

How to Teach a Child with Autism to Talk

By Renai Jonas, Ed. D, CCC- SLP

It is well documented that speech and language impairments and communication deficits are symptoms of children with Autism Spectrum Disorder (DSM IV-TR). Approximately twenty-five percent (25%) of children with Autism Spectrum Disorder (ASD) are nonverbal (do not talk). These children are able to communicate using other means (Autismspeaks.org, 2011), such as leading, sign language, or by using helpful devices, such as the iPad. However, it is encouraging to know that by eight years of age many children across the autism spectrum are able to talk or communicate at some level.

The following concepts, suggestions, and proven strategies may contradict long standing beliefs about an individual's perceived inability to speak. I recognize the value of these beliefs and do not wish to negate them, nor give parents, grandparents or significant others false hopes. However, over my past 37 years of experience working with children who have acquired speech after being diagnosed as nonverbal, I feel it is critical that the following approach(es) be given equal consideration and application as any others. While there is much debate about which approaches to speech development are the "right ones," there is no debate when it comes to the universal commitment of all parents and therapists to help every child reach his or her fullest potential. After all, the right approach is the one that works for each individual.

In order to turn a nonverbal child into a verbal child or to speed up speech and language development, first it is necessary to determine why the child is not talking. The following are six possibilities:

1. The child is not interested or motivated to talk (a symptom of Autism).
2. There is a motor planning issue. The child may have difficulty forming the sounds necessary to talk, making it too difficult to speak. There may be unsuccessful attempts to speak. Their sound repertoire can be severely limited to only a few consonants and vowels with a consistent vocabulary of only one to five word approximations, i.e. "ahm" for mommy or "yahyah" for daddy or "ahmah" for grandma. This is often diagnosed as childhood onset Apraxia as opposed to adult onset Apraxia caused by a stroke (an identifiable neurological impairment). Apraxia occurs more frequently in children with ASD than suspected and often goes undiagnosed at first.
3. The child communicates effectively by using nonverbal means, i.e. tantrums, leading (bringing), showing, sign language or gestures, using an augmentative system (e.g. Picture Exchange Communication-PEC pictures/book, iPad, Dynavox), etc.
4. Others talk for the child.
5. All needs are anticipated and met without the need to communicate.
6. The child has poor focus and attention with an increased activity level.

The first step the family should take in order to evaluate the nonverbal child is to schedule an audiological assessment (formal hearing test) by a licensed audiologist to rule out hearing impairment

(especially if this runs in the family). It is equally important to schedule a speech and language assessment by a licensed speech and language pathologist who is experienced in both Autism and Apraxia.

I feel it is extremely important for parents, grandparents, other family members and caregivers to learn how to encourage the child to learn the skill of orally speaking as soon as possible in order to reduce behavioral issues resulting from frustration and to develop social interactions. Even though alternative means of communication like the iPad and PECS are very helpful, these can always be introduced when speaking alone is not going to be a successful means of communication. However, first and foremost, early on (starting at 8 to 12 months), I want parents as well as significant others to focus on the following suggestions to develop and enhance speech in children with Autism.

The My-COMMUNICATION Approach

My motivation is the key to talk or to communicate. If the child is not motivated, create a motivation! For example, don't allow the child get a desired object or food unless a sound(s) is produced. Later, you can go back and shape the sound in order to develop a closer word approximation or clearer word, phrase, or sentence (e.g. "I want more").

Can't talk. Talking (motor planning) is too difficult? Make it *EASY!* When it is too difficult to form the sound, then the sound(s) must be physically shaped at the mouth by the adult. For example:

Hold the lips closed for "m" (for the word more)

Round the lips for "w" (for the word water)

Other means of communication must be abandoned or avoided at first. Focus on *TALKING!* The child will use the method of least resistance. If sign language or another means of communication has been introduced, then there may not be a need to speak unless the child is also expected to vocalize (use a word or word approximation along with the nonverbal means). With sign language a child's hands are readily available and easier to use to communicate rather than to talk verbally. In fact, the research during the past five years has shown that when a deaf child is given surgery (cochlear implant) to restore hearing, sign language must be discontinued or not introduced since this will slow down speech development. In children with ASD, alternative methods to communicate do not encourage speech production or face to face contact except for PECS which involves a communicative exchange and is more cumbersome. I have found clinically that giving a child more when he uses the sign for "more" often reduces a young child's attempts to vocalize "more," delaying the ability to produce the word.

Make the child attempt to say the word. At first, any attempt is acceptable. Wait for the child to vocalize before you give the highly preferred item (placed in front of the child). As soon as he/she verbalizes (not cries) he/she gets the toy/edible and you say, "You said more, more pretzels." This will encourage communicative intent (when I say this, then I get that).

Make a choice. Do not anticipate the child's needs. Give a choice, "Do you want a pretzel or water" and *wait* for a response.

Under your nose. Get the child's focus and attention by holding the object near your mouth even if it is only for a few seconds. The child will make closer attempts if he/she sees your mouth produce the sounds, words, etc. Looking also increases focus and attention.

Nose and eye level. Get down to the child's level so you can talk eye to eye and face to face.

It's too fast. Slow down your rate of speech when talking to a young child. Speak slowly and clearly.

Communicate one word ahead of the child (e.g. if the child is using a one word utterances such as "go" you should use two words such as "papa go") when giving a direction or requiring a response.

Asking should be avoided. Commenting is preferable. Use more comments than questions. Instead of "You want more?" say, "Oh, you want more!"

Two compliments/praises should be given per attempt/utterance at first. Praise is always good!

It's easy. Focus on frequently used words such as:

yes /no	cookie	open	stop	potty
eat	water	up	go	
drink	ball	help	hi	
all done	I want	give me	bye	

As the child practices these words that occur naturally all day and day after day, the approximations will get closer and clearer.

Oh blow. Use blowing games, noisemakers, blowers, and wind instruments that require lip closure and lip rounding such as:

- bubbles
- blowers
- horns & wind instruments

No anxiety. Do not get anxious or get the child anxious. Turn every attempt into a positive one. If the child cannot imitate or produce a sound or a word, then accept and praise an approximation.

It is my experience that individuals (parents, grandparents, caregivers, significant others, teachers, therapists, etc.) who use **The My-COMMUNICATION Approach** in order to help the child learn to talk or to produce clearer speech will see the child advance in speech, language and communication skills within a matter of months.

Dr. Renai Jonas is a Speech and Language Pathologist who has been providing pediatric intervention for the past 37 years with a specialty in Autism and Apraxia

Written by: Renai Jonas Ed.D.,CCC-SLP, drrenaikjonas@gmail.com

May 2012