these features, that person wouldn't be considered as having a disorder. In general, professionals label such features a disorder if there is distress or a significantly negative effect on a person's quality of life. It is also worth noting that, too often, an individual is impaired, at least in part, because of insufficient support. This is a "disorder of society."

Research shows that if there is developmental variation of one kind in an individual, such as ADHD, other family members are more likely to have similar developmental variation. It has also been shown that family members are more likely to have other kinds of developmental differences. For example, individuals with ASD often have family members with ADHD or mood regulation problems, such as anxiety and depression. People with ADHD often have family members with anxiety or ASD. The more we learn about the genetics of these three conditions, the more we realize that they cannot always be divided into clear or distinct categories. There's a mixture of developmental differences within individuals and within families, and there is much more overlap than previously expected.

The Importance of a Diagnosis

There are three different types of assessments used by developmental specialists in diagnosing disorders.

Categorical Assessment

For diagnostic categories, professionals rely on the Diagnostic and Statistical Manual of Mental Disorders (DSM), the International Classification of Diseases (ICD), or World Health Organization (WHO). It is important to note that a categorical diagnosis will open doors to children receiving services, including those funded by health insurance. These can be services in the school system or the community, or through the federal government. A categorical diagnosis aids in the communication among clinicians, parents and teachers. It serves as a common language and helps professionals, family and friends understand why your child has differences. A diagnosis or label might also give your child a sense of belonging and can even bring people together for purposes of activism and social change.

Etiological Assessment

This assessment evaluates the genetic, metabolic or environmental cause, if any, of a condition. Some conditions, such as phenylketonuria (PKU) which can cause intellectual disability, hyperactivity and seizures, have a specific treatment. A special diet can effectively prevent brain damage. However, PKU is an exception. In the world of developmental differences, very few etiological diagnoses guide management.

Functional Assessment

In most cases, this assessment is what guides symptom management. A functional assessment covers all the child's different developmental domains: temperament, sensory processing, language, learning profile, motor functioning, adaptive behavior, environmental factors, and more. The developmental clinician will determine the child's current, or baseline, level of functioning, then set realistic goals, and create a plan for the child to meet his or her developmental potential.

Under- and Over-Inhibition

One specific type of functional assessment relates to under-inhibition and over-inhibition, a factor which plays a major role in autism, ADHD and anxiety. The excitatory systems in the brain, for example, allow someone to follow directions, initiate work on a task or dodge oncoming vehicles. The inhibitory systems in the brain allow people to wait, pause, stop and think. ADHD can be thought of as a difficulty with *too little* inhibition, while anxiety is viewed as a difficulty with *too much* inhibition. Autism can include a combination of these tendencies. Some of autism's typical features include rigid and repetitive patterns of behaviors which are examples of over-inhibition. Within an individual, however, the level of inhibition can change depending on the task or setting. For example, a child might be hyper-focused when playing with building blocks, a visual-motor activity. However, the same child might be easily distracted and unfocused in "circle time," an auditory-verbal activity.

ADHD	Anxiety/Autism
under-inhibition	over-inhibition
distractibility, poor focus	perseveration, hyperfocus
brakes too loose	brakes too tight
gears shift too easily	stuck in one gear
impulsive, prefer novelty	inflexible, prefer repetition and ritual
leap before looking, dangerous	step back, avoid, shut down, safe
too much in the moment, here and now	too much in the past and/or future
focus on too many things rather than concentrate on one	focus on one thing exclusively

Management

Since many individuals have autism, ADHD and anxiety, management can be complex. Indeed, some patients need treatment for both under-inhibition (ADHD) and over-inhibition (anxiety), even though treatment for one would seem to go counter to the other. Practitioners often determine what is the **core** problem across most settings and what is causing the most impairment. This allows them to begin with a treatment for the core problem.

Medication is considered the first-line treatment for **ADHD**. Medications can manage the under-inhibition and can dampen the excitatory neurons. In contrast, cognitive behavioral therapy (CBT) is considered the first-line treatment for **anxiety**. If an individual cannot access such therapy, if it isn't proving to be effective, or if the anxiety is severe, medications may also be used. Many patients require treatment for both ADHD and anxiety. It is important to note that there is no medication for the core symptoms of **autism**, which are social impairment and repetitive behaviors.

Effective treatment involves doing something *with* the child, not *to* the child. Children need to understand their own developmental differences and know that their feelings and perspectives are being heard. If you speak the language of a child's developmental age, he or she can be included in care conversations at surprisingly young ages. If your child has ADHD, you can speak about "stop and think" medicines, and ask questions like, "Is it a little hard to focus, really hard to focus, or not hard at all?" For those who suffer from anxiety, you can introduce them to the "worry monster." You can use puppets and toy figures for very young children. As children get older, the conversations and evaluations can become more sophisticated.

Final Thoughts

There is no perfect treatment. Each child is unique and complex, especially if he or she has multiple co-occurring conditions. We absolutely want to relieve the distress children experience and remove some of the hurdles in the road ahead. A combination of early and accurate diagnosis, as well as early evidence-based treatments, can make a significant difference in your children's success and happiness. However, it is at least as important to accept your children for who they are, appreciate their differences and broaden your view of success in life.

KEY POINTS

ADHD can be defined as living too much in the moment. These individuals often focus on too many things at once rather than concentrating on just one.

Autism/Anxiety is often characterized by living too much in the past or future. These individuals will frequently focus on one thing to the exclusion of others.

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Dr. Dan Shapiro, M.D., came from his hometown of East Lansing, Michigan, to attend medical school at George Washington University in D.C. His Pediatric Residency training was at Children's Hospital in D.C. Then he practiced Pediatric and Adolescent Medicine in Silver Spring, Maryland, for 13 years before shifting his focus to Developmental and Behavioral Pediatrics. Dr. Dan enjoys seeing children and consulting with parents in his home office. He also observes children and collaborates with educators at dozens of area schools. He developed the Parent Child Journey and Excursions Programs, offering these behavior management training courses throughout Greater Washington and internationally online. He is the author of numerous articles and three books: *Parent Child Journey: An Individualized Approach to Raising Your Challenging Child, Parent Child Excursions: ADHD, Anxiety and Autism* and *Raph's Tale,* a children's book on developmental difference. He is a Fellow of the American Academy of Pediatrics and a member of the Society for Developmental and Behavioral Pediatrics. He is married with 4 children and 2 grandchildren- all wonderfully different. His hobbies include music, reading and floating down the Potomac in a kayak.

Ideal Nutrition for AUTISM

Crystal Jordan, B.I.S.

It is well established that the food consumed by autistic children plays a key role in their functional ability. Food has the potential to exacerbate existing challenges *or* to promote better health and behavioral abilities. Many children with autism have highly reactive systems, which means autoimmune dysfunction and inflammation are more common in these children than in their neurotypical peers. Ensuring dietary intake that includes only low-inflammatory foods helps reduce the stress on their bodies. This, in turn, lets them find their best functional ability, reduces problematic behaviors and discomfort, and allows development, health and learning to take place more easily.

Foods You Should Avoid

Anything that enhances inflammation throughout the body or aggravates a digestive dysfunction should be avoided. Keep in mind that digestive issues are up to 65 percent more common in autistic children than in their neurotypical peers.

Soy

Soy — Soy products are now commonly over-processed to the point of being almost intolerable for the body. Soy can also block mineral absorption and contains phytoestrogen compounds, which may be linked to an increased susceptibility to several types of cancers within specific populations.

Peanuts

Peanuts — Peanuts are high in lectins, a type of protein that is resistant to digestion. They also contain specific proteins that promote inflammation once they cross into the bloodstream. One of the most common and dangerous allergies is peanut allergy.

Artificial Sweeteners

Artificial Sweeteners — These substances can promote overall poor body function and increase inflammation. They also range in their level of safety. While some are semi-natural as they have been modified and processed in a lab, others are of questionable safety.

Dairy

Dairy — This includes all forms of animal milk, cheese, and yogurt. Due to its inflammatory proteins, dairy can cause a harmful immune response that is not always detected. Lactose is a carbohydrate that is found in milk. When this carbohydrate binds with the protein in milk, an inflammatory response is triggered. Casein — a dairy protein — can also lead to inflammation, and may be associated with an increased risk of autoimmune disease and more severe allergies and infections.

High Glutamate Foods

High Glutamate Foods — Glutamate occurs naturally within the body and in many foods. However, an excess of this amino acid can contribute to many problems. In particular, it can affect the brain and result in headaches, anxiety, depression, and mood swings. Foods that are high in glutamate include monosodium glutamate (MSG), many artificial sweeteners, and soy products. High levels can also be found in tomatoes, mushrooms, peas, parmesan cheese, processed meat, yeast and cow's milk.

Foods You May Wish to Avoid

The following foods *can* have anti-inflammatory effects but are often not ideal for sensitive systems. They will promote inflammation if an intolerance exists.

Whole Grains

Whole Grains — This includes wheat, rice, oats, quinoa, corn, buckwheat, barley, rye, semolina and several other grains. While whole grains contain health-promoting benefits, they can cause inflammation in those who are not currently equipped to handle them. This inflammation will be manifested in behavioral, emotional, and physical ways. Whole grains also contain phytic acid, a substance that binds to, and inhibits proper digestion of, certain minerals, such as calcium, magnesium, iron and zinc. This effect makes the nutrients partially unavailable for absorption despite the food's actual content. As a result of this process, grains are nutrient-poor when compared to fruits and vegetables.

Legumes

Legumes — This category includes beans, peas, lentils, soy and peanuts. Since these foods also contain phytic acid, they can cause problems similar to those brought on by grains. If you choose to include legumes in your child's diet, make a habit of preparing them at home instead of purchasing them already canned at the store. This allows you to properly soak, rinse and cook them, a process that most manufacturers do not follow before canning. Soaking legumes reduces the levels of phytic acid, which makes them more nutritious. This process can also help dissolve the outer shell, which makes them easier to digest without causing digestive problems.

What's on the Menu?

While the list of foods to avoid may seem daunting, there is still a lot of healthy food that is available for your child. This includes vegetables, fruits, organic meats, and natural fats, such as coconut oil, olive oil, nuts and seeds. These foods will all promote the optimal functioning of the body and will not inflame tissues. In fact, many foods in these groups are considered anti-inflammatory. These foods also have antioxidant potential, which is particularly important for those with autism. Research has found that individuals with an ASD diagnosis tend to have more oxidative stress, which can lead to other health conditions.

Fruits, vegetables, and protein are filled with critical nutrients, while healthy fats promote functional energy and cardiovascular health. Eating a diet that consists primarily of these four powerful and wholesome foods is ideal for kids with autism.

Many parents struggle with children who are picky eaters. I always recommend that parents try to increase their children's nutritional intake through pureed soups and smoothies. Fussy eaters will often tolerate these foods. They are an excellent way to ensure your children are getting quality calories. It is also important to start with what you know your child will eat. If that happens to be just watermelon, grilled chicken and cashews, start with that. You can slowly work your way up to new foods by using reward charts to motivate your children. If you are concerned about how much they are eating, be sure to track their calories or work closely with a doctor.

Food is one of the few substances that we actually take into our bodies. As a result, the type of food and the impact it has while being digested should be of the utmost concern and focus. Countless studies and personal stories have identified the incredible impact a wholesome diet can have on individuals with autism. Every child can experience the health and wellness benefits that come from a balanced and nutritious diet.

Recommended Reading

To learn more about the positive effects of diet on autism, you can research and implement the GAPS Diet, SCD Diet, AIP Diet, Whole30 Diet, or my own program, Foods Four Thought Diet. The books associated with these diets look at the amount of stress certain foods place on a body that is already in survival mode. They also outline steps on getting started and ways to be successful with the dietary changes.

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Crystal Jordan, B.I.S., is a passionate advocate for dietary health and its critical role in our world today. She especially champions the use of proper nutrition to support neurodiverse individuals. She teaches caregivers why proper nutrition works for their unique child, how to make proper nutrition possible for picky eaters and low communicators, and encourages families to make these changes together as a team. Crystal holds a Bachelor of Integrated Studies degree which encompasses Nutrition, Health, and Family Studies. She has had the opportunity to witness firsthand the power nutrition has for all of us, particularly those within the neurodivergent and autoimmune population. This knowledge has come through her own family experiences and those she has been fortunate to work with and support.
Website: www.foodsfourthought.com
Instagram: @foodsfourthought
Facebook: @foodsfourthought

Self-injury and AGGRESSION

Timothy R. Vollmer, Ph.D
Kerri P. Peters, Ph.D

Some individuals with autism spectrum disorder display severe behavior that can be harmful to themselves or others. While behavior that is harmful to self is known as self-injurious behavior (SIB), that which is harmful to others is known as aggression.[1,2] SIB can take many forms, but most commonly involves self-biting, self-hitting, head or body banging against a wall or other object, or self-pinching. Aggression also takes many forms, but usually includes hitting, kicking or scratching others, or pulling hair. The severity or intensity of SIB and aggression can vary greatly. Sometimes the behavior only produces minor injury to self or others, but in other cases it can produce significant injury. As practitioners, we have known individuals who have been hospitalized due to the severity of the SIB and aggression. As a result, it is important to acknowledge, address and intervene, when necessary. Even in milder cases, the behavior can significantly disrupt family life. For example, siblings may be afraid to approach their brother or sister, or parents might begin to spend inordinate amounts of time protecting themselves or their child. The psychological effects of stress can be overwhelming for many families. In fact, some families may begin to avoid certain situations completely, such as shopping or dining out. The question is why behavior such as SIB and aggression occurs.

Rule Out Medical Variables

If your child begins to display SIB or aggression suddenly or cyclically, it is often an indication that something is physically wrong, such as illness or discomfort.[3] Self-hitting has been shown to elevate when the child has developed an ear infection, tooth pain or other discomfort in the head region. Aggression is a common response to pain, even if the child realizes that the other person is not the one inflicting the pain. It is a natural human response, especially if there is no way to communicate one's pain or discomfort. Other states of pain or discomfort that have been shown to correlate with SIB and aggression include onset of menses, gastrointestinal distress, including constipation, and allergies, among others.[3] If you suspect that something is bothering your child physically, a crucial first step is to seek guidance from your pediatrician or physician. Since some doctors are not familiar with autism, they may initially infer that the severe behavior is caused by the autism. That's why it is so important to have specific questions ready for the doctor. For example, if you've noticed that your child always hits his or her ears, or around the ears, you could ask the doctor to check for an ear infection.

Social and Environmental Factors

Even if pain and discomfort initially contribute to SIB and aggression, sometimes the child learns to engage in the behavior because it produces temporary outcomes that are favorable from the child's perspective.[2] Research has shown that SIB and aggression often occur because of the response to the behavior. For example, much of this behavior occurs because it attracts the attention of adults or because it provides access to a highly preferred item, such as a toy, an electronic tablet or even food.[4] An adult's natural reaction to dangerous behavior is to calm children down by soothing them or giving them something they like. The problem is this can inadvertently strengthen the behavior, making it more likely to occur in the future. Similarly, children learn that severe behavior can help them escape or avoid situations they do not enjoy, such as instructional activity, self-care routines, or the tasks of daily living. Again, a parent or teacher may stop the activity when dangerous behavior begins, and this can inadvertently end up reinforcing the behavior. In addition, the behavior may automatically produce a favorable form of stimulation for the child. For example, children with an itching sensation from a skin allergy may scratch it to the point of bleeding. Some children may hit their head with their hand because, counterintuitively, it feels good.

Functional Analysis and Behavioral Treatment

If you have ruled out medical problems and still need help with your child's SIB or aggression, you may wish to seek the assistance of a Board Certified Behavior Analyst.[3] The analyst will conduct a "functional analysis" of the behavior to determine the contexts in which the behavior is more or less likely to occur, as well as why the behavior is happening.[2] He or she will then design a behavioral intervention plan that aims to replace the dangerous behavior with something safer and more functional. One common behavioral intervention is differential reinforcement, in which the child learns behavior that replaces dangerous behavior.[5] For example, the child might learn to ask for preferred toys or electronics, and the parents can then reinforce the communication while minimizing their reaction to the dangerous behavior. Once the behavior analyst has identified an effective intervention, he or she can guide family members through the process until they learn how to implement the procedures. It is important to note that interventions do not necessarily reduce the behavior to zero. Research shows, however, that significant reductions can be expected.

It is important to note that interventions do not necessarily reduce the behavior to zero. Research shows, however, that significant reductions can be expected.

Coordination of Care

As Board Certified Behavior Analysts, we are also firm believers in the importance of coordinating care with other professionals. As we have mentioned, medical care is crucial. Other professionals who may be of assistance include occupational therapists, speech-language pathologists, and physical therapists. For example, we have worked with occupational therapists to design enriched environments as alternative stimulation to compete with stimulation produced by SIB. We have also worked with speech-language pathologists to design functional communication modalities to replace those being expressed by SIB or aggression. In addition, we have worked with physical therapists to identify levels of motor skills that are appropriate for a given client to ensure that we are not presenting instructional activity that is outside the child's range of physical skills. Physical therapists can also ensure that your child is protected during crisis situations, such as when protective gear may be needed on a temporary basis. In short, a range of professionals can provide useful information on ways to reduce the occurrence of aggression and SIB.

CHECKLIST

The following checklist is aimed at helping parents know how to address SIB and aggression in their children.

- [x] If your child is suddenly showing SIB or aggression, give some thought to the type of questions you will ask the pediatrician or other medical doctor. Be specific. For example, it is better to ask if there might be something wrong with your child's teeth than it is to state that he or she is not feeling well. Common sources of sudden discomfort include ear infections, sore teeth or gums, sleep disorders, gastroesophageal reflux disease, and constipation. If you suspect constipation is the problem, it may be useful to track bowel movements over a period of time.

- [x] Follow a similar medical strategy if the behavior seems to emerge seasonally, such as allergies, cyclically, such as menses, or off and on, such as colds or flu. Work with your speech-language pathologist and behavior analyst on teaching your child communication skills to indicate when he or she is in pain or discomfort. Sometimes pain and discomfort interact with social or environmental factors. For example, if your child is having a bad day with allergies, you may see more escape behavior than usual during instructional activity.

- [x] Consider the immediate environment. Try to provide an enriched environment with many preferred activities. Provide positive feedback on good behavior, and reward participation in instructional activity and self-care/daily living routines.[5] If you sense that your child is becoming frustrated, it is better to reinforce early indicators with attention, distractors, or an escape from the activity rather than waiting until a full blown episode has occurred.

- [x] Seek out a Board Certified Behavior Analyst to conduct a functional analysis and behavioral intervention. Behavior analysts are specifically trained to evaluate SIB and aggression, and should be able to put together a good intervention when medical variables are ruled out. The analyst can also provide guidance to families or teachers on implementation of the procedures in home, school, or community settings.

- [x] Involve other professionals to address communication, leisure skills, and physical agility and mobility. The coordination of care is a new standard of professional care. All of your child's therapists should be willing to work together on common goals, even if their individual approaches may not perfectly align at all times.

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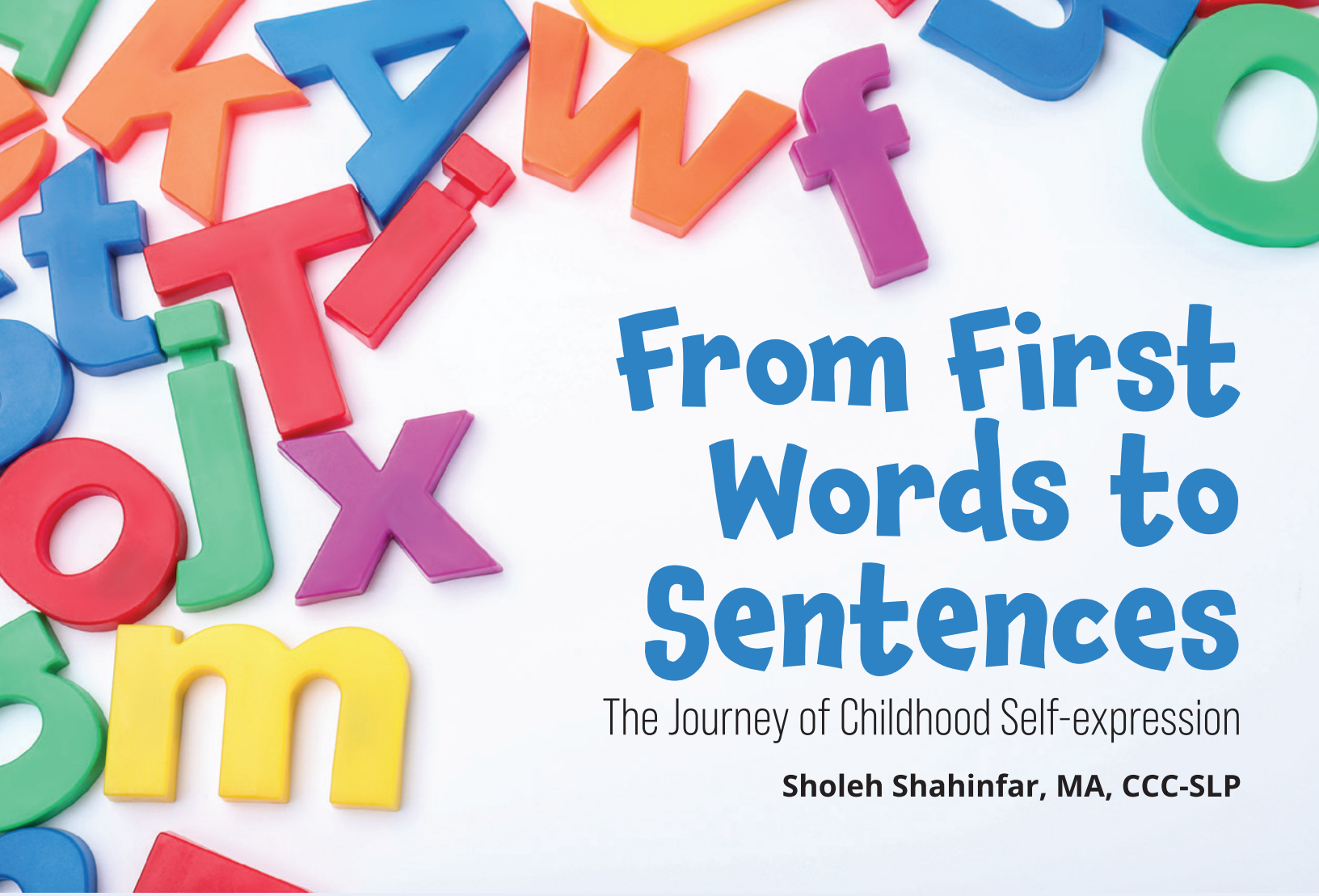
Timothy R. Vollmer, Ph.D., received his doctorate from the University of Florida in 1992. From 1992 until 1996 he was on the psychology faculty at Louisiana State University. From 1996 to 1998 he was on the faculty at the University of Pennsylvania Medical School. He returned to the University of Florida in 1998 and is now a Professor and Associate Chair of Psychology. His primary area of research is applied behavior analysis, with emphases in autism, developmental disabilities, reinforcement schedules, and parenting. He has published over 200 articles and book chapters related to behavior analysis. He was the recipient of the 1996 B.F. Skinner New Researcher award from the American Psychological Association (APA). He received another APA award in August, 2004, for significant contributions to applied behavior analysis. He served as the Editor-in-Chief of the Journal of Applied Behavior Analysis from 2014-2016. He is a fellow of the Association for Behavior Analysis International (ABAI), and received the ABAI mentoring award in 2017.

Kerri P. Peters, Ph.D., is a Clinical Assistant Professor in the Department of Psychiatry, Division of Psychology at the University of Florida (UF) and Behavior Analyst at UF Health Center for Autism and Neurodevelopment. She received her master's degree in Behavior Analysis from the University of North Texas in 2007 and her Ph.D. in Psychology from UF in 2013. Dr. Peters is also the Clinical and Research Director of the UF Behavior Analysis Research Clinic and her primary area of research is Applied Behavioral Analysis, with emphases in the areas of autism spectrum disorders. She has conducted research on quality of care and consultation in clinical settings, behavioral assessment, and treatment, feeding disorders, positive parenting, and restricted and repetitive behavior. Dr. Peters was the recipient of the Henry C. and Audrey S. Schumacher Fellowship demonstrating outstanding scientific promise. She currently serves on the Editorial Board of the Journal of Behavioral Development, and on the Florida Association for Behavioral Analysis Executive Committee in the role of Secretary.



From First Words to Sentences

The Journey of Childhood Self-expression

Sholeh Shahinfar, MA, CCC-SLP

The moment your little one says that first word is filled with magic, excitement and a whole new world of opportunities. Your little one has spoken the first word, and you are so excited for what is to come. So, what comes next? What can you do to help turn words into phrases and sentences?

At the outset, I would like to offer a quick reminder that childhood speech and language development is highly individualized and includes many layers. Although developmental milestones can be helpful guidelines, they should not be interpreted as indicating exactly where your child needs to be. Simply use milestones as guideposts in your child's growth.

How Do I Know My Child is Ready to Combine Words?

You will know your children are ready to combine words when they have two ideas that they want to express. For example, if your little one wants to be picked up and says, "mama," to get your attention (idea 1) and puts his or her arms up (idea 2), then your child is ready to begin combining words. Your little one is pairing a word with a symbolic gesture in a message that has two ideas: to get your attention; and to be picked up.

Typically, children begin combining two words together between 18 and 24 months of age. Known as **telegraphic speech**, this practice involves combining a noun and a verb, such as "mommy eat" or "sleep baby." Many children can use about 40 verbs by 24 months of age. If your toddler isn't there yet, don't worry!

Before your child even begins putting two ideas or words together, you need to make sure your child understands various word types.

What is a Word Type?

Typically, our little ones learn nouns first; they label things in their environment and pictures in books. A great way to begin exposing children to more language is by expanding what they are saying. For example, if your child sees the garbage truck go by and says, "truck," you can expand by saying, "Yes, that's a **big** truck." If your child points to a bird in the sky and says, "bird," you can expand by saying "**Fly** bird."

The foundation to expressive language is receptive language, or the language that we understand. If your little ones are only using nouns, they aren't able to effectively communicate their wants and needs. That's why you want to make sure your children understand a concept before being asked to use it. So, how can you make sure your child understands other word types besides nouns? Try asking your child to do the following.

- Point to actions in pictures, such as the boy who is eating.
- Follow directions, such as jumping when asked.
- Point to colors, sizes and other adjectives, such as the red truck, an item that is big, or something that is small.

The next step is to begin modeling and narrating verbs and other word types throughout your daily routines, and creating the opportunities to use them.

In addition to nouns, such as people, places and things, and verbs, like run, sleep, go and want, the following are some other word types:

- **Adjectives**, like *hot*, *big*, *yellow*, *fast*
- **Prepositions**, such as *in*, *out*, *on*, *under*
- **Social Words**, like *hi*, *bye-bye*
- **Pronouns**, including *me*, *I*, *you*, *mine*
- **Requests**, such as *more*, *again*, *all done*
- **Negation**, like *no*, *can't*, *don't*.

How Can I Support My Child?

I've touched on a few ways to support your child's progression from words to phrases and sentences, but I'd like to recap and expand on the topic.

Expansion

Expansion is one of the greatest ways to model word combinations for your child. If your child is just using one word now, like "dog," take that word and add on an extra word, such as "brown dog." If your child is using two to three words, like "brown dog," take those words and add more, such as "the brown dog is running."

Emphasize

Emphasize the important words to draw them to your little one's attention. A great time to do this is when you model language, narrate, and use expansion. When your child says, "dog," you say, "brown dog," with added emphasis on "brown" so that your child tunes into the new word that you just said. The more you emphasize, the more your little one will tune into the new word. This helps boost language development.

Choices are a great way to elicit word combinations. Here is one of my favorite tricks: if your child loves to play with balls, Legos, cars, or whatever it may be, get out a ton of the objects in various colors and sizes and keep them in your lap or in a box. If your child requests a "ball," take out two or three at a time, and say "Hmm, which one?" See if your child will expand his or her own language to clarify the request by asking, for example, for the "green ball" or the "big ball." If your little one has difficulty independently using two words here, offer choices using just two words. Hold up each object as you name it and ask, for example, "Green ball or red ball?"

Gestures and signs provide another way of learning and developing language. When you give your child more water, pair the sign for "more" with the spoken word and say, "more water." Pairing gestures with words boosts your child's understanding of language, which in turn will support his or her expression of language.

Repetition is one of the greatest tools to help develop understanding and use of language. The more you repeat, the more your child hears, which means the more opportunities to learn!

Respond and acknowledge your little one's attempts at communication. For example, if your child says, "Daddy goed outside," acknowledge the communication and respond by providing the correct grammar: "That's right, daddy went outside." Don't forget to emphasize the word you want your child to learn.

Fun Activities to Get you Started

I always tell my families that expanding a child's language should be something that is happening **naturally**. The opportunities happen every day, all the time. Some fun activities you can use as part of your daily routine are listed below.

- Create a fun washing or bathing game. You can do this during bath time or play by filling up a bucket with water and grabbing a bunch of toys. Target the verb "wash" and describe what you are doing. For example, say, "wash hands," "wash head," "wash feet."
- Use the words your child already knows. Use the nouns that your little one knows, and create opportunities to expand to phrases and sentences. For example, when your child requests a "cookie" for a snack, offer instead small pieces of the cookie each time and model "more cookie" or "want cookie." If your child is already at this phase, then increase it to "I want cookie" or "I want more cookie."
- Create a "bye-bye box" or "gone box." Get a box or bin to use when you are cleaning up activities or toys. Have your child put the object in the box while saying, "bye-bye teddy," or "teddy gone." You can also use this activity to include prepositions, such as "teddy in" or "teddy in box."
- Play, play, play all day! There are so many opportunities to work on receptive language skills through play. Take advantage of every opportunity to narrate, model and expand language so that your little one is learning and using new words!

This is such an exciting time filled with so many celebrations! Keep in mind, however, that part of the celebration is embracing all of it, including the setbacks and the struggles. Be sure to encourage your little one, expand on the use of current words, and provide chances to combine words together in a natural way. You can use the tips and tools outlined above to guide you. Remember that you are an important part of the process on your child's journey of self-expression!

Sholeh Shahinfar, MA, CCC-SLP, RYT, is a board certified and licensed Speech Language Pathologist and Founder of Valued Voices. She has earned her Bachelor of Arts (B.A.) degree in Hearing and Speech Sciences from the University of Maryland, and Master's of Arts (M.A.) in Communicative Disorders from California State University Long Beach. She holds a Certificate of Clinical Competence in Speech Language Pathology (CCC-SLP) and is a certified Beckman Oral Motor Trained therapist. She holds multiple state licensures and is a member of the American Speech and Hearing Association (ASHA) and California Speech Language and Hearing Association (CSHA).

Sholeh has extensive experience working with children with autism, apraxia, phonological impairments, intellectual disabilities, expressive and/or receptive language delays, and feeding/swallowing deficits. She also has extensive training and experience working with adults with aphasia, apraxia, dysphagia, traumatic brain injury, voice and cognitive deficits, among many more speech and language differences.

Sholeh continues to expand her knowledge by attending various continuing education services in order to implement the most evidence-based treatment into her work with individuals with speech and language needs. Sholeh's passion for the profession has led her to work with a variety of individuals, in several different settings throughout the years. Sholeh embodies and cultivates a whole-family, child-centered and naturalistic approach when working with clients. Developing relationships with her clients and their families is one of the great rewards of her career. She is dedicated to connecting children to their voice and inspiring self-expression.

Website: valuedvoicestherapy.com | Online Courses: https://valued-voices.teachable.com/p/get-talking-now
Email: sholeh@valuedvoicestherapy.com | IG: valuedvoices

Supporting Neurodiversity with INDIVIDUALIZED, AFFIRMATIVE SUPPORT

Jaclyn Halpern, Psy.D.
Gonzalo Laje, M.D.
Washington Behavioral Medicine Associates, LLC

Supporting neurodiversity begins with understanding that every person's brain, whether neurotypical or neurodivergent, is unique, and has both strengths and vulnerabilities. It involves seeking out those areas in which someone already excels, and offering personalized supports for areas in which that individual struggles. There is no "one size fits all" treatment approach. It is also important to recognize that individuals do not necessarily require treatment just because they are neurodivergent. Shifting to a neurodiversity-affirmative lens allows us to focus on the whole person and to offer supports to individuals who are working to embrace who they are. Such individuals, with the active participation of their family and/or support system, consent to the supports they want, and hone in on strengths to aid positive growth, when change is desired.

Listening

Autism is one form of neurodivergence. When an autistic patient comes to our practice, we have a variety of supports that we can offer. However, the first step is to listen. We seek to understand what concern is leading the person — or, in the case of children, the parents — to seek our support. We want to learn about patients. What are their interests? What are their strengths? How are they doing emotionally? In what ways are they struggling? Are the concerns that have brought them to our practice those of the patient, the family, or both? Once we've gained a better understanding of the situation, we can identify the best ways to offer help and guidance.

Support Patients for Who They Are

In many cases, we begin with psychoeducation. We help patients and families move away from such labels as high-functioning or low-functioning, and towards recognizing the individual as a whole person. Each patient has unique strengths, vulnerabilities, and support needs, and is deserving of autonomy, respect, and a presumption of competence. We seek to help families and patients communicate in ways that support the patients for who they are, rather than seeking to change them to appear and act in more neurotypical ways. We educate patients and families about ableism, which is discrimination or prejudice against individuals with disabilities, and help families begin to embrace the neurodiversity within their own unique family unit. We might suggest supports such as Dr. Ross Greene's model of care known as Collaborative and Proactive Solutions, the Connect and Redirect strategy of Dr. Dan Siegel and Dr. Tina Payne Bryson, or Dr. Mona Delahooke's book *Beyond Behaviors: Using Brain Science and Compassion*

to Understand and Solve Children's Behavioral Challenges. Each of these resources teaches families to look for the reason behind external behaviors, such as emotional dysregulation, unmet needs, or undeveloped skills. Additionally, part of embracing autism and neurodivergence involves learning from, and listening to, the autistic community. Other outstanding resources for parents and professionals include AUsome Autistic Training, as well as the Neuroclastic website and books by autistic authors, such as Naoki Higashida's *The Reason I Jump*.

Collaborate

As we work with autistic patients, we may provide outside referrals. For example, patients who feel overwhelmed by sensory stimuli at school or at work might be referred to a neurodiversity-affirmative occupational therapist to support their areas of discomfort so that they can find an equilibrium. Autistic individuals with speech or language vulnerabilities, or who may be non-speaking, will be referred to a speech-language pathologist that can help patients communicate in a way that is comfortable and effective for them, such as through body language or assistive technology.

Build a Connection

We always start therapy with autistic patients by building a connection in ways that feel comfortable to them. We usually engage in play or talk about areas of interest. As the therapy progresses, we help patients identify areas of life in which they are struggling or which are a source of distress. Together, we explore ways in which they may wish to make changes, as well as ways to communicate what they need to those around them. Some autistic patients want help improving relationships, identifying both external and internal ableism, working through distressing experiences, building self-esteem, working through trauma, or identifying strengths. We also help patients come up with strategies to aid executive functioning, decode social interactions, understand their own experience of emotion and empathy, recognize masking, feel heard, create supportive routines, or gain insight. The bottom line is making sure that the therapy is individualized, respectful, and guided by the patient's needs and wants.

The bottom line is making sure that the therapy is individualized, respectful, and guided by the patient's needs and wants.

Strengths-based Approach

Similarly, when patients seek an evaluation, whether because they already know they are autistic or suspect that they may be, we take a strengths-based approach. Through testing, we help patients better understand their brains and identify supports that address vulnerabilities. We also highlight and explore strengths that can help overcome or balance vulnerabilities, which can lead to paths for hobbies, careers, relationships and general well-being. In many cases, we are also able to help patients identify positive mirror traits that outweigh the negative aspects of some of their vulnerabilities.

Multifaceted Approach to Psychiatry

When neurodivergent patients seek psychiatric assistance, we take a multifaceted approach. Consideration may be given to evaluations that include genetics and electroencephalograms (EEG). These methods can further personalize patient care, as well as guide pharmacology and other treatments that may reduce a patient's identified distress. Genetic evaluations can help us identify mutations and other genetic changes that may be associated with specific strengths and vulnerabilities. They may inform us about potential medication efficacy and side effects, as well. We approach medication use, when needed, to assist with distressing symptoms like anxiety, mood fluctuations, irritability, inattention, and impulsivity. We also look at maximizing diet, exercise, and sleep. Finally, we consider neurofeedback paired with videogames as a form of brain training to optimize strengths and reduce vulnerabilities and distress. We even consider virtual reality to do guided exposure when patients want to reduce specific intense fears or phobias.

Support, Support, Support

Neurodiversity affirmative support is crucial for well-being, and preventive against depression, anxiety, trauma, and suicidality, each of which can be increased by non-affirmative treatments. Neurodiversity affirmative support embraces each individual as competent, whole, and valuable. It supports stimming, redirecting it only when a person is causing self-harm in the process. It moves at a pace that is respectful and supportive to each individual's unique processing. It validates experiences, thoughts, and feelings. It involves clear communication, and allows for misunderstandings to be explored. It also requires the provider to constantly learn and grow by encouraging the reexamination of preconceived notions, stereotypes, and the potential harm of ineffective or non-affirmative treatment strategies.

Jaclyn Halpern, Psy.D., is a licensed psychologist in Maryland, DC, Delaware, and Virginia with Authority to Practice Interjurisdictional Telepsychology under the PSYPACT Commission. She is the Director and Co-Founder of The SOAR Program for Psychotherapy and Testing at Washington Behavioral Medicine Associates, LLC in Chevy Chase, MD. Dr. Halpern supervises clinical staff and oversees general programming. She has extensive experience as a clinical director, evaluator, therapist, parent coach, and supervisor. Her approach is neurodiversity affirmative, strengths based, and inclusive and welcoming to all.

Dr. Halpern focuses foremost on building nurturing, supportive, honest, and empathic relationships with therapy patients. She develops treatment plans based on the specific needs, strengths, vulnerabilities, and goals of the patient(s) in individual, group, and family therapy. Dr. Halpern also provides parent coaching, utilizing gentle and positive parenting techniques. When testing, Dr. Halpern designs and administers personalized assessments. She seeks to understand, integrate, and explain educational, social-emotional, cognitive, and adaptive strengths and vulnerabilities to support each patient as a 'whole' person, and to inform recommendations for every aspect of daily life.

Dr. Halpern has spoken on NPR, on panels for WISER and Diamonds in the Rough, and at conferences and trainings for mental health providers, educators, and parents. Her most recent presentations include Positive Discipline for the home and at school, and Therapeutic Brain Breaks within the school setting.

Gonzalo Laje, M.D., is a Clinical Professor of Psychiatry at Texas Tech University and a member of the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry. Dr. Laje completed his medical education at the University of Buenos Aires in Argentina and then moved to the U.S. and worked at the Anxiety Disorders Clinic at Columbia University. He completed his training in general psychiatry at New York University/Bellevue Hospital in New York City, and his training in child and adolescent psychiatry through the combined program NIMH/Children's National Medical Center in Washington, DC. He completed a research fellowship at the National Institute of Mental Health (NIMH) in psychiatric genetics and became an Associate Clinical Investigator. His research has focused on pharmacogenetics, clinical trials and neuroimaging, as well as pharmacological interventions to address behavioral and emotional difficulties in genetic disorders. Dr. Laje is author and co-author of peer-reviewed publications in major psychiatric and genetics journals. Dr. Laje earned a Master of Health Sciences in Clinical Research from Duke University.

Dr. Laje is a former member of the American Society of Human Genetics and the International Society of Psychiatric Genetics. He is a former Board member of the Washington Psychiatric Society (WPS), the Winter Conference on Brain Research (WCBR), the Montgomery County Public Schools Educational Foundation. He serves on the Scientific Advisory Board of Madison House Autism Foundation, and has served on the Scientific Advisory Board of Parents and Researchers Interested in Smith-Magenis Syndrome (PRISMS). He serves on the Editorial Board of the journal Child Psychiatry & Human Development. Dr. Laje is the founder of Washington Behavioral Medicine Associates, LLC and co-founder of Autism Spectrum Partners.

Teaching Concepts

A "Top-Down" Approach

Karla Pretorius, MA, Psyc

When a child is diagnosed with Autism Spectrum Disorder (ASD) or other related condition, parents are usually inundated with information and suggestions on therapy. After parents decide on the therapy that is right for their child, more tests are completed and an Individualized Education Plan (IEP) is created to support their child in the school system. The plan consists of many goals that are broken down into "reachable targets," which become the focus of systematic teaching efforts. What if a more "top-down" approach were implemented that emphasized **concepts** rather than individual goals or skills?

In economics, taking a "top-down" approach typically means looking at the bigger picture and making decisions based on macroeconomic factors. If we take this approach to our children's therapy and education, we look at the concepts that they find challenging and those where they excel, as well as the reasons for both. In contrast, if you take a "bottom-up" perspective, you might review an IEP that covers all the basics for your child's specific age and developmental level, and focus on the associated micro-skills. This could mean we miss the real reason why our child is not motivated to complete a task, rather than viewing it as a compliance or ability issue.

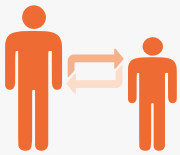
Let's imagine for a moment that we didn't know why we had to wear a mask during the pandemic. Few people would wear a mask willingly. Consider, also, if I forced you to put a mask on first thing in the morning, and that you struggled to breathe and couldn't understand the reasoning behind it. Do you think your mood would be positive or that you would be inclined to listen to me again? Of course, we do understand the reason for wearing a mask, and we know the settings in which it is crucial to wear it. While we still might not like wearing masks, we know it's in our best interest to do so. We recognize the importance of protecting ourselves and others.

Why can't we teach our children in the same way? If your child is motivated to bake cookies or plant trees, you can use these activities to teach various "academic" targets, and your child will understand the significance of learning each step.

I remember once being told by a behavioral therapist to write down a 50-step task analysis to tie shoelaces. This meant not only that I had to write the whole thing down but I also had to oblige the child with whom I was working to do each step individually and copy me or imitate the actions. With a "top-down" approach, I might ask children **why** they need to wear shoes or show them a picture of a favorite character wearing shoes similar to their footwear, and then a video of other children putting their shoes on. I might also show children that they could step on rocks or dirt if they don't wear shoes for their favorite outing. This teaches children the reason behind certain tasks.

The following are some research-based concepts that are crucial for any child's educational program, whether in a private, public or home-based system.

Ask for a Break: One of the most important concepts that increases children's ability to use appropriate coping skills in various situations is to teach them to ask for a break before they feel overwhelmed. We should let our children know that they are allowed to take frequent breaks when they feel like they need it. This, in turn, will teach our children to trust their intuition and support their own sensory needs.



Collaboration: If we want our children to make friends and engage in social settings, we need to set them up for success. Join your children in their favorite activities, even if this means jumping on the trampoline for the hundredth time. The more we show our children that we want to engage in their interests, the more likely they will be willing to collaborate with us in other activities.

Communication: For many parents, getting their child to communicate verbally is a major goal. This is understandable and should continue to be a key objective. However, including a second or third mode of communication will reduce the pressure on your child to only communicate verbally. Certain studies have shown that incorporating additional modes of communication increases verbal communication.[1,2] A visual choice board is an excellent addition in the home environment. It allows children to point or give you a photo of a specific activity instead of always needing to make the request verbally. For children who are working on longer sentences, a visual choice board with words to form sentences can also be a great learning tool.

Critical Thinking: Many parents tend to intervene even before their children get a question wrong or take an incorrect turn. Promoting critical thinking means parents and teachers allow children the opportunity to figure out a solution to a possible problem in their own way. Children can try out different options, and it should be noted that there is no "one right answer." The lessons we learn through making mistakes usually form the clearest and most enduring memories.

Interest-based Activities: This concept is often overlooked by therapies and school systems. We all want to engage in activities and interactions that motivate us. For example, while I would not be able to sit through a Star Wars convention, a friend might count down the days until the much-anticipated event. Our children want to learn more about their interests, and this will happen quicker and more naturally if these interests are included as the main activities for the day. If your child loves dinosaurs, you can include academic goals, creative plans, outings and role-play situations all within an activity that includes dinosaurs.

Mindfulness: In today's fast-paced world, we often forget to be present in the current moment. When we go online, we are constantly bombarded with marketing videos, as well as original content and ideas from people who live all over the world. We think about tomorrow's schedule today and often forget to focus on the here and now. We don't take time to rejuvenate ourselves. Our children might go to various therapies that don't include mindfulness as one of the goals. As parents, we can easily take a few deep breaths at home on a daily basis or start the day with a short meditation. This not only helps us but also our children as we are able to engage in joint attention, a shared moment, with our children.

Self-awareness and Self-regulation: If we can help our children become more aware of their sensory and other needs, we can support them in being able to regulate these needs independently. The ultimate goal for parents is usually for their children to be as independent as possible and to be living a happy and fulfilling life. We can teach our children from a young age that they are not only able to identify their specific needs in various ways, but also able to regulate these by requesting the type of activity, input or item that they need.

You might think that using those concepts is easier said than done. Below is an activity map to show you how brilliant a parent you already are. You may already be including the above-mentioned concepts, and some other ones, in your daily activities without even realizing it! Make your activities interest-based and fun. If we plan activities that motivate our children, they will meet their targets naturally.

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Karla Pretorius, MA, Psyc., is a Research Psychologist and Co-founder of AIMS Global. She started working in the field of autism in 2004 and has played an instrumental role on an international level in advocating for autism awareness, acceptance, and understanding. Karla received a double Honours degree in the US and South Africa, and completed her Master's degree in Psychology through the University of Stellenbosch as a Research Psychologist. Karla, together with her colleague, Nanette Botha, has presented in many countries, including Denmark, Indonesia, Singapore, South Africa, and the US. The pair have collaborated with autism advocates and adults on the spectrum by providing a holistic support system that evolves as our understanding of autism does too. Karla currently resides in Portugal but travels all over the world to work with clients. Her passion for autism drives her to continue learning from her clients, their parents, adults on the spectrum, and professionals in the field.
Website: www.aimsglobal.info
Instagram: @aims.global
Facebook: @aimsglobalautism

BUBBLING LAVA LAMP

WHAT YOU NEED:

Clear bottle (alternative: wine glass or any clear tall drinking glass
Vegetable oil
Water
Food coloring
Fizzing tablet (Alka-Seltzer)

TIPS:

1. Use your child's visual schedule consistently especially when moving from one activity to another.
2. Supervise your child for the entire duration of the activity.
3. You can reuse empty bottle containers.

INSTRUCTIONS:

1. Fill the bottle 3/4 full with vegetable oil.
2. Fill the rest of the bottle with water (almost to the top but not overflowing).
3. Add at least 10 drops of food coloring or until the water turns fairly dark.
4. Divide the Alka-Seltzer tablet into four pieces.
5. Drop one tiny piece of the Alka-Seltzer tablet into the oil and water mixture.

DURATION:

5-10 minutes

LEVEL OF DIFFICULTY:

INTERMEDIATE

YOU'RE WORKING ON:

- Collaboration
- Planning and prioritizing
- Organization
- Task Initiation
- Mindfulness
- Fine motor skills

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Here is a template activity map that you can use as a way to incorporate fun, interest-based activities into your child's day.

ACTIVITY

WHAT YOU NEED:

TIPS:

INSTRUCTIONS:

DURATION:

YOU'RE WORKING ON:

LEVEL OF DIFFICULTY:

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Our Journey to Becoming Supercharged, Successful and Thriving!

Tasnuva Tunna, Ph.D.

I never thought I would hear my son speak, look at me in a meaningful way, ask me for toys, or laugh out loud. What will happen to him when I die? What if he is being bullied at school, like I was? What if he can't tell me his needs and is left alone in a dark corner throughout his life?

These thoughts, and many others, plagued me for a long time. While we were waiting for an official diagnosis, my son began to deteriorate. He became self-harming and started to threaten his baby sister. I knew I had to take concrete steps. I had to find a way to help him.

During this difficult time, I persevered and made my weakness into my strength, and my strength into my superpower. This is my journey, and it can be yours too.

I am a pharmacist and a research scientist. My passion for natural and holistic medicine took root after I completed my doctorate in health science. During that time, I read about the difference that elimination diets could make for children with autism, so I started by trying various elimination diets myself. My lifelong brain fog and fatigue started melting away, and my mood and well-being improved significantly. I decided to eliminate certain foods from my son's diet as well.

I knew the importance of detoxification, proper bowel movements and gut health. I found many great research articles and books on the gut-brain connection.

I am also neurodiverse. I have had many learning challenges, and my lack of social skills has impeded my growth and success since I was a child. I wanted to give my son the support that I never had. In order to make that possible, I developed a personal protocol organized around five key pillars that guides how my son and I live. These five pillars have made a real change in my family, and I hope that they can make a difference in your life, too.

Caregivers need to take care of their **mindset and emotional health**. This can be accomplished through daily meditation, journaling, practical self-care, and building routines and systems. I believe this is the first pillar because it ensures caregivers are in good physical and mental health, and are able to serve their children and family from a place of freedom, joy and serenity.

Detoxification of the body in a safe and natural way is important. Most of our children have a variety of digestive health issues, including severe constipation. Detoxification is an important part of our children's health. Under the direction of a health care professional, parents should find safe and natural protocols to slowly, effectively and safely reduce their child's general toxic load.

Healing of the gut ensures a healthy digestive tract and can help reduce and manage inflammation. Since the gut holds 80 percent of the body's immunity, poor gut health will mean frequent infections, colds, flus, and other health issues. Healing the gut also includes ensuring that it is populated with good bacteria and not overrun with harmful bacteria. Good bacterial colonies are essential for many body and mood functions, such as digestion, evacuation, behavior, and emotional regulation.

Ensure Proper Nutrition with natural, unprocessed and easily digestible foods. Since children on the spectrum are often picky and restrictive eaters, they may be missing many essential nutrients. Supplements can aid a child's nutrition, but cannot replace a healthy natural meal. There are many resources to help children overcome their selective eating habits. Be patient, and seek help, if needed. The goal is to get your child to accept, try, and start liking new foods.

Maintain your family's health and well-being through a balanced lifestyle. As you work toward building a healthy and nurturing lifestyle, you will see that your efforts are paying off. Remember that it is a lifelong journey, and changes require time and patience.

Please note that that my intention for my child, for those whom I serve, and for the autism community in general is not to change our neurodiverse children! ***My aim is to help our neurodiverse children become healthy, independent, successful and thriving, and for them to reach developmental milestones in a way that is safe, effective and natural.***

I write about my son's journey in order to offer hope to others. He is healthy and happy, communicates with us, understands social norms, makes friends easily, and is ready for school. We now feel that we can live our best. My child is my asset. I wasn't happy when my son was labelled as being "disabled," so I did my best to make his weakness be his strength, and his strength become his superpower.

Dr. Tasnuva Tunna, Ph.D., is the Founder of Autism Success Academy. This program helps autistic children reach their highest developmental success and potential by providing parents with the tools they need to be their child's primary care provider. Dr. Tunna is neurodiverse herself and an autism mom of three, residing in Ottawa, Canada. Dr. Tunna writes and advocates regularly in printed media, in her blog and on social media platforms. She is a trained and certified Pharmacist, a published scientist, an educator, author, and cook. You can subscribe to her email newsletter where she shares transformational resources for a parent's mental health, as well as information on autism health, well being, nutrition and lifestyle.

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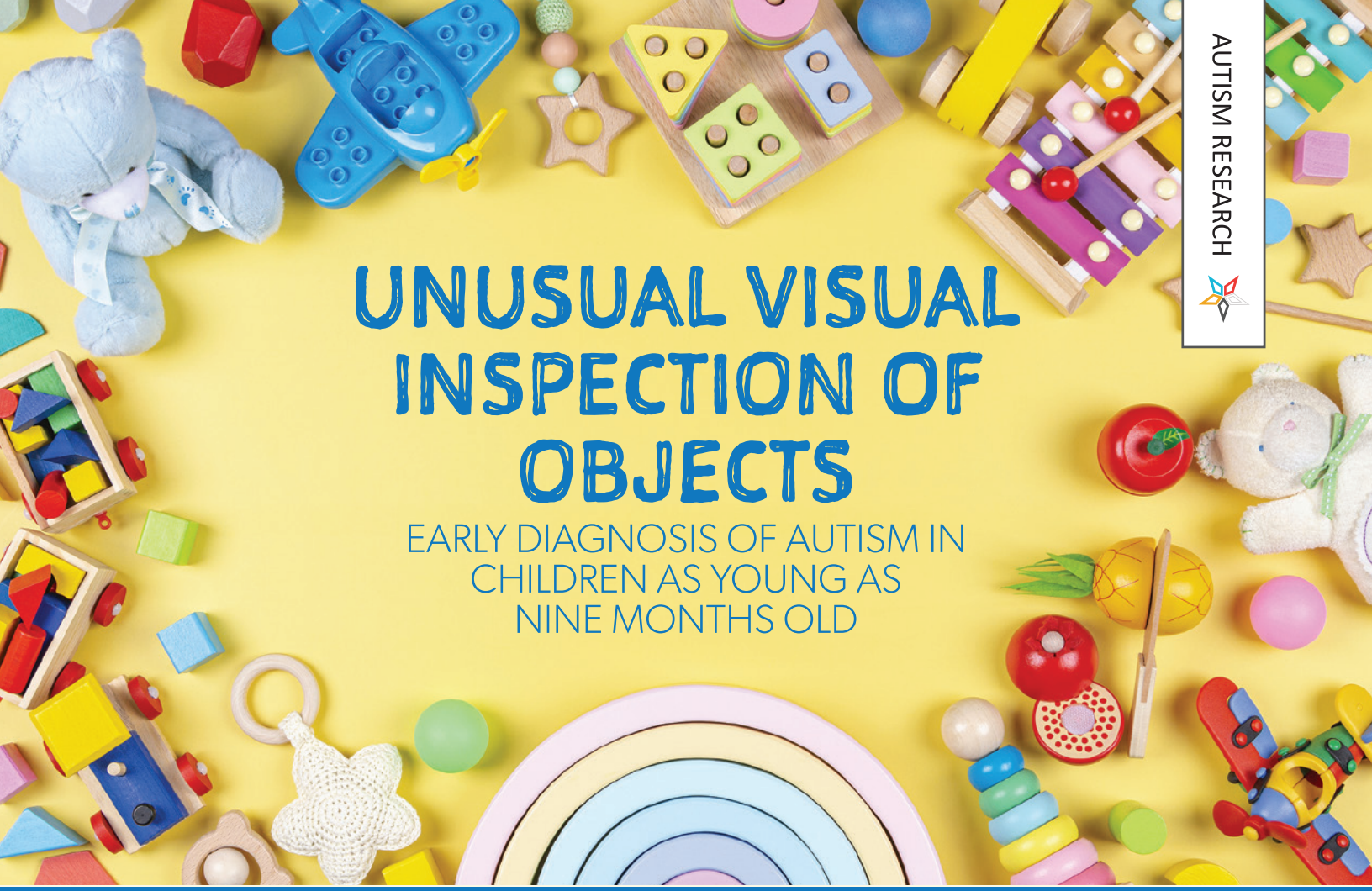

UNUSUAL VISUAL INSPECTION OF OBJECTS

EARLY DIAGNOSIS OF AUTISM IN CHILDREN AS YOUNG AS NINE MONTHS OLD

This article is a review of the following research: Miller, M., Sun, S., Iosif, A. M., Young, G. S., Belding, A., Tubbs, A., & Ozonoff, S. (2021). Repetitive behavior with objects in infants developing autism predicts diagnosis and later social behavior as early as 9 months. *Journal of Abnormal Psychology*, 130(6), 665–675.

Autism spectrum disorder (ASD) is a neurodevelopmental condition characterized by social communication deficits, as well as restricted and repetitive behaviors, interests or activities.[1]

Social deficits can be seen early in many children with autism. These can include not making eye contact, preferring to play alone, and not responding to their name. However, abnormal repetitive behaviors are more difficult to detect since repetitive behaviors are a part of typical childhood development in the first year of life. This makes autism extremely difficult to diagnose in an infant. Many practitioners wait until toddlerhood to make a formal diagnosis to ensure that the behaviors are in line with autism spectrum disorder (ASD).

Even though autism is not typically diagnosed until toddlerhood or later, early detection is extremely important and can make a significant difference in an autistic child's life. When autism is diagnosed early in life, children can receive important supports during key developmental periods of growth. Research has shown that autistic children are more likely to gain social, emotional, and physical skills with early intervention.[2,3]

Given the importance of early detection, it is worth asking if there are early repetitive behaviors that can help clinicians reach the diagnostic criteria needed to make an accurate diagnosis in infants.

Some studies have found that infants who later develop autism show higher levels of stereotyped motor mannerisms and repetitive movements at 12 months of age.[4,5] Another study showed that 12-month-old children who later develop ASD inspect toys by spinning and rotating them, and by staring at toys for more time than their peers.[6]

A research team led by Dr. Sally Ozonoff wanted to build on these findings and investigate if there are any repetitive behaviors that could be identified in autistic children before their first birthday. The team also sought to determine what relationship these repetitive behaviors have with social engagement.

Study

Study participants were either infant siblings of children with autism, or high risk, or infant siblings of typical development, or low risk. Each child was evaluated at 9, 12, 15, 18, 24 and 36 months of age. In each evaluation, children were given four different toys or objects to play with for 30 seconds each. After each toy had been presented individually, all the objects were presented together for 30 seconds. The clinicians watched for any unusual visual inspection of the toys. This would include: examination of the object from odd angles; squinting or blinking repeatedly while examining the object; and staring at an object uninterrupted for more than 10 seconds. They also watched to see if the children rotated the toy to examine it, or if they tried to spin it.

In addition, clinicians examined each infant's social engagement behavior at each time point. They measured the infant's frequency of eye contact, frequency of shared effect and overall social responsiveness. At the end of the 36-month trial, each child was categorized as being in one of three groups: low-risk non-ASD; high-risk non-ASD; and ASD.

Results

- As early as at nine months of age, children with autism had significant differences when presented with a toy. They engaged in 139 percent more unusual visual inspection of objects when compared to the low-risk non-ASD group. At 9, 12, 15, 18, 24, and 36 months of age, autistic infants more frequently examined objects from odd angles, squinted or blinked repeatedly while examining the object, and stared at an object uninterrupted for more than 10 seconds.
- Children with autism were found to rotate and spin their objects more than children without an autism diagnosis. However, this was not prominently seen at nine months of age but was more evident at 15 to 18 months of age.
- Children who had unusual visual inspections of objects at nine months of age showed low levels of social engagement three months later at age 12 months.

Conclusion

This study presents some interesting results. The researchers have identified an early marker and potential diagnostic tool for identifying autism in children as young as nine months of age. When paired with social deficits seen in autistic infants, this could be grounds for an earlier diagnosis of autism than at the standard two to four years old.

This research also highlights the fact that the unusual visual behaviors seen in playing with toys **predicts** which children will go on to develop social deficits. The finding implies that children with autism are focused on objects and toys instead of engaging with parents, siblings and peers, and that they miss key social development and engagement. This information could help clinicians and parents to introduce therapeutics that encourage and improve social development and engagement from a very young age.

This finding of unusual visual inspection of objects is the earliest behavioral predictor of autism yet documented, and could be a game-changer for diagnosticians. This study should be replicated using a larger sample size to confirm the results, but it is a promising finding for future generations.

Written by Autism Advocate Parenting Magazine

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CATS AND AUTISM

RESEARCH SUGGESTS A MUTUALLY BENEFICIAL RELATIONSHIP

This article is a review of the following research: Carlisle, G. K., Johnson, R. A., Koch, C. S., Lyons, L. A., Wang, Z., Bibbo, J., & Cheak-Zamora, N. (2021). Exploratory Study of Fecal Cortisol, Weight, and Behavior as Measures of Stress and Welfare in Shelter Cats During Assimilation Into Families of Children With Autism Spectrum Disorder. *Frontiers in Veterinary Science*, 8, 643803.

Many studies show that children and families with autism benefit from having a companion animal or pet in the home.[1] Pets can exercise a calming influence, lower stress and anxiety, and help teach responsibility. They can also be a listening ear, a companion and a playmate. One study showed that autistic people smile more when they are around animals, and that children with autism tend to be more verbal with classmates in the presence of an animal, such as a guinea pig.[2] Another study showed that children with autism had a decrease in problem behaviors, such as hyperactivity and inattention, after the adoption of a cat.[3] The research clearly shows that an animal can benefit a child with a diagnosis of autism.

While we know that autism families can benefit from a pet, it is worth considering if the relationship is beneficial to the pet as well. A child with autism sometimes has unpredictable or aggressive behavior, as well as meltdowns, which could cause a pet increased stress. This, in turn, could trigger undesirable behavior in the pet, such as aggression, weight loss, or medical complications. Families should seek to find a pet that will be just as happy to be a part of their family as they are to have it as a family member.

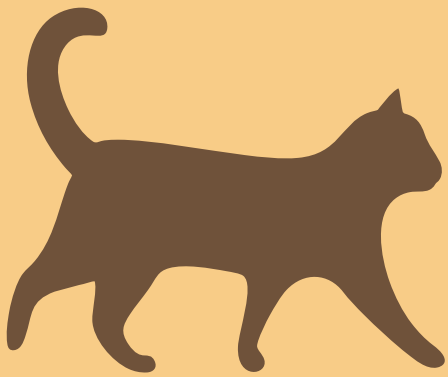
Cats are one of the most popular household pets. The American Veterinary Medical Association reports that about 31 million households in the United States have a cat as a pet.[4] Cats are considered good pets for families with autism because their behavior is fairly predictable, they usually don't jump up on people, they typically aren't very loud, and they do not require as much care as other animals.

Researchers from the University of Missouri wanted to investigate the stress and welfare of cats living in homes where one or more of the children has autism.

Study

In this study, cats from a rescue shelter were adopted into homes where one or more of the children had a diagnosis of autism spectrum disorder. Prior to adoption, each cat underwent a Feline Temperament Profile to evaluate its temperament, sociability, flexibility and aggressiveness. Only cats with easy-going temperaments were adopted into homes in order to increase the likelihood of a long-term match.

Cortisol, a stress hormone, was measured in each cat by collecting and analyzing the cat's feces. Weight was also measured during the course of the study as weight loss is a sign of stress. Measurements were taken in the shelter, two to three days after adoption, and then in weeks 6, 12 and 18. The cats were between the ages of 10 months and four years old.



Results

- The results showed that the cortisol levels — an indicator of stress — decreased after the cats were adopted into the home.
- Most cats gained weight initially and then maintained their weight for the duration of the 18-week study.
- There were no reports of aggression, anorexia, decreased appetite, or inflammation of the bladder known as cystitis, all common stress indicators in cats.

Conclusion

Although the study was small and preliminary in nature, the results suggest that cats with calm temperaments are not stressed when adopted into a home with an autistic child. The cats showed no sign of distress or aggression in the homes, which suggests a mutually beneficial arrangement.

The results could have differed if the cats were not screened for temperament, and if the cats adopted in the home were skittish or aggressive. This highlights the importance of ensuring that families, with or without children with autism, choose a pet with a temperament that is a good match for their family.

As next steps, the researchers could repeat this study with a larger sample size and include families without autism for comparison purposes, as well as households with varying levels of noise and aggression. While more research is needed, this exploratory study suggests that families thinking about a pet may wish to consider adopting a cat.

*The research presented in this article was funded by the Human Animal Bond Research Institute (HABRI) and EveryCat Health Foundation.

Written by Autism Advocate Parenting Magazine

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Augmentative and Alternative Communication

Brandi Wentland, M.A., CCC-SLP

Many children with autism spectrum disorder (ASD) have difficulty with verbal speech, and demonstrate receptive and expressive language disorders. While some may have no verbal speech, others may have verbal speech with echolalia or a limited vocabulary. Augmentative and Alternative Communication (AAC) has been shown to be an effective means of communication that also improves verbal speech.

What is AAC?

AAC often involves a speech-generating device (SGD) or tablet with an application and voice output. However, it includes all the ways we can communicate, including gestures, texting, written messages, ASL, and picture communication boards.

Light-tech vs. High-tech

AAC can be broken into two categories: high-tech and light-tech. Light-tech supports are tools and printables that do not involve electronics or require batteries. They can include letterboards, PECS™ (Picture Exchange Communication Systems), core boards, PODD™ (Pragmatic Organization Dynamic Display) and more. High-tech supports include anything that is electronic. Many people assume you need to start with light-tech and gradually move on to high-tech, or that it is a choice between one or the other. However, current best practices in AAC suggest using multiple modes of communication. Some companies, such as PicSeePal (www.picseepal.com), Cboard (www.cboard.io), and Lincare AAC (www.lincareaac.com), are working together to bundle light-tech with high-tech AAC. They recognize the importance of having light-tech in outdoor situations, like the pool or horseback riding, or in messy play in occupational therapy in order to prevent a high-tech device from being damaged. Additionally, light-tech supports can be beneficial in that they are lightweight, easily transported, and can be worn during active sports. When a high-tech device is not charged or is broken, light-tech can be used as a backup. Additionally, caregivers and staff may find that modeling is easier to achieve on a light-tech board or system.

Aided Language Stimulation

Aided Language Stimulation (ALgS) is a strategy in which a communication partner pairs verbal speech with a gesture or selection on an AAC device. For example, when a teacher says, "It is time to go to lunch," she could pair this by pointing to the word "go" on the individual's communication system. However, some users of AAC do not like to have others touch or use their device. In these situations, a teacher could use a light-tech board to model the word "go" near the user of AAC. If a caregiver or staff member is unfamiliar with the AAC device and location of the symbols, a light-tech copy of the AAC system can be printed through a screenshot from the device and utilized to model AAC. This lets the caregiver or staff member become more familiar with the layout of the vocabulary set.

The Cost of AAC

The cost of AAC may be a barrier for some families. Light-tech AAC is often less expensive or free. In some developing countries where cost, electricity, or technology may be a barrier, light-tech AAC may be the only solution. Cboard considered some of these obstacles and, with support from UNICEF, created a free, open-source AAC high-tech solution that is available on any platform. Recently, Cboard began partnering with PicSeePal to offer a light-tech solution for use in situations in which technology and electricity

are a barrier. PicSeePal is a light-weight, splash-proof and durable light-tech AAC housing solution. Together with Cboard, PicSeePal is creating a free vocabulary that can be utilized for high-tech and/or light-tech AAC.

We all want our children to be able to communicate with us. It gives our children a voice, confidence, and self-esteem. An SLP can provide an AAC evaluation to help determine which AAC works best for your child, and can help facilitate effective communication. Parents can print and laminate each of the pages below so that they remain durable.

Brandi Wentland, M.A., CCC-SLP, is a speech-language pathologist who specializes in augmentative and alternative communication (AAC). She is passionate about coaching communication partners on their AAC journey and provides AAC training and implementation through social groups, consultations, and ongoing therapy. Brandi is a professional development provider who has presented courses on AAC at conferences, schools, clinics, universities and privately held events. After graduating from California State University, Chico, she taught a course on AAC for graduate students. Brandi has helped start Out & About community groups for AAC users across the country. She administers various Facebook groups for AAC including: We Speak AAC and Out & About. Brandi is the US Distributor for PicSeePal and co-authored the book, *Becoming an Exceptional AAC Leader*.

My Letter Board

YES

NO

1 2 3 4 5 6 7 8 9 0

A B C D E F G H I J

K L M N O P Q R S

T U V W X Y Z ?

It starts with...

New word

I'd like to ask you something.

I'm not sure.

I made a mistake. I'll start again.

Thank you.

My Core Board

who	yes	family	can	do	drink	and	good	bad	in	no
what	I	he	eat	finish	get	for	big	little	out	not
where	my	she	go	help	like	is	all	some	on	bathroom
why	it	that	look	make	need	to	fast	slow	off	here
when	you	they	open	put	stop	was	same	different	up	water
Keyboard ABC...	People	we	Actions	turn	want	with	Describe	more	down	Groups

Onion Rings

INGREDIENTS

gluten free flour + extra for coating onion slices ..... ½ cup + 2 tbsp

water ..... ½ cup

flax egg (1 flax egg = add 1 tbs flax meal to 2 tbs water, mix, and allow to set for 5 min) 1

OR vegan mayo ..... ¼ cup

baking powder ..... ½ tsp

salt, plus extra for sprinkling ..... ¼ tsp

large onion 1

favorite spice(s) (for example, 1/2 tsp chili powder + 1/4 tsp garlic + 1/4 tsp cumin)

oil for frying

INSTRUCTIONS

Combine flour, baking powder, water, flax egg or vegan mayo, 1/4 tsp salt and spice(s) in a medium to large mixing bowl. Mix with a whisk for about 1 to 2 min until well combined. Set mixture aside. If using a pan to fry, pour enough oil in the pan to be 1 inch deep, and warm over medium high heat until approximately 375°F. If smoke appears, the oil is burning. Take it off the heat, allow to cool and discard oil. If using a deep fryer, add 1 inch of oil and preheat to 375°F. If using an air fryer add 1 to 2 tbs of oil to the tray and preheat to 400°F.

Cut onion into slices no thicker than 1/8 to 1/4 inch. Coat sliced onion in flour and allow to rest 1 to 2 min. Dip flour-coated onions into the prepared batter and add to the pre-heated oil. Cook about 1 to 2 min per side or until golden brown. Remove the cooked onion rings from the oil with a slotted spoon and drain the oil from the rings by placing them on a paper towel or a clean cloth to absorb any excess oil. Serve immediately with your favorite sauce.

NOTE: Hot oil is dangerous and must be handled with care. Never add water to hot oil.

I'm David Chapman and I am an artist, father of five kiddos, and the 'cook' at home. I prepare food that is healthy and tasty without gluten for my family and amigos. I like being in charge of the fridge and groceries, and I try to keep the best and freshest ingredients nearby for us and the kiddos.

The need to eat quickly turned cooking and baking into hobbies for me, and having family members with sensitivities to gluten while being picky eaters (some of them) challenged me to prepare food that is healthy for them while still being tasty.

Feeding a family three times a day can be daunting. For a while, I felt like a "stay-at-home-COOK!" But it doesn't need to feel that way. Cooking and baking without gluten or casein are really very simple. I like to share ideas and ways to prepare food that is healthy and, of course, tasty, without gluten. Follow me on instagram for more great recipes: @Tasty_without_gluten

Happy Cooking!

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Social Story Printable

INSTRUCTIONS

This Social Story is provided as a template for parents and caregivers. This PDF is designed to allow you to replace the sample text with your own words, using language that is appropriate for your child. You can leave the text as is, replace it with your own, or print the pages with no text at all.

The sequence of images and words will help you teach your child important concepts. We hope you enjoy these Social Stories and have success using them in your daily living.

The Following Social Story Was Written by Robyn Weilbacher, M.S. CCC/SLP

Robyn is an award-winning ASHA Certified Speech-Language Therapist, Certified Autism Specialist, and Certified Hanen Centre Speech-Language Therapist for the *More Than Words Program*. She has been working with children ages two to six years old for more than 30 years.

Robyn established *RW Language Therapy and Consulting* (Specializing in Autism, Family Support, and Coaching) to teach families that have children on the Autism Spectrum how to build functional communication and social-language skills in everyday life experiences, activities, and interactions at home. She provides resources, therapy, strategies, and customized materials, such as social stories, core words, and visual supports.

Robyn teaches Hanen Centre's *More Than Words* evidence-based 8-week program for families having children ages two through five on the Autism Spectrum. By providing tools, strategies, and real-life videos, families can better connect with their child and expand purposeful, interactive communication and social interactions. Services are provided via video conferencing.

RW LANGUAGE THERAPY AND CONSULTING
www.rwltc.com
robyn@rwltc.com

My Social Story:

I Can Ask For Help

Sometimes I don't know what to do.

Sometimes things are hard, and I need help.

Maybe I can't reach the juice in the fridge, or I need help brushing my teeth.

Maybe I need help with my schoolwork.

Maybe I've finished my chores, and I don't know what to do next.

I don't need to cry, get mad or get frustrated.

I can use my words and say, "I need help."

My parents and my teachers are happy when I use my words to ask for help.

I am proud of myself for asking for help.

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My Next Steps

Knowledge Combined with Action is a Key for Success.

What inspired me?

What is something new I learned?

Items I want to research further:

Items I want to discuss with my Autism Support Team:

Doctors, Researchers or Professionals I would like to contact for more information:

My Next Steps

Items I would like to implement/notes


“If you’ve met ONE INDIVIDUAL WITH AUTISM, you’ve met ONE INDIVIDUAL WITH AUTISM.”
— Dr. Stephen Shore


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