



THE MILLER METHOD NEWSLETTER™

Fall Quarter, 1996 Arnold Miller, Ph.D., Editor Vol. 1, Issue No. 3

GESTURE RESEARCH WITH TYPICAL BABIES SUPPORTS MILLER METHOD USE OF SIGNS

The Millers have long held that gestures contribute to the development of spoken language. They demonstrated the importance of signs for children with autism in their 1973 article (Cognitive Developmental Training with Elevated Boards and Sign Language, *Journal of Autism and Childhood Schizophrenia*, 3, 65-69) and in their 1989 book (From Ritual to Repertoire, New York: Wiley). It is for this reason that the use of gesture-signs is an integral part of the Miller Method. Now there is research which documents that the use of gestures by typical babies is part of their natural development and both precedes and facilitates their first words.

This view is presented in a new book by developmental psychologist Linda Acredolo ("Baby Signs, How to Talk with Your Baby Before Your Baby Can Talk," Contemporary Books, 1996 with developmental psychologist Susan Goodwyn) which shows parents how to interpret a baby's signals and how to develop enough signs together to have conversations.

Based on 12 years of research the book documents the finding that infant gesture-signs precede and contribute to the development of spoken language. A good example is pointing. "It develops from reaching," she says. "The baby wants something, leans toward it, reaches, grunts. The parent responds. Soon the reach becomes a point, a gimme gesture. We respond without thinking twice." We model gesturing which the 7-9 month old baby begins to imitate: the crooked finger for "come here"; a finger in front of the lips for "quiet"; your head resting on your hands for sleep. Given the greater ease of forming gestures than words, it is not surprising that the infants gesture meaningfully well before the first word appears at between 10 to 14 months.

These findings are consistent with our view that gesture-signs are an important stepping stone toward functional spoken language for disordered as well as for typical children. It is for this reason, we feel, that many children with autism and PDD who were "stuck" at a preverbal stage of development

The Miller Method Newsletter is a publication of the Language and Cognitive Development Center (LCDC) of Boston. Its purpose is to encourage exchanges of information between Miller Method programs and practitioners in the United States and abroad. For parents of children with developmental problems, this newsletter will always contain strategies for helping children with autism and pervasive developmental disorders as well as a list of parents whose children either are or have been in Miller Method programs and who have volunteered to have their names and phone numbers listed so that they might respond to questions from other parents or professionals.

have been able to resume their language development through the Miller Method. This has happened as teachers, therapists and parents have systematically introduced gesture-signs with spoken words as the children performed actions related to the signs and words they heard. For further information on this important aspect of the Miller Method, request the pamphlet, *A New Way for Children with Autism or Pervasive Developmental Disorders*.



CONTRASTING THE MILLER METHOD WITH BEHAVIOR MODIFICATION

(Editorial Note: Because many parents and professionals have asked us to clarify how the Miller Method differs from Behavior Modification, we have contrasted the two approaches.)

Two Different Mind Sets. The way of thinking behind these two approaches is so different that they cannot be mixed without confusing the child with autism or pervasive developmental disorder. Because the behavioral approach stems mostly from animal research and the work of B.F. Skinner it does not concern itself with whether or not what a child does or says is meaningful. For behaviorists the *appearance* of meaningful performance is sufficient as they assert, "If it walks like a duck and quacks like a duck, it's a duck!" In contrast, the Miller Method – building on the work of developmental psychologists Vygotsky, Werner and Piaget – argues that *appearance* is insufficient because duck-walking and quacking may come – not from a real duck – but from a decoy. For example, a child's production of a word-like sound does not imply that the child knows what he or she is saying or reading. Miller Method workers consider attention to the distinction between "duck and decoy" or between meaningful speech and empty sound-form to be vital for a disordered child's future development.

Attitude Toward Learning. The behaviorist feels that "compliance training" is an essential prerequisite for teaching children with autism and pervasive

Visit Our Website at www.millermethod.org

(Continued from Column 2, Page 1)

developmental disorders. This usually takes the form of requiring the child to remain seated in a chair next to a table (following the model of what typical children do in school). To achieve compliance the behaviorist rewards the child's conforming behavior with praise or candy and punishes undesired behavior by ignoring the child or by some aversive maneuver. Once the child can sit at the table for an extended period, the behavior therapist systematically rewards approximations of words related to pictures or objects in an effort to develop language.

Working from a developmental framework, the Miller Method worker assumes that the child with these disorders can learn best by using his/her entire body. Accordingly, the child is encouraged to climb and move on a variety of elevated structures. On these structures various problems (detours, obstacles) are introduced that the child learns to cope with and solve. Because options are limited by the design of these structures (there are only certain ways the child can move on an "elevated square"), the child's movements become more directed and attention more focused. In this elevated context the child learns how to transition from one task to another since different tasks are performed on stations placed strategically on the elevated structures. The teacher or therapist narrates what the child does (like a sports announcer) so the child begins to relate the words heard and the signs seen, to what he/she is doing. Later, whatever the child has learned on the elevated structures he/she learns to respond to on the ground and elsewhere.

Treatment of Stereotypies. Stereotypies of disordered children (repetitive throwing of objects, flicking light switches, lining up blocks, etc.) for the behaviorist are negative, abnormal-looking behaviors which need to be extinguished either by redirecting the child to other more acceptable activities or by punishing them.

Stereotypies for the Miller Method practitioner are valuable sources of organized, integrated behavior which need to be transformed or expanded so that they become more functional and interactive. For example, repetitive throwing of objects can be transformed into careful dropping of objects into various receptacles in different locations; flicking on/off light switches can be used as one of a series of causal tasks that the child learns to move between

(Continued next page)

MILLER METHOD STRATEGIES FOR PARENTS AND PROFESSIONALS

Dealing with "Glomming"

Glomming refers to the tendency of some children to hang-on-to or "blend" their body with any adult who sits or comes near them. Glomming occurs most frequently when a child feels the presence of an adult next to him or her and persistently tries to lean against them. In the absence of an adult the child tends to "glom" on-to (lean into) the back of his/her chair. This behavior tends to be chronic and actively interferes with the child's awareness of objects or material being introduced by the teacher.

We understand glomming to be related to the child's poor differentiation of his/her body from others and find that "rough and tumble" activity (see Vol. 1, Issue #1) during daily orientation tends to reduce it. We find, also, that having the child sit on backless stools is helpful since the child must now substitute his own erect posture for the adult support provided by glomming. The use of such stools tends to orient the child toward the group around the table rather than backward toward the adult aide. Aides working in back of such a child are trained — while helping the child "hand-over-hand" on certain tasks — to back away slightly when the child tries to glom so that self-righting occurs. This may have to be repeated a number of times until the child "owns" his own erect posture on the stool.

The Randomly Aggressive Child

We have, on several occasions, had children with autism in our program who — without any provocation — would strike out and slap a child passing by or seated next to them at the table. Recently, a 10-year old boy with autism, new to our Center (having been expelled because of his aggressive behavior from his previous school) behaved in this way. Firmly confronting him seemed to have no effect. Indeed, this seemed to be one of those instances where the boy seemed to seek out confrontation — perhaps because the intensity of the teacher's response ("You do not hit other children!") helped him become more aware of himself.)

Going on the assumption that he was groping for a way to experience his own existence, we sought a method that would enhance his self-experience while reducing his tendency to strike out. The technique developed entailed alternating his wearing roller skates on one day and mini-stilts that increased his height by 3-4 inches on another day. The immediate effect of wearing the skates and stilts in school was a dramatic reduction in striking out and other physical assaults.

The reason for this, we felt, was three fold: First, the skates and stilts tended to make him more aware of how he used his body. With skates or stilts on, lashing out at someone could cause him to lose his balance. To avoid this, he had to become much more conscious as to how he moved and used his body. The second reason for the positive effect was that the skates and stilts conferred a certain uniqueness on him. Not only did the skates and stilts make him taller (he tended to be shorter than the other children in his class) but he was the only child in the class that wore skates or stilts throughout the day. The third reason for this method's effectiveness was that it "bought time" for him to establish relationships with both teaching staff and with the other children in his class...These relationships are now making it possible for him to sustain himself in class without striking out and without wearing the skates or stilts.

(multi-sphere strategies); lining up blocks can become an interactive task as the child learns to accept blocks from the teacher or therapist and to tolerate introduced changes as the worker slightly changes their direction, alters their structure or presents them in different ways to the child.

Treatment of Tantrums. The classical response of the behaviorist with regard to tantrums is to ignore them or to place the child in a “time out” place until the child is “ready” to rejoin the group. The assumption here is that any “attention” given the child during tantrum will inevitably lead to “reinforcing” this behavior.

Miller Method workers assume that tantrums are mostly a breakdown in the child’s ability to cope and that they occur for a variety of reasons. Consequently, the approach to a particular tantrumming child is varied. If the tantrum is related to a significant change in the child’s life (loss of loved teacher, new baby at home, etc.) the worker may provide more nurturing and “special time.”

Alternatively, the worker may introduce a repetitive and calming ritual. (One child rapidly resolves her tantrums when allowed to repetitively pour rice or water from one container to another; another child becomes calm with repetitive scribbling with crayon). If all else fails — and the child is in danger of hurting himself/herself or others — the child may be restrained while the worker maintains face-to-face contact and speaks quietly to the child. Under no circumstances is the child ever placed in a “time out” room since this merely intensifies the child’s autistic isolation.

The Role of Interruption. Behaviorists tend not to interrupt an activity that the child is performing because in their view this will make the task “aversive” for the child who will then not wish to continue with it.

In contrast, Miller Method workers understand that once a child has formed a coherent system around a particular object such as putting pegs in holes, interrupting that activity often induces a need on the child’s part to continue that activity. Further, if the worker has been introducing words and gesture-signs with that activity, interrupting it will often induce the child to produce those signs and words as part of an effort to restore the interrupted activity. Used judiciously, interruption of tasks (systems) is one important way to help children develop meaningful language.

PARENTS OF CHILDREN WHO HAVE PARTICIPATED IN AN LCDC PROGRAM

The parents listed below have given their permission to have their names and phone numbers included in this newsletter so that they may share their first hand LCDC experience with other parents of children with autism or pervasive developmental disorders seeking an effective, developmentally oriented program.

LCDC School Program

Barbara & Jack Hitchcock (LCDC/Boston) (508) 376-5365
 Robin & David Hoffman (LCDC/Lynnfield) (617) 334-4067
 Dr. & Mrs. Stephen Kastl
 (Moved from Louisiana to LCDC/Boston) (919) 510-8184
 Dr. & Mrs. Charles Tucker
 (Moved from Kentucky to LCDC/Lynnfield) (502) 753-7463
 Janine and Paul Herron (LCDC/Boston)* (617) 860-7459
 (Moved from Canada)
 Barbara and Jim Witt (LCDC/Boston)* (617) 860-7239
 (Moved from Canada)
 Janet Abramson (LCDC/Boston)* (617) 863-5521
 (Moved from Canada)
 Wilma Arthurs (Robarts School, London, OT) (519) 869-8387
 Joanne & Eric Branzetti (LCDC/Cape Cod) (508) 420-1383
 Lucille & Richard Deroeck (LCDC/Lynnfield) (617) 273-5849
 Eileen & Neil Mullen (LCDC/Boston) (617) 770-4577
 Katherine & John Princiotta (LCDC/Boston) (617) 364-5669

One-Week Parent-Child Training Program

Dolly and Mo Akintobi (770) 449-7415
 Rubina and Karim Jessani (905) 569-2409
 Sherry and John Hoty (216) 967-3291
 Karen and Larry Graham (506) 847-5742
 Katha and Timothy Lacey (301) 933-6368

**Child attended 6-week summer program before being enrolled in regular LCDC School*

Professionals who have recently participated in the 5-Day Intensive Training on the Miller Method

Dr. Steve Buttrum, Clinical Psychologist (905) 890-122?
 Elizabeth Farrell, Special Education Teacher (718) 824-4633
 Vanessa Georges, Speech and Language Pathologist (718) 849-3002
 Lisa Hauben, Special Education Teacher (718) 849-3002
 Sue Henry, Speech and Language Pathologist (519) 453-4400
 Deborah Klinger, School Psychologist (914) 735-3006



ANNOUNCEMENT OF NEW WORKSHOPS

Location:

County College of Morris,
Rte. 10 & Center Grove Road, Randolph, NJ

Fee: \$170. Make check or purchase order out to:
*Educational Services Commission of
Morris County Courthouse*
and mail to:
PO Box 900, Morristown, NJ 07963-0900

Contact: Diane Moscarello 1-201-540-8844 x23

INTENSIVE 5-DAY TRAINING IN THE MILLER METHOD

Open to professionals of all relevant discipline this workshop conducted by the Millers and the staff of the Language and Cognitive Development Center, combines theory with hands-on practice in the course of 30 hours. For those seeking certification as a Miller Method Specialist, this course constitutes the First Phase of Certification.

Registration is limited to 20.

Dates: January 13 through 17, 1997
March 10 through 14, 1997

Location:

The Language and Cognitive Development Center
11 Wyman Street, Boston, MA 02173
Phone: 1-800-218-5232

Tuition: \$975.

1.5 DAY WORKSHOP ON THE MILLER METHOD

*A Developmental Approach for Children with Autism
and Pervasive Developmental Disorders*

Dates: February 14 & 15, 1997

Time: 9:00 - 4:00 PM (Friday);
9:00 - 12:00 (Saturday)

Presenters:

Arnold Miller, Ph.D. & Eileen Eller-Miller, M.A., CCC

ONE-WEEK PARENT-CHILD TRAINING

This ten hour training with parent and child consists of 10 hours distributed over 5 days. The first 2 hours on Day 1 are devoted to assessment. The next 6 hours (Days 2,3 & 4) are devoted to interventions in the areas of major concern (usually socialization and communication). On Day 5 the last 2-hours are devoted to sharing findings, discussing prognosis and future planning.

*Offered throughout the year depending on
openings available.*

Conducted by the Millers and/or Senior LCDC staff.

Fee: \$1975.

Contact: LCDC at 1-800-218-5232.

SIX WEEK SUMMER PROGRAM

Date: July 7 through August 15, 1997

Applications are being accepted now for the summer program located either at LCDC/Boston, LCDC/Lynnfield or LCDC/Cape Cod.

*Acceptance depends on availability of openings in
an appropriate class and results of assessment.*

Fee: \$5800.

Contact: Dr. Miller 1-800-218-5232
for further information.



LCDC

P.O. Box 270 / 11 Wyman Street
Boston (JP), MA 02130