



## **Autism Spectrum Disorder**

Though we start this page with a diagnosis statement to make sure we draw your interest to this page, we want to be quick to state that we do not plan a child's intervention program by diagnosis alone. What are of most interest to us are the child's developmental profile, his / her individual strengths and weaknesses, and the family structure.

### **What we believe**

When we design an intervention program for a child on the spectrum, we always assume intelligence, no matter how much relational difficulty there may be. There is a developing person in there who may be afraid of the stimuli of this world, but is also yearning for human contact. This human contact is very necessary and core to developing the deficit of, what scientists call, "theory of mind". So many children and families arrive at our door looking for the answer with regards to social skills, relationship recognition and a need for the child to be able to play with peers. Simply putting them in a group or with another child is not the answer, but looking at what is contributing to the developmental delay certainly is.

We are not a medical diagnostic center and we are not about deciding which diagnosis is going the right fit, but we are about the "how" and "what" to do to intervene in the life of each individual child.

We also need families to understand that it is not about age, the brain remains neuro-plastic until we leave this world permanently. The prime time for maturation of the central nervous system does occur between 5 to 7 years of age, but this does not mean there is a sudden cap or ceiling at that age. Once a child is older, his habits and most frequently used central nervous system pathways are more strongly formed, and even though this might mean taking a longer time to work through these habits, it certainly does not mean that we cannot effect change. We see ample change in also older children.

When we deal with a pervasive developmental disorder, we are dealing with a neurobiological factor and this factor involves the central nervous system. In order to effect change, you have to deal with the development of all the entry points of stimulation of the body as this is the first order of business as the baby is born. This does not mean families should not seek biomedical interventions if they are so inclined, but it refers to where our intervention program starts. Something else might have caused the "injury" (still much debate about that), but we are more concerned with the downward spiral of the developmental delay that it causes. It is a simple fact that we have to consider the origin of a problem, if we are going to be able to affect the product.

We believe in the inner self of each child and any child's internal drive to want to connect to another person. We do not believe that it is about the behavior or the outcome or product, that which we can "see". It is about what is causing that behavior to occur, what is making this behavior necessary for the child to use it, and how do we deal with this in our intervention plan. We do not believe in extinguishing behaviors for the sake of public need or an adult need for the child to "fit in", though of course we consider it. We believe in the child's ability to react to what pressures the environment is placing on him or her and that the child would want to participate in anything they feel successful at. On that same level, they will want to avoid what they do not feel successful at or feel uncomfortable with. All of us love our comfort zones and being a child does not make this affinity any different.

One of the key features of our program is to work on that internal drive to become motivated to want to participate in the world around them, to find pleasure in relationships and the complexity that this brings to the table. This is not an easy quantifiable or researchable area, but it is the very complexity and individuality that we as typical adults enjoy in our relationships with people. This is, in essence, true theory of mind.

We believe in play, not regimen. It is through play that all typical children learn in the early developmental years and it is through the fun of play that we can draw children into the world. The belief that play has no meaning but is considered a passing of idle time is a myth. Children gain so much richness from play in terms of social and cognitive abilities, including sequencing and problem solving, not to forget mentioning what is socially acceptable to a play partner or not. Most children come to us with strong delays in play skills, yet we expect them to understand what it means to be in a group, to attend to circle time, and to understand concepts that we take for granted in typical children. Children with delays in play skills have difficulty understanding how their selves fit into any social sphere, how cause and effect really works and what change really means.

Other concepts they have difficulty with are concepts of before and after, time, sequences, and also the concept of order. These concepts are not found in curriculums today, but it is expected of the learning child. Typically developing children learn this through play and it highly affects their readiness with regards to academic achievement. Children with this diagnosis are usually cognitively intact, but because of the lack in development in these developmental areas they are unable to show and comprehend the richness of learning and the abstract meaning of concepts, which causes them to compensate with their extensive memories and literal capacities to learn. It is not about teaching the understanding of non-verbal skills, it is about applying methods and techniques to facilitate these very necessary areas of development in order for the child to more fully grasp complexity, rather than only focusing on what he or she sees.

A final thought is that it is about process and not product. If a child understands the "how" in getting there and has the ability to figure things out, the product will always be there. The building of self esteem does not lie in following other people's expectations or agenda's, but having the ability to cause an effect on something or someone yourself and know that you have

done it. The achievement has to be yours! So many educational programs we visit are very well meaning and well thought through, but lack the understanding of the complication the child's emotional world brings to the table. Sometimes it is not about inability (often wrongly assessed as uncooperative, unwilling or even stubborn), but about fear and anxiety and using whatever means the child has to get out of the situation. It is so important to us that our families understand this, though we understand that these areas are incredibly gray and our need is so high for the child to be "better" and enjoy life more.

### **A Developmental Progressive Program**

Over the years we have developed a phase system that seems to work well with our children who exhibit pervasive developmental delays. Our program is defined as a developmental progressive program that truly enhances all the developmental aspects based on typical development. The program does not constitute a "cure", as many adults with spectrum disorder diagnosis would prefer not to be referred to as "cured or being cured", but we have certainly seen much success in transitioning children into public school systems with minimal to no assistance. It is also not an overnight cure and is certainly no "quick fix", but it focuses on the steady development of core issues affecting the very areas of need that we see in their learning and behavior.

Though the methodology used in the different programs may appear to be similar for some children, the art of facilitation and programming is different for each child. We have not originated the different programs, though we certainly hold certifications in all the different aspects and attend national and international conferences to remain updated in newest developments. We have researched these programs and have first-hand experience that these programs work as described in the multiple [testimonials](#) on our website. It is not about only having one program to offer, but deciding at each juncture, which program would be more beneficial for the child at this point in time of his or her development. What we will describe now is the general direction of an intervention program that might take 18 months to 3 years, though not ongoing and with periods of consolidation and "breaks".

#### **Phase One:**

The developmental processes that started during the development in the womb continue to work on maturing the central nervous system when the baby is born. This is the first place of origin, not in terms of causal entities, but in terms of known intervention program planning. We use [Sensory Processing](#) as our primary "developer" in the first phase of 6 months. In order for the brain to learn and grow, it has to depend on the processing of incoming information as a first process. If the processing in our different senses is delayed, it makes sense that the way we organize and respond to the incoming information will be delayed as well. During the initial [evaluation / screening](#) all the different sensory systems are looked at in depth and the primary players that is causing the most difficulty is identified. Our occupational therapists and physical therapist is trained in sensory processing work and there might be different possible options for your child to consider.

## **Under Age 2**

At this time, we might suggest attending [occupational therapy](#) and/or [physical therapy](#) on a weekly basis with the combination of home programs at home that might include [Therapeutic Listening](#) over a stereo system at home. We also might recommend a 5 week course in [Infant Massage](#) (not just for infants) to empower the parent with a powerful tool that is not only essential to the somatosensory system, but also assists tremendously in those early bonding and attachment times. To also initiate social and emotional wellbeing and play, we would recommend [DIR / Floortime](#) services as well. This could be in the form of a weekly visit, when an occupational therapist will coach the family in how to use this method at home more effectively to effect generalization of skills as early as possible. This could also occur through our [P.L.A.Y. Project](#), which consists of monthly home visits.

## **Over age 2:**

We would recommend weekly visits with [occupational therapy](#) and / or [physical therapy](#), again with the combination of home programs that may include sound therapy, such as [Therapeutic Listening](#). Or we might make a recommendation for a stronger clinic based intensive program, which will include occupational therapy and / or physical therapy with [Tomatis Training](#). This program has been highly effective in creating lasting results in children of many different ages and there are multiple [testimonials](#) on our website testifying to this.

There are some things we would like to mention with regards to intensive programming. Families often have the idea that an intensive program would be a “quick fix” for their child. We have not seen this exist. What we have seen, is that if you stay true to development and gently build the developmental layers one step at a time, the child certainly has more “hold” for the layers that still is to come. During the course of adding Tomatis sound therapy work to our therapy intensives, we have seen quite miraculous results and we have seen slower results. Though it is becoming easier with experience to predict some possible outcomes, the focus must remain on the process of development rather than expecting speech on the second day of treatment. The treatment is highly individualized and follows the curve of the child’s development. We have certainly witnessed some general areas that always improve, such as body awareness, motor planning, more awareness of the environment (being more open to the world), increased ability to play and certainly improved listening ability. We always see increases in the areas of sensory processing during our post assessment after the intensives.

Another aspect that families need to understand about intensive neural work is that most of the time the clinical changes are seen, before the functional changes at home and at school. The child has adapted to his or her developmental delays, which has become the comfort zone with which they cope with. Just because we have new pathways does not necessarily mean they will trust it overnight, but some children need a little bit more time after intensive treatment to enable the new skill and start trusting it enough to use it. Having said this, there

are of course other children who appear to have been waiting for this change all this time and start using it as soon as possible. Much depends on the emotional life of the child, and their hidden fears and anxieties. Sometimes we see a complete “waking up”, just as described in the book “Awakening Ashley” (Sharon Ruben), only then to go through a period of apparent “regression” afterward. This is never found to be a true aggression, but rather an overreaction to the ability to take in more information than before and not quite knowing what to do with it. It is almost like the blind man, who can now see, but wish he could not, because the visual world simply contains too much information and is considered too overwhelming. We do not want to create unrealistic expectations in parents and therefore we are taking the time to make this clear. At the same token though, read the [testimonials](#), as we really do get remarkable results from this highly effective intensive therapy program.

Just as children might be hypersensitive to sounds, they might also be quite sensitive to visual information and we might recommend an [Irlen Syndrome](#) screening for some children to assess whether colored filters might correct their visual perceptual experiences. At the end of the first 6 months of treatment intervention, a re-assessment is completed to compare the changes made, as well as plan the next steps of intervention.

## **Phase 2:**

For some children this phase (6 to 12 months) is a continuation of the weekly [Occupational therapy](#) and [Physical therapy](#) services with home programs, as well the [DIR / Floortime](#) work. We also would like to assess the child’s speech language therapy intervention programs from other sources at this time. Since the child’s is more receptive to language work at this time, the time is ripe for children to really benefit from more intense [Speech Language therapy](#). Some children might benefit from one or more 10-day booster loops of therapy intensives with [Tomatis Sound Therapy](#). Others might be ready to complete a program called [Interactive Metronome](#). This program is ideally suited in the developmental trajectory when the child is struggling with sequencing, albeit in motor skills or speech language skills, or organizational skills, social reciprocity and timing, as well as needing improved motor coordination skills.

Sometimes we might see from our assessment that the child can benefit from more [Sensory Processing](#) work with Tomatis Sound Therapy, but in combination with the [Interactive Metronome Program](#). We will then combine the two programs in a 15 day intensive over 3 weeks to complete occupational therapy work with [Tomatis Training](#) during the first hour and [Interactive Metronome](#) in the second hour. This frequently occurs when the child is not quite ready for the exact rigor of the interactive Metronome program, and needs some intensive therapy work in the first hour to gain more intensity and readiness. All the while though, parents will report functional changes. This phase is generally concerned with working on the motor planning and organizational structures of the brain and will also affect the child’s ability to pay more effective attention and also promote increased active working memory. At the end of this phase another [re-assessment](#) occurs.

## **Phase 3:**

This phase could also constitute a period of between 6 to 12 months and could still involve weekly therapies with home programs, though the home programs are more directed to refining higher order skills and executive functioning skills, such as social and fine motor skills. It makes developmental sense when you consider that we have first spent time working on incoming processing, then how the brain organizes it, then how the child produces a product, albeit socially or academically. So frequently we observe treatment plans that want to see the fine motor and social skills develop above and beyond what the child's developmental layers are capable of. When you test fine motor dexterity the child may have all the fine motor muscles intact, but it is really how the brain is organizing itself in applying the goal to the action. Some IEP's (Individualized Educational Plans) have handwriting as a goal for years, yet if the child is unable to plan his or her thought into a productive action, all we will have gained is rote memorization skills, which inhibits the child's ability to perform flexibly in a timely manner with the same timing and rhythmicity than his or her peers.

During this phase we could also be recommending more therapy intensive work through the combination of Occupational, Physical, Speech Language and DIR / Floortime therapies. These could also occur in combination with Tomatis Sound Therapy, Interactive Metronome and [Captain's Log](#), a cognitive training program with a big boost in attention ability. Intensives could be planned for two, three to four hours daily for a period of two to 4 weeks and usually with 2 to 3 months break in-between.

We might also recommend an intensive loop of [occupational therapy](#) to specifically target learning to read and write the alphabet. The first level is working through the alphabet upper and lower case. The second level works on word attack, and the third level on reading and writing comprehension. We also utilize [Balametrics](#) and other laterality based activities during these three levels of programming. This program, might be a combination of more than one intensive of 10 days times 2 hours daily with weekly visits in-between and will be individualized for each child's needs. Attention is paid to the complex visual, auditory, and motor aspects of learning to read and write.

Even though some children, with a pervasive developmental diagnosis, have been observed to read from as early as the age of 2, most of these cases were found to be cases of hyperlexia, a reading diagnosis made when the child is able to identify the different stable shapes of the letters, but not derive meaning from reading. Research has also shown that it is not the language center in the brain that is lighting up during this type of reading, but the areas of the brain that are more concerned with form and shape. In order to create meaning from reading and put your own thoughts on paper, we still have to go through intervention programming for this area.

At this time we hope to not have overwhelmed you, but to have given you insight into what it takes to plan a comprehensive intervention plan for a child on the spectrum. We also do not contend that other medical, biomedical, counseling or other services are not relevant, as we

certainly do refer as needed. This is merely a synopsis of what we are currently offering as we continue to develop our understanding of this very complex neuro-biological disorder.

### **For Siblings and Families:**

***Mothers:*** We offer a Tomatis Pregnancy Program for mothers in their third trimester of pregnancy. Since research is showing us that many siblings of older brother and sisters could have possible developmental delays as well, we wanted to offer something for at-risk mothers as well. Since we have seen so frequently how children calm down and express so much less anxiety while in our intensive programs with sound therapy, we want to offer this same calming opportunity to the pregnant parent. It is only a 10-day commitment, but quite powerful in calming both parent and unborn baby. The new born baby can hear and smell everything the mother is exposed to in the third trimester of pregnancy. We also then highly recommend completing the 5-week course of [Infant Massage](#) as soon as mother can make it in after the new baby is born to assist with those crucial early developmental months.

***Siblings:*** Many parents have requested over and over again for programs to assist the siblings of their children with special needs. Groups do work to some extent, especially when the children are able to verbalize their feelings and able to express them. We have found another avenue over the years to be quite effective and this is through the medium of [Play Therapy](#). This therapy focuses on the child's external expression of their inner self in a totally accepting and validating way. We have referred many families to play therapists in our areas with great success. We are currently planning to provide this therapy at our facility as well. This makes it easier for parents to travel to one place and possibly have both children receive their therapy at the same time.