

Situation Improvement Summary

The aim of this essay is to identify an individual's situation in need of improvement and provide ways in which the situation can be improved through the use of an action plan.

The client chosen for this essay has been diagnosed with 'classic autism' since the age of four. He is now seven years old and has been attending a special school for seven months. For the purpose of the essay the client's parents and teacher have allowed me to observe and access confidential information needed in order to gain an understanding of the problems later identified. Before identifying the problems it is important for nurses to understand what autism is and how the individual is affected.

Autism is a spectrum developmental disorder that affects many aspects of how an individual communicates and relates to the world around them (Howlin, 1997). This means that the individual can be affected to different degrees, and no individual is the same (Legge, 2002). Currently there is no treatment available to cure autism as the cause of autism has not been fully identified. There are some medications which improve problems associated with autism such as hyperactivity behaviour.

Over the years many causes for autism have been suggested. It is evident from ongoing research that the causes of autism involve genetics, biology and neurology in combination with a number of environmental factors, such as infections, antibiotics, vaccinations, allergies and toxins that may all have a vital significance (Yapko, 2003).

The physical dysfunction of the brain causes the inability to interact with other human beings and communicate their needs and not, as once thought the result of emotional disturbance caused by inadequate mothering (Yapko, 2003). Viral encephalitis before birth or in early childhood has also been implicated as a cause of autism. Good epidemiological evidence argues that the Measles, Mumps and Rubella (MMR) vaccine is not an environmental risk factor for autism (Nursing Times, 2003).

The most common explanation is that several genes appear to be involved, and the extent to which someone is affected depends on their combined effect. Ives et al, (2002) found that three to six per cent of siblings of individuals with autism also have autism or a related developmental disorder. It was also found that upto a further twenty per cent of siblings have milder problems such as language delay or social difficulties. Recent studies suggest that parents with one child with autism are a hundred times more likely to have another child with the condition compared with other families (BBC News, 2004). Furthermore the BBC News (2004) reported that scientist Dr Buxbaum and colleagues have identified a gene that may increase the risk of developing autism. The gene involved is part of a molecule that provides the energy that cells need to function. The children used for the study were found to have variations of this gene and this could disrupt the production of fuel needed by the cells. Obviously the condition is far more complex than this and more than one gene is involved. When all or most of these genes have been identified then new diagnostic tools and approaches to treatment can be developed.

The prevalence rates have shifted over time. Autism is now thought to be relatively common (Gabriels et al, 2002). The National Autistic Society (2003) suggests

that autistic spectrum disorders have been identified in five hundred thousand families in the United Kingdom. Currently there is no central register of all people with autism. The current estimated rate of people with autistic spectrum disorders in the United Kingdom is ninety-one per ten thousand people (Shattock et al, 2001). Autism is found in families of all races, ethnic and socioeconomic background (Holmes, 1998). The condition affects four times as many boys as girls, however Yapko (2003, pg 39) states that 'when females are diagnosed with autism, they are typically more severely affected and exhibit more severe mental retardation'.

Individuals with autism have difficulties in three areas of development, Wing (1979) called these the 'triad of impairments' (Gabriels, pg 69, 2002). These are verbal and non-verbal communication, social interaction and imaginative play (Gates, 2003). Difficulties such as inconsistent patterns of responses to smells, sights, sounds and abnormalities in behaviour, sleep patterns and eating and drinking patterns are also common.

The causes of speech and language problems are unknown. Watson (1989) suggests that autistic children often fail to understand the purpose and meaning of language as a means to influence their surroundings (Gabriels et al, pg 27, 2002). Those who can speak often exhibit impairments in their ability to initiate and sustain conversation. Fifty percent of autistic children never develop useful language (Yapko, 2003). The child may repeat phrases over and over again or use echolalia, repeating what others say without understanding the meaning of what is being said. Further more, they are likely to confuse personal pronouns, for example talking about the self in the third

person, and may have problems with turn taking in conversation. Many do not make eye contact and have poor attention skills making communication difficult. The National Autistic Society (2003) suggests that if a child does not want to communicate they will not explore their ability to vocalise, learn new sounds or listen. This will ultimately result in a delay in their language acquisition. While communication problems are often a major concern, the underlying core deficit in autism is believed to be in social behaviour (Williams et al, 2000).

Garfin and Lord (1986) state ‘children with autism lack social understanding’ (Gabriels et al, pg 129, 2002). They fail to develop typical peer interactions and relationships and show no understanding of how others feel or think. They have the inability to attribute thoughts, beliefs or actions and are averse to affection, particularly of a physical kind. Self occupying behaviour and an inability to participate in group activities are usually apparent. Much of their behaviour is routine-led, and if their routine is broken they become extremely distressed. This is because they are unable to extract meaning from their experiences and therefore fail to anticipate what will happen next; routines are therefore a means of avoiding surprises which might be distressing to them. Restricted, repetitive, and stereotyped behaviours frequently represent what is most easily observed to be normal in autism. Autistic children tend to play in repetitive ways, they have the inability to develop imaginative play like their peers and may interact with toys in an unusual way, such as arranging the same toy(s) by colour or shape. From a recent speech and language assessment the client is currently at the exploratory stage which is recognised in three to twelve month olds. It is evident from seeing him play that he is at this stage as he explores the toys rather than use them for imaginative play like his peers.

The client has 'classic autism' this means he has severe qualitative deficits in all three of the triads described above (Yapko, 2003). By the age of thirty-six months a small proportion of children diagnosed with classic autism have snippets of exceptional ability in areas such as drawing, music and mathematics (DfES, 2002). The client is extremely good at drawing although the pictures drawn are repetitive unless he is told what to draw.

Finally before looking at the problems needed to be improved the nurse needs to understand what the diagnosis process is for autism as they will need to explain this to the child's family. It is not easily recognisable in its early stages; however the onset of autism is within the first thirty months of life, although abnormalities are generally apparent from birth. Howlin and Moore (1997) states that 'Autism is observable in very young children but it may not be diagnosed until age four or five' (DfES, 2002, p8). This is because all children regardless of whether they have autism develop at different stages in the early years of life. There are no medical tests to diagnose autism. The only way to diagnose is through a combination of clinical observations and questions from a multidisciplinary team of professionals made up for example, with paediatricians, dieticians, educational psychologists, and speech and language therapists all who have experience of autism. The overall diagnosis is made using criteria found in the Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association or the International Classification of Diseases (ICD-10). In order to be diagnosed with an autistic spectrum disorder a person must have at least six of the possible twelve diagnostic statements with at least two from the area of social impairments and at least one from each in the areas of communication and behaviour (Yapko, 2003).

From observing the client within the school environment I have chosen two main problems that need to be improved, both regard the issue of eating. Firstly the child has a very poor appetite and refuses to try new foods. If he is asked to try them he starts crying. This causes disruption for others trying to eat their meal. Secondly, he will only pick certain types of food which are limited in range, such as chicken nuggets, chips and mars bars, all of which could compromise his health.

In order to develop an action plan it is important that the nurse understands her role in eating and nutritional issues when dealing with autistic children. As I have included a lot of information in the essay the plan will be placed in the appendices (see appendix one), along side the techniques of managing the problem (see appendix two).

The 'Charter of Rights for Persons with Autism' (1992) states that the client and their family have a right to be involved in all decisions affecting their future and their wishes must be respected. It is also advised by the Department of Health (2001) that 'children with autism are children first and their needs as children should be the main focus.' The nurse needs to understand the psychological profile of autism, and know how to encourage healthy eating alongside meeting the needs of the family as a whole, whilst working together with other professionals. One skill of the nurse is to ensure parents and the child that they are not to blame for the problems that occur and provide support for any concerns they have (Legge, 2002). Having good communication skills will help the parents and child adjust to what is happening around them.

The dietician for example will rely on the nurse for accurate information about the child's condition and in particular, comment on the child's progress and help comfort the

child. Good record keeping is essential not only from a legal perspective but in enhancing the relationships between the dietician, family and the nurse (Grandis et al, 2003)

There are many explanations into what causes children with autism to have difficulty eating for example, they are resistant to change, have a tendency to cling to special routines and fear anything new (Wing, 1996). Another explanation is that if the child is sick during tasting a new food they will associate the food with being ill and therefore afraid to try the food again. Cornish (1998) and Isherwood et al (2003) both state that children with autism frequently have very selective eating habits that go beyond the usual 'picky' eating behaviour seen in most children. The National Autistic Society (2003) found that the difficulties are due to sensory sensitivity (including oral), difficulty accepting new foods, the colour, texture, and packaging of food, the temperatures the food requires, routine, environments, and presentation. Set routine's can also upset some autistic children, for example if a roast dinner is given on a different day rather than the day they are use to they will not eat it (Legge, 2002). Cornish (1998) found ninety-four percent of parents with autistic children reported feeding difficulties compared to fifty-nine percent of parents with normally developing children. Batchelor and Kerslake (1990) claim that one in twenty children suffer feeding problems and that feeding difficulties seem to be more prevalent in children with developmental disabilities (Legge, pg 9, 2002). An autistic child does not understand the importance of needing to eat (Wing, 1996). Food is essential for the body to function. It provides us with energy to maintain structure, function and protect us from diseases (Hogston et al, 2002).

The Government Food Standards Agency (2003) says that a seven year old male should have an intake of around one thousand nine hundred and seventy calories a day depending on his level of activity. They should also weigh around twenty to twenty-five kg depending on height. From weighing the client and observing what he eats, no improvement is needed surrounding weight. Over the six weeks the client's parents and teacher have kept a report containing his daily food intake. Despite the limited types of foods eaten he may not need to take any vitamin and mineral supplements. This can easily be identified by seeing a dietician who can calculate the client's daily intake and work out whether any vitamins are missing in his diet. Evidence suggests that most autistic children do not suffer nutrient intakes as low as might be expected (Cornish, 1998). In fact forty-seven percent of children in Cornish's (1998) study met the recommended nutritional intake. If the child takes adequate quantities of essential nutrients and fluid, it does not matter if they refuse certain kinds of food, or eat only one meal a day. This obviously takes away a great feeling of guilt from the parents as they have said they feel as though they are not feeding him properly.

A balanced diet during childhood helps to ensure that children grow well and do not become overweight as they get older. Experts advise us that a balanced diet should consist of at least five servings of fruit and vegetables a day. A study carried out for the Department of Health (Gregory, 2000) shows that on average British children are eating less than half this amount. The client currently eats no fruit and vegetables and this obviously covers a large proportion of proteins and vitamins needed daily, therefore this is one of his goals to achieve through support. Starchy food should be one third of the client's intake as this is rich in fibre, vitamins and minerals which are a good source of

energy. These can be found in pasta, rice, potatoes and bread. This is another type of food the client refuses to eat. These foods should then be supported with moderate amounts of meat or fish as these contain more proteins and vitamins. The client currently only eats chicken and fish fingers. Regular milk and dairy products should also be in moderation as they contain proteins and calcium (Grandis et al, 2003). Fat, salt and sugar should be eaten in small quantities however this is the major part of the client's diet, another area to be improved.

The feeding team will be able to assess what the problem is and develop a plan such as the one in the appendices. This is carried out through a number of meetings over a period of six months. The child will attend a play therapy session, where they explore new foods through the use of all senses and play. By giving the client time to allow their phobia to be broken down in small steps should help them try new foods (Jordan, 1999). The parents will see a clinical psychologist and dietician to discuss how to manage the problems occurring (see appendix two). They then get together for a meal and the child is set a small task to complete, this usually involves the food the child has played with during the therapy session. They discuss how the child feels and what they hope to achieve. However this is not always possible for children with autism, new faces and environments can cause more upset and distress. At present the client seems able to deal with new environments and people if he has a familiar person near by. If he did have a problem then the feeding team would use the telephone to help the parents. Information and assessments are shared, and the parents are encouraged to try out techniques such as those in appendix two to help the child.

As well as the health service the education service is just as important. Legge (2002) suggests that schools are able to support and help introduce new foods, monitor the child's behaviour and keep records to help parents and other professionals involved. Currently the client's school is very supportive and have a very good relationship with the client's parents.

Although special diets are available for autistic children such as the gluten and casein free diet. The National Autism Plan for Children (2003) argue that restricting the diet of a child who already has rigid eating habits can lead to an exacerbation of feeding problems. Therefore I have decided not to include this in the action plan at this stage. If he develops a more healthy appetite and chooses more food then the diet could be used to eliminate some autistic behaviours.

The roles of the professionals are to assist parents with concerns about eating and provide techniques how to overcome these. A systematic introduction of new foods and facilitation during meals on a routine basis may be appropriate. Most children with autism given patience and interventions are eventually able to establish socially appropriate behaviours around eating. Through the use of information provided in the essay and appendices the overall improvements can be evaluated through records, observations and questioning. If the child chooses different types of food this can also help suggest that the plan has worked. As a majority of children have used similar plans devised by feeding teams in hospitals it would be good to assume that this plan will work for the client.

To conclude I feel that the aim of the essay has been achieved. I have improved the situation through the development of an action plan, supported this through biological, physiological and psychological explanations whilst reflecting on the role of the nurse and professionals needed to help the client. Obviously if the word limit was increased I would have included more evidence and arguments to support my judgements.

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