Making Special Accommodations for Special Needs Populations:

Evidence-Based Tips and Tricks to Ease the Evaluation of Special Needs Patients

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Disclosure

I have no relevant relationships with ineligible companies to disclose within the past 24 months.

Objectives

- At the conclusion of this session, participants should be able to:
  - Categorize the unique sensory needs of children with autism spectrum disorder (ASD) and developmental disorders (DD).
  - Identify the responses that children with ASD/DD experience during physical exams, highlighting challenges related to anxiety and specific phobias.
  - Apply behavioral techniques to assist with the use of instruments/procedures that are often problematic in the examination of children with ASD/DD.
  - Describe the common components of coping kits and demonstrate the proper use of these elements during the examination of children with ASD/DD .
  - Discuss current research on the examination of children with ASD/DD, delineating components that may prove useful to clinicians and parents/caregivers.

Pre-test Question 1

- All of the following represent established approaches to facilitate the physical examination of a resistant/agitated patient with ASD except:
  - A. Use of distractive tools such as those found in a coping kit.
  - B. Using specific and detailed written and verbal instructions to outline the entire procedure at all once.
  - C. Modifying the physical environment to tailor the stimuli experience (i.e.- dimming lights, providing head phones, and chewy tubes).
  - D. Providing visual cues of the procedure/exam using visual models such as dolls or stuffed animals prior to performing the procedure.

Pre-test Question 2

- All of the following are methods of alternative communication that you may see commonly used by children with ASD to assist their communication and decrease anxiety/fear with health care providers during their exam EXCEPT:
  - A. Speech Generation Devices (SGD)
  - B. Picture Exchange (PE)
  - C. Functional Magnetic Resonance Imaging (fMRI) enabled speech device
  - D. Micro Switches

Pre-test Question 3

- Based on research performed on the physical examination of children with ASD, which of the following techniques is NOT a preferred technique for the routine behavioral management of fear/anxiety related to physical exam:
  - A. Intermittent graduated exposure to fearful stimuli
  - B. Tell-Show-Feel-Do (T-S-F-D)
  - C. Differential reinforcement of other behavior (DRO)
  - D. General sedation

Roadmap

- Intro/Demographics/Terminology
- Sensory Concerns
- Communication Concerns
- Safety concerns (Anxiety/Fear)
- Mobility concerns
- Research

The Reality of Medical Care in Special Needs Populations

- Children with ASD and developmental disorders (DD)
  - Often require more frequent medical care
  - Experience more difficulties during the history and physical examination than neurotypical peers (Cuvo et al., 2010).

The Reality of Medical Care in Special Needs Populations

77%

- % of primary health care providers- self-rated their ability to care for someone with ASD as (Wexler, Holmes, Shore, & Rollins, 2015):
  - Poor
  - Fail

The Fallout – History Taking and Physical Exams in ASD

(Cuvo, Readan, Ackerlund, Huckfeldt, & Kelly, 2010).

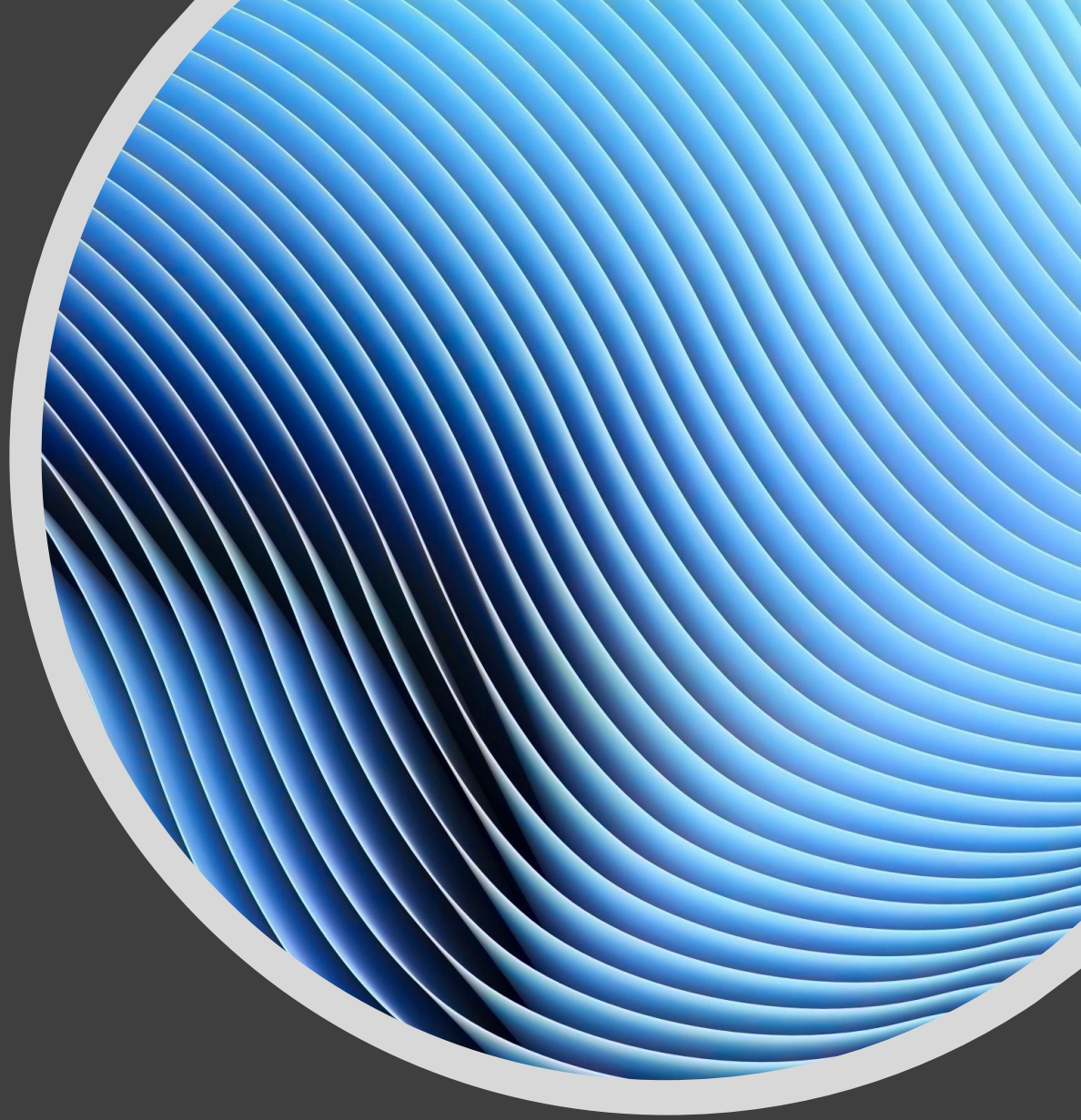
- Health care providers often fail to obtain a detailed medical history relying on:
  - Parents/caregivers
  - Incomplete preexisting medical records
- Essential health care procedures in this population:
  - Physical restraint
  - Sedation
  - Forgo procedures due to non-compliance

Importance of Performing Proper Exams

Negative health care experiences can adversely affect children with ASD/DDs perceptions of medical care for future visits

Targeted behavioral support can facilitate the examination of this unique patient population, preventing child:

- Stress
- Adverse events
- Future aversion to medical care (Drake, Johnson, Stoneck, Martinez, & Massey, 2012, p. 215)

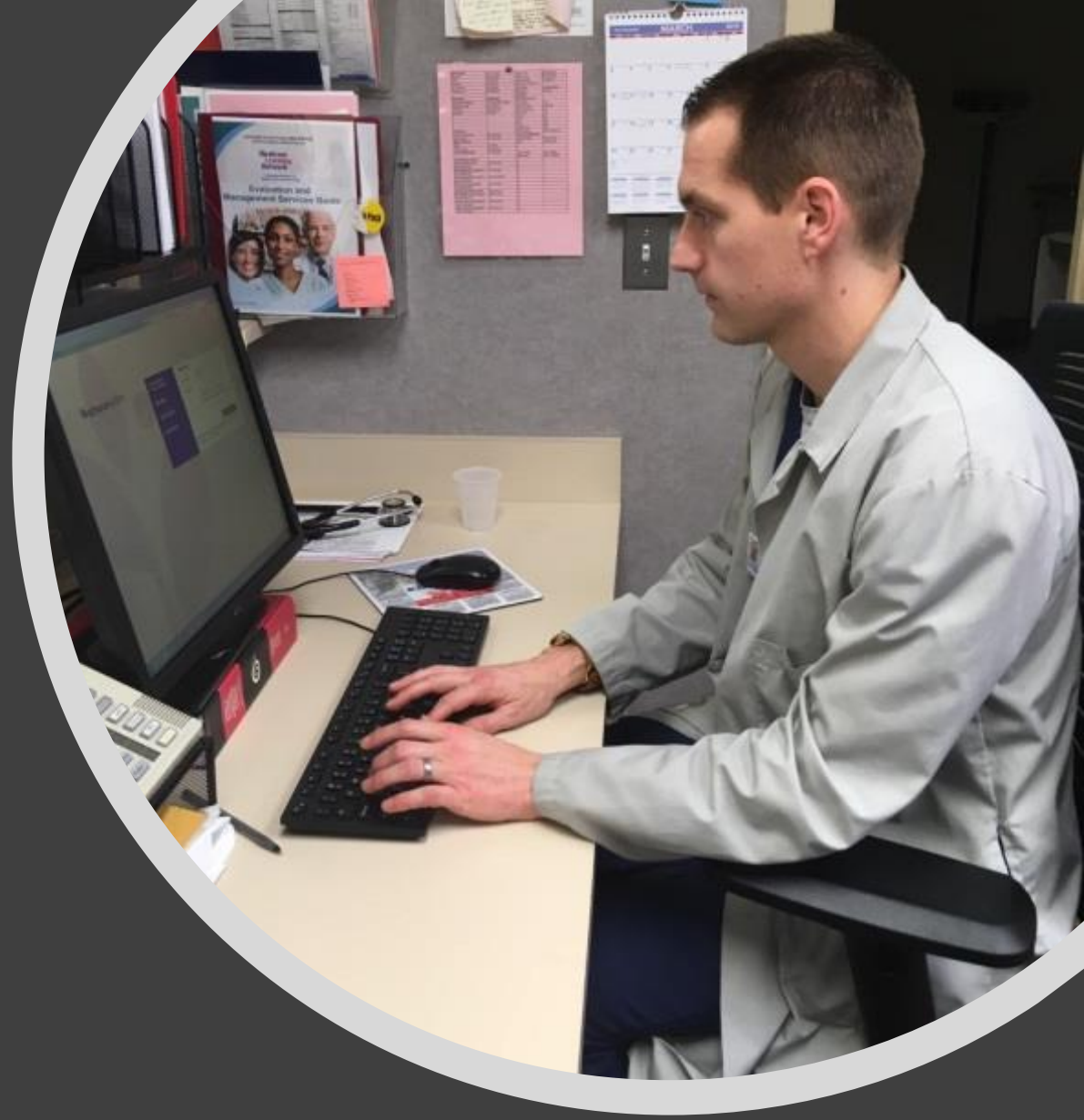


Clinical Scenario

- 6-year-old male patient, named Jack, presents to your outpatient clinic with chief complaint of “he feels warm” for the past 2 days per the parent. You observe as the patient is wheeled into his room by stroller/community access device that Jack is grunting, repeating the words “all done”, watching a video on a tablet device, and constantly sucking on his finger. He appears agitated, makes poor eye contact with the nurse, and responds in a limited manner using “yes/no” answers to questions primarily with laminated cards his parent brought in for the examination. Your clinician coworker rolls their eyes, looks to you and says, “Well, I guess Jack is back again.”

Clinical Scenario

- Your best course of action for Jack is:
  - A. Run and hide in the bathroom.
  - B. Take an early lunch.
  - C. Spend time catching up on charts and hope your colleagues see Jack instead.
  - D. Review his medical history and enter the room, discussing the history with the parent but never examining Jack due to “combativeness” and “non-compliance” during the clinical interaction.
  - E. None of the above.



Definitions

- Developmental disabilities are defined as:
  - “a diverse group of severe chronic conditions that are due to mental and/or physical impairments that affect language, mobility, learning, self-help, and independent living… [that] may include autism spectrum disorder (ASD)” (Drake, Johnson, Stoneck, Martinez, & Massey, 2012, p. 215).
  - Often not a single condition but various causes show a set of symptoms (Rah, Hong, yoon, 2021)
  - High genetic causality
  - Difficulties in multiple domains (Rah, Hong, yoon, 2021; Zablotsky, Black, & Blumberg, 2017):

More Important Terminology- Developmental Disorders/ Special Needs Population

- **Developmental Delay** – failure to meet typical developmental milestones within typical time range.
- **Developmental Disability**- medical condition impairing development such as ASD, ADHD, intellectual disability
- **Intellectual Disability**- specific form of developmental disability, originating prior to age 18, limiting intellectual functioning.
    - May include a specific genetic disability, autism spectrum disorder, or global developmental delay (Kaiser & Roberts, 2013).

Definitions (Autism Speaks, 2018)

- Autism Spectrum Disorder (ASD)
- DSM-5 Criteria - Symptoms
  - Persistent deficits in social communication/interaction
    - Deficits in:
      - Social/emotional reciprocity
      - Nonverbal communicative behaviors
      - Developing, maintaining, understanding relationships
  - Restricted, repetitive patterns of behavior, interest, activities (2+)
    - Stereotyped/repetitive movements/speech/use of objects
    - Insistence on sameness, routines, patterns
    - Restricted, fixated interests
    - Hyper/hyporeactivity to sensory inputs
  - Symptoms are not better explained by intellectual disability or developmental delay

Demographics - ASD

- Prevalence of ASD
  - 2021 CDC estimates:
    - 1 in 44 US Children
    - 1 in 27 Boys
    - 1 in 116 Girls
      - Boys > 4 x more likely to have ASD than girls
  - Most diagnosed after age 4
    - Reliable diagnosis as early as 2-years-old

Autism Statistics and Facts. (2021). Retrieved from https://www.autismspeaks.org/autism-statistics-asd

Demographics – ASD (Facts and Figures. (2018). Retrieved from https://www.autismspeaks.org/autism-facts-and-figures)

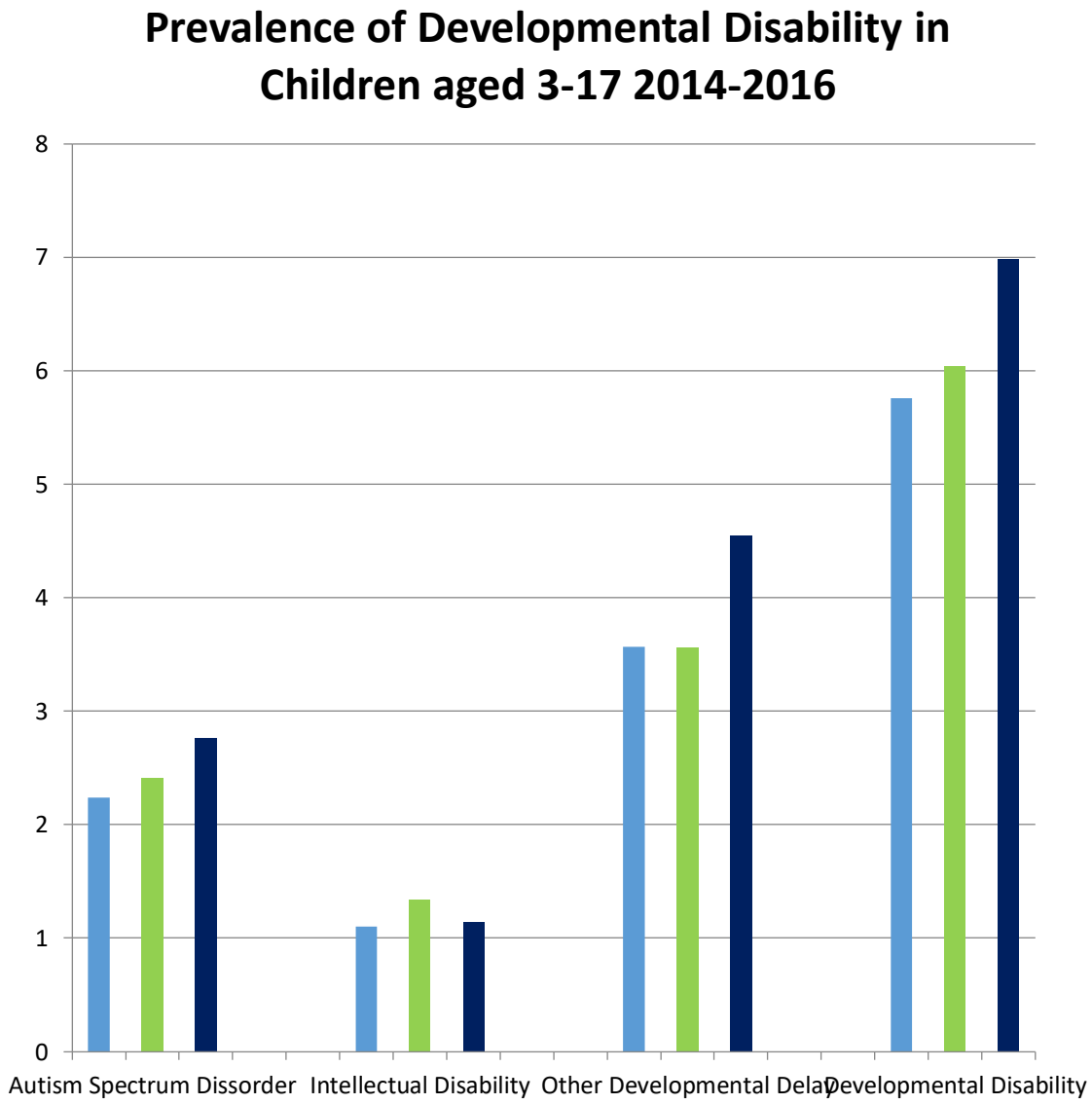
- Challenges:
  - Nearly half all children wander/bolt from safety
  - High rates of self injurious behavior
    - Head banging, arm biting, skin scratching most common
  - Intellectual Disability and ASD
    - 31% also have ID
    - 25% borderline Intelligence Quotient
    - 44% average-above average IQ
  - Medical expenditures average 4.1-6.2 times higher
  - Passage of autism insurance legislation, including mandates requiring some level of coverage, in all 50 states and Washington, D.C. (Bernard, 2019).
    - Treatment for autism a medical necessity, including ABA in some states.
    - Increased access to medical care/treatment

Demographics of DDs

Prevalence of DDs in United States (Zablotsky, Black, & Blumberg, 2017)

- Developmental Disability 2014-2016 in CDC Sample
  - Children aged 3-17 – Increase from 5.79% to 6.99%
  - No relative significant increase in ASD or Intellectual Disability(ID)
  - DD- Boys (8.15%) > Girls (4.29%)
    - ASD – Boys (3.63%) > Girls (1.25%)

- Adapted from Zablotsky et al., 2017



Prevalence of Developmental Disorder Worldwide (Rah, Hong, and Yoon, 2020)

- United Kingdom - 4.8% school age children in state-funded schools (Emerson, 2012)
- Taiwan – Developmental Delay – Up from 0.16 to 3.25% over 12 year period children aged 0-6-years-old

Incidence in all Causes of DDs (% increase)			
ASD	Developmental Delay	Language Disorders	Boys vs Girls (Gap)
13.7%	817.6%	30.7%	31.4% (Up from 19.1%)

- Increases in DDs believed to be independent of changes in diagnostic criteria, research methods, or diagnostic awareness (Rah, Hong, and Yoon, 2020).

Important Terminology- Developmental Disorders(Harris, 2013)

- Please avoid:
  - Mental Retardation(MR)/“Retarded”
  - Adopted by medical societies in 1961
  - Replaced terms feeblemindedness, idiocy, and mental subnormality.
  - All are now considered pejorative
- APA revised preferred terminology in 2013 with DSM-5 and ICD-11.
- In US, federal statute has replaced MR with Intellectual Disability (ID).

Roadmap

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Anatomy and Pathophysiology of Autism (Lathe, 2006)

MRI

- Abnormal size of limbic structures
  - Fewer hippocampal dendrites, abnormal hippocampal volume
  - Higher neuronal density in amygdala, abnormal volume

Histology

- Prefrontal and temporal lobe cell columns increased in number, but smaller and fewer neurons per column

fMRI

- Examine blood flow and energy utilization
  - Reduced blood flow to temporal lobes
  - Asperger – abnormal functional integration amygdala and parahippocampal gyrus

Reduced neuronal metabolite in hipocampus/amygdala and cerebellum

- Indicates diminished metabolic activity in these areas
- Sign. Correlation between parent rated ASD severity and limbic neuronal density

SPECT

- Decreased blood flow to left temporal lobe

PET

- Decreased blood flow to temporal lobes

Pathophysiology of Autism – ASD Phenotype (Lathe, 2006)

- Memory
  - Hippocampal dependent memory affected in ASD
  - Repeat training can overcome hippocampal damage/lesions and also in ASD
    - Difficulty relearning “new rules”
- Anxiety/Stress
  - Associated with hippocampal function in ASD
- Desire for sameness
  - Decreased blood flow to right amygdala/hippocampus associated with obsessive desire for sameness
- Perception of facial emotions
  - Associated with limbic atrophy, facial recognition temporal lobe
- Social interaction
  - Amygdala lesions associated with impaired evaluation of social stimuli
- Language
  - Limbic lesions associated with speech/language impairment
- Stereotypical/repetitive behavior
  - Associated with hippocampal lesions
- Sensory Deficits
  - Temporal lobe/lymbic lesions associated with auditory agnosia (“hearing blindness”)

Pathophysiology of Autism – ASD Phenotype (Lathe, 2006)

- Consensus:
  - Abnormalities in the medial temporal lobe, hippocampus, and amygdala
    - Cognitive, perceptual, social and language impairments of ASD
  - Cerebellar abnormalities
    - Impaired coordination/posture/locomotion

Sensory Experience of ASD

CGI Animated Shorts : "Listen" - by Alexander Bernard ... – YouTube – 2:41.

Bernard, A., & Fernandez, M.(2016, June 7). *Listen Senior Film*.[Video File]. Retrieved from https://www.youtube.com/watch?v=ibylThIMErE

DMV…

Sensory Experience of ASD

Sensory processing difficulties are universally present in children with ASD (Lathe, 2006)

- Hearing deficits in 8.6%
- Varying visual inpairments in 25%

Sensory difficulties correlated with maladaptive behaviors (Nieto, López, & Gandía, 2017)

- Key driver of parental stress

Sensory Experience of ASD

- Sensory disturbances may involve acoustic, visual, tactile, and pain stimuli (Lathe, 2006)
  - Heightened response
  - Reduced response
    - Less clear anatomical/physiological linkage than non-sensory ASD deficits

Hypersensitivity (over responsive)	Hyposensitivity (under responsive)	Impaired Sense	Accommodation in Clinic
	Poor response to visual cues	Vision	Pictures/items with high contrast
	Poor Balance/Coordination	Proprioceptive/Vestibular	Opportunities for rocking/swinging/weighted vests or blankets
	Oral seeking	Tactile/oral	Chewable tubes
Spectrum of light		Visual	Room without fluorescent lamps
Loud Noises		Auditory/vestibular	Ear plugs/Headphones/ Close door
Sensitivity to touch		Tactile	Request permission prior to touching
Bright light		Visual	Dimmed lights/visor/sunglasses

Hypersensitivity (over responsive)	Hyposensitivity (under responsive)	Impaired Sense	Accommodation in Clinic
Withdrawing from soft touch		Nociceptive/Tactile	Avoid rough stimuli
Avoidance of textures		Tactile	Avoid painful/rough stimuli
Smell		Gustatory	Avoid perfumes, colognes, or scented items
	Seek out strong tastes/odors	Gustatory	Flavored chewable tubes
	Unresponsive to loud noises	Vestibular/Auditory	Noisy toys, play loud music, running commentary

(Brownlee, 2010; Fun and Function, 2018; Developmental Delay, 2014; Newman, 2008)

Big Picture Check

- Which of the following statements are TRUE regarding sensory stimuli that can trigger of sensory disturbances for children with ASD?
  - A. Hypersensitivity to stimuli is the most common general sensory trigger.
  - B. Hyposensitivity to stimuli is the most common general sensory trigger.
  - C. Sensory triggers are similar in this population to those of neurotypical peers.
  - D. BOTH hyposensitivity and hypersensitivity are common general sensory triggers

Language and Developmental Disability

- Basic Terms
  - Speech (Mulhern et al., 2017) – ability to articulate needs or thoughts
  - Vocalizations (Mulhern et al., 2017) – act/process of producing voice sounds
  - Receptive language (Lim, 2011)
    - What the individual understands
  - Expressive language (Lim, 2011)
    - What is spoken/expressed by the individual

Language and ASD

(Lim, 2011)

- Key consideration
  - *Lack of expressive language does not signify a lack of receptive language*.

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Language and ASD

- “Inadequate” use of language key feature of ASD (Lim, 2011).
  - Early speech delay/regression
  - 1/3rd to ½ of individuals with ASD are unable to communicate at a level to express daily needs.
  - Non-verbal
    - 25-30% of children with ASD fail to acquire speech without direct intervention (Mulhern, Lydon, Healy, Mollaghan, Ramey, & Leoni, 2017).

Language and ASD

- Verbal ASD children display:
  - Unusual word choice
  - Echololia
  - Unresponsiveness to questions
  - Lack of drive to communicate
  - Absent “Give and take” of communication
  - Inability to understand body language, tone of voice, subtle language queues

Language and Developmental Disability

Significant speech deficits found in 62% of severely intellectually disabled (Mulhern et al., 2017).

Significant decline in speech acquisition in individuals with DDs after age 5-years-old.

Language and Developmental Disability

- Similar to ASD challenges with speech acquisition affect quality of life
  - Decreased independence
  - Decreased social adaptive functioning
    - Struggles integrating with peers and more withdrawn
  - Development of speech one of most significant predictive factors of positive outcomes for:
    - Behavioral symptom severity
    - Improved socialization

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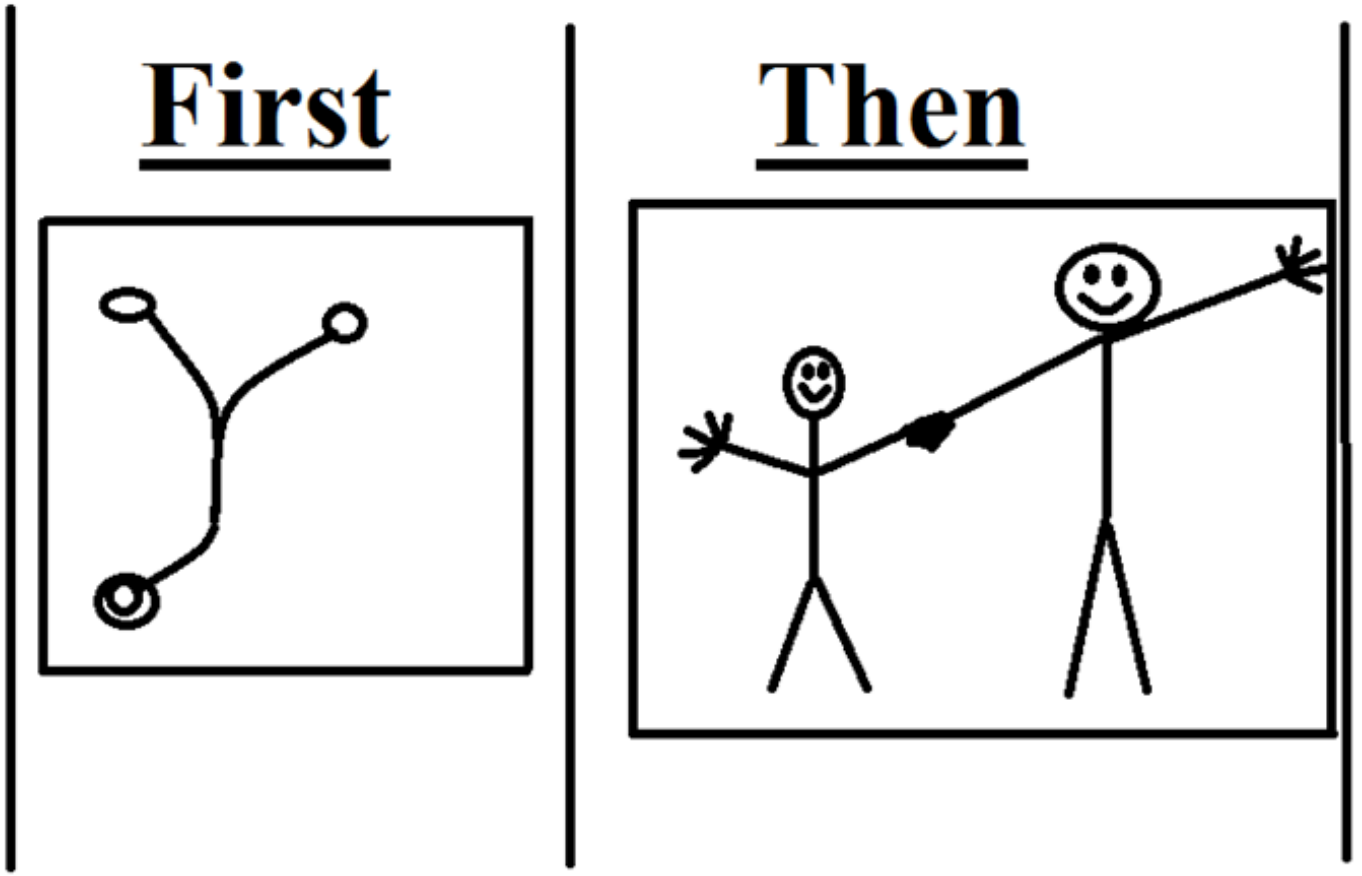
Alternative Communication Options

Objects of Reference

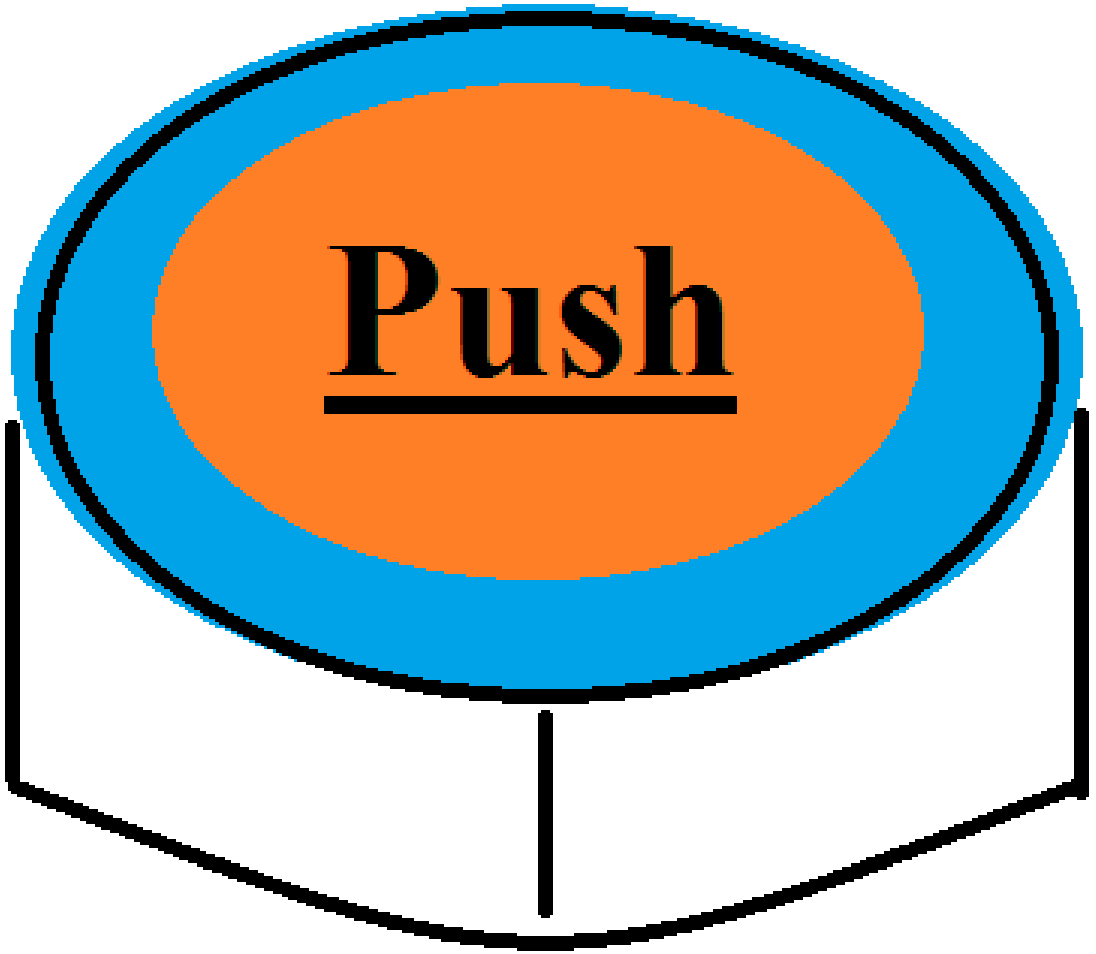
- Visual representation of the tasks asked of the individual (Goldbart et al., 2014).



Micro Switches

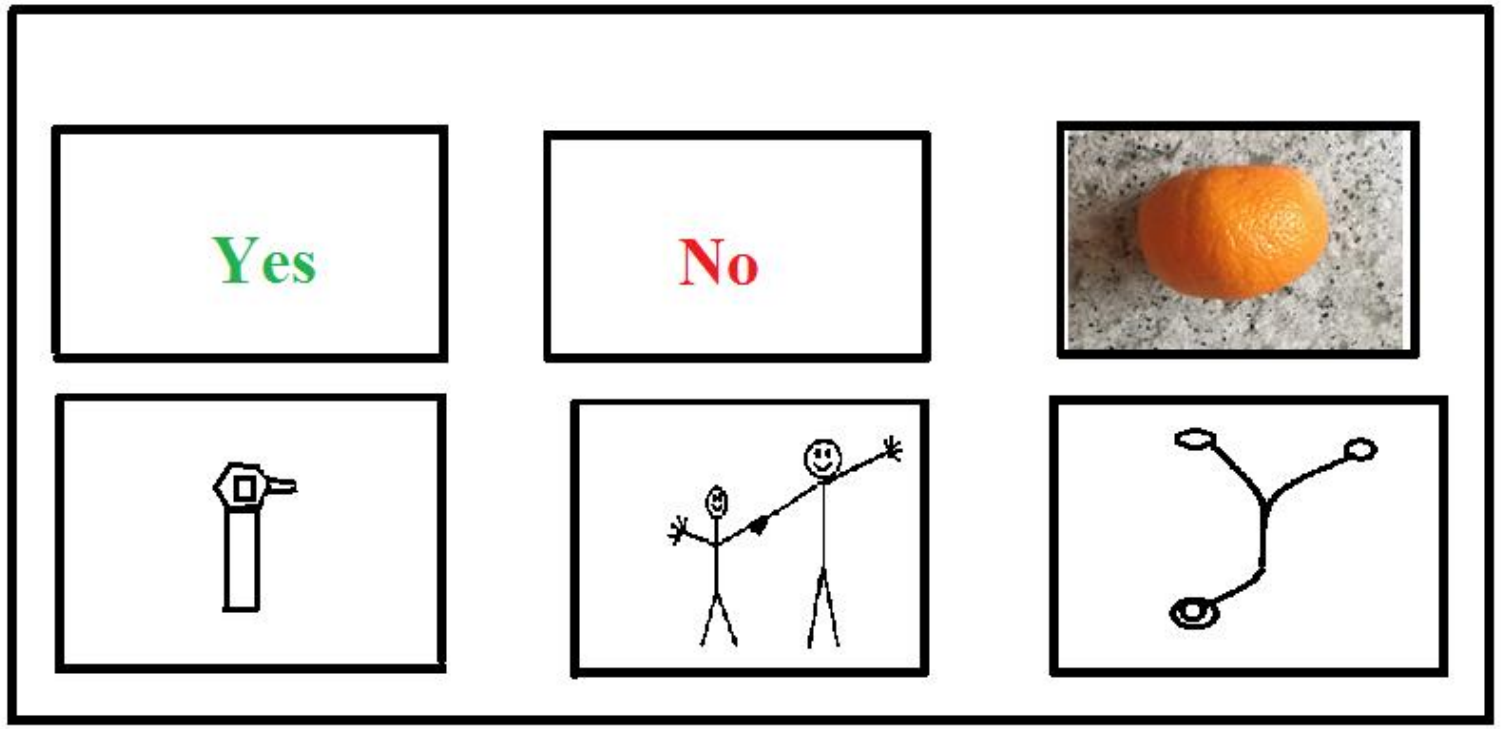
(Cable, 2015; Lancioni, O'Reilly, & Basili, 2001)

- Applying tactile pressure to an electronic switch
  - Wobble
  - Pressure
  - Pull
  - Pedal type inputs (Lancioni, O'Reilly, & Basili, 2001)



Picture Exchange (PE)
Ganz et al., 2014
Lancioni et al.,2001

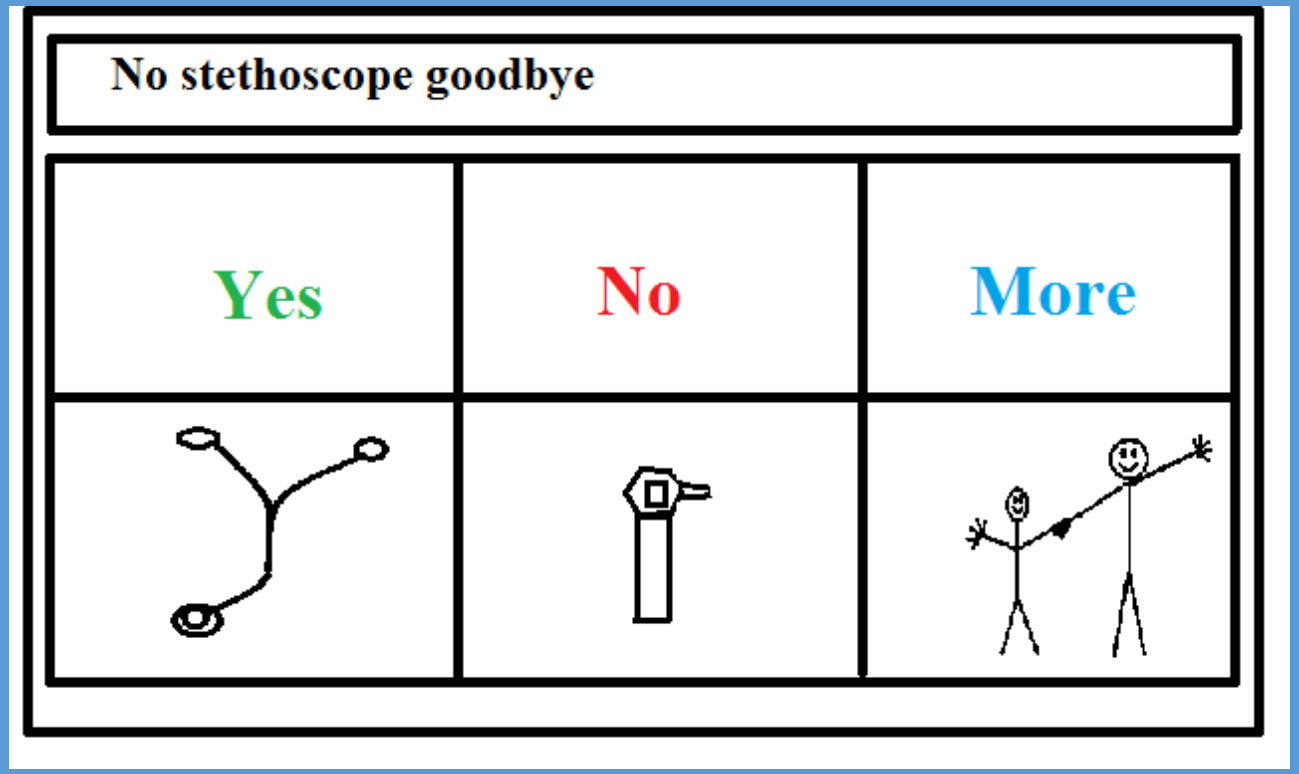
- PE techniques comparable effectiveness speech generation devices in children with comorbid ID (Ganz et al., 2014)

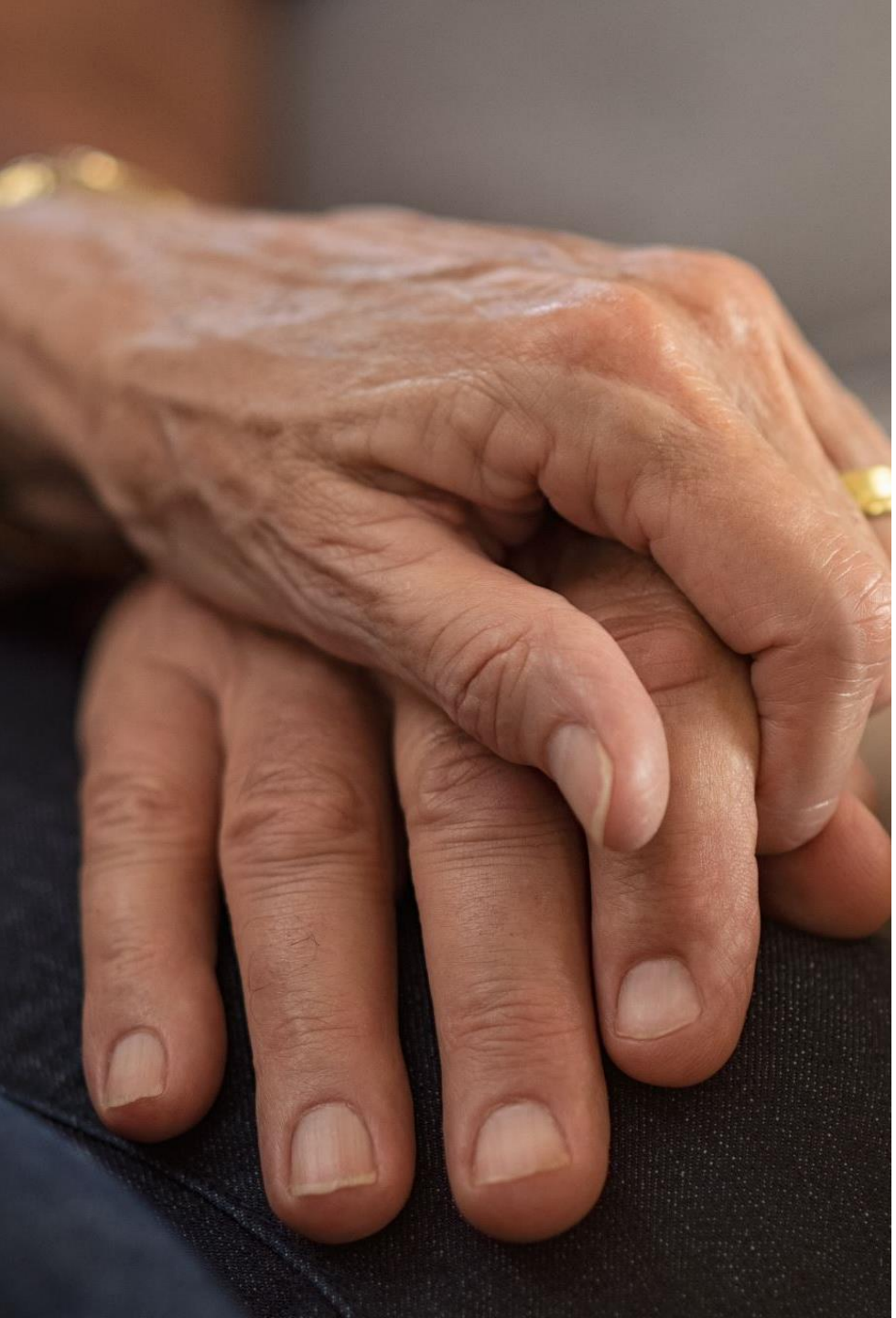


Speech Generation/ Generating Devices (SGDs) (Hagan and Thompson, 2013)

- Advanced means of communication that uses touched symbols to trigger recorded messages.
- Mimic verbal speech
  - Speakers
  - Increase communication competence in children with ID
  - Studies also showing effectiveness in children with multiple disabilities and ASD
  - Increased rate, complexity, and length of speech in children with impaired speech (Luckins & Clarke, 2021).
    - Gains sustained and generalized, including verbal speech
  - Increased probability of listener response (Broadhead et al., 2020)

Speech Generation Devices (SGDs)





Sign Language (Vandereet et al., 2013)

- Impairments in fine and gross motor functioning may limit the use of sign language in children with ID (Vandereet et al., 2013)
  - ***Sign language may be an adjunct for communication, provided:
    - Baseline cognition is relatively high
    - Fine motor skills are advanced enough to allow hand manipulation to form signs consistently
  - Compared to other AAC forms of communication, manual sign language is poorly understood/responded to by individuals unfamiliar with the manual signs (Broadhead et al., 2020).

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Anxiety (Gillis, Natof, Lockshin, & Romanczyk, 2009).

- Anxiety and fear associated with medical evaluation is increased in the pediatric ASD population.
  - Specific phobias affect
    - 44% of children with ASD
    - 5% of typically developing children (Gillis et al., 2009)

- Minimizing anxiety to medical instruments and procedures higher yield in ASD population (Gillis et al., 2009).

Mountain of Emotion

(Hudson, 2006)

-Child overwhelmed
-Environment loaded with stimuli
-Lack understanding

-Remind child of coping technique
-Talk through cues
-Adult intervention
-Encourage positive aspects

-Child "meltdown"
-Extreme behavior/emotions
-Fight or flight

-Give space and quiet
-No intervention besides safety

-Child Calms down
-Begins to relax

-Adult review of episode
-Strategize for future episodes

Phobias in ASD

- Communication tools and distractive items may decrease anxiety/stress and assist the clinician with performing an exam (Drake et al., 2012).

Distraction Tools (Breslin & Liu, 2015; Drake et al., 2012)

- Examples:
  - Coping kits
  - Social stories/Written schedules
  - Sensory input activities
  - Other visual communication techniques
- Limit auditory and verbal instructions to short verbal commands

Distractive Items/Techniques

Coping Kits- Improved willingness to cooperate through an observed change in child behavior in 79% of cases (19/24). (Drake et al., 2012)

Otoscope light onto a child's hand, moving forward and back to display the lights scope (Narula-Isaac, 2005)

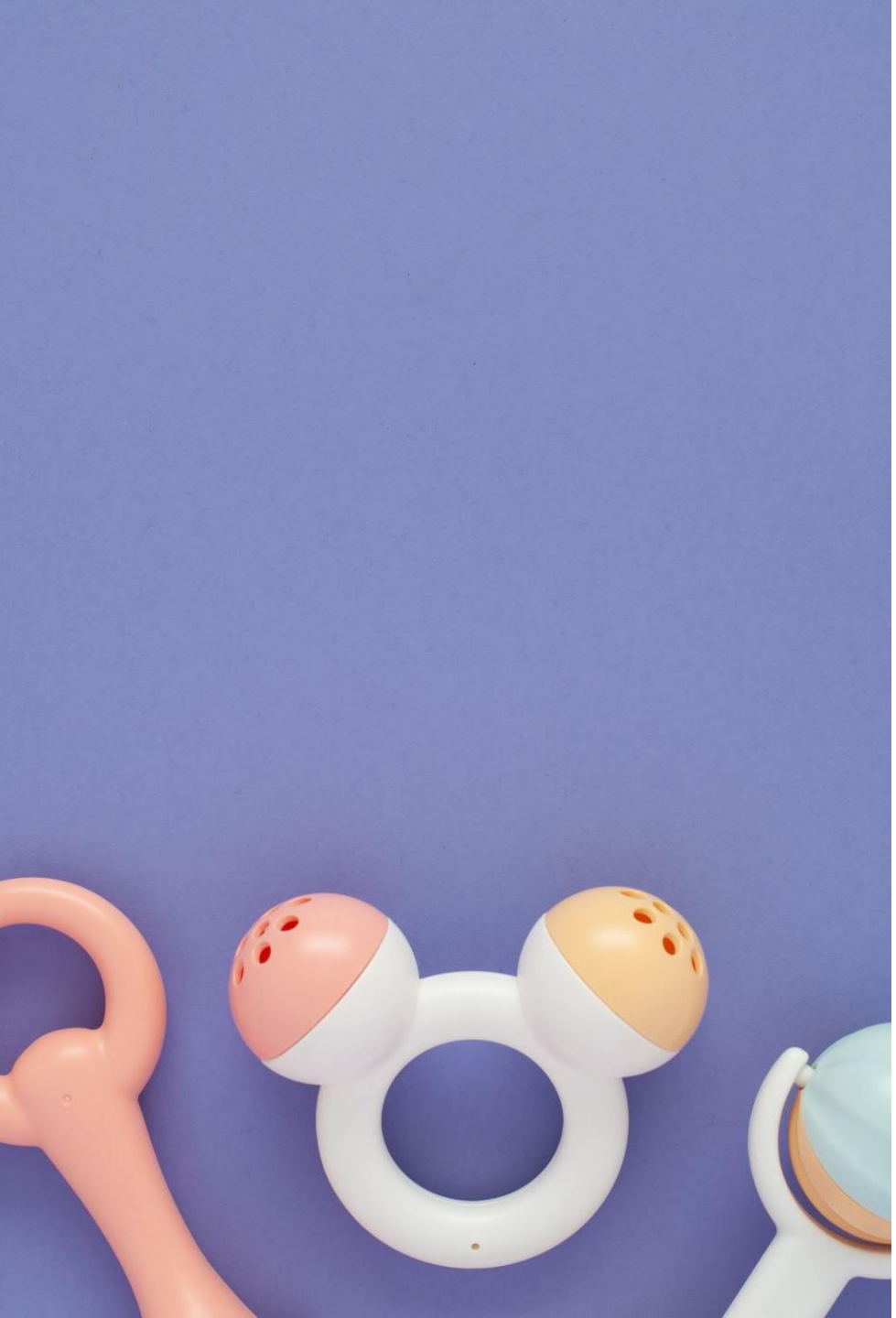
- Repetition of this routine beneficial in ASD

Chewable toy (Drake et al., 2012)

Light-up spinning fan toy (Drake et al., 2012)

Bubble wand (Weltman, 2007).

Tablet/Smartphone



Other Distractive Items in Coping Kit

- Sand
- Ear plugs / ear phones
- Visors/ hats
- Fidget toys
- Weighted vest / weighted blanket
- Soothing music
- Lava Tubes (bubbles/floating objects)

Big Picture Check

- Question: Besides communication, what are the other two main areas of focus for your physical examination of the ASD/DD child in this lecture?
  - A. Sedation
  - B. Restraints
  - C. Safety Concerns (anxiety/phobias)
  - D. Mobility Concerns

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Mobility/Examination

(Breslin & Liu, 2015).

Attire

- Logos on clinician clothing may be distracting/point of perseveration
- Child clothing preferences may be related to tactile input
  - Shirt tags
  - Loud clothing
- Substitute for different color/texture if distracting or child is tactile sensitive

Equipment

-Substitute for different color/texture if distracting or child is tactile sensitive

Rely on support personnel

Mobility/Examination

- DD (Palisano, Shimmell, Stewart, Lawless, Rosenbaum, & Russell, 2009)
  - Gross Motor Function Classification System
    - Level I – Walks without limitations at school, outdoors, etc
    - Level II- Walks in most settings. Environment/setting may use wheelchair based on preference
    - Level III- Walks with handheld device (cane/crutches/walker)

    Wheelchair outdoors, environment.
    - Level IV- Wheeled mobility in most settings. Self mobility using powered mobility options. Adaptive seating, assisted transfer.
    - Level V – Self mobility severely limited even with assisted technology. Physical assistance from 1-2 others for transfers.

So how do we ensure we are meeting children’s needs and assessing their level of functioning?

ASD Needs Assessment

- Quick
- Easy
- Parent/caretaker facilitated
- Administered at the point of entry/triage for medical care
- Take into consideration communication, anxiety and mobility for each child

Initial Assessment (Hudson, 2006)

- Childs Name:
- Medical Diagnosis:
- Reason for medical visit:
- Excels in these skills:
- Activities in which the child enjoys:
- Activities the child avoids:
- Motivators:
- Stress triggers:
- Adaptations already in place:
- Communication system in place:
- Known Sensory issues:
- Special Diet/food allergies:
- Optional add ons:
  - Mobility Needs:
  - S.W.O.T

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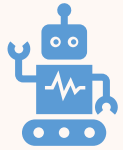
Training Compliance with PE (Cuvo et al., 2010)

Applied Behavioral Analysis (ABA)

Developed tailored procedures based on the reasons for non-compliance



10 component, 10-minute physical exam performed by PA

Participants watched 9-min DVD modelling successful exam

Dinosaur puppet narrated steps of exam praising good behavior

Close ups of medical equipment

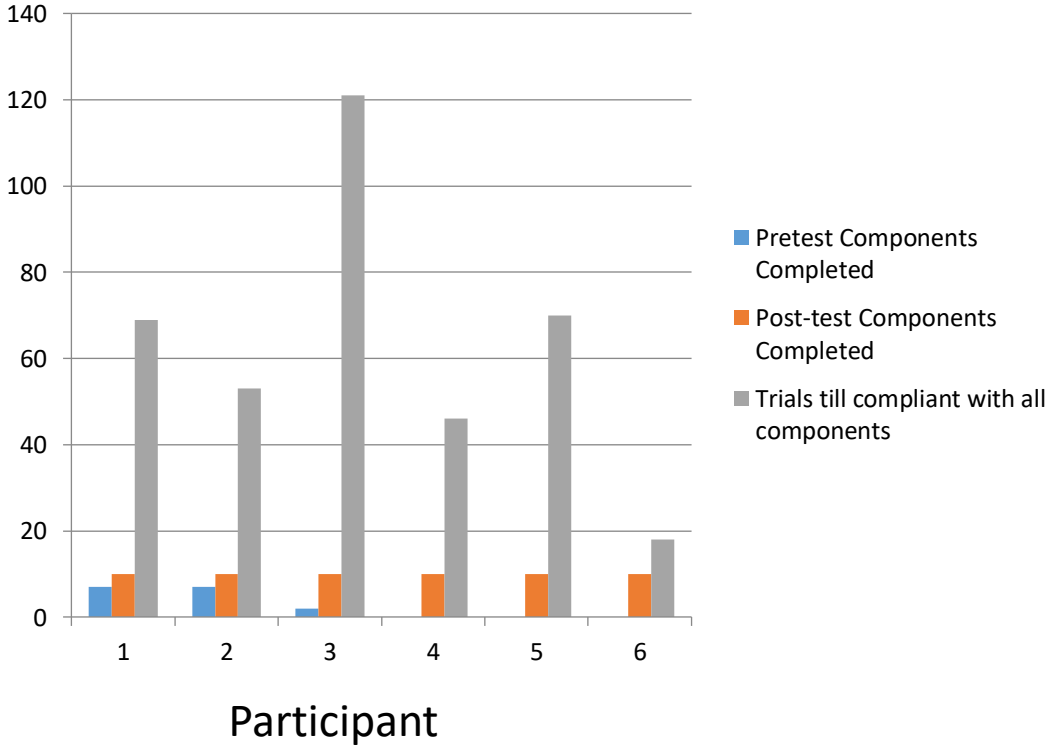
Training Compliance with PE (Cuvo et al., 2010)

- Each exam/training session
  - Contact desensitization – gradual exposure to non-preferred stimuli
  - Shaping – address skill deficits
  - Differential reinforcement of other behavior (DRO) – use of preferred reinforcers
  - Escape extinction – aversive stimuli present for at least 10 seconds

Training Compliance with PE (Cuvo et al., 2010)

- Results
- All participants eventually completed all 10 exam components
- Most problematic

  exam components:
  - Lung
  - Mouth/throat
  - Nose
  - Ear



TEACCH (Orellana et al., 2014)

- Training approach
  - Interact with exam equipment/instruments and with dentist
  - Tell-Show-Feel-Do (T-S-F-D) – For example…
    - Tell what's going to happen, Show what they will do, Feel instrument, Do the exam technique.
  - Visual pedagogy – 20 step-by-step photos
  - A-V modeling – live modeling videotaped and played back
  - Behavioral trials – step through 10 component exam
  - Auto modeling – photos of subjects modeling behavior used later in practice sessions
  - Results –
    - Pre-test – 73% of children and 67% adults showed reluctant behavior
    - Post-test- 81.6% of children and 100% of adults showed positive behavior

Exposure-based interventions in children with ASD (Gillis et al., 2009)

Population

- Mean age of 8.4 years
- Majority non-verbal (10/18)
- All students of specialized ASD school

Results:

- Repeated exposure to a clinical setting to fearful stimuli during a routine exam decreased fear-related behaviors
  - 83% of participants (*15*/18)
  - 3 remaining participants still fearful
  - Still showed progress after 38, 42, and 62 visits
  - Did not complete protocols, but still made progress

More Tricks of the Trade (M. Bellatuono, personal communication, November 28, 2018)

1. Use clear, simple language
2. Give child time to process information
3. Repeat instructions
4. Redirect by using visual tools

Post-Test Question 1

- All of the following represent established approaches to facilitate the physical examination of a resistant/agitated patient with ASD except:
  - A. Use of distractive tools such as those found in a coping kit.
  - B. Using specific and detailed verbal and written instructions to outline the entire procedure all at once.
  - C. Modifying the physical environment to tailor the stimuli experience (i.e.- dimming lights, providing head phones, and chewy tubes).
  - D. Providing visual cues of the procedure/exam using visual models such as dolls or stuffed animals prior to performing the procedure.

Post-test Question 2

- All of the following are methods of alternative communication that you may see commonly used by children with ASD to assist their communication and decrease anxiety/fear with health care providers during their exam EXCEPT:
  - A. Speech Generation Devices (SGD)
  - B. Picture Exchange (PE)
  - C. Functional Magnetic Resonance Imaging (fMRI) enabled speech device
  - D. Micro Switches

Post-test Question 3

- Based on research performed on the physical examination of children with ASD/DD, which of the following techniques is NOT a preferred technique for the routine behavioral management of fear/anxiety related to physical exam:
  - A. Intermittent graduated exposure to fearful stimuli
  - B. Tell-Show-Feel-Do (T-S-F-D)
  - C. Differential reinforcement of other behavior (DRO)
  - D. General sedation

Clinical Scenario Revisited

- Jack, 6-year old
- Needs assessment completed
  - Sensory
    - Oral hyposensitivity/seeking
    - Light hypersensitivity
  - Communication
    - Non-verbal, uses visual communication
  - Mobility
    - Stroller/Community Access Device
  - Anxiety
    - Hates ENT exams

Putting it all together

- Accommodations made
  - Lights
  - Chewy tube
  - Examine in stroller
  - Specialized Techniques used
    - Custom First-Then Board
    - T-S-F-D
    - Repetition
    - Video after completion

Summary

- These are simple techniques
- Effective resources are inexpensive
- Donate your time (a.k.a.- hit the breaks)
- Identify and address sensory needs/ triggers-crucial to smooth outcomes. DON’T REINVENT THE WHEEL, ASK PARENTS!
- One child unnecessarily sedated/restrained/traumatized is one too many
- Small efforts make big differences in special needs
- Bail out your colleagues – grab these charts- help these kiddos!

One last thought…

“I don’t want to be autistic. But I am, so don’t be mad. Be understanding.” – Carly Fleischman

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Questions???
Comments?
Tips?
Criticism?

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