



Feeding and Autism

BY ASHLEY STEPHEN, SPEECH-LANGUAGE PATHOLOGIST, BCBA

“Feeding disorder” is a broad term that is often used to describe abnormalities in a child’s diet that results in inadequate nutritional intake. The child’s poor diet may result in a failure to maintain or sustain a typical growth rate (Crosby, 2007; Piazza, 2008).

Approximately 67% of children with autism can be described as “poor” or “picky” eaters (Williams et al., 2007). These children may have strong food preferences, may refuse to try new foods, and/or may have a very limited diet. Children with autism may also insist on their food being prepared the same way, a specific brand, or mealtime rules. Attempts to expand the child’s diet may be met with behaviors like whining, crying, and pushing foods away. These behaviors may make meal times a struggle for both the child who refuses to try a new food and for the parent who is worried about their child’s health.

There are multiple causes to why a child may refuse to eat new foods. The first reason a child may have feeding issues is that they have a medical condition such as food allergies or gastro-esophageal reflux (also known as GERD or acid reflux). We often recommend that your physician, prior to beginning any treatment, rule out medical causes as they may cause pain or discomfort for the child while he or she is eating. Second, the child may have weak and uncoordinated muscles within the mouth making eating and chewing difficult. A child’s muscles may be weak if they have not learned how to chew different textures at an early age. The last possible cause is behavioral issues. Ultimately, they just don’t want to eat what you are giving them.



It can be very challenging to pinpoint feeding challenges to one cause and may in fact be caused by a combination of all three: medical issues, motor deficits, and behavioral challenges. So where do you even begin? As previously mentioned, it is very important to talk to your physician about any feeding challenges your child has and rule out any medical conditions. Your physician may then recommend that a behavioral therapist, speech therapist, and/or an occupational therapist do a feeding evaluation. Treatment may be recommended to improve the feeding problem.

At Gabe’s Place, feeding treatment is conducted by a classroom behavior therapist using methods of Applied Behavior Analysis (ABA) and is overseen by a Board Certified Behavior Analyst and/or a Speech-Language Pathologist. Your child may be a good candidate for feeding therapy if any of the following apply:

- Food or drink refusal
- Difficulties swallowing
- Gagging or choking during meals
- Vomiting while eating
- Behaviors occur when trying new foods
- Pocketing food in their cheeks
- Insistence on preparing meals the same way

If you are interested in beginning treatment to target feeding issues please contact the center today.



INSIDE THIS ISSUE

Meet Our Staff	1
Student Spotlight.....	1
Four Functions of Behavior.....	2
Home Visits.....	2
Most Current Research	3
Feeding and Autism	4

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Meet Our Staff

Front Row: Beth Cowart, Ivy Hiatt, Jamie Sims, Samantha Borowiak, Brittany Case, Ashley Burgoyne, Christina Nickert and April DeGroat

Back Row: Joey Norcross, Veronica Kazmierski, Katalin Geeck, Leah Palm, Tim Obertein, Drew Gerow and Jessica Ray

Not pictured: Michelle Griffin, Trevor Charbonneau, Carmen Poink, Farrah Piegols, Justine Snyder, MacKenzie Lipps, Autumn Sacquety, Cody Repragal, Kara Laitinen and Morgan Trinklein



Student Spotlight: Tristan

Tristan has been attending Gabe’s Place since April 2014. At that time, he was not potty-trained, had constant self-injurious behaviors, limited learning readiness skills, no fine motor skills and could only say a few one-syllable words. Being in a new place with new people, Tristan showed his anxiousness and frustrations through problem behaviors such as flopping to the floor. Today, Tristan is fully potty-trained and has all of his learning readiness skills and excels in more difficult programs such as following multi-step written direction, sequencing, labeling attributes of objects, beginning middle and end sounds, concepts of print, prepositions and adding! He is also learning many fine motor imitation skills. Tristan quickly worked through one and two syllable words and can now independently form sentences and requests. The number of instances per day of self-injurious behavior, as well as flopping, has significantly decreased. Tristan loves to learn and has mastered many programs. He gets excited about anything to do with letters or counting and loves to count “super duper fast”. Tristan works very hard every day and we are incredibly proud of him and all of his progress and accomplishments!



TRISTAN

Fun At The Center...



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The Four Functions of Behavior BY SAMANTHA BOROWIAK, BEHAVIOR THERAPIST

We know that these suggestions are best case scenario and sometimes life is too tricky to always be thinking behaviorally towards your child, because they are just that, a child. If you have a question about a behavior your child engages in and need help identifying what it is and what you can do at home to help, please contact Joey, Tim, Ashley, or your therapist. We are always happy to help.

FUNCTION	EXAMPLE IN EVERYDAY LIFE	WHAT TO DO	PREVENTIVE MEASURES	WHAT NOT TO DO
ONE: Tangible	At the grocery store, child wants to buy cookies and you say no. They drop to the ground or start screaming.	Ignore the behavior. Keep shopping or end the trip if the behavior becomes too much to handle.	If this is an usual occurrence, tell child "first shop nicely, then cookies" (or some other reinforcer).	Do not buy the cookies to get child to stop tantrum.
TWO: Attention	Child dumps toys after they have just been cleaned up and is looking at you while smiling or laughing.	Start by ignoring child. If you are able to consistently ignore them, the behavior should go away on it's own. Try to catch child before toys are dumped while making little or no eye contact, if they start to engage. Help them play with the toys appropriately.	Give child lots of attention while playing with toys, and a lot of reinforcement for playing with toys and not engaging in the dumping behavior. If they are constantly receiving attention, they should not be searching for it any other way.	Never scold or say "no". When the function is attention, the child may not care if it is positive or negative attention. Try to clean up the toys without being upset or without the child watching, and do not tell them to clean them up.
THREE: Escape	Trying to get a child to eat a new food or child throws food on the floor.	Put small amounts of food in front of them at a time, so they can't get away from all food at once. Use first, then statements and always have a reinforcer.	If this is a new food, have very small quantities of the target food and a large reinforcer. If it's just something they don't like before they start tantruming, give them appropriate words to use (i.e. "Can I have something else" or "No thank you")	Once the behavior has started, do not give them something else to eat. This will create an escape contingency and trying new foods or eating anything that isn't preferred will start to always end like this.
FOUR: Automatic	Putting toys or other inedible objects in mouth.	Prompt the child to do whatever the decided replacement behavior is. Reinforce the replacement behavior.	Find a replacement behavior. Something that is more acceptable that still reaching the same goal for the child. An example of a replacement behavior: If a child engages in hitting because they like the feeling of force on their hand, teach them to clap hands or give high fives to get that same feeling in a more appropriate way.	Very dependent on the situation. In most cases, we don't just ignore. Ignoring it alone will not make it go away.

Home Visits and Why They Are Important BY JOEY NORCROSS, BCBA

At Gabe's Place, the goal is to have at least two home visits yearly. These visits serve an important purpose. When kids are at Gabe's Place they are one-on-one with us and we have control over most variables that could affect treatment. When a child goes home, they are go back to real life where parents are busy with the entire family, running errands, cooking, cleaning, etc. It's impossible for any parent to have 100% control over all variables in everyday life no matter how well organized or ambitious the parent may be. Here is what we can do at a home visit:

- Analyze behaviors
- Behavior management strategies
- Community outings (dentist, haircuts, etc.)
- Eating new foods
- Eating meals at a table
- Toilet training
- Environmental arrangements for teaching at home
- Generalization of skills
- Identifying opportunities for transfer of skills
- Sibling training

A BCBA and a therapist will come to your home and work with your family to maximize your child's potential at home. These visits also help the child's treatment team to make adjustments at the Center based on observations made in the home environment. If it has been awhile since your last home visit, or you haven't had one, please contact us to set one up as soon as possible.

OUR VIEW ON THE Most Current Research

This short section is to give you our advice and opinions on the current research on prevention, causation and treatment of autism. It's great that you want to be as educated as possible to help your child, and we want to help steer you in the right direction.

Autism and C-Sections

BY JAMIE SIMMS
BEHAVIOR THERAPIST

A recent study published in the *JAMA Psychiatry* journal noted an association between Autism and C-section deliveries. Evidently, Autism is 20% higher among children born by caesarian section. This may appear to some pregnant women a very frightening statistic when considering birth plan options, but if we take a closer look at the facts in the article, it becomes clear that there is no evidence that C-section births cause Autism. When using sibling controls, no association was found, meaning this correlation is caused by others factors, such as genetics or environmental factors. It is important to recognize words like "association" and "correlation," as neither of these words imply cause.

Over the past decade there have been a multitude of debates on whether or not the measles, mumps, and rubella (MMR) vaccine causes autism. The controversy began when British researcher, Andrew Wakefield fraudulently claimed that he found a link between the two. It later was revealed that he falsified the data to support his hypothesis. Since the claim, numerous amount of studies have looked at the different ingredients in the MMR vaccine and all research findings are consistent with no link between MMR vaccine and autism. One study looked at vaccinated verses non-vaccinated children and some who had older siblings already diagnosed with autism. This study found that even with having an older sibling, there was no difference in autism comparing the vaccinated and non-vaccinated children. Studies have also been done to test the different ingredients in the MMR vaccine, and no links have been found between any of the ingredients in the MMR vaccine and autism. Lastly, the number of antigens was looked from time of vaccine through 2 years of life and compared children with autism spectrum disorders (ASD) and children without ASD. Results indicated that there was no difference in the amount of antigens present between the two groups. The Center for Disease Control is confident to say that "there is no [known] link between the MMR vaccine and autism". If you have more questions on these specific studies, please contact the center and we would be happy to go over them with you. In all, we would recommend getting the MMR vaccine if you are questioning it only because of the false accusations of it causing autism. Measles, mumps, and rubella are preventable, and at this current time autism is not.

Autism and the MMR Debate

BY SAMANTHA BOROWIAK
BEHAVIOR THERAPIST

Pre-Symptom Marker of Autism

BY LEAH PALM
BEHAVIOR THERAPIST

Autism Speaks recently posted an article finding a pre-symptom marker of autism. Researches used a group of 92 children all with older siblings diagnosed with autism. This group of children was given a special type of magnetic resonance imaging (MRI) called diffuser tensor imaging. The MRI was given at 6, 12, and 24 months of age. All of the children were also give a behavioral assessment for autism. 28 of the 92 children were diagnosed with ASD. In these 28 children researchers found distinctive differences in the white matter of the brain compared to those who were not diagnosed. White matter is made up of nerve fibers that connect the different regions of the brain. The differences found in the children diagnosed with autism suggested a blunted development of this brain wiring during early infancy, which is earlier than core clinical symptoms are found. The research team observed the pattern of differences in all 15 white matter tracks of the brain that were examined in the study. The researchers say it is too early to tell if this MRI can be used to identify children at risk for ASD in early infancy. This may be something useful in the future, but today it is still correlational, and does not infer causation. Looking for changes in white brain matter could show progress if it was causal and even then, if the brain matter changes but inappropriate behavior persisted, it would be insignificant. It is important to remember to always take new and emerging research with a grain of salt, because often, when more in depth research is done, the results don't hold up.