

Residences: does size matter?

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residents each) clustered around specialized medical, job-related, recreational and domestic centers. The homes, in contrast, had an average of only four residents each and—unlike the campuses—were indistinguishable from other houses in the community.

S. Lister Brook and D. M. Bowler report that “the only significant changes found in individual subjects’ behavior [after moving from the hospital to the campuses or homes] were a decrease in performance on cognitive tasks... [and] improved reports of cooperativeness and greater use of household equipment.” Most of the changes were seen in individuals moved to the campuses, not those moved to the smaller homes. In addition, significant reductions in behavioral problems occurred in the campus group but not the individuals who moved to group homes—possibly because the latter had fewer behavior problems to begin with.

The researchers say that 12 of 17 “lifestyle measures,” such as freedom of movement, privacy, and contact with community residents, became more “normal” after the move, but that “these changes [were] not accompanied by similar levels of change in the residents’ levels of skills and behavior.”

Brook and Bowler say previous studies, which almost uniformly found that smaller home-like settings led to more adaptive skills and fewer behavior problems, tended to have “a number of problems of design.”

Norwegian study: size matters... somewhat

A recent study from Norway suggests that the size of individual living units within facilities is more important than the overall size of facilities—but that differences are insignificant once size increases beyond five residents per home.

Jan Tøssebro evaluated retarded subjects in 36 different facilities, using staff inter-

views. Two measures—privacy and self-determination—were studied. According to Tøssebro, “the size of the facility had insignificant or minor impact on the measures considered.” There was a moderate correlation, however, between privacy/self-determination ratings and the size of each living unit in a facility. The difference was only apparent, however, when unit size dropped to five or fewer residents.

Tøssebro notes that since higher-functioning children tend to be placed in smaller homes in Norway, even the moderate advantages that appear to accrue from reducing residency below five may be an artifact. In addition, the researcher notes, “the small units are some kind of *avant garde* for the ‘improvement-movement.’ and this position may have caused the quality advantage.”

“It’s not where but how you live: choice and adaptive/maladaptive behavior in persons with severe handicaps,” Christopher A. Kearney, V. Mark Durand, and Jodi A. Mindell; *Journal of Developmental and Physical Disabilities*, Vol. 7, No. 1, 1995. Address: Christopher Kearney, University of Nevada at Las Vegas, Las Vegas, NV 89154.

—and—

“Community adjustment of mobile people with learning difficulties after total hospital closure: a preliminary report,” S. Lister Brook and D. M. Bowler; *Journal of Intellectual Disability Research*, Vol. 38, Part 3, June 1995, pp. 177-185. Address: Sarah Lister Brook, Centre for Social and Communication Disorders, Elliot House, 113 Masons Hill, Bromley, Kent BR2 9HT, England.

—and—

“Impact of size revisited: relation of number of residents to self-determination and deprivatization,” Jan Tøssebro, *American Journal on Mental Retardation*, Vol. 100, No. 1, 1995, pp. 59-67. Address: Jan Tøssebro, University of Trondheim, Dept. of Sociology and Political Science, N-7055 Drogvoll, Norway.

LETTERS

Dehydration, SIB: Help!

To the Editor:

Our four-year-old autistic son has been hospitalized for dehydration on four occasions—every six months from the age of two. He eats and drinks normally but then throws up everything.

Our doctors are baffled. Readers who can shed light on this problem, please call.

Richard Bazy
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To the Editor:

I would like to get in touch with other parents, anywhere in the world, who have children with severe self-injurious behaviors. Nothing we have tried has worked. I would like to get together a group of parents in my situation.

I wish self-injurious behavior was classified as a separate and unique disorder. Quite frankly, our son’s autism doesn’t even matter any more. All we do is try to control the self-injury. He has our entire house wrapped around his finger.

Kimberlie Gilbert-Oakley
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Sensory integration therapy

To the Editor:

[Re ARRI 9/2 article on the question of whether or not sensory integration therapy is effective:] As an occupational therapist providing sensory integration treatment in a clinic setting for (currently) around 30 autistic children, I experience frustration with the lack of research.... Part of the problem results from the poorly recognized components of what sensory integrative treatment is. It is a total approach. Studies and facilities have tried to evaluate it and use sensory integration fractionally. Behavior modification used inconsistently and incorrectly is not very effective, either.

For parents looking for an effective approach, the following definition from an article published by Sensory Integration International should be considered:

1. Active participation.
2. Child directed.
3. Individualized treatment.
4. Purposeful activity.
5. Need for an adaptive response.
6. Input varies on child’s response.
7. Activity rich in proprioceptive, vestibular and tactile input.
8. Implied or stated goal of improving processing and organization of sensation (not teaching of specific skills).
9. Administered by a trained therapist (occupational or physical).

I have designed a tool for measuring changes in the autistic children we treat, and we see children moving to within the grossly normal range in sensory registration. Subjectively, parents have reported a decrease in

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LKS therapy effective in atypical case

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A diagnosis of LKS is generally based on specific abnormalities detected by sleep EEGs. In their new paper, however, Stefanatos et al. report on an autistic-like six-year-old child who did not have an abnormal sleep EEG, but still responded to corticosteroid treatment.

The researchers tried the treatment despite the boy’s normal EEGs, because a SPECT (single-photon emission computed tomography) scan revealed abnormalities in his frontal and temporal lobes which were consistent with LKS. In addition, auditory evoked potential studies designed to test for LKS showed unusual brainwave patterns.

Stefanatos et al. treated the boy with the drug prednisone and report that “within several weeks of treatment, there was a significant increase in spontaneous speech, greater responsiveness to verbal communications, and improved social relatedness.” In addition, they say, “significant gains were

evident on measures of receptive and expressive vocabulary, although auditory comprehension showed only moderate improvement.”

“We suspect,” the researchers say, “that this case may be representative of a subgroup of children who receive the diagnosis of PDD or autistic disorder and have histories of early language regression.”

Editor’s note: See ARRI 7/4 for report from Germany on the use of megadose vitamin B6 on seizures in infants. The B6 was found to be better and safer than the conventional treatment with steroids.

“Case study: corticosteroid treatment of language regression in pervasive developmental disorder,” Gerry A. Stefanatos, Warren Grover, and Evan Geller; *Journal of the American Academy of Child and Adolescent Psychiatry*, August 1995. Address: Gerry Stefanatos, Child and Adolescent Psychiatry, Thomas Jefferson University, 1201 Chestnut Street, Suite 400, Philadelphia, PA 19107.