Autism Spectrum Disorders

A Resource Guide

Compiled by:
Eileen Cekay
Stephanie Johnson
Melissa Starkweather

University of Illinois at Chicago
May 1, 2013

What is Autism?

Autism Spectrum Disorders (ASDs) are a group of neurologically-based developmental disabilities. Scientists do not know exactly what causes the problem. ASDs can impact a person's functioning across a wide range, from very mild to severe. Individuals with ASD are not different in appearance, but they may communicate, interact, behave and learn in ways that are different from typical peers.

Recent statistics from the U.S. Centers for Disease Control and Prevention (CDC) suggest that 1 in 110 children in the United States could be diagnosed with ASD. That means 29,000 children in Illinois have an ASD.

People with ASDs may have problems with social, emotional, and communication skills. They might repeat certain behaviors and might not want change their daily routines. Many people with ASDs also have different ways of learning, paying attention, or reacting to things. ASDs begin during early childhood and last throughout a person's life.

A child or an adult with ASD might:

- Not play "pretend games" (like feeding a doll)
- Not look at objects when another person points at them
- Have trouble relating to others or not have an interest in other people at all
- Avoid eye contact and want to be alone
- Have trouble understanding other people's feelings or talking about their own feelings
- Prefer not to be held or cuddled or may cuddle only when they want to
- Appear to be unaware when other people talk to them but respond to other sounds
- Be very interested in people, but not know how to talk, play or relate to them
- Repeat or echo words or phrases said to them, or repeat words or phrases in place of normal language
- Have trouble expressing their needs using typical word or motions
- Repeat actions over and over again
- Have trouble adapting when a routine changes
- Have unusual reactions to the way things smell, taste, look, feel or sound
- Lose skills they once had (for instance, stop saying words they were once using)

Adapted from The Autism Program of Illinois: *What is Autism?*
http://www.theautismprogram.org/autism-resources/what-is-autism/

Part I. What is Autism?: Reference Links

A. What is Autism? (Video Link)
http://www.theautismprogram.org/autism-resources/what-is-autism/

B. DSM-IV-TR Diagnostic Criteria
http://www.cdc.gov/ncbddd/actearly/autism/case-modules/pdf/diagnosis/DSM-IV-TR%20Diagnostic%20Criteria%20for%20Pervasive%20Development%20Disorders.pdf

C. Changes in the DSM-5
http://www.autismspeaks.org/science/policy-statements/statement-revisions-dsm-definition-autism-spectrum-disorder/frequently-ask

Your Baby at 2 Months

What most babies do at this age:

Act early by talking to your child's doctor if your child:

- ❑ Doesn't respond to loud sounds
- ❑ Doesn't watch things as they move
- ❑ Doesn't smile at people
- ❑ Doesn't bring hands to mouth
- ❑ Can't hold head up when pushing up when on tummy

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned** or call **1-800-CDC-INFO**.

www.cdc.gov/actearly | 1-800-CDC-INFO

CDC

Learn the Signs. Act Early.

Su bebé a los 2 meses

¿Qué hacen los bebés a esta edad?

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No responde ante ruidos fuertes
- ❑ No sigue con la vista a las cosas que se mueven
- ❑ No le sonríe a las personas
- ❑ No se lleva las manos a la boca
- ❑ No puede sostener la cabeza en alto cuando empuja el cuerpo hacia arriba estando boca abajo

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado** o llame **1-800-CDC-INFO**.

www.cdc.gov/pronto | 1-800-CDC-INFO

CDC

Aprenda los signos. Reaccione pronto.

Your Baby at 4 Months

What most babies do at this age:

Act early by talking to your child's doctor if your child:

- ❑ Doesn't watch things as they move
- ❑ Doesn't smile at people
- ❑ Can't hold head steady
- ❑ Doesn't coo or make sounds
- ❑ Doesn't bring things to mouth
- ❑ Doesn't push down with legs when feet are placed on a hard surface
- ❑ Has trouble moving one or both eyes in all directions

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned** or call **1-800-CDC-INFO**.

www.cdc.gov/actearly | 1-800-CDC-INFO

CDC

Learn the Signs. Act Early.

Su bebé a los 4 meses

¿Qué hacen los bebés a esta edad?

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No sigue con la vista a las cosas que se mueven
- ❑ No le sonríe a las personas
- ❑ No puede sostener la cabeza con firmeza
- ❑ No gorjea ni hace sonidos con la boca
- ❑ No se lleva las cosas a la boca
- ❑ No empuja con los pies cuando le apoyan sobre una superficie dura
- ❑ Tiene dificultad para mover uno o los dos ojos en todas las direcciones

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado** o llame **1-800-CDC-INFO**.

www.cdc.gov/pronto | 1-800-CDC-INFO

CDC

Aprenda los signos. Reaccione pronto.

Your Baby at 6 Months

What most babies do at this age:

Act early by talking to your child's doctor if your child:

- ❑ Doesn't try to get things that are in reach
- ❑ Shows no affection for caregivers
- ❑ Doesn't respond to sounds around him
- ❑ Has difficulty getting things to mouth
- ❑ Doesn't make vowel sounds ("ah", "eh", "oh")
- ❑ Doesn't roll over in either direction
- ❑ Doesn't laugh or make squealing sounds
- ❑ Seems very stiff, with tight muscles
- ❑ Seems very floppy, like a rag doll

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned** or call **1-800-CDC-INFO**.

www.cdc.gov/actearly | 1-800-CDC-INFO

CDC

Learn the Signs. Act Early.

Su bebé a los 6 meses

¿Qué hacen los bebés a esta edad?

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No trata de agarrar cosas que están a su alcance
- ❑ No demuestra afecto por quienes le cuidan
- ❑ No reacciona ante los sonidos de alrededor
- ❑ Tiene dificultad para llevarse cosas a la boca
- ❑ No emite sonidos de vocales ("a", "e", "o")
- ❑ No rueda en ninguna dirección para darse vuelta
- ❑ No se ríe ni hace sonidos de placer
- ❑ Se ve rígido y con los músculos tensos
- ❑ Se ve sin fuerza como un muñeco de trapo

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado** o llame **1-800-CDC-INFO**.

www.cdc.gov/pronto | 1-800-CDC-INFO

Aprenda los signos. Reaccione pronto.

Your Baby at 9 Months

What most babies do at this age:

Act early by talking to your child's doctor if your child:

- ❑ Doesn't bear weight on legs with support
- ❑ Doesn't sit with help
- ❑ Doesn't babble ("mama", "baba", "dada")
- ❑ Doesn't play any games involving back-and-forth play
- ❑ Doesn't respond to own name
- ❑ Doesn't seem to recognize familiar people
- ❑ Doesn't look where you point
- ❑ Doesn't transfer toys from one hand to the other

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned** or call **1-800-CDC-INFO**.

The American Academy of Pediatrics recommends that children be screened for general development at the 9-month visit. Ask your child's doctor about your child's developmental screening.

www.cdc.gov/actearly | 1-800-CDC-INFO

CDC

Learn the Signs. Act Early.

Su bebé a los 9 meses

¿Qué hacen los bebés a esta edad?

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No se apoya en las piernas con ayuda
- ❑ No se sostiene en las piernas con apoyo
- ❑ No balbucea ("mama", "baba", "papa")
- ❑ No juega a nada que sea por turnos como "me toca a mí, te toca a ti"
- ❑ No responde cuando le llaman por su nombre
- ❑ No parece reconocer a las personas conocidas
- ❑ No mira hacia donde usted señala
- ❑ No pasa juguetes de una mano a la otra

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado** o llame **1-800-CDC-INFO**.

La Academia Americana de Pediatría recomienda que se evalúe el desarrollo general de los niños a los 9 meses. Pregúntele al médico de su hijo si el niño necesita ser evaluado.

www.cdc.gov/pronto | 1-800-CDC-INFO

CDC

Aprenda los signos. Reaccione pronto.

Your Child at 1 Year

What most children do at this age:

Act early by talking to your child's doctor if your child:

- ❑ Doesn't crawl
- ❑ Can't stand when supported
- ❑ Doesn't search for things that she sees you hide.
- ❑ Doesn't say single words like "mama" or "dada"
- ❑ Doesn't learn gestures like waving or shaking head
- ❑ Doesn't point to things
- ❑ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned** or call **1-800-CDC-INFO**.

www.cdc.gov/actearly | 1-800-CDC-INFO

CDC

Learn the Signs. Act Early.

Su hijo de 1 año

¿Qué hacen los niños a esta edad?

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No gatea
- ❑ No puede permanecer de pie con ayuda
- ❑ No busca las cosas que la ve esconder
- ❑ No dice palabras sencillas como "mamá" o "papá"
- ❑ No aprende a usar gestos como saludar con la mano o mover la cabeza
- ❑ No señala cosas
- ❑ Pierde habilidades que había adquirido

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado** o llame **1-800-CDC-INFO**.

www.cdc.gov/pronto | 1-800-CDC-INFO

CDC

Aprenda los signos. Reaccione pronto.

Your Child at 18 Months (1½ Years)

Child's Name _____ Child's Age _____ Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by the end of 18 months. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What most children do at this age:

Social/Emotional

- ❑ Likes to hand things to others as play
- ❑ May have temper tantrums
- ❑ May be afraid of strangers
- ❑ Shows affection to familiar people
- ❑ Plays simple pretend, such as feeding a doll
- ❑ May cling to caregivers in new situations
- ❑ Points to show others something interesting
- ❑ Explores alone but with parent close by

Language/Communication

- ❑ Says several single words
- ❑ Says and shakes head "no"
- ❑ Points to show someone what he wants

Cognitive (learning, thinking, problem-solving)

- ❑ Knows what ordinary things are for; for example, telephone, brush, spoon
- ❑ Points to get the attention of others
- ❑ Shows interest in a doll or stuffed animal by pretending to feed
- ❑ Points to one body part
- ❑ Scribbles on his own
- ❑ Can follow 1-step verbal commands without any gestures; for example, sits when you say "sit down"

Movement/Physical Development

- ❑ Walks alone
- ❑ May walk up steps and run
- ❑ Pulls toys while walking
- ❑ Can help undress herself
- ❑ Drinks from a cup
- ❑ Eats with a spoon

Act early by talking to your child's doctor if your child:

- ❑ Doesn't point to show things to others
- ❑ Can't walk
- ❑ Doesn't know what familiar things are for
- ❑ Doesn't copy others
- ❑ Doesn't gain new words
- ❑ Doesn't have at least 6 words
- ❑ Doesn't notice or mind when a caregiver leaves or returns
- ❑ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned** or call **1-800-CDC-INFO.**

The American Academy of Pediatrics recommends that children be screened for general development and autism at the 18-month visit. Ask your child's doctor about your child's developmental screening.

Adapted from CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Fifth Edition, edited by Steven Shelov and Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 by the American Academy of Pediatrics and BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, Third Edition, edited by Joseph Hagan, Jr., Judith S. Shaw, and Paula M. Duncan, 2008, Elk Grove Village, IL: American Academy of Pediatrics.

www.cdc.gov/actearly | 1-800-CDC-INFO

Learn the Signs. Act Early.

Su bebé a los 18 meses (1½ años)

Nombre del niño _____ Edad del niño _____ Fecha de hoy _____

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo justo antes de cumplir 19 meses. En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

En las áreas social y emocional

- ❑ Le gusta alcanzarle cosas a los demás como un juego
- ❑ Puede tener rabietas
- ❑ Puede ser que le tenga miedo a los desconocidos
- ❑ Le demuestra afecto a las personas conocidas
- ❑ Juega a imitar cosas sencillas, como alimentar a una muñeca
- ❑ Se aferra a la persona que le cuida en situaciones nuevas
- ❑ Señala para mostrarle a otras personas algo interesante
- ❑ Explora solo, pero con la presencia cercana de los padres

En las áreas del habla y la comunicación

- ❑ Puede decir varias palabras
- ❑ Dice "no" y sacude la cabeza como negación
- ❑ Señala para mostrarle a otra persona lo que quiere

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Sabe para qué sirven las cosas comunes; por ejemplo, teléfono, cepillo, cuchara
- ❑ Señala una parte del cuerpo
- ❑ Señala para llamar la atención de otras personas
- ❑ Demuestra interés en una muñeca o animal de peluche y hace de cuenta que le da de comer
- ❑ Hace garabatos sin ayuda
- ❑ Puede seguir instrucciones verbales de un solo paso que no se acompañan de gestos; por ejemplo, se sienta cuando se le dice "siéntate"

En las áreas motora y de desarrollo físico

- ❑ Camina solo
- ❑ Jala juguetes detrás de él mientras camina
- ❑ Puede subir las escaleras y correr
- ❑ Puede ayudar a desvestirse
- ❑ Bebe de una taza
- ❑ Come con cuchara

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No señala cosas para mostrárselas a otras personas
- ❑ No puede caminar
- ❑ No sabe para qué sirven las cosas familiares
- ❑ No copia lo que hacen las demás personas
- ❑ No aprende nuevas palabras
- ❑ No sabe por lo menos 6 palabras
- ❑ No se da cuenta ni parece importarle si la persona que le cuida se va a o regresa
- ❑ Pierde habilidades que había adquirido

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado** o llame **1-800-CDC-INFO**.

La Academia Americana de Pediatría recomienda que, a los 18 meses de edad, se evalúe el desarrollo general de los niños y se realicen pruebas de detección del autismo. Pregúntele al médico de su hijo si el niño necesita ser evaluado.

Tomado de CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Quinta Edición, editado por Steven Shelov y Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 por la Academia Americana de Pediatría y BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, tercera edición, editado por Joseph Hagan, Jr., Judith S. Shaw y Paula M. Duncan, 2008, Elk Grove Village, IL: Academia Americana de Pediatría.

Your Child at 2 Years

What most children do at this age:

Act early by talking to your child's doctor if your child:

- ❑ Doesn't use 2-word phrases (for example, "drink milk")
- ❑ Doesn't know what to do with common things, like a brush, phone, fork, spoon
- ❑ Doesn't copy actions and words
- ❑ Doesn't follow simple instructions
- ❑ Doesn't walk steadily
- ❑ Loses skills she once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your state's public early intervention program. For more information, go to **www.cdc.gov/concerned** or call **1-800-CDC-INFO**.

The American Academy of Pediatrics recommends that children be screened for general development and autism at the 24-month visit. Ask your child's doctor about your child's developmental screening.

www.cdc.gov/actearly | 1-800-CDC-INFO

CDC

Learn the Signs. Act Early.

Su hijo de 2 años

Nombre del niño | **Edad del niño** | **Fecha de hoy**

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo cuando cumple 2 años de edad. En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

En las áreas social y emocional

- ❑ Copia a otras personas, especialmente a adultos y niños mayores
- ❑ Se entusiasma cuando está con otros niños
- ❑ Demuestra ser cada vez más independiente
- ❑ Demuestra un comportamiento desafiante (hace lo que se le ha dicho que no haga)
- ❑ Comienza a incluir otros niños en sus juegos, como jugar a sentarse a comer con las muñecas o a correr y perseguirse

En las áreas del habla y la comunicación

- ❑ Señala a objetos o ilustraciones cuando se los nombra
- ❑ Sabe los nombres de personas conocidas y partes del cuerpo
- ❑ Dice frases de 2 a 4 palabras
- ❑ Sigue instrucciones sencillas
- ❑ Repite palabras que escuchó en alguna conversación
- ❑ Señala las cosas que aparecen en un libro

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Encuentra cosas aun cuando están escondidas debajo de dos o tres sábanas
- ❑ Empieza a clasificar por formas y colores
- ❑ Completa las frases y las rimas de los cuentos que conoce
- ❑ Juega con su imaginación de manera sencilla
- ❑ Construye torres de 4 bloques o más
- ❑ Puede que use una mano más que la otra
- ❑ Sigue instrucciones para hacer dos cosas como por ejemplo, "levanta tus zapatos y ponlos en su lugar"
- ❑ Nombra las ilustraciones de los libros como un gato, pájaro o perro

En las áreas motora y de desarrollo físico

- ❑ Se para en las puntas de los dedos
- ❑ Patea una pelota
- ❑ Empieza a correr
- ❑ Se trepa y baja de muebles sin ayuda
- ❑ Sube y baja las escaleras agarrándose
- ❑ Tira la pelota por encima de la cabeza
- ❑ Dibuja o copia líneas rectas y círculos

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No usa frases de 2 palabras (por ejemplo, "toma leche")
- ❑ No sabe cómo utilizar objetos de uso común, como un cepillo, teléfono, tenedor o cuchara
- ❑ No copia acciones ni palabras
- ❑ No puede seguir instrucciones sencillas
- ❑ No camina con estabilidad
- ❑ Pierde habilidades que había logrado

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo el programa público de intervención temprana patrocinado por el estado. Para obtener más información, consulte **www.cdc.gov/preocupado** o llame **1-800-CDC-INFO**.

La Academia Americana de Pediatría recomienda que, a los 24 meses de edad, se evalúe el desarrollo general de los niños y se realicen pruebas de detección del autismo. Pregúntele al médico de su hijo si el niño necesita ser evaluado.

Tomado de CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Quinta Edición, editado por Steven Shelov y Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 por la Academia Americana de Pediatría y BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, tercera edición, editado por Joseph Hagan, Jr., Judith S. Shaw y Paula M. Duncan, 2008, Elk Grove Village, IL: Academia Americana de Pediatría.

www.cdc.gov/pronto | 1-800-CDC-INFO

Aprenda los signos. Reaccione pronto.

Your Child at 3 Years

Child's Name _____ Child's Age _____ Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by his or her 3rd birthday. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What most children do at this age:

Social/Emotional

- ❑ Copies adults and friends
- ❑ Shows affection for friends without prompting
- ❑ Takes turns in games
- ❑ Shows concern for a crying friend
- ❑ Understands the idea of "mine" and "his" or "hers"
- ❑ Shows a wide range of emotions
- ❑ Separates easily from mom and dad
- ❑ May get upset with major changes in routine
- ❑ Dresses and undresses self

Language/Communication

- ❑ Follows instructions with 2 or 3 steps
- ❑ Can name most familiar things
- ❑ Understands words like "in," "on," and "under"
- ❑ Says first name, age, and sex
- ❑ Names a friend
- ❑ Says words like "I," "me," "we," and "you" and some plurals (cars, dogs, cats)
- ❑ Talks well enough for strangers to understand most of the time
- ❑ Carries on a conversation using 2 to 3 sentences

Cognitive (learning, thinking, problem-solving)

- ❑ Can work toys with buttons, levers, and moving parts
- ❑ Plays make-believe with dolls, animals, and people
- ❑ Does puzzles with 3 or 4 pieces
- ❑ Understands what "two" means
- ❑ Copies a circle with pencil or crayon
- ❑ Turns book pages one at a time
- ❑ Builds towers of more than 6 blocks
- ❑ Screws and unscrews jar lids or turns door handle

Movement/Physical Development

- ❑ Climbs well
- ❑ Runs easily
- ❑ Pedals a tricycle (3-wheel bike)
- ❑ Walks up and down stairs, one foot on each step

Act early by talking to your child's doctor if your child:

- ❑ Falls down a lot or has trouble with stairs
- ❑ Drools or has very unclear speech
- ❑ Can't work simple toys (such as peg boards, simple puzzles, turning handle)
- ❑ Doesn't speak in sentences
- ❑ Doesn't understand simple instructions
- ❑ Doesn't play pretend or make-believe
- ❑ Doesn't want to play with other children or with toys
- ❑ Doesn't make eye contact
- ❑ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your local public school. For more information, go to **www.cdc.gov/concerned** or call **1-800-CDC-INFO.**

Adapted from CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Fifth Edition, edited by Steven Shelov and Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 by the American Academy of Pediatrics and BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, Third Edition, edited by Joseph Hagan, Jr., Judith S. Shaw, and Paula M. Duncan, 2008, Elk Grove Village, IL: American Academy of Pediatrics.

www.cdc.gov/actearly | 1-800-CDC-INFO

Learn the Signs. Act Early.

Su hijo de 3 años

Nombre del niño _____ **Edad del niño** _____ **Fecha de hoy** _____

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo cuando cumple 3 años de edad. En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

En las áreas social y emocional

- ❑ Copia a los adultos y los amigos
- ❑ Demuestra afecto por sus amigos espontáneamente
- ❑ Espera su turno en los juegos
- ❑ Demuestra su preocupación por un amigo que está llorando
- ❑ Entiende la idea de lo que "es mío", "de él" o "de ella"
- ❑ Expresa una gran variedad de emociones
- ❑ Se separa de su mamá y su papá con facilidad
- ❑ Se molesta con los cambios de rutina grandes
- ❑ Se viste y desviste

En las áreas del habla y la comunicación

- ❑ Sigue instrucciones de 2 o 3 pasos
- ❑ Sabe el nombre de la mayoría de las cosas conocidas
- ❑ Entiende palabras como "adentro", "arriba" o "debajo"
- ❑ Puede decir su nombre, edad y sexo
- ❑ Sabe el nombre de un amigo
- ❑ Dice palabras como "yo", "mi", "nosotros", "tú" y algunos plurales (autos, perros, gatos)
- ❑ Habla bien de manera que los desconocidos pueden entender la mayor parte de lo que dice
- ❑ Puede conversar usando 2 o 3 oraciones

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Puede operar juguetes con botones, palancas y piezas móviles
- ❑ Juega imaginativamente con muñecas, animales y personas
- ❑ Arma rompecabezas de 3 y 4 piezas
- ❑ Entiende lo que significa "dos"
- ❑ Copia un círculo con lápiz o crayón
- ❑ Pasa las hojas de los libros una a la vez
- ❑ Arma torres de más de 6 bloquecitos
- ❑ Enrosca y desenrosca las tapas de jarras o abre la manija de la puerta

En las áreas motora y de desarrollo físico

- ❑ Trepa bien
- ❑ Corre fácilmente
- ❑ Puede pedalear un triciclo (bicicleta de 3 ruedas)
- ❑ Sube y baja escaleras, un pie por escalón

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ Se cae mucho o tiene problemas para subir y bajar escaleras
- ❑ Se babea o no se le entiende cuando habla
- ❑ No puede operar juguetes sencillos (tableros de piezas para encajar, rompecabezas sencillos, girar una manija)
- ❑ No usa oraciones para hablar
- ❑ No entiende instrucciones sencillas
- ❑ No imita ni usa la imaginación en sus juegos
- ❑ No quiere jugar con otros niños ni con juguetes
- ❑ No mira a las personas a los ojos
- ❑ Pierde habilidades que había adquirido

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo la escuela pública más cercana. Para obtener más información, consulte **www.cdc.gov/preocupado** o llame **1-800-CDC-INFO**.

Tomado de CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Quinta Edición, editado por Steven Shelov y Tanya Remer Altmann © 1991, 1998, 2004, 2009 por la Academia Americana de Pediatría y BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, tercera edición, editado por Joseph Hagan, Jr., Judith S. Shaw y Paula M. Duncan, 2008, Elk Grove Village, IL: Academia Americana de Pediatría.

Your Child at 4 Years

Child's Name _____ Child's Age _____ Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by his or her 4th birthday. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What most children do at this age:

Social/Emotional

- ❑ Enjoys doing new things
- ❑ Plays "Mom" and "Dad"
- ❑ Is more and more creative with make-believe play
- ❑ Would rather play with other children than by himself
- ❑ Cooperates with other children
- ❑ Often can't tell what's real and what's make-believe
- ❑ Talks about what she likes and what she is interested in

Language/Communication

- ❑ Knows some basic rules of grammar, such as correctly using "he" and "she"
- ❑ Sings a song or says a poem from memory such as the "Itsy Bitsy Spider" or the "Wheels on the Bus"
- ❑ Tells stories
- ❑ Can say first and last name

Cognitive (learning, thinking, problem-solving)

- ❑ Names some colors and some numbers
- ❑ Understands the idea of counting
- ❑ Starts to understand time
- ❑ Remembers parts of a story
- ❑ Understands the idea of "same" and "different"
- ❑ Draws a person with 2 to 4 body parts
- ❑ Uses scissors
- ❑ Starts to copy some capital letters
- ❑ Names four colors
- ❑ Plays board or card games
- ❑ Tells you what he thinks is going to happen next in a book

Movement/Physical Development

- ❑ Hops and stands on one foot up to 2 seconds
- ❑ Catches a bounced ball most of the time
- ❑ Pours, cuts with supervision, and mashes own food

Act early by talking to your child's doctor if your child:

- ❑ Can't jump in place
- ❑ Has trouble scribbling
- ❑ Shows no interest in interactive games or make-believe
- ❑ Ignores other children or doesn't respond to people outside the family
- ❑ Resists dressing, sleeping, and using the toilet
- ❑ Can't retell a favorite story
- ❑ Doesn't follow 3-part commands
- ❑ Doesn't understand "same" and "different"
- ❑ Doesn't use "me" and "you" correctly
- ❑ Speaks unclearly
- ❑ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your local public school. For more information, go to **www.cdc.gov/concerned** or call **1-800-CDC-INFO.**

Adapted from CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Fifth Edition, edited by Steven Shelov and Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 by the American Academy of Pediatrics and BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, Third Edition, edited by Joseph Hagan, Jr., Judith S. Shaw, and Paula M. Duncan, 2008, Elk Grove Village, IL: American Academy of Pediatrics.

www.cdc.gov/actearly | 1-800-CDC-INFO

Learn the Signs. Act Early.

Su hijo de 4 años

Nombre del niño | **Edad del niño** | **Fecha de hoy**

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo cuando cumple 4 años de edad. En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

En las áreas social y emocional

- ❑ Disfruta haciendo cosas nuevas
- ❑ Juega a "papá y mamá"
- ❑ Cada vez se muestra más creativo en los juegos de imaginación
- ❑ Le gusta más jugar con otros niños que solo
- ❑ Juega en cooperación con otros
- ❑ Generalmente no puede distinguir la fantasía de la realidad
- ❑ Describe lo que le gusta y lo que le interesa

En las áreas del habla y la comunicación

- ❑ Sabe algunas reglas básicas de gramática, como el uso correcto de "él" y "ella"
- ❑ Canta una canción o recita un poema de memoria como "La araña pequeñita" o "Las ruedas de los autobuses"
- ❑ Relata cuentos
- ❑ Puede decir su nombre y apellido

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Nombra algunos colores y números
- ❑ Entiende la idea de contar
- ❑ Comienza a entender el concepto de tiempo
- ❑ Recuerda partes de un cuento
- ❑ Entiende el concepto de "igual" y "diferente"
- ❑ Dibuja una persona con 2 o 4 partes del cuerpo
- ❑ Sabe usar tijeras
- ❑ Empieza a copiar algunas letras mayúsculas
- ❑ Juega juegos infantiles de mesa o de cartas
- ❑ Le dice lo que le parece que va a suceder en un libro a continuación

En las áreas motora y de desarrollo físico

- ❑ Brinca y se sostiene en un pie hasta por 2 segundos
- ❑ La mayoría de las veces agarra una pelota que rebota
- ❑ Se sirve los alimentos, los hace papilla y los corta (mientras usted lo vigila)

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No puede saltar en el mismo sitio
- ❑ Tiene dificultades para hacer garabatos
- ❑ No muestra interés en los juegos interactivos o de imaginación
- ❑ Ignora a otros niños o no responde a las personas que no son de la familia
- ❑ Rehúsa vestirse, dormir y usar el baño
- ❑ No puede relatar su cuento favorito
- ❑ No sigue instrucciones de 3 partes
- ❑ No entiende lo que quieren decir "igual" y "diferente"
- ❑ No usa correctamente las palabras "yo" y "tú"
- ❑ Habla con poca claridad
- ❑ Pierde habilidades que había adquirido

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo la escuela pública más cercana. Para obtener más información, consulte **www.cdc.gov/preocupado** o llame **1-800-CDC-INFO**.

Tomado de CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Quinta Edición, editado por Steven Shelov y Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 por la Academia Americana de Pediatría y BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, tercera edición, editado por Joseph Hagan, Jr., Judith S. Shaw y Paula M. Duncan, 2008, Elk Grove Village, IL: Academia Americana de Pediatría.

Your Child at 5 Years

Child's Name _____ Child's Age _____ Today's Date _____

How your child plays, learns, speaks, and acts offers important clues about your child's development. Developmental milestones are things most children can do by a certain age.

Check the milestones your child has reached by his or her 5th birthday. Take this with you and talk with your child's doctor at every visit about the milestones your child has reached and what to expect next.

What most children do at this age:

Social/Emotional

- ❑ Wants to please friends
- ❑ Wants to be like friends
- ❑ More likely to agree with rules
- ❑ Likes to sing, dance, and act
- ❑ Is aware of gender
- ❑ Can tell what's real and what's make-believe
- ❑ Shows more independence (for example, may visit a next-door neighbor by himself [adult supervision is still needed])
- ❑ Is sometimes demanding and sometimes very cooperative

Language/Communication

- ❑ Speaks very clearly
- ❑ Tells a simple story using full sentences
- ❑ Uses future tense; for example, "Grandma will be here."
- ❑ Says name and address

Cognitive (learning, thinking, problem-solving)

- ❑ Counts 10 or more things
- ❑ Can draw a person with at least 6 body parts
- ❑ Can print some letters or numbers
- ❑ Copies a triangle and other geometric shapes
- ❑ Knows about things used every day, like money and food

Movement/Physical Development

- ❑ Stands on one foot for 10 seconds or longer
- ❑ Hops; may be able to skip
- ❑ Can do a somersault
- ❑ Uses a fork and spoon and sometimes a table knife
- ❑ Can use the toilet on her own
- ❑ Swings and climbs

Act early by talking to your child's doctor if your child:

- ❑ Doesn't show a wide range of emotions
- ❑ Shows extreme behavior (unusually fearful, aggressive, shy or sad)
- ❑ Unusually withdrawn and not active
- ❑ Is easily distracted, has trouble focusing on one activity for more than 5 minutes
- ❑ Doesn't respond to people, or responds only superficially
- ❑ Can't tell what's real and what's make-believe
- ❑ Doesn't play a variety of games and activities
- ❑ Can't give first and last name
- ❑ Doesn't use plurals or past tense properly
- ❑ Doesn't talk about daily activities or experiences
- ❑ Doesn't draw pictures
- ❑ Can't brush teeth, wash and dry hands, or get undressed without help
- ❑ Loses skills he once had

Tell your child's doctor or nurse if you notice any of these signs of possible developmental delay for this age, and talk with someone in your community who is familiar with services for young children in your area, such as your local public school. For more information, go to **www.cdc.gov/concerned** or call **1-800-CDC-INFO**.

Adapted from CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Fifth Edition, edited by Steven Shelov and Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 by the American Academy of Pediatrics and BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, Third Edition, edited by Joseph Hagan, Jr., Judith S. Shaw, and Paula M. Duncan, 2008, Elk Grove Village, IL: American Academy of Pediatrics.

www.cdc.gov/actearly | 1-800-CDC-INFO

Learn the Signs. Act Early.

Su hijo de 5 años

Nombre del niño _____ Edad del niño _____ Fecha de hoy _____

La manera en que su hijo juega, aprende, habla y actúa nos ofrece pistas importantes sobre cómo se está desarrollando. Los indicadores del desarrollo son las cosas que la mayoría de los niños pueden hacer a una edad determinada.

Marque los indicadores del desarrollo que puede ver en su hijo cuando cumple 5 años de edad. En cada visita médica de su hijo, lleve esta información y hable con el pediatra sobre los indicadores que su hijo alcanzó y cuáles son los que debería alcanzar a continuación.

¿Qué hacen los niños a esta edad?

En las áreas social y emocional

- ❑ Quiere complacer a los amigos
- ❑ Quiere parecerse a los amigos
- ❑ Es posible que haga más caso a las reglas
- ❑ Le gusta cantar, bailar y actuar
- ❑ Está consciente de la diferencia de los sexos
- ❑ Puede distinguir la fantasía de la realidad
- ❑ Es más independiente (por ejemplo, puede ir solo a visitar a los vecinos de al lado) (para esto todavía necesita la supervisión de un adulto)
- ❑ A veces es muy exigente y a veces muy cooperador

En las áreas del habla y la comunicación

- ❑ Habla con mucha claridad
- ❑ Puede contar una historia sencilla usando oraciones completas
- ❑ Puede usar el tiempo futuro; por ejemplo, "la abuelita va a venir"
- ❑ Dice su nombre y dirección

En el área cognitiva (aprendizaje, razonamiento, resolución de problemas)

- ❑ Cuenta 10 o más cosas
- ❑ Puede dibujar una persona con al menos 6 partes del cuerpo
- ❑ Puede escribir algunas letras o números
- ❑ Puede copiar triángulos y otras figuras geométricas
- ❑ Conoce las cosas de uso diario como el dinero y la comida

En las áreas motora y de desarrollo físico

- ❑ Se para en un pie por 10 segundos o más
- ❑ Brinca y puede ser que dé saltos de lado
- ❑ Puede dar volteretas en el aire
- ❑ Usa tenedor y cuchara y, a veces, cuchillo
- ❑ Puede ir al baño solo
- ❑ Se columpia y trepa

Reaccione pronto y hable con el doctor de su hijo si el niño:

- ❑ No expresa una gran variedad de emociones
- ❑ Tiene comportamientos extremos (demasiado miedo, agresión, timidez o tristeza)
- ❑ Es demasiado retraído y pasivo
- ❑ Se distrae con facilidad, tiene problemas para concentrarse en una actividad por más de 5 minutes
- ❑ No le responde a las personas o lo hace solo superficialmente
- ❑ No puede distinguir la fantasía de la realidad
- ❑ No juega a una variedad de juegos y actividades
- ❑ No puede decir su nombre y apellido
- ❑ No usa correctamente los plurales y el tiempo pasado
- ❑ No habla de sus actividades o experiencias diarias
- ❑ No dibuja
- ❑ No puede cepillarse los dientes, lavarse y secarse las manos o desvestirse sin ayuda
- ❑ Pierde habilidades que había adquirido

Dígale al médico o a la enfermera de su hijo si nota cualquiera de estos signos de posible retraso del desarrollo para su edad, y converse con alguien de su comunidad que conozca los servicios para niños de su área, como por ejemplo la escuela pública más cercana. Para obtener más información, consulte **www.cdc.gov/preocupado** o llame **1-800-CDC-INFO**.

Tomado de CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Quinta Edición, editado por Steven Shelov y Tanya Remer Altmann © 1991, 1998, 2004, 2009 por la Academia Americana de Pediatría y BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, tercera edición, editado por Joseph Hagan, Jr., Judith S. Shaw y Paula M. Duncan, 2008, Elk Grove Village, IL: Academia Americana de Pediatría

Resources for Parents

A. ASD Fact Sheet
B. Pediatric Developmental Screening Flowchart
C. Family Resource Specialist Network Map
D. Helpful Links for Parents

Autism Spectrum Disorders
FACT SHEET

What are autism spectrum disorders?

Autism spectrum disorders (ASDs) are a group of developmental disabilities caused by a problem with the brain. Scientists do not know yet exactly what causes this problem. ASDs can impact a person's functioning at different levels, from very mildly to severely. There is usually nothing about how a person with an ASD looks that sets them apart from other people, but they may communicate, interact, behave, and learn in ways that are different from most people. The thinking and learning abilities of people with ASDs can vary – from gifted to severely challenged. Autistic disorder is the most commonly known type of ASD, but there are others, including "pervasive developmental disorder-not otherwise specified" (PDD-NOS) and Asperger Syndrome.

What are some of the signs of ASDs?

People with ASDs may have problems with social, emotional, and communication skills. They might repeat certain behaviors and might not want change in their daily activities. Many people with ASDs also have different ways of learning, paying attention, or reacting to things. ASDs begin during early childhood and last throughout a person's life.

A child or adult with an ASD might:

- not play "pretend" games (pretend to "feed" a doll)
- not point at objects to show interest (point at an airplane flying over)
- not look at objects when another person points at them
- have trouble relating to others or not have an interest in other people at all
- avoid eye contact and want to be alone
- have trouble understanding other people's feelings or talking about their own feelings
- prefer not to be held or cuddled or might cuddle only when they want to
- appear to be unaware when other people talk to them but respond to other sounds
- be very interested in people, but not know how to talk, play, or relate to them
- repeat or echo words or phrases said to them, or repeat words or phrases in place of normal language (echolalia)
- have trouble expressing their needs using typical words or motions
- repeat actions over and over again
- have trouble adapting when a routine changes
- have unusual reactions to the way things smell, taste, look, feel, or sound
- lose skills they once had (for instance, stop saying words they were using)

What can I do if I think my child has an ASD?

Talk with your child's doctor or nurse. If you or your doctor think there could be a problem, ask for a referral to see a developmental pediatrician or other specialist, or you can contact your local early intervention agency (for children under 3) or public school (for children 3 and older). To find out who to speak to in your area, you can contact the National Information Center for Children and Youth with Disabilities (NICHCY) by logging onto **www.nichcy.org** or call **1-800-695-0285**. In addition, the Centers for Disease Control and Prevention (CDC) has links to information for families on their Autism Information Center Web page (**www.cdc.gov/ncbddd/dd/aic/resources**).

Right now, the main research-based treatment for ASDs is intensive structured teaching of skills, often called behavioral intervention. It is **very** important to begin this intervention as early as possible in order to help your child reach his or her full potential. Acting early can make a real difference!

1-800-CDC-INFO www.cdc.gov/actearly

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CDC

SAFER · HEALTHIER · PEOPLE™

Learn the Signs. Act Early.

Hoja informativa sobre los trastornos del espectro autista (TEA)

¿Qué son los trastornos del espectro autista?

Los trastornos del espectro autista (TEA) son un grupo de discapacidades del desarrollo provocados por un problema en el cerebro. Los científicos aun no conocen con exactitud las causas de este problema. Los TEA pueden afectar el funcionamiento de las personas a diferentes niveles, de manera muy leve a grave. Por lo general no se puede notar diferencia alguna en el aspecto de una persona con TEA, pero es probable que tenga maneras diferentes de comunicarse, interactuar, comportarse y aprender. Las aptitudes mentales y la capacidad de aprendizaje de las personas con TEA pueden variar, encontrándose desde personas talentosas hasta personas con problemas muy serios. El trastorno autístico es el tipo de TEA más conocido, aunque también existen otros, como el trastorno generalizado del desarrollo, no especificado de otra manera (PDD – NOS, por sus siglas en inglés) y el síndrome de Asperger.

¿Cuáles son algunos de los signos de los TEA?

Es probable que los que sufren de TEA tengan problemas sociales, emocionales y de comunicación. También es probable que repitan conductas y no quieran cambiar sus actividades diarias. Muchas personas con TEA también tienen diferentes maneras de aprender, prestar atención y reaccionar ante las cosas. Los TEA comienzan en la infancia y perduran durante toda la vida de una persona.

Los niños o adultos con TEA puede que:

- no jueguen a imitar a los grandes (por ejemplo, dar de "comer" a la muñeca para imitar a la mamá)
- no señalen objetos para mostrar interés (señalar un avión que está volando cerca)
- no miren objetos que otras personas les estén señalando
- tengan problemas para relacionarse con otros o no estén interesados en ellos del todo.
- eviten el contacto visual y prefieran estar solos
- tengan problemas para comprender los sentimientos de otras personas o para expresar sus propios sentimientos
- prefieran que no los abracen o permitan que lo hagan solo cuando ellos lo desean
- aparenten no percatarse cuando otras personas les hablan, pero responden a otros sonidos.
- estén muy interesados en otras personas, pero no sepan cómo hablarles, jugar o establecer contacto con ellas
- presenten ecolalia, es decir, repiten palabras o frases que se les dicen en vez de responder y usar la forma normal del lenguaje
- tengan problemas para expresar sus necesidades mediante palabras o movimientos
- repitan las mismas acciones una y otra vez (agitar las manos, mover los dedos, mecerse, etc.)
- tengan problemas para adaptarse a cambios en la rutina
- reaccionen de manera extraña a la forma en que las cosas huelen, saben, se ven, se sienten o suenan
- pierdan las destrezas que en algún momento tuvieron (por ejemplo, dejan de decir palabras que estaban usando anteriormente)

* Nota: comuníquese con el médico o la enfermera de su hijo si el niño experimenta una pérdida drástica de habilidades a cualquier edad.

¿Qué puedo hacer si creo que mi hijo tiene un TEA?

Por favor hable con el médico o enfermera de su hijo. Si usted o su doctor piensan que podría existir algún problema, pídale al doctor que remita a su hijo a un pediatra especializado en desarrollo u otro especialista en este campo; también puede llamar a su agencia local de intervención temprana (para niños menores de 3 años) o su escuela pública (para niños de 3 años o más). Para saber con quién hablar en su área, puede comunicarse con el Centro Nacional de Diseminación de Información para Niños con Discapacidades (National Information Center for Children and Youth with Disabilities – NICHCY) a través del siguiente sitio web: **www.nichcy.org/states.htm**. Además, el Centro para el Control y la Prevención de Enfermedades (CDC) tiene enlaces a páginas con información para las familias en el sitio web de su Centro de Información sobre el Autismo (Autism Information Center) en (**www.cdc.gov/autism**).

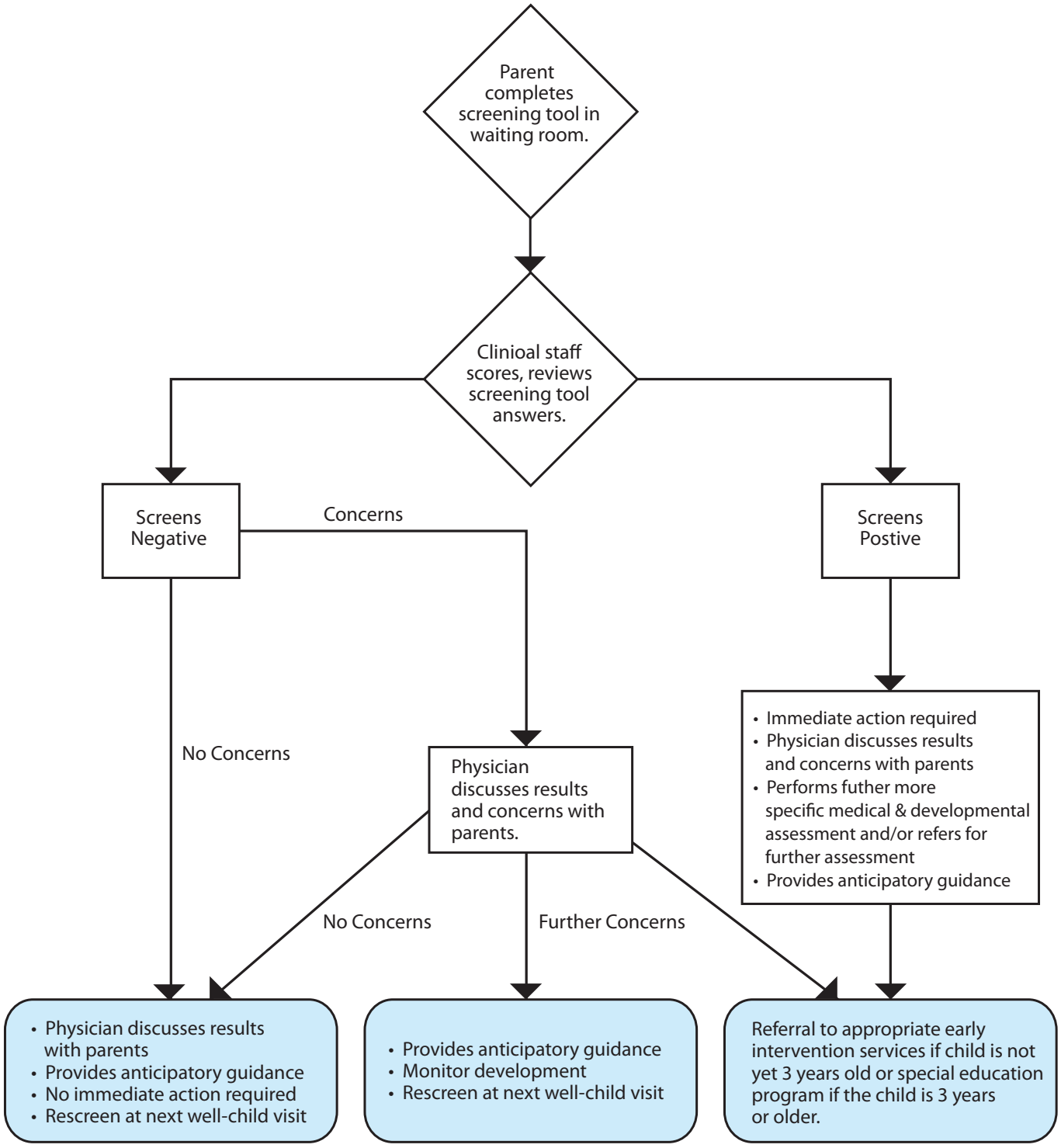
En la actualidad, el tratamiento más importante para los TEA es la enseñanza estructurada de destrezas, a menudo llamada intervención conductual. Es muy importante empezar la intervención tan pronto sea posible para ayudar al niño a alcanzar su máximo potencial. ¡Actuar rápido puede hacer

1-800-CDC-INFO www.cdc.gov/pronto

SAFER • HEALTHIER • PEOPLE™

Aprenda los signos. Reaccione pronto.

Pediatric Developmental Screening Flowchart



FAMILY RESOURCE SPECIALIST NETWORK

LOCATION & CONTACT

REGION I

Grace Dyson – Chicago (Cook)
773.233.4716 dysongraceladyd@aol.com

Gloria Kern – Crest Hill (Will)
815.722.2698 kern75@ispwest.com

Carla Oldham – Aurora (Kane)
630.978.1615 AutismTeam@aol.com

Andrea Damenti – Antioch (Lake)
847-970-2347 zw9901@comcast.net

Rachel Westberg – Woodridge (DuPage)
708-533-2485 westberg.rachel@gmail.com

REGION II

Rick Ramirez - Moline (Rock Island)
309.797.4838 or 800-813-0392
rick.ramirez@mchsi.com

REGION III

Sandy Valentine – East Peoria (Tazewell)
309-698-4831
Mobile: 309.251.9522
Ajv1952@aol.com

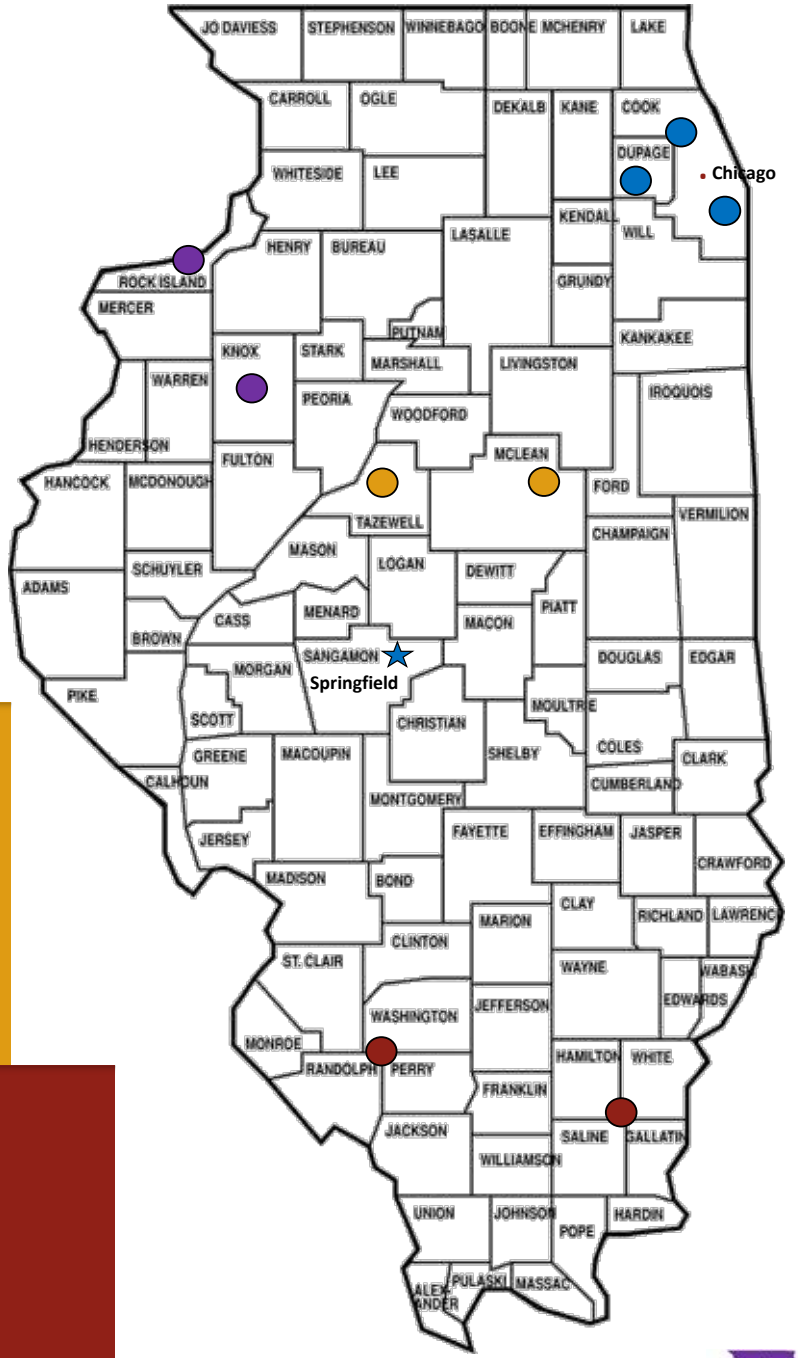
Jacquie Mace – Bloomington (McLean)
309.824.4555
Mace.jacquie@comcast.net

REGION IV

Penny Salvato – STL Metro East& Alton area.
618-467-0207 dapsalvato@sbcglobal.net

Lyndsey Reedy –Mattoon (Coles)
217-258-6616 l.reedy@live.com

Kristen Wright – New Baden (Clinton)
618-917-9633 kwright5035@gmail.com



Illinois Autism Training and Technical Assistance Project

Illinois Statewide Technical Assistance Center

The Illinois Autism/PDD Training and Technical Assistance Project (IATTAP) is one of four **Illinois State Board of Education** initiatives under the Illinois Statewide Technical Assistance Center (ISTAC) that provide training and technical assistance to schools in Illinois. Other ISTAC partners are PBIS Network, Project CHOICES and ISTAC-Parent. IATTAP focuses on educating and supporting children with autism spectrum disorders (ASD) and their families. The Project is operated under a grant to the School Association for Special Education in DuPage County and its **major goals** are to: Build local capacity to establish and implement effective educational supports and services in the least restrictive environment for children with ASD; Promote a proactive approach to working with individuals with ASD and their families; Help children with ASD remain with their families in their home communities and become productive; Increase the percentage of students with ASD who are educated in the general education classroom in their home schools; and Increase the effective and meaningful involvement of parents in their children's education.

FAMILY RESOURCE SPECIALIST NETWORK

The Family Resource Specialist Network creates a parent-to-parent connection of parents and family members who have children on the autism spectrum in different areas of Illinois. The network gives families the opportunity to contact another parent of a child with autism in their own or nearby community. The Family Resource Specialists organize Saturday parent conferences in their area and help to develop and disseminate a regional resource guide. They are also available to talk with parents by phone or e-mail, offering valuable information and a listening ear from another parent's perspective.

Information in resource guides include local education and other professional referrals, autism organizations and support groups (local, state, and national), community resources, autism support web sites, Illinois parent and professional training organizations, educational rights and advocate groups, newsletters and magazines, books, information regarding financial assistance, teaching aides, and safety aides.

The Family Resource Specialist Network helps to connect parents who share the experience of having a child with autism and to distribute valuable resource information from family to family.

MEET THE FAMILY RESOURCE SPECIALIST NETWORK . . .

Aurora
Carla Oldham –Carla and her husband, Walt are parents of 12 year-old twins, one of whom has autism. Carla founded PROUDD, (Parents Resource Organization for the Understanding of Disabilities and Developmental Delays) .

Antioch
Andrea Damenti – Andrea is a parent of a child with autism an co-president of a special ed CO-OP Advisory Board.

Bloomington
Jacquie Mace –Jacquie is the mom of 4 children. One of her 15 year-old twin boys has ASD. She the founded the Autism Society of McLean County and the authored the T.R.A.I.N. RESOURCE BOOK .

Chicago
Grace Dyson – Grace is the president of the Chicago Metropolitan Chapter #714 Autism Society of America. Grace has a 20 year old grandson who has autism. Grace loves football and basketball.

Mattoon
Lyndsey Reedy – Lyndsey is the mother of 2 kids, one which has ASD. Her motivation lies in seeing results of a family coming together and succeeding.

Mt. Vernon
Nicole Gaunt – Nicole and her husband J.C. are the parents of a 7 year old daughter and a 5 year old son , with autism. The Gaunts enjoy family time in the great outdoors.

Moline
Rick Ramirez –Rick and his wife, Cheryl have been married for 26 years. They are the parents of 18year-old son, Marcus, who has autism, and 27year-old daughter, Ericka. Rick's main interests are tennis and politics.

STL Metro East
Penny Salvato - Penny and her husband Andrew are the parents of 6 year old Daniel & live in Godfrey, IL. Daniel has High Functioning Autism & ADHD. Penny & her husband started a local support group (A.O.K. - Autism & Our Kids) that tries to meet the diverse needs of ASD children their families.

Woodridge
Rachel Westberg – Rachel is an insightful, caring individual and very passionate about her work in the autism field. Rachel is a sibling of a family member with autism. Rachel is a recreational therapist by trade.

East Peoria
Sandy Valentine –Sandy and husband Stan are parents of 3 children. Their youngest, Jack, is 19 and has autism. She has been providing support and encouragement to other families who have children with disabilities and medical issues for over 16 years.

New Baden
Kristen Wright – Kristen and her husband, Nathan are the parents of a 6 year old with high functioning autism. Kristen is very dedicated and passionate about working with individuals with ASD and their families. Kristen is a Board Certified Behavior Analyst.

Project Director Kathy Gould

1590 S. Fairfield Ave, Lombard Illinois 60148 **ph: 630-889-7398** **gouldkl@comcast.net**

www.illinoisautismproject.org

88% of annual funding for this project is from federal sources under a grant from the Illinois State Board of Education

Helpful Links for Parents

Autism Speaks! 100-Day Kit

http://www.autismspeaks.org/family-services/tool-kits/100-day-kit

Provides resources to be used in the 100 days following a child's diagnosis. Provides information to assist in understanding the diagnosis, resources, therapies, etc.

IEP Chat

http://www.theautismprogram.org/iep_chat/light_index.html

Resources for parents to assist parents in best participating in the planning of their child's IEP

Search for Services

http://www.theautismprogram.org/search-for-services/

Database which allows parents to search for locations of services available to their child

Part III. Resources for Parents: Reference Links

A. ASD Fact Sheet
http://www.cdc.gov/ncbddd/actearly/pdf/parents_pdfs/autismfactsheet.pdf

B. Pediatric Developmental Screening Flowchart
http://www.cdc.gov/ncbddd/childdevelopment/documents/screening-chart.pdf

C. Family Resource Specialist Network Map
http://autism.pbisillinois.org/pdfs/resource%20specialis20.pdf

Tips from Professionals

1. **Use a team approach.**
   Collaborate with parents and any other professionals working with the child as needed to provide the best service for all areas of his environment (home, school, outside therapies, etc.). This is critical for the child being able to generalize skills to the community or at home. Parents are also usually looking for "quick fixes" so getting some negativity from them is common.

2. **Have a plan.**
   Know and understand any strategies, and/or behavior plans that are currently in place for the student. Share any that you find successful. Children with ASD do best with consistency!

3. **Use visuals**.
   Use pictures or textual visuals paired with language as appropriate. If a child with ASD is upset, remove the language and use the visuals. Visuals, written directions, role modeling, video modeling are also good alternatives to verbal communication.

4. **Consider sensory needs.**
   Understand a child's sensory needs, especially his or her response to touch (may be defensive or seek touch, or a combination depending on day/mood). "Stimming" behaviors, such as hand flapping, spinning, waving their fingers in front of their face are common for individuals with autism. These actions are not necessarily inappropriate and don't always need to be "fixed". Unless they're harmful, extremely disruptive, or inappropriate there is nothing wrong with someone with autism stimming. It's okay to do those things and still function in society and it's okay to wait for the stimming to stop and then carry on with an activity as if it never happened.

5. **Establish a routine.**
   Create a predictable routine including a scheduled day and time for service in the same location (as appropriate), creating a routine of activities that is similar. This goes back to the consistency!

6. **Find out what motivates the child.**
   You can talk to those who know the child best (parents, other service providers, etc.) or complete an interest inventory. Then, you can use these motivators to increase student engagement in therapy.

A Final Tip from Professionals

Autism Spectrum Disorder is a spectrum!

Knowing autism characteristics, or experience with another child on the spectrum does not necessarily transfer to all students with ASD. For example, one student may hate to be touched, while another craves a big hug. Or, one child may have a favorite subject (like trains, Legos, video games, sea life, etc.) while others do not obsess over one topic. Each child is unique!

Evaluating Interventions

Treatment approaches and nontraditional therapies identified for autism spectrum disorders are debated by researchers, parents and professionals on a regular basis. Many approaches exist that promise cures or, at the very least, dramatic improvement. While some of these strategies are effective for some, there is no one approach that is effective for all people with autism spectrum disorders. Most importantly, autism cannot be cured. However, early intervention and appropriate educational planning can minimize the effects of autism on a person's life by teaching them skills to enhance their ability to communicate and socialize.

Parents are strongly encouraged to investigate thoroughly any treatment approaches or nontraditional therapies prior to implementing them with their child. The following is a list of questions that should be considered:

1. **What is the treatment/therapy?**
    a. Is there written information, a program description, or detailed brochure?
    b. Exactly what is involved for the family and the child?
    c. What is the length of treatment:
    d. How much parent time is required?
    e. What are the financial costs?
    f. Is there training required for parents, care providers, teachers and others?
    g. Is there follow-up and/or support after treatment termination?

2. **Is there reliable evidence of the effectiveness of the technique/intervention?**
    a. Does the treatment promise a cure?
    b. Does the treatment claim to be effective and appropriate for everyone?
    c. Does research support these claims? Is there quality empirical evidence?
    d. Do the claims made correspond to what is known about autism, language, and neurological functioning?

3. **What is the rationale, philosophy, or underlying purpose of the treatment program?**
    a. Does the treatment address important aspects of the autistic disorder (e.g., social interaction, cognitive issues, and language)?
    b. How is the philosophy tied to the specific treatment techniques?
    c. How were the philosophy and treatment methods developed (e.g., scientific research or clinical experience)?

4. **How is the determination made that the treatment/therapy is warranted and appropriate?**

5. **Does the treatment focus on one particular aspect or is it a general comprehensive approach?**
    a. Does it allow the integration of other techniques?
    b. Are the components of the treatment program compatible?
    c. Are the treatment goals individualized for each person and their family?

6. **What are the credentials of the program director and the staff?**
    a. What are the background, training and credentials of the program staff?
    b. What are the staff's understanding, training and experience in autism?
    c. How much experience have they had in providing the treatment?
    d. Are they open to questions and input from family members and other professionals involved with the child?

7. **Is there evidence that supports the effectiveness of the treatment/therapy?**
    a. Is there independent confirmation of the effectiveness?
    b. What are the possible negative effects or side effects of the treatment?
    c. What impact might the treatment have on the family's lifestyle (e.g, time, finances)?

8. **Does the treatment/therapy promise a cure?**

9. **Is there excessive hype surrounding the treatment?**

There are many people that claim to have a cure for autism. However, the majority of treatments and claims of cures that exist have yet to be scientifically documented. Treatment decisions are best made following a comprehensive assessment and after thorough investigation of the various treatment options being considered. Education and investigation will help parents arrive at the conclusion of what is the best treatment option for their child and family.

References:

Sasso, G. (1995, November). Choosing Interventions for Individuals with Autism. Presentation conducted at the Midwest Autism Conference.

Center for Disabilities
1400 West 22nd Street
Sioux Falls, South Dakota 57105

(605) 357-1439
1-800-658-3080 (Voice/TTY)
www.usd.edu/cd

The Autism Program of Illinois (TAP): Tip Sheets and Tools

Tip Sheets

1. Tips to Reduce Behavioral Difficulties with Children (2 pages)
2. General Tips, Communicating and FAQs (2 pages)
3. The Power of Choice
4. Autism Treatments (2 pages)
5. Progressive Muscle Relaxation for Children and Adolescents (2 pages)
6. Helping Children Develop Impulse Control
7. Planning Ahead to Prevent Tantrums
8. General Calming Techniques (3 pages)
9. Structured Play

Tools

10. 1-2-3 Communication Tool (2 pages)
11. Social Guide: 5 Point Scale (3 pages)
12. Social Guide: The 5 Point Voice Scale
13. Social Guide: Things I Can Do To Stay Calm
14. What Hurts Self-Identification Tool
15. Social Guide: Relaxation Scripts (3 pages)
16. First-Then Transition Cards
17. First-Then Transition Cards (Spanish version)
18. I Can Do It Reward Chart

Autism Spectrum Disorders
Tips & Resources

Tip Sheet 24

Tips to Reduce Behavioral Difficulties with Children

Focus on the positive.

The best way to eliminate negative behaviors is to reinforce the positive behaviors children engage in throughout the day. This will increase the likelihood they will repeat the preferred behaviors. For example, praising your child for homework they have already completed is more effective than yelling at them to finish it. Use motivating statements like, "Wow, I see you've been working hard on your homework. I'll bet you'll be finished in no time at all."

Tell them what to do instead of what not to do.

It is more effective to give children direct commands. This is particularly true for children who are concrete thinkers. When we tell kids what not to do, we assume they know what the appropriate alternative behavior is. For instance, if you tell your child not to jump in a puddle, they might not understand that means go around the puddle; they might think it is ok to splash in the puddle, walk through the puddle, etc. Saying, "Walk around the puddle" makes expectations clear and reduces behavioral outbursts.

Offer limited, reasonable choices.

When possible, offering children controlled choices can allow them to feel more in control and can often make them more willing to comply with your request. For example, if your child doesn't want to get into his car seat, one way to avoid a power struggle is to provide controlled choices. You could say, "Do you want to climb in by yourself or do you want Mommy to put you in?"

Avoid too much language.

Rather than trying to reason with a child in the middle of a tantrum, try to use as few words as possible and try to use concrete language. Sometimes statements such as "It is time to get in the car" are more easily processed and followed than longer explanations about why the child needs to get in the car, how you are going to be late and what will happen if you are late.

Warn of upcoming transitions or changes.

While it may not always be possible, it is best to tell your child about any upcoming changes in order to give them time to adjust. If you are buying new furniture, try bringing your child to the store to see and touch the new items. Perhaps you could ask for their help in deciding where to place the new furniture. These strategies will prepare your child for the change and reduce their anxiety.

Use visual schedules or reminders.

Structure and consistency are two keys to improving behaviors. A fun way to do this is to develop simple visual reminders or schedules. This can be as simple as placing a picture of your child's teacher on every day that he needs to go to school, or as complex as having a full schedule written out for every step of getting ready for school.

Rev.0612
Adapted from Laurie Stephens' article in the Spring 2006 issue of The Help Group's HelpLetter
Prepared by: The TAP Center at The University of Illinois at Urbana/Champaign

Teach calming techniques.

Often we tell children to "calm down" when they are upset and feeling anxious. The problem is that we only use the word "calm" when a child is upset! It is important to identify for children what it means to be relaxed or calm so that they know the feeling we want them to experience. Try different relaxation techniques to see which ones work best for your child. For example: counting to ten, taking deep breaths, practicing yoga, listening to music.

Stay calm.

Remember, the smallest response is usually the best. Acting calm with a minimum of attention will reduce the risk of reinforcing the very behavior you wish to discourage. When you remain calm it also gives you time to think about how you want to respond. Remember, you are modeling desired behavior for your child, the more out of control your child becomes, the more in control you need to appear. When you remain calm, you are teaching your child an appropriate way to handle difficult situations.

Rev.0612
Adapted from Laurie Stephens' article in the Spring 2006 issue of The Help Group's HelpLetter
Prepared by: The TAP Center at The University of Illinois at Urbana/Champaign

Tip Sheet 23

General Tips, Communicating and FAQ's
For Working with Children with Autism Spectrum Disorders

Communication Tips

Helping your child communicate more effectively:

- Teach communication skills that are functional and meaningful
- Teach communication in the context of everyday activities
- Provide multiple opportunities for communication practice throughout the day
- Arrange the environment as necessary to create the need to communicate
- Reduce stressful speaking situations by avoiding:
  - Competition for speaking opportunity
  - Frequent interruptions
  - Demand for display speech
  - Loss of listener attention
  - Frequent questions
  - Excitement when speaking

Communicating more effectively with your child:

- Slow down when speaking with your child
- Replace long, complex sentences with short simple sentences
- Stress key words
- Use other modalities to enhance meaning
- When using spoken commands, make them simple
- Use visual supports
- Use object supports
- Be consistent

General Tips

Consistency, consistency, consistency

Do things the same way with your child each time, and do things the same way with other people. Without consistency your child may become confused or discover opportunities for manipulation.

Catch 'em being good

Whenever the opportunity presents itself, use a lot of positive reinforcement. Some children thrive on positive attention. Let them know when they are acting appropriately. If we praise good behavior we can hopefully decrease the need for inappropriate behavior.

Remain neutral and calm

Be sure not to raise your voice or show emotional reaction when your child uses inappropriate behaviors.

Use few words when addressing an inappropriate behavior

Using too many words provides unneeded attention. Keep requests simple. Tell your child what TO do rather than what not to do. Avoid using "stop" or "don't" statements and always use a firm., calm respectful tone of voice.

FAQ's

1. What symptoms or observations signal an immediate need for an evaluation?

9 months: No babbling
12 months: No pointing or other gestures
16 months: No single words
24 months: No functional 2-word phrases
Any age: Any loss of any language or social skills

2. Are Autism Spectrum Disorders rare?

No. Current statistics from the Center for Disease Control indicate that 1 in 166 children have an Autism Spectrum Disorder.

3. Do all children with autism have intellectual impairments?

No. The intellectual abilities of children with autism vary from the gifted range to severe and profound mental retardation. Studies indicate that 50 to 70 percent of individuals with classic autism have some level of mental retardation. It is important to note that intellectual functioning is difficult to assess in individuals with autism, and assessment of intellectual functioning in very young children may not be accurate.

4. Do all children with autism have some special gift, such as the ability to calculate dates or compose music?

No. There are a limited number of people with autism who are identified as savants. Savants are individuals with isolated giftedness in one or more areas. It is true that individuals with autism have what is called, splinter skills or scattered abilities. These terms refer to the fact that many people with autism have an uneven pattern of intellectual strengths and weaknesses.

5. Can individuals with autism respond to treatment?

Yes. We know that individuals with autism spectrum disorders learn through visual presentation, repetition and predictability. An environment that provides visual supports, structure, and repetition is most helpful. For more information on treatment options you should research University of North Carolina-Division TEACCH; Applied Behavior Analysis and Picture Exchange Communication.

6. What are some common elements seen in effective programs for young children?

- Comprehensive assessment leading to diagnosis and to an individualized treatment plan
- Individualized programming that is reevaluated to keep pace with the child's progress
- Predictable routines
- Functional analysis of problem behaviors
- Active family involvement
- Careful transitions across intervention settings (EI to School Programs; Grade Levels)
- Highly trained staff and use of empirically demonstrated strategies
- Focus on Early Intervention
- Intensive intervention (intensity measured by frequency of interactions and level of engagement)
- Attempts to generalize learning across environments (carrying things learned at school to home, etc.). A good program will assure that the child can demonstrate gains with multiple people and in multiple settings.

Autism Spectrum Disorders
Tips & Resources

THE AUTISM PROGRAM of Illinois TAP

Tip Sheet 26

The Power of Choice

Giving children choices is a very effective way to enlist their cooperation. It takes the pressure out of your request and allows the child to feel in control, which makes them more willing to comply. Providing controlled choices also gives children the structure they need, while allowing them to practice decision making.

KEYS TO OFFERING CHOICES

1. Limit the field of possible choices to 2.
2. Never offer a choice you can't live with.
3. If age appropriate, discuss the potential outcomes of each choice.
4. Don't interfere or tamper with the outcome of a particular choice, as long as the outcome doesn't put the child in physical danger. Interfering with the outcome teaches your children that they don't really have to take responsibility for their decisions.

EXAMPLES

- Do you want to wear your Big Bird pajamas or your Mickey Mouse pajamas?
- What pair of shorts would you like to wear today, the plaid ones or the orange ones?
- Do you want to do your homework at the kitchen table or the desk?
- Would you rather stop at the gas station or give me the money to fill the tank?
- Do you want to put your coat on or do you want me to put it on for you?
- Would you prefer to let the dog out in the yard or take him for a walk?
- Do you want to run up to bed or hop like a bunny?
- What do you want to do first, take out the trash or dry the dishes?
- Do you want to watch five more minutes of TV or ten?
- Do you want to take a bath or a shower?

Using choice is an effective way to achieve results, and when you get in the habit of offering choices you are doing your children a big favor. As children learn to make simple choices—Milk or juice?—they get the practice required to make bigger choices—Buy two class T-shirts or one sweatshirt?—which gives them the ability as they grow to make more important decisions—Save or spend? Drink beer or soda? Study or fail? Giving children choices allows them to learn to listen to their inner voice. It is a valuable skill that they will carry with them to adulthood.

A typical problem with choices is the child who makes up his own option! For example, "Taylor, do you want to put on your pajamas first, or brush your teeth?" To which little Taylor answers, "I want to watch TV." What to do? Just say, "That wasn't one of the choices. What do you want to do first, put on your pajamas or brush your teeth?"

If your child is still reluctant to choose from the options that you offer, then simply ask, "Would you like to choose or shall I choose for you?" If an appropriate answer is not forthcoming then you can say, "I see that you want me to choose for you." Then follow through. Make your choice and help your child — by leading or carrying them — so that they can cooperate.

Rev.0612
Adapted from an article by Elizabeth Pantley
Prepared by: The TAP Center at The University of Illinois at Urbana/Champaign

Autism Spectrum Disorders
Tips & Resources

THE AUTISM PROGRAM of Illinois TAP

Tip Sheet 19

Autism Treatments

Current Interventions in Autism - A Brief Analysis

	Lovaas	TEACCH	PECS
Background	Also known as Discrete Trial (DT), Intensive Behavior Intervention (IBI), Applied Behavior Analysis (ABA); DT was earliest form of behavior modification; initial research reported in 1987; initial intent to achieve inclusive kindergarten readiness; has "morphed" into IBI and ABA.	Stands for Treatment and Education of Autistic and related Communication-handicapped Children; over 32 years empirical data on efficacy of TEACCH approach exists; includes parents as co-therapists; recognizes need for supports from early childhood through adulthood; main focus is on autism rather than behavior.	Stands for Picture Exchange Communication System; derived from need to differentiate between *talking* and *communicating*; combines in-depth knowledge of speech therapy with understanding of communication where student does not typically attach meaning to words and lack of understanding of communication exists; high compatibility with TEACCH.
Goals	Teach child *how to learn* by focusing on developing skills in attending, imitation, receptive/expressive language, pre-academics, and self-help.	Provide strategies that support person throughout lifespan; facilitate autonomy at all levels of functioning; can be accommodated to individual needs.	Help child *spontaneously* initiate communicative interaction; help child understand the *function* of communication; develop communicative competency.
How Implemented	Uses ABC model; every trial or task given to the child consists of; antecedent – a directive or request for child to perform an action, behavior – a response from the child that may include successful performance, non-compliance, no response, consequence – a reaction from the therapist, including a range of responses from strong positive reinforcement to faint praise to a negative "No!", pause – to separate trials from one another (intertrial interval).	Clearly organized, structured, modified environments and activities; emphasis on visual learning modalities; uses functional contexts for teaching concepts; curriculum is individualized based on individual assessment; uses structure and predictability to promote spontaneous communication.	Recognizes that young children with autism are not strongly influenced by social rewards; training begins with functional acts that bring child into contact with rewards; begins with physically assisted exchanges and proceeds through a hierarchy of eight phases; requires initial ratio of 2:1.
Reported Outcomes	First replications of initial research reporting gains in IQ, language comprehension and expression, adaptive and social skills.	Gains in function and development; improved adaptation and increase in functional skills; learned skills generalized to other environments; North Carolina reports lowest parental stress rates and rate of requests for out-of-home placement, and highest successful employment rates.	Pyramid Educational Consultants report incoming empirical data supporting; increased communicative competency among users (children understanding the *function* of communication); increasing reports of emerging spontaneous *speech*.
Advantages of Approach	Recognizes need for 1:1 instruction; utilizes repetitions of learned responses until firmly imbedded; tends to keep child engaged for increasing periods of time; effective at eliciting verbal production in select children; is a "jump start" for many children, with best outcomes for those in mild-to-moderate range.	Dynamic model that takes advantage of and incorporates research from multiple fields; model does not remain static; anticipates and supports inclusive strategies; compatible with PECS, Floor Time, OT, PT, selected therapies; addresses sub-types of autism, using individualized assessment and approach; identifies emerging skills, with highest probability of success; modifiable to reduce stress on child and/or family.	Helps to get language started; addresses both the communicative and social deficits of autism; well-suited for pre-verbal and non-verbal children AND children with a higher Performance IQ than Verbal IQ; semantics of PECS more like spoken language than signing.
Concerns with Approach	Heavily promoted as THE approach for autism in absence of any comparative research to support claim; no differentiation for subtypes when creating curriculum; emphasizes compliance training, prompt dependence; heave focus on behavioral approach may ignore underlying neurological aspects of autism, including issues of executive function and attention switching; may overstress child and/or family; costs reported as high as $50,000 per child per year; prohibits equal access.	Belief that TEACCH "gives in" to autism rather than fighting it; seen by some as an exclusionary approach that segregates children with autism; does not place enough emphasis on communication and social development; independent work centers may isolate when there is a need to be with other children to develop social skills.	May suppress spoken language (evidence is to the contrary).
Errors to Avoid	Creating dependency on 1:1; overstressing child or family; interpreting all behaviors as willful rather than neurological manifestations of syndrome; ignoring sensory issues or processing difficulties; failing to recognize when it is time to move to another approach	Failing to offer sufficient training, consultancy, and follow-up training to teachers for program to be properly implemented; treating TEACCH as a single classroom approach rather than a comprehensive continuum of supports and strategies; expecting minimally trained teacher to inform and train all other personnel in TEACCH approach; failing to work collaboratively with parents.	Failing to strictly adhere to the teaching principles in Phase 1; tendency to rush through Phase 1 or to use only one trainer; providing inadequate support or follow-up for teacher after attending two-day training; training only one person in approach rather than all classroom personnel; inconsistently implementing in classroom

Autism Spectrum Disorders

Tips & Resources

	Greenspan	Inc1usion	Social Stories
Background	Also known as "Floor Time," DIR (Developmental Individual-Difference, Relationship-Based) Model; targets emotional development following developmental model; depends on informed and acute observations of child to determine current level of functioning; has child-centered focus; builds from the child; "Floor Time" is only one piece of a three-part model that also includes spontaneity along with semi-structured play, and motor and sensory play.	Initially intended for children with mental retardation and disabilities other than autism; sociological, educational, and political mandates in contrast to psychology as root source for other approaches; inclusion defined in three federal laws – PL 94-142, REI, and IDEA.	Also known as Social Scripts; developed by Carol Gray in 1991 initially to help student with autism understand rules of a game; was further developed to address understanding subtle social rules of "neurotypical" culture; addresses "Theory of Mind" deficits (the ability to take the perspective of another person).
Goals	Targets personal interactions to facilitate mastery of developmental skills; helps professionals see child as functionally integrated and connected; does not treat in separate pieces for speech development, motor development, etc.	Educate children with disabilities with NT children to the maximum extent possible; educate children with disabilities in the chronological setting they would be in if they had no disability and they lived at home; does not apply to separate educational channels except under specific circumstances.	Clarify social expectations for students with ASD; address issues from the student's perspective; redefine social misinterpretations; provide a guide for conduct or self-management in specific social situations.
How Implemented	Teaches in interactive contexts; addresses developmental delays in *sensory modulation, motor planning and sequencing,* and *perceptual processing;* usually done in 20-minute segments followed by 20-minute breaks, each segment addressing one each of above-identified delays.	Children with autism typically placed in inclusive settings with 1:1 aide; curriculum modified to accommodate to specific learning strengths and deficits; requires team approach to planning; approach may be selective inclusion (by subject matter or class), partial inclusion (1/2 day included, ½ day separate instruction), or full, radical inclusion with no exceptions.	Stories or scripts are specific to the person, addressing situations which are problematic for that individual; Social Stories typically comprised of three types of sentences; perspective, descriptive, and directive; types of sentences follow a ratio for frequency of inclusion in the Social Story; Social Story can be read TO or BY the person with autism; introduced far enough in advance of situation to allow multiple readings, but especially *just before* the situation is to occur.
Reported Outcomes	Teaches parents how to engage child in happier, more relaxed ways; hypothetically lays stronger framework for future neurological/cognitive development.	In *certain circumstances*, some children with autism can survive and even become more social in classrooms with NT peers; benefits children who cognitively match classmates.	Stabilization of behavior specific to the situation being addressed; reduction in frustration and anxiety of students; improved behavior when approach is *consistently* implemented.
Advantages of Approach	Addresses emotional development in contrast to other approaches, which tend to focus on cognitive development; avoids drilling in deficit areas, which feeds child's frustrations and highlights inadequacies; is non-threatening approach; helps to turn child's actions into interactions.	More opportunities for role modeling and social interaction; greater exposure to verbal communication; opportunities for peers to gain greater understanding of and tolerance for differences; greater opportunities for friendships with typically developing peers.	Developed specifically to address autistic social deficits; tailored to individual and specific needs; is time and cost efficient/flexible.
Concerns with Approach	Does not focus on specific areas for competency; no research to support efficacy for children with autism; approach based on hypotheses, not research; is a more passive approach.	*Automatic* inclusion violates spirit and letter of IDEA; opportunities for successful inclusion begin to plateau by end of third grade as work becomes more abstract and faster paced; increasing use of language-based instruction puts students with autism at great disadvantage; sensory and processing difficulties tend to be insufficiently accommodated; regular education setting not necessarily best learning environment for students with autism; teachers and students in inclusion class rooms are typically ill prepared to receive student.	Supportive data is anecdotal rather than empirical; benefit depends on skill of writer and writer's understanding of autism, as well as writer's ability to take an autistic perspective.
Errors to Avoid	Attempting to implement approach without training or professional oversight; taking the lead, trying to get the child to do what YOU think he should do; allowing inadequate time; attempting to implement in midst of ongoing activities for other children.	Providing insufficient training, preparation, information, and support to personnel; placing student in setting where level of auditory and visual stimulation is typically too intense; assigning student work in which cognitive demands exceed student's ability to comprehend; depending on support of 1:1 aide, maintaining placement behaviors; focusing on academics to detriment or exclusion of functional competencies; not offering multiple opportunities to apply functional skills.	Including too many directive sentences in proportion to perspective and descriptive sentences; stating directive sentences I inflexible terms (e.g., "I will do ___" rather than "I will try to ___"); writing above the person's cognitive developmental age; using complex language; not being specific enough in describing either the situation or the desired behavioral response.

Tip Sheet 11

Progressive Muscle Relaxation for Children and Adolescents

When talking to younger children, use a simple definition of stress:

"Stress is the feeling of being out of control."

The main presenting symptoms of stress in children and adolescents I have seen are:

- Excessive headaches, nausea and abdominal pain
- Tendency to worry a lot
- Low self-esteem
- Sleep disturbances
- Excessive anger
- Moodiness
- Difficulty with concentration
- Having a delicate equilibrium/being easily upset

To help reduce stress levels, regain confidence and promote a sense of being in control. There are a number of simple techniques that children and adolescents can learn. These include breathing awareness, progressive muscle relaxation and visualization. Breathing awareness can be practiced almost anywhere and at anytime, and can ideally be used several times a day. After the body is relaxed with the progressive muscle relaxation exercise, there is a visualization that deepens the relaxation of the mind. For best results, they can be combined in a daily practice session.

Breathing Awareness

When our stress levels rise, our breathing speeds up and becomes shallower. Becoming aware of our breathing, slowing down and deepen each breath will allow us to feel more relaxed. Becoming aware of our breathing is a simple strategy. Two favorite breathing techniques are abdominal breathing and sigh of breath.

- Abdominal breathing is a useful breathing technique. It may take a little to practice to master but be patient and it will happen. Place one hand on your tummy so that the belly button is below the center of the palm. Now place the other hand on top of that first hand. Take a slow deep breath in and imagine the diaphragm, a large band of muscle below your lungs, moving down as your lungs expand and causing your tummy to rise gently under your hands. As you breathe out, your lungs contract. The diaphragm moves back up and you can feel your tummy gently fall. Breathe in slowly and deeply, feel your tummy rise. Breathe out slowly and feel your tummy fall. Don't force your breathing, just make it deeper and slower. Continue breathing in this manner for at least 10 to 20 cycles.

- Sigh breathing involves taking a moderately deep breath in through your nose and pausing only briefly, let the air out slowly through your nose. The slow gentle exhale is the key to sigh breathing. Be sure to lengthen your outward breath. Now, as you breathe out, let go---relax your muscles of your face, your jaw and your shoulders. Let go of tension in your chest and stomach. Let your arms and legs relax. As you breathe out, feel a wave of relaxation flow from the top of your head and all the way down to your feet. Continue to breathe in this manner for at least 10 to 20 cycles.

Progressive Muscle Relaxation

Progressive Muscle Relaxation is a technique that relaxes the body progressively as you focus on different muscle groups in the body. For beginners to highlight the difference between a tensed state and a relaxed state there is a simple tensing exercise:

- Point your fingers and toes while stretching all the muscles in your arms and legs. Really feel the stretch and hold. Big breath in and as you breath out, relax the muscles and allow your whole body to soften and relax.

- Ben your knees towards your chest and wrap your arms around your knees. Curl yourself up in a ball shape bringing your head forward towards your knees. Tighten the muscles and hold the ball shape. Now take a deep breath in and as you breath out, uncurl your body and relax the muscles. Allow your whole body to soften and relax feeling soft and relaxed like a sleep cat.

- Focus on specific muscle groups relaxing those muscles before moving on to the next group.
  For example:

  Focus your attention on your feet, toes, and ankles. As you breathe in, imagine your breath flowing all the way down to your toes and as you breathe out, let go of any tightness, tension and discomfort. Allow the muscles to relax and soften.

- Focus on your calf muscles. As you breath in, imagine your breathe flowing all the way down to your calf muscles. As you breath out relaxing the calf muscles, let go of any tightness and tension.

Visualization

Visualization is thinking in pictures, images and sensations. Visualization is a powerful technique as it enlists the imagination to problem solve, provide a haven to calm and nurture the soul and stimulate creativity. Visualization is very absorbing and tends to stop or slow down the "chatter of the mind" giving time out from everyday worries, concerns and negative thoughts. Ideally, visualization is introduced after progressive muscle relaxation so you relax the body and then relax the mind.

The following is a simple example of visualization:

- Imagine there is a butterfly sitting on your chest. It has wings spread and it is preparing to take flight.
- It seems more and more likely to do so every time you breath in and out, but it remains sitting on your chest for some time.
- Look at this butterfly carefully. Examine its color and shape.
- Soon the butterfly will take flight. Imagine following the butterfly to a pleasant place where you feel relaxed, comfortable and safe.
- Pay careful attention to the sights, sounds, smells and sensations of this place…how it feels and how you feel being there.
- Allow yourself to enjoy being there and to relax as fully as possible. You have 1 minute to enjoy this place and it is all the time you need.
- Remember that you carry this peaceful place inside you and you can come here and visit any time you wish.

Tip Sheet 10

Helping Children Develop "Impulse Control"

- **Impulse control helps children make and keep friends**
  - Children who can control their anger and frustration, and use words to express their feelings are likely to be able to make and keep friends.
  - Making friends can boost self-esteem and later school success.

- **Early experiences can contribute to later success with impulse control**
  - *Infants need a responsive and predictable environment.* When you respond to their physical needs with love and care, they learn to expect order in their world. They also learn their actions affect others.
  - *Toddlers need to feel independent and capable.* You can help them use their developing language skills to label their own and others' actions. Learning to describe actions, thoughts, and feelings with words is key to having good impulse control.
  - *Older preschool children learn to control their impulses by taking turns or sharing their toys.* They are increasingly able to use language to control their emotions and interact with others.

- **You can encourage the development of impulse control in your 3-, 4-, and 5 year olds in the following ways:**
  - *Suggest words that your child can use to say how she feels.* If your child gets mad while playing a game, encourage her to use words to show her anger, such as "That really makes me mad!"
  - *Make it clear that hurting others is not allowed.* When your child gets mad playing a game and pushes or hits another child, take him aside and remind him that hurting others is not allowed.
  - *Help your child think of new ways to solve problems.* When your child has a disagreement with another child, suggest solutions such as taking turns or sharing.
  - *Respond to your child's misbehavior with words.* When you tell your child the reasons behind rules and explain the consequences for misbehavior, you help her develop inner controls on her behavior.
  - *Model self-control when dealing with stress or frustration.* Your child learns many behaviors from observing you. When you model self-discipline and self-control in difficult situations, your child will learn to follow your example.

Rev.0612
Information provided by 29 Children's Research Center - http://illinoisearlylearning.org
Prepared by: The TAP Service Center at The Hope Institute for Children and Families

Tip Sheet 9

Planning Ahead to Prevent Tantrums

Go on practice outings and errand with your child

→ Have pretend outings at home to teach your child what you expect. Play "riding the bus," "getting groceries," and "having a check-up."

→ Go on short simple outings for practice. Use ideas such as "Look, don't touch" and "Stay next to me."

Plan errands and other outings with your child's needs in mind

→ Sometimes a child should not go with you. You may need to have him stay home with a caregiver.

→ Pack wisely if he does go with you. You may need:
- *Healthy snacks and drinks*
- *Comfort items…blanket, small toys, books*
- *A list of his favorite songs*

Prepare yourself

→ Be ready to divide your time between "taking care of business" and interacting with your child.

→ Some experts suggest that parents not reward children for good behavior on outings because they believe that having a pleasant time is its own reward and rewards lead to frustration.

→ Ask the pediatrician about motion sickness if your child often complains of stomach upset, headache, or unusual tiredness when traveling.

Rev.0612
Information provided by 29 Children's Research Center - http://illinoisearlylearning.org
Prepared by: The TAP Service Center at The Hope Institute for Children and Families

Autism Spectrum Disorders
Tips & Resources

Tip Sheet 8

GENERAL CALMING TECHNIQUES

1. Communicate clearly what the child needs to do

Visually communicate what the child needs to do to calm or stop the inappropriate behavior. Use pictures, gestures or other visual supports to show the child what to do.

- **Try to engage the child in a "neutral" behavior.** Neutral behaviors are designed to stop the negative behavior and help the child regain control. If he is engaging in the neutral behavior, the child can't be doing the inappropriate behavior, or at least it will be somewhat modified.

- OR, **Make it clear what the child is supposed to be doing.** Communicate a request of direction to get the child engaged in the activity that was occurring when the behavior erupted. Be sure to support your directions visually.

2. Talk less

Use very little language. Give a simple verbal direction paired with visual supports and then be quiet. When children are having difficulties, there is a huge temptation to talk more; explaining or giving directions. If the child is out of control, the extra verbal bombardment can serve to escalate his behavior even more. Children who are sensitive to sound can become super-hyper-sensitive in times of frustration. Generally, limited language works best, however, there are a few children who recoup better and faster if verbal language is totally eliminated and only visual forms of communication are used.

3. Use yourself as a visual tool

Your body language, stance, position, and facial expressions will visually demonstrate to the chld what you expect him to do.

- **Use your body to make things happen**
  Look like you are expecting the child to respond. Look like you are ready. Hold out your hand. Point to what the child is supposed to do. Hold out the object of contention. Wait expectantly.

- **Use your body to communicate what should not happen**
  Push away an item of dispute, fold your arms and shake your head, or use other gestures to make your point.

- **Use your body to prevent things from happening**
  Position yourself to prevent a problem. Standing between the child and an object, blocking a doorway or sitting in a location that keeps the child in a specific area are ways to control difficulties. Avoid turning your back to the child.

4. Wait

Once you have communicated what the child needs to do, wait. When everything is going well, these children frequently need some "wait" time during communication interactions. At times of distress, that need for wait time may increase. Wait expectantly. Continue to *show* the child what he needs to do. The visual supports will keep communicating even if you are not talking.

Rev.0612
Reference - Linda Hodgdon: Solving Behavior Problems in Autism (Pgs. 228-231)
Prepared by: The TAP Service Center at The Hope Institute for Children and Families

5. Be aware of eye contact

Children can be remarkably aware of your attention or the attention of other to their behavior. Sometimes, looking at them serves to give attention that will perpetuate their actions. If attention seems to be contributing to the problem, change something. Try looking away, avoiding eye contact, changing your body orientation or moving some distance away from the child. This does not mean to totally leave a child or stop watching him. You must maintain visual awareness and an appropriate distance for safety. Be aware that adjusting your presence may help the situation.

6. Reduce the audience

Be aware that children who generally seem oblivious to their peers or the people around them can become remarkably aware of their presence and attention during times of distress. There are some children that will take advantage of being out in the community. They may threaten to behave badly as a means of getting their own way in those environments. Do what you can to remove an audience that will reinforce bad behavior.

7. Avoid physical injury

Do not let children, their caregivers or others get injured. When children are having problems, it is very tempting to try to physically manage them. Use great caution when considering this option. Changing the situation by physically prompting a child can sometimes appear to be an easy solution. People commonly get close to children or physically help them in interventions such as:

- *Moving the child*
- *Helping the child perform an action*
- *Removing him from a situation*
- *Removing him from a location*
- *Removing an object that is instrumental in the problem*
- *Attempting to stop physical aggression*

Sometimes you have to move a child to prevent injury. At times, physical prompting or guidance is appropriate. In other situation, it may be unnecessary. It may even escalate a confrontation. Observe carefully what is happening. Be aware of the child's personal space. It is not unusual for a child's need for personal space to increase in the midst of a severe difficultly. Instead of jumping in with some form of physical maneuvering, a more effective response may be to stand back and give the child some space to collect himself. Then he will be ready to do what is required.

There are some caregivers who are constantly getting hurt. This can be more common for new staff. They model "battle scars" from biting, scratching, pinching, head butting, and other child aggression. This should not happen. If a person is experiencing more than an occasional or accidental injury, something needs to change quickly. It is time for a meeting and a new plan.

There may be times when physically prompting or moving a child is a part of the child's intervention plan. Just be aware of this:

- *In times of distress, children who are sensitive to touch will probably be even more sensitive. Children may physically protest to avoid touch or being contained.*
- *It is not unusual for a child's need for personal space to increase when he is having a problem. Getting close when trying to physically prompt him may actually escalate his behavior.*
- *Because very young children do not understand well, physically managing them during behavior crisis situations is a natural reaction. Holding them, picking them up, or moving them to other locations are instinctive reactions. Techniques that work well for preschoolers will not be appropriate as children get older. Make sure your behavior interventions programs are working toward using techniques that will be appropriate as the child matures. Visual tools are frequently effective options.*

8. Remind the child what he needs to do . . . then wait

Observe the child. It may be necessary to communicate your requests again. Perhaps several times. *Visually* remind the child what needs to be done. A reminder does not have to be verbal. Simply moving a visual tool or object or pointing again can be enough. Just avoid the temptation to bombard the child with repeated verbal requests.

9. As the child calms, prompt the appropriate behavior

Negotiate an acceptable ending to the event. This is a time to teach the child some appropriate alternatives to the inappropriate behavior.

- *Help the child communicate the appropriate information for the situation.*
- *Show him a gesture or visual tool or teach the words that he needs to learn.*
- *Give him a choice.*
- *Redirect him to another activity.*
- *Guide him to complete the original activity.*

Reference - Linda Hodgdon: Solving Behavior Problems in Autism (Pgs. 228-231)

Tip Sheet 2

Structured Play

Structured play is an approach to teach children how to play appropriately with toys, expand their use/variety and developmental level of play.

Structured play emphasizes organizing and clarifying their play activities. By structuring play, more abstract concepts can become visually clear and make sense to the child increasing motivation and willingness to participate.

Many children with autism do not know how to play with a toy. This is part of the reason why they sometimes focus on a single aspect of a toy. In order to help the children enjoy toys in a more creative way, we need to make the play activities and toys make sense to them.

Developmental levels of play:

Sensory play is the first level of play. Children learn to explore sensory material or objects with sustained interest. This gives the child needed sensory input as well as being a calm independent activity. At first, the child is encouraged to explore the material with sustained attention.

Cause and effect play is the level of play where children are starting to understand their actions and how they make something happen. Structuring play with cause and effect toys help organize the child's approach to the toy and visually indicate to the child when the toy is finished.

Functional play is using a toy functionally or for its intended use. This could be pushing cars along a race track, using a hammer to knock down pegs in a peg and hammer toy, or using blocks and legos appropriately. These are usually one step activities.

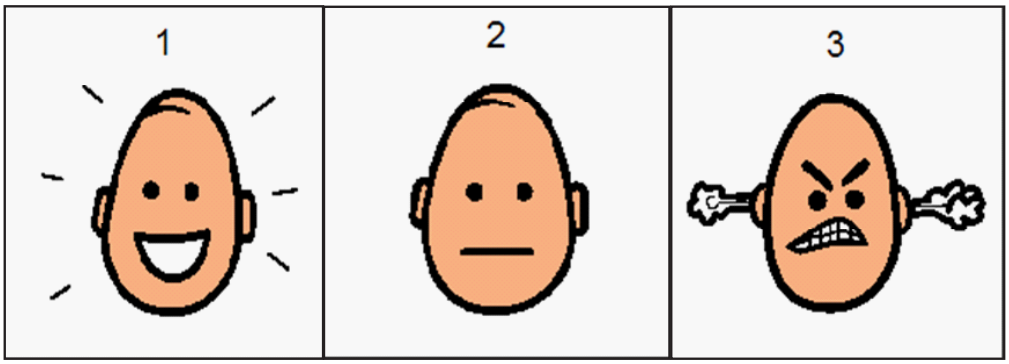
Pretend play is using imagination with toys. These skills can be taught by giving visual supports to aid in play schemes. When starting to teach pretend play, be sure to use visual supports to lead the child through the play schemes from start to finish.

Other considerations of play: Often, there are too many toys or toys are disorganized. This will overwhelm the child and discourage play. Have only the toys out that you are focusing on. Also, rotate the toys in and out so the child does not get bored. Make sure to keep all toys organized.

**Use a toy that your child has an interest in but does not know how to play with independently. The toy should be matched to his/her current developmental and skill level.*

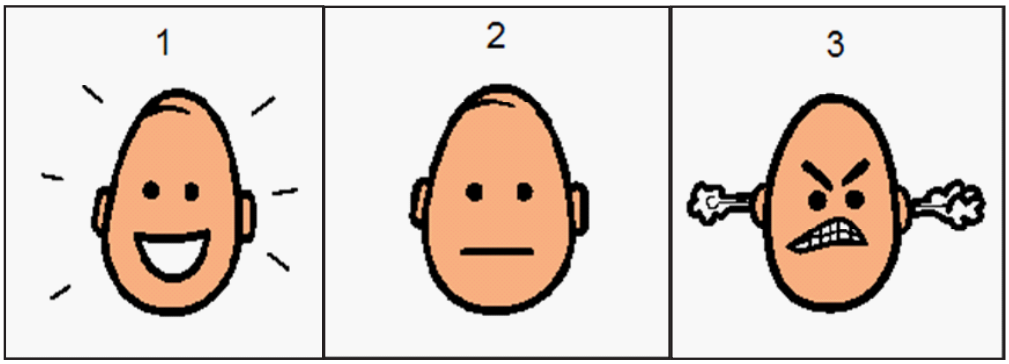
THE AUTISM PROGRAM of Illinois TAP
The Hope Institute for Children and Families

www.theautismprogram.org



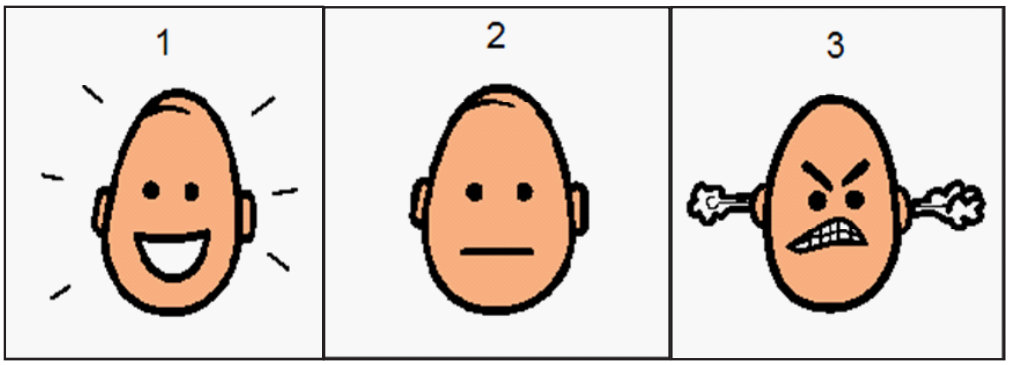
THE AUTISM PROGRAM of Illinois TAP
The Hope Institute for Children and Families

www.theautismprogram.org



THE AUTISM PROGRAM of Illinois TAP
The Hope Institute for Children and Families

www.theautismprogram.org



10. 123 Communication Tool

The 1-2-3 method is taught to monitor and address three primary emotional phases. Use this visual tool to teach an individual with an ASD to communicate their emotional state. Although it may appear that individuals with ASD move from complete calm (Phase 1) to crisis (Phase 3), this is not the case. We can observe increases in emotional intensity in ourselves and in others (Phase 2) early, allowing us to take proactive steps to keep emotions and behaviors under control. Identifying behaviors, facial expressions, thoughts, and physical sensations that occur during Phase 2 and providing calming activities or redirection during this time can return a person to calm (Phase 1) and prevent crisis.

Use this visual to help a person with ASD to identify their moods and identify enjoyable, calming activities to prevent crisis.

- Phase 1: Calm and content- reinforce productive behaviors, teach new skills, have fun.
- Phase 2: Building emotional intensity- identify emotions; identify and provide calming activities and support to return to Phase 1.
- Phase 3: Crisis- ensure safety of individuals and others in the environment. The individual in crisis might be unable to respond to redirection or other positive activities.

The 1-2-3 method is taught to monitor and address three primary emotional phases. Use this visual tool to teach an individual with an ASD to communicate their emotional state. Although it may appear that individuals with ASD move from complete calm (Phase 1) to crisis (Phase 3), this is not the case. We can observe increases in emotional intensity in ourselves and in others (Phase 2) early, allowing us to take proactive steps to keep emotions and behaviors under control. Identifying behaviors, facial expressions, thoughts, and physical sensations that occur during Phase 2 and providing calming activities or redirection during this time can return a person to calm (Phase 1) and prevent crisis.

Use this visual to help a person with ASD to identify their moods and identify enjoyable, calming activities to prevent crisis.

- Phase 1: Calm and content- reinforce productive behaviors, teach new skills, have fun.
- Phase 2: Building emotional intensity- identify emotions; identify and provide calming activities and support to return to Phase 1.
- Phase 3: Crisis- ensure safety of individuals and others in the environment. The individual in crisis might be unable to respond to redirection or other positive activities.

The Picture Communcation Symbols 1981-2000 by
Mayer-Johnson LLC. All Rights Reserved Worldwide.
Used with permission
Mayer-Johnson
P.O. Box 1579, Solana Beach, CA 92075
1-800-588-4548 Fax: 1-858-550-0084

The 1-2-3 method is taught to monitor and address three primary emotional phases. Use this visual tool to teach an individual with an ASD to communicate their emotional state. Although it may appear that individuals with ASD move from complete calm (Phase 1) to crisis (Phase 3), this is not the case. We can observe increases in emotional intensity in ourselves and in others (Phase 2) early, allowing us to take proactive steps to keep emotions and behaviors under control. Identifying behaviors, facial expressions, thoughts, and physical sensations that occur during Phase 2 and providing calming activities or redirection during this time can return a person to calm (Phase 1) and prevent crisis.

Use this visual to help a person with ASD to identify their moods and identify enjoyable, calming activities to prevent crisis.

- Phase 1: Calm and content- reinforce productive behaviors, teach new skills, have fun.
- Phase 2: Building emotional intensity- identify emotions; identify and provide calming activities and support to return to Phase 1.
- Phase 3: Crisis- ensure safety of individuals and others in the environment. The individual in crisis might be unable to respond to redirection or other positive activities.

The Picture Communcation Symbols 1981-2000 by
Mayer-Johnson LLC. All Rights Reserved Worldwide.
Used with permission
Mayer-Johnson
P.O. Box 1579, Solana Beach, CA 92075
1-800-588-4548 Fax: 1-858-550-0084

Tip Sheet 25

The Incredible 5-Point Scale

DESCRIPTION

The Incredible 5-Point Scale (Buron & Curtis, 2003) is a simple strategy that involves breaking down behaviors into concrete parts in order to help a child more easily understand their own responses and feelings. By rating their behavior on a visual scale, children can learn to identify and label their own feelings and ultimately learn to manage their behavior. This technique can be very effective with a wide range of children and can be used to target any behavior. Additionally, 5-point scales create a non judgmental language that can be shared by parents, students and caregivers to help regulate behavior and minimize power struggles.

HOW TO IMPLEMENT THE SCALE

The following steps may be used when implementing a 5-point scale with a child:

1. *Choose the target behavior you wish to address*. Any behavior or issue can be a target behavior as long as it can be broken into concrete levels. Anxiety or other feelings that usually result in problematic behaviors may also be targeted for rating.

2. *Decide on the content for each point on the scale*. Each of the five stages on the scale represents the level or magnitude of the target behavior. Work together with the child to identify each level and its corresponding behaviors.

3. *Develop a story or visual cue for the story.* The story or visual cue should be developed carefully, based on the student's interest or level of understanding. It should also explain how the scale is to be used.

4. *Introduce the scale to the child*. Meet with the child one on one to introduce the concept via social story, memo or use another creative visual strategy that appeals to the child.

5. *Practice the scale with the child, revising as necessary.* Support the child as they practice the appropriate behavior or interaction by using the scale. In order to learn the scale successfully, the child must learn how to discriminate between each stage. Adults can help by identifying the number ratings associated with behaviors the child exhibits.

Autism Spectrum Disorders
Tips & Resources

HOW TO IMPLEMENT THE SCALE

My Control Scale

Rating	Looks like	Feels like	I can try to
5	Hitting, kicking	My head will explode	Go to my room
4	Screaming and Swearing	Nervous	Go for a walk
3	Quiet, sometimes rude talk	Bad mood, grumpy	Take deep breaths
2	Regular kid!	Good	Stay that way!
1	Playing, having a great time	A million bucks!	Enjoy!

My Problem Scale

Rating	Type of Problem	Possible Responses
5	Catastrophe *Brother gets hurt*	Might cry and yell, need immediate adult help
4	Big Problem *I have no where to sit at lunch*	Take a few deep breaths. Say " I can get help with this."
3	Medium Problem *Lost Homework*	Take a break Say" I can get through this."
2	Little Problem (Annoyance) *Missing Lego*	Take a few breaths Say" I can work it out"
1	Glitch Friend is late coming over	Say "Oh well", It's OK"

A 5 is Against the Law! Kari Dunn Muron
Prepared by: The TAP Center at The University of Illinois at Urbana/Champaign

5

Physically hurtful or threatening behavior. These are behaviors that are against the law. For example, hitting someone or grabbing them in a private place. You will get fired from a job, suspended from school and maybe even go to jail if you engage in these behaviors.

4

Scary Behavior. This could include swearing or staring. You would probably get fired from a job for this behavior or suspended from school. This behavior could also end up being against the law.

3

Odd Behavior. This behavior could make other people uncomfortable. It might include sitting too close to someone or putting your face too close to someone who wasn't expecting it. It could also include showing up at a party you weren't invited to. You might get fired from a job because this behavior makes other people nervous. This is not against the law.

2

Reasonable Behavior. This type of behavior is like going to a party you have been invited to and talking appropriately to someone you know. It might be playing a game with someone, working with someone in a group at school or eating lunch with someone. People are enjoying each other's company at this level. This is where people get to know each other better.

1

Very Informal Social Behavior. This is like waving to someone or smiling at someone in the hallway at school. If you just say "Hi' and keep on walking it is also a 1. This is totally OK and is the way most people first notice each other.

Tip Sheet 28

The 5-Point Voice Scale

5

This is a number 5 voice. It is VERY LOUD. I should only use my number 5 voice in an emergency when someone needs help.

4

This is a number 4 voice. It is loud. I can use this voice outside or on the playground. I can use it to get someone's attention outside.

3

This is a number 3 voice. It is no t really loud but it is loud enough for someone to hear me when I am talking. I use this voice to answer my teacher's questions in school. I use it in the classroom and re source room. My teacher re ally like s my number 3 voice.

2

This is a number 2 voice. A number 2 voice is re ally quiet. It is sometimes called a whisper. I can use a number 2 voice in the hall way or in the library or when someone is sleeping.

1

This is a number 1 voice. It means 

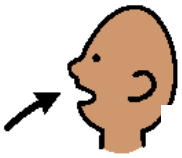
talking. My mouth is closed and no noise is coming out. I use this voice when my teacher is talking at school. When my teacher tells me "number 1 voice please" I should stop talking.

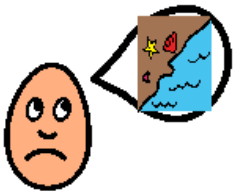
It is really important to know which voice to use at school. My teacher can remind me which voice I should use by pointing to the number on my 5-point scale. This will help me remember what number my voice should be.

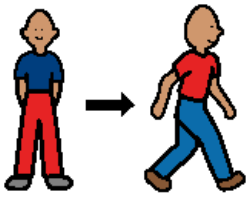
Rev.0612
A 5 is Against the Law! Kari Dunn Muron
Prepared by: The TAP Center at The University of Illinois at Urbana/Champaign

Social Guide 1

THINGS I CAN DO TO STAY CALM

I can take three deep breaths. 

I can envision a calm place, like the beach. 

I can walk away. 

I can write down what I am feeling. I 

can get a drink of water. 

I can listen to a calm song. 

I can lie down (if appropriate.) 

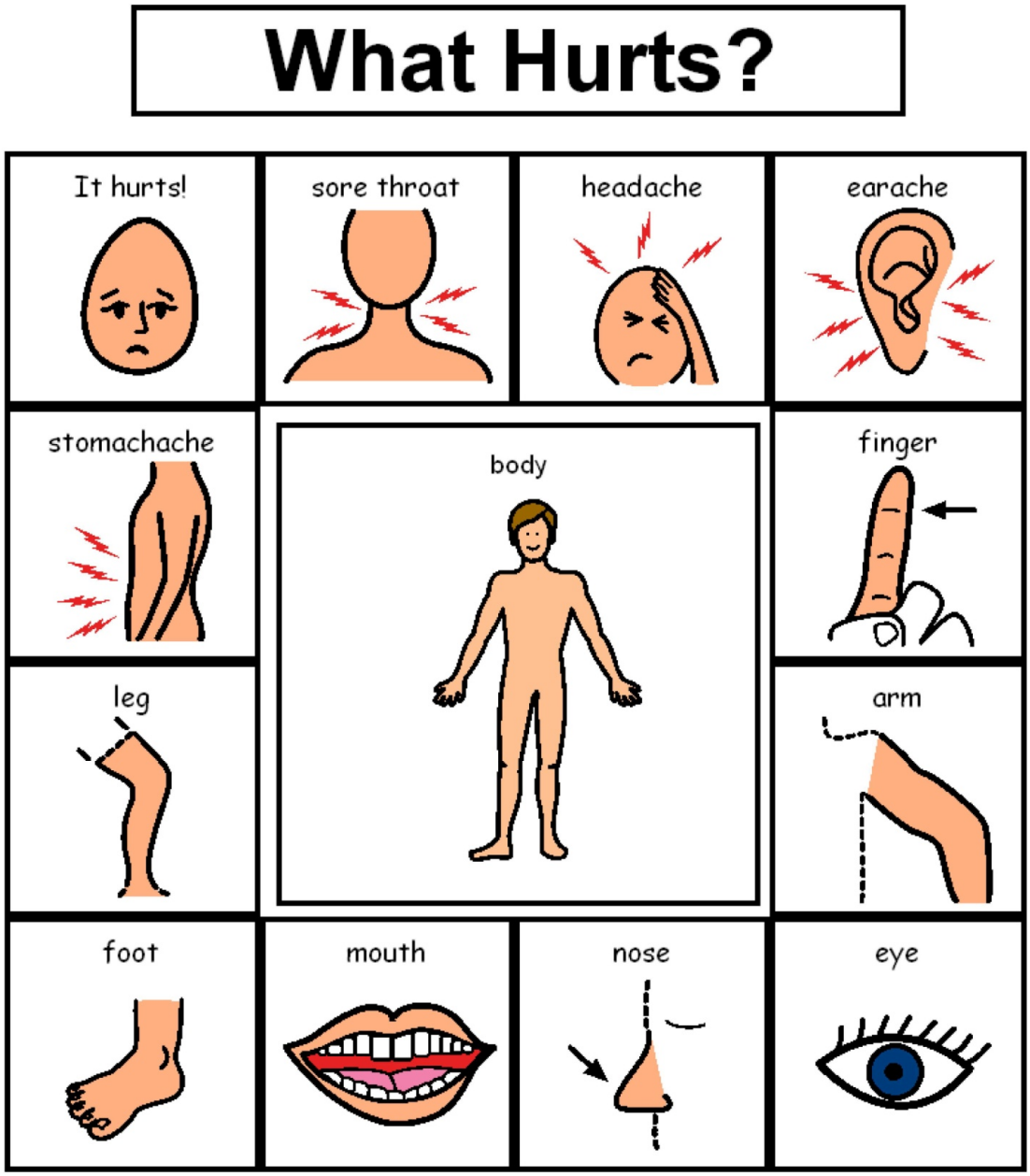
I can stretch. 

I can squeeze a ball or rub my hands together. 

Autism Spectrum Disorders
Tips & Resources

Social Guide 2

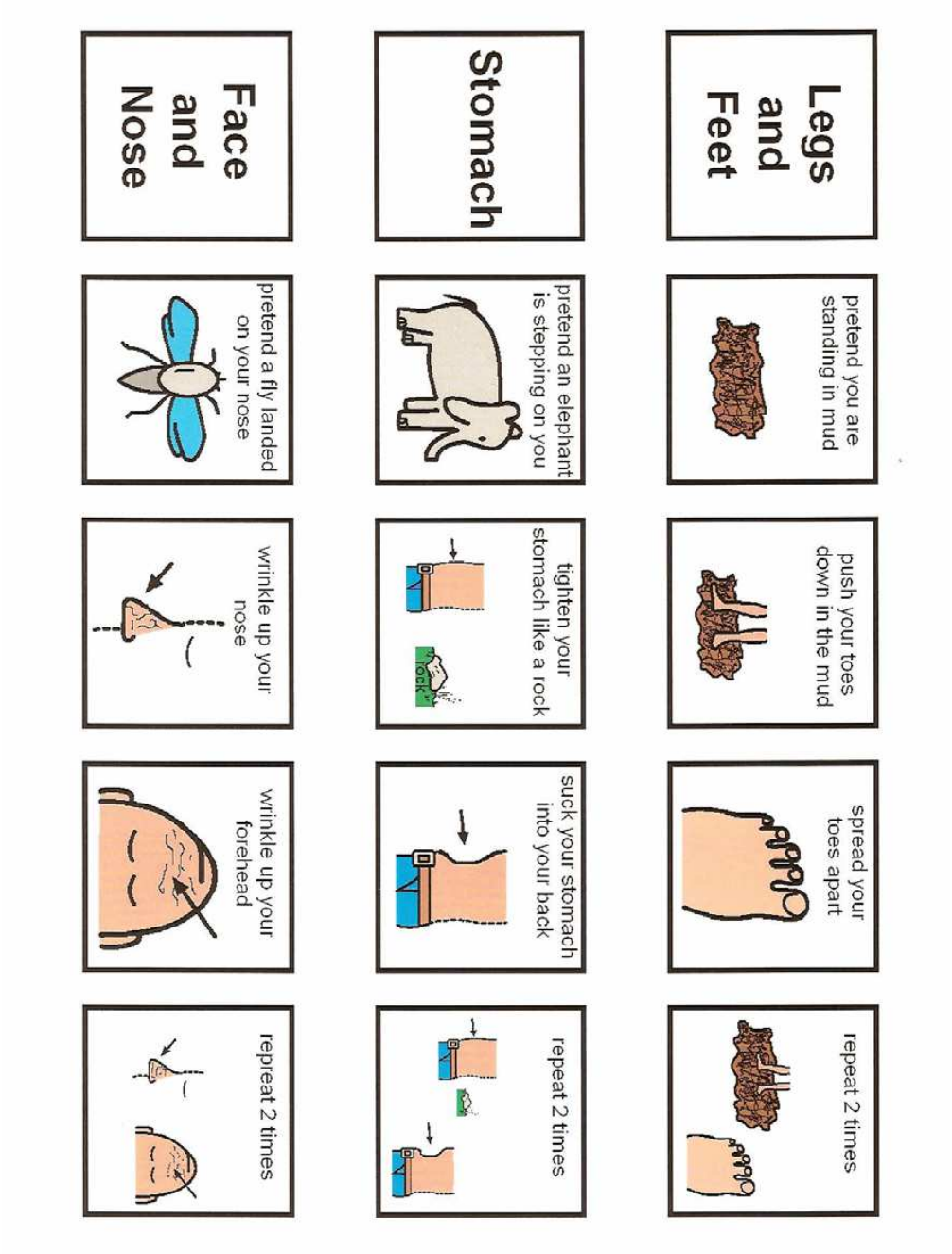
What Hurts Self-Identification Tool

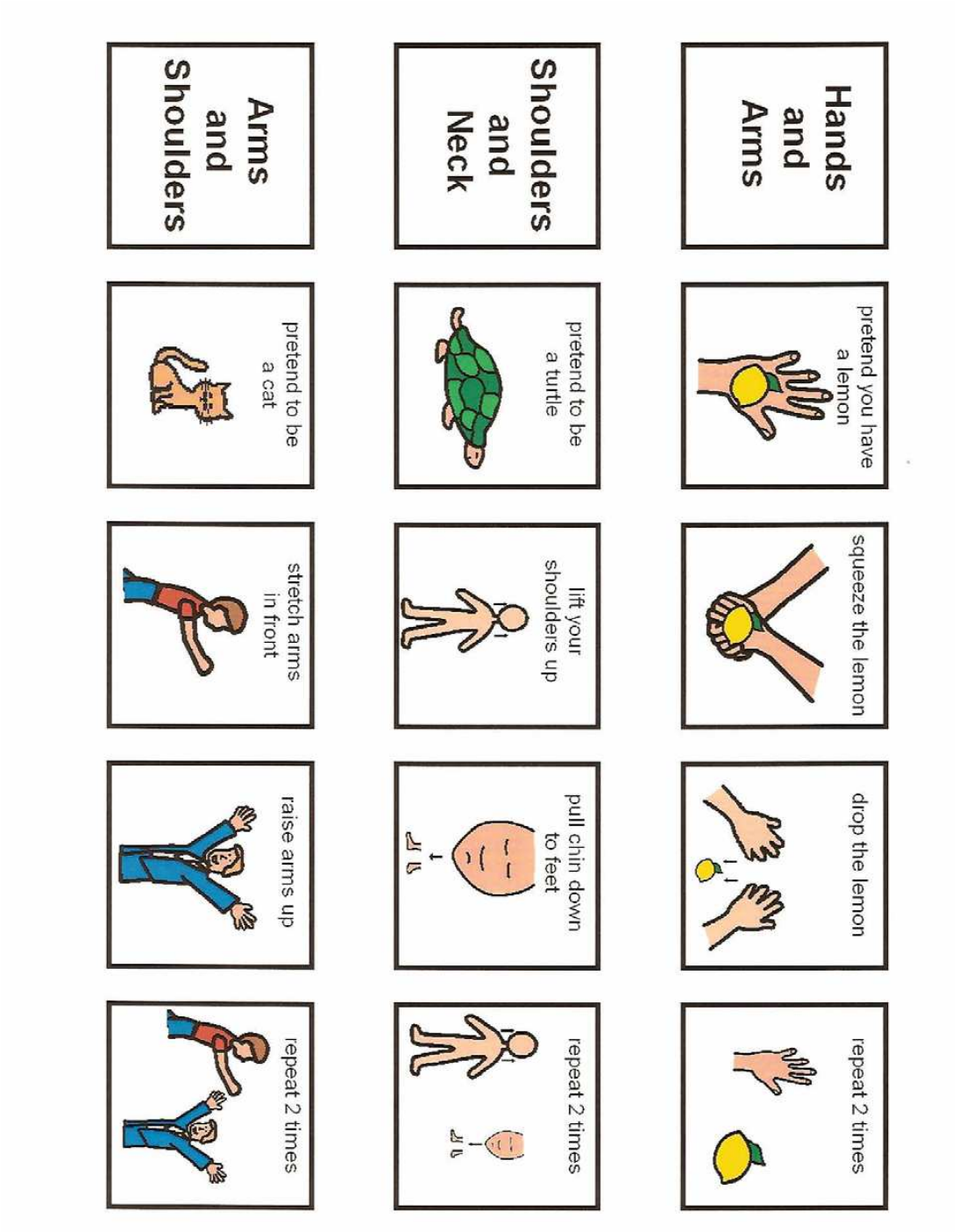


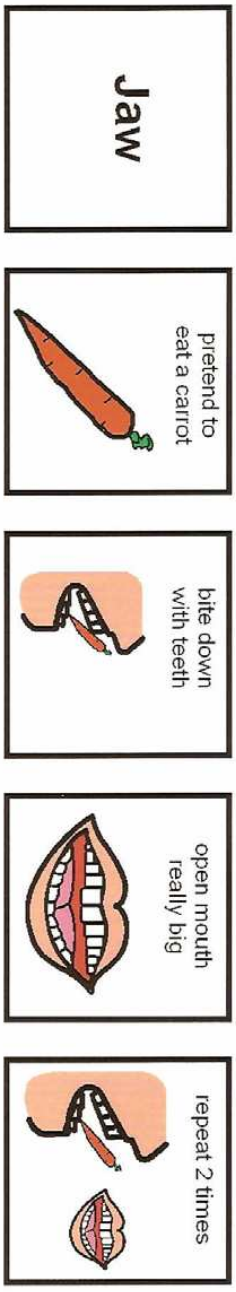
From Prekindergarten Program for Children with Disabilities
http://prekese.dadeschools.net

Social Guide 9

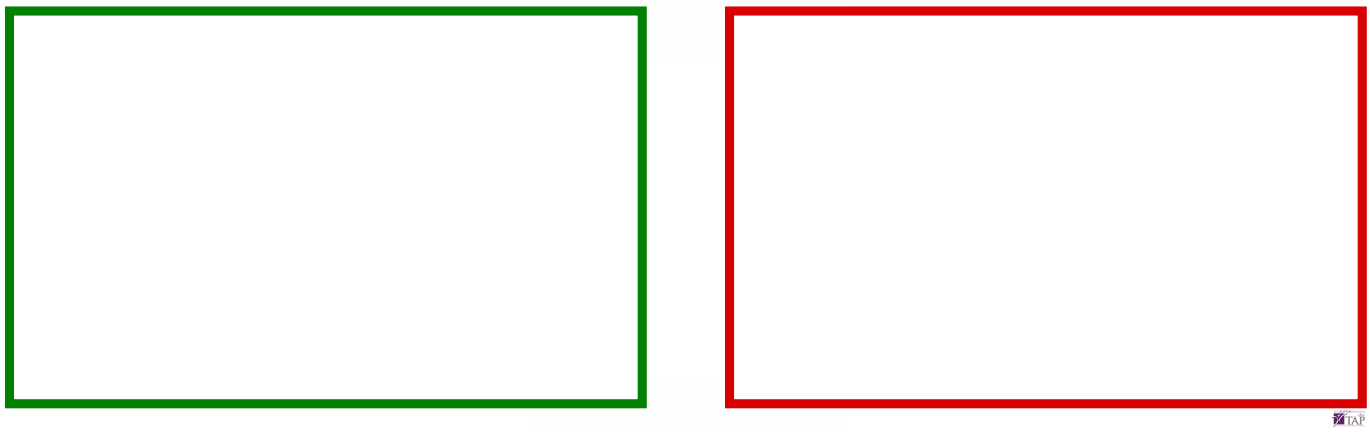
Relaxation Scripts



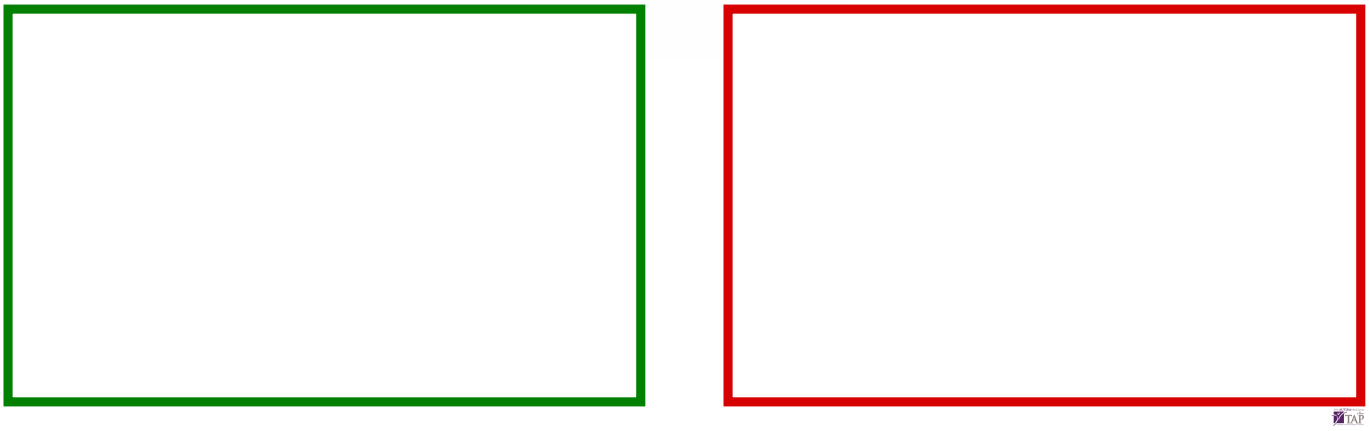

Hands and Arms
pretend you have a lemon
squeeze the lemon
drop the lemon
repeat 2 times
Shoulders and Neck
pretend to be a turtle
lift your shoulders up
pull chin down to feet
repeat 2 times
Arms and Shoulders
pretend to be a cat
stretch arms in front
raise arms up
repeat 2 times


Jaw
pretend to eat a carrot
bite down with teeth
open mouth really big
repeat 2 times

First → Then



First → Then



el primero → entonces

el primero → entonces

I Can Do It!

Reward Chart

Tasks	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

My Goal Is:

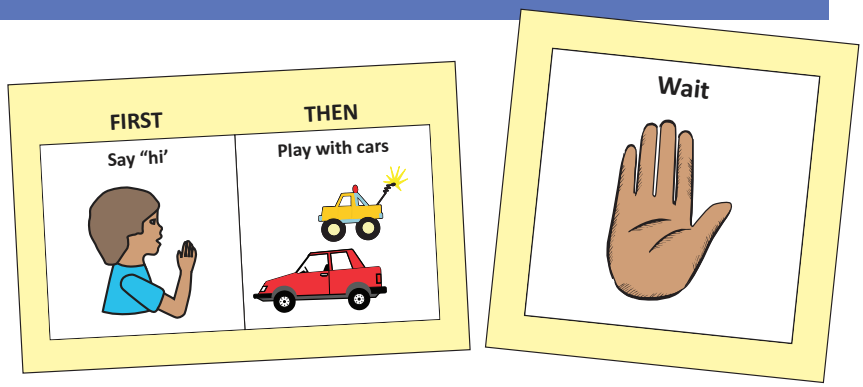
This Week I've Earned:

My Reward Is:

THE AUTISM PROGRAM of Illinois TAP
THE HOPE INSTITUTE FOR CHILDREN AND FAMILIES

Visual Supports and Autism Spectrum Disorders

Introduction



What are visual supports? A visual support refers to using a picture or other visual item to communicate with a child who has difficulty understanding or using language. Visual supports can be photographs, drawings, objects, written words, or lists. Research has shown that visual supports work well as a way to communicate.

Visual supports are used with children who have autism spectrum disorders (ASD) for two main purposes. They help parents communicate better with their child, and they help their child communicate better with others.

This brochure introduces parents, caregivers, and professionals to visual supports and provides instruction on how to use them effectively. Visual supports can be used with persons of any age, although this brochure refers to children. Also, visual supports can be used by caregivers other than parents.

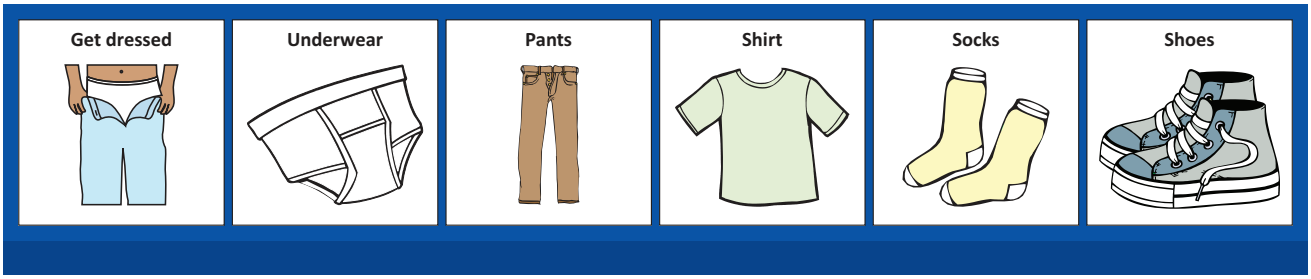
Why are visual supports important? The main features of ASD are challenges in interacting socially, using language, and having limited interests or repetitive behaviors. Visual supports help in all three areas.

First, children with ASD may not understand social cues as they interact with others in daily activities. They may not grasp social expectations, like how to start a conversation, how to respond when others make social approaches, or how to change behavior based on unspoken social rules. Visual supports can help teach social skills and help children with ASD use them on their own in social situations.

Second, children with ASD often find it difficult to understand and follow spoken instructions. They may not be able to express well what they want or need. Visuals can help parents communicate what they expect. This decreases frustration and may help decrease problem behaviors that result from difficulty communicating. Visuals can promote appropriate, positive ways to communicate.

Finally, some children with ASD are anxious or act out when their routines change or they are in unfamiliar situations. Visuals can help them understand what to expect and will happen next and also reduce anxiety. Visuals can help them pay attention to important details and help them cope with change.

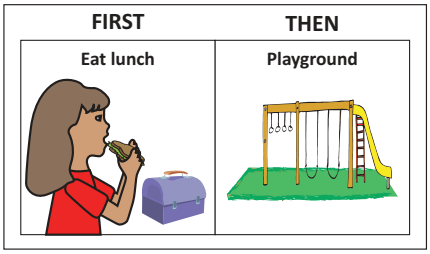
Continued on next page



First – Then Board

❏ **What is it?**

A First-Then Board is a visual display of something your child prefers that will happen after completing a task that is less preferred.



❏ **When is it helpful?**

A First-Then Board is helpful in teaching children with ASD to follow directions and learn new skills. A First-Then Board motivates them to do activities that they do not like and clarifies when they can do what they like. A First-Then Board lays the language foundation needed to complete multi-step directions and activities and to use more complex visual systems.

❏ **How do I teach it and use it?**

Decide what task you want your child to complete first (what goes in the "first" box) and the preferred item or activity (what goes in the "then" box) that your child can have immediately after the "first" task is done. This preferred item/activity should be motivating enough to increase the likelihood that your child will follow your direction.

Put the visuals on the board (e.g., photos, drawings, written words) that represent the activity you identified. Present the board to the child with a brief, verbal instruction. Try to use the least amount of words possible. For example, before beginning the "first" task, say, "First, put on shoes, then swing." If needed, refer to the board while your child is doing the task. For example, say "One more shoe, then swing" when your child is almost done.

When the "first" task is completed, refer back to the board. For example, say "All done putting on shoes, now swing!" and immediately provide the preferred, reinforcing item or activity.

In order to teach children with ASD the value of the First-Then Board, you must give them the reinforcing activity or item after they complete the "first" task. Otherwise, your child may not trust the board the next time you use it.

❏ **What if challenging behaviors occur?**

If challenging behaviors occur, continue by physically prompting your child to complete the "first" task. Keep your focus on the task rather than on the challenging behavior. Then it is important to still provide the reinforcing item or activity, since the focus of the board is on completing the "first" task, and not on addressing challenging behaviors.

If you think challenging behaviors may happen, begin by introducing the First-Then Board for a task that your child usually completes willingly and successfully. If challenging behaviors become more difficult to control, it may be appropriate to consider behavioral consultation with a professional to address these behaviors directly.

Visual Schedule

❏ **What is it?**

A visual schedule is a visual representation of what is going to happen throughout the day or within a task or activity.

❏ **When is it helpful?**

A visual schedule is helpful for breaking down a task that has multiple steps to ensure the teaching and compliance of those steps. It is also helpful in decreasing anxiety and rigidity surrounding transitions by communicating when certain activities will occur throughout the day or part of the day.

❏ **How do I teach it and use it?**

After your child understands the concept of sequencing activities through the use of a First-Then Board, you can develop a more complex schedule for a series of activities during the day.

Decide the activities that you will picture in the schedule. Choose activities that really will happen in that particular order. Try to mix in preferred activities with non-preferred ones.

Put on the schedule the visuals (e.g., photos, drawings, written words) that show the activities that you have identified. The schedule can be portable, for example, on a binder or clipboard, or it can be fixed to a permanent place, like a refrigerator or wall. Your child should be able to see the schedule before beginning the first activity on the schedule. It should continue to be visible to your child during the rest of the activities.

When it is time for an activity on the schedule to occur, cue your child with a brief, verbal instruction. For example, say "Check the schedule." This helps your child pay attention as the next activity begins. At first, you may need to physically guide your child to check the schedule (e.g., gently guide by shoulders and prompt your child to point to the next activity on the schedule). You can gradually decrease physical prompts as your child begins to use the schedule more independently.

When a task is completed, cue your child to check the schedule again, using the procedure described above, and transition to the next activity.

Provide praise and/or other positive reinforcement to your child for following the schedule and for transitioning to and completing activities on the schedule. It may be helpful to use a timer that your child can hear to make transition times clear to your child.

Mix variability into the schedule by introducing a symbol that represents an unknown activity (e.g., "oops" or "surprise activity"). Begin to teach this concept by pairing this with a positive activity or surprise. Gradually use this for unexpected changes in the schedule.

❏ **What if challenging behaviors occur?**

If challenging behaviors occur, continue by physically prompting your child to complete the task that is occurring. Keep your focus on the task rather than on the challenging behavior. Then transition to the next activity as communicated by the schedule and still provide the reinforcing item or activities indicated on the schedule, since the focus of the schedule is on completing the tasks, and not on addressing challenging behaviors.

If you think challenging behaviors may happen, begin by introducing the visual schedule during tasks that your child usually completes willingly and successfully. If challenging behaviors become more difficult to control, it may be appropriate to consider behavioral consultation with a professional to address these behaviors directly.

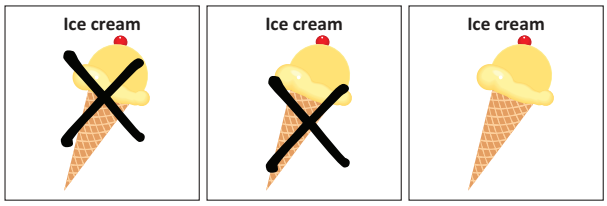
Visually Setting Parameters

❏ **What is it?**

Setting parameters involves using visuals to set clear boundaries around items or activities and to communicate basic expected behaviors, like waiting.

❏ **When is it helpful?**

Visually setting parameters is helpful in communicating limits that are part of an activity and that may seem unclear to your child. Some examples of situations where this might be useful follow. Communicate physical boundaries of an area or activity, for example, use a "stop" sign to mark where to stop in the backyard. Or show how much of an item or activity is available before it is gone. For example, place a "not available" picture on the computer when it is not time to play on the computer. Or place pictures of 3 juice boxes on the refrigerator and remove or cover one each time juice is given. Show the need to wait for something that is delayed but will be available soon, for example, by providing a "wait" card paired with a timer.



❏ **How do I teach it and use it?**

Begin to teach the use of these visuals in situations that have clear, defined, brief parameters. As your child understands these visuals better, gradually increase their use in more long-term activities and with more abstract parameters.

❏ **Examples:**

Physical boundaries: Place the visual on physical boundaries that already are defined (e.g., a door) and refer to it when the rule is followed. For example, when your child stops at the door, point to the stop sign and say, "Stop." Give praise or reinforcement for complying with this parameter. After you have taught the concept, use the same visual during other activities or in other settings where the same boundary is needed but is not as clear, such as a "Stop" sign on the playground.

Limited availability: Decide the number of times or length of time that the item or activity is available. Indicate that through the visual, for example, 3 pictures of a juice box on the refrigerator to indicate that 3 juice boxes are allowed that day. After the item or activity has been used or done, show the change by using the visual, for example, cross out or remove one of the juice box pictures. When the item is no longer available, use the visual to show this. For example, show your child that there are no more pictures of juice on the refrigerator after they have used them all.

Wait: Begin by presenting the symbol for "wait' for a very brief amount of time before your child can have a preferred item or activity. It may help to pair the use of the "wait' symbol with a timer. Have your child trade the "wait" card for the item or activity. For example, when your child asks for a snack, hand your child the "wait" card, set the timer for 10 seconds, and then praise your child's waiting and trade the snack for the "wait" card.

As your child learns to use visuals for setting parameters, gradually increase the length of time or the number of situations in which your child is expected to wait for items or activities.

❏ **What if challenging behaviors occur?**
If you think that challenging behaviors may occur, introduce these parameters during less difficult situations or begin with simple expectations.

If problem behaviors occur, be consistent with the parameters you have set. Focus on praising any aspects of the parameters that are being followed, rather than shifting your focus to the challenging behaviors.

Using visual supports can help you and your child with ASD communicate and manage everyday activities in positive ways.

This publication was written by Whitney Loring, Psy.D., TRIAD Postdoctoral Fellow, and Mary Hamilton, M.Ed., BCBA, TRIAD Educational and Behavioral Consultant. This work was supported through Beth Malow, M.D., M.S., Professor of Neurology, Principal Investigator, Vanderbilt Autism Treatment Network Site, and Zachary Warren, Ph.D., Assistant Professor of Pediatrics, Co-Principal Investigator, Vanderbilt Autism Treatment Network Site. It was edited, designed, and produced by the Dissemination and Graphics staff of the Vanderbilt Kennedy Center for Excellence in Developmental Disabilities. We are grateful for review and suggestions by many, including by faculty of the Vanderbilt Kennedy Treatment and Research Institute for Autism Spectrum Disorders (TRIAD) and by the Autism Society of Middle Tennessee. This publication may be distributed as is or, at no cost, may be individualized as an electronic file for your production and dissemination, so that it includes your organization and its most frequent referrals. For revision information, please contact courtney.taylor@vanderbilt.edu, (615) 322-5658, (866) 936-8852.

These materials are the product of on-going activities of the Autism Speaks Autism Treatment Network, a funded program of Autism Speaks. This publication was made possible, in part, by Grant no. T73MC00050 from the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the MCHB, HRSA, HHS. Printed March 2011.

AUTISM SPEAKS™ ATN Autism Treatment Network

VANDERBILT KENNEDY CENTER

Resources for Using Visual Supports:

- ❏ www.do2learn.com
- ❏ card.ufl.edu/content/visual.html
- ❏ www.kidaccess.com/index.html
- ❏ Eckenrode, L., Fennell, P., & Hearsey, K. (2004). *Tasks Galore for the Real World*. Raleigh, NC: Tasks Galore.

Resources on Autism Spectrum Disorders:

❏ **Treatment and Research Institute for Autism Spectrum Disorders** (TRIAD), Vanderbilt Kennedy Center, is dedicated to improving assessment and treatment services for children with autism spectrum disorders and their families, while advancing knowledge and training. For information on TRIAD and Vanderbilt autism services and resources:

Vanderbilt Autism Resource Line
Local (615) 322-7565
Toll free (1-877) ASD-VUMC [273-8862]
Email: autismresources@vanderbilt.edu

TRIAD Outreach and Training
(615) 936-1705
Web: triad.vanderbilt.edu

❏ **Tennessee Disability Pathfinder**, a free information and referral service for all types of disabilities, all ages, provides information on autism resources external to Vanderbilt. Local (615) 322-8529, (1-800) 640-4636. Web: www.familypathfinder.org

❏ Local chapters of the **Autism Society of America** (ASA) (www.autism-society.org) provide information, support, and advocacy for individuals with ASD and their families.

Autism Society of Middle Tennessee
Phone: (615) 385-2077, (866) 508-4987
Email: asmt@tnautism.org
Web: www.tnautism.org

Autism Society of the Mid South
Phone: (901) 542-2767
Email: autismsocietymidsouth@yahoo.com
Web: www.autismsocietymidsouth.org

Autism Society of East Tennessee
Phone: (865) 247-5082
Email: asaetc@gmail.com

❏ **Autism Speaks** (www.autismspeaks.org/) provides resources and support for individuals with ASD and their families.

Part IV. Therapy Strategies and Ideas: Reference Links

B. Evaluating Interventions
http://www.theautismprogram.org/wp-content/uploads/evaluating-interventions.pdf

C. TAP Tip Sheets and Tools
http://www.theautismprogram.org/autism-resources/free-aides/tips/

D. Visual Supports
http://www.autismspeaks.org/docs/sciencedocs/atn/visual_supports.pdf

Web Resources Overview

CDC: Autism

http://www.cdc.gov/ncbddd/autism/index.html

CDC: "Learn the Signs. Act Early." Campaign

http://www.cdc.gov/ncbddd/actearly/index.html

Autism Speaks

www.autismspeaks.org

The Autism Program of Illinois

www.theautismprogram.org

Illinois Autism Training and Technical Assistance Project

http://www.illinoisautismproject.org/

References

American Academy of Pediatrics. (2007). Explaining the results of a "failed" screen. *AAP Section on Developmental and Behavioral Pediatrics Newsletter, Fall,* (9-10)

Johnson, C.P. (2004). Early clinical characteristics of children with autism. *Autistic Spectrum Disorders in Children.* 85-123.

Lord, C., Risi, S., Dilavore, P.S., Shulman, C., Thurm, A., & Pickles, A. (2006). Autism from 2 to 9 years of age. *Archives of General Psychiatry, 63*(6), 694-701.

Lauritsen MB. Autism spectrum disorders. *Eur Child Adolesc Psychiatry*. 2013;22(1):S37-S42.

Mahjouri S, Lord CE. What the DSM-5 portends for research, diagnosis, and treatment of autism spectrum disorders. *Curr Psychiatry Rep.* 2012;14(6):739-747.

Slices, L., Egbert, L. & Mercer, M.B. (2009). Sugar-coaters and straight talkers: Communicating about developmental delays in primary care. *Pediatrics, 124*(4), 705-713.