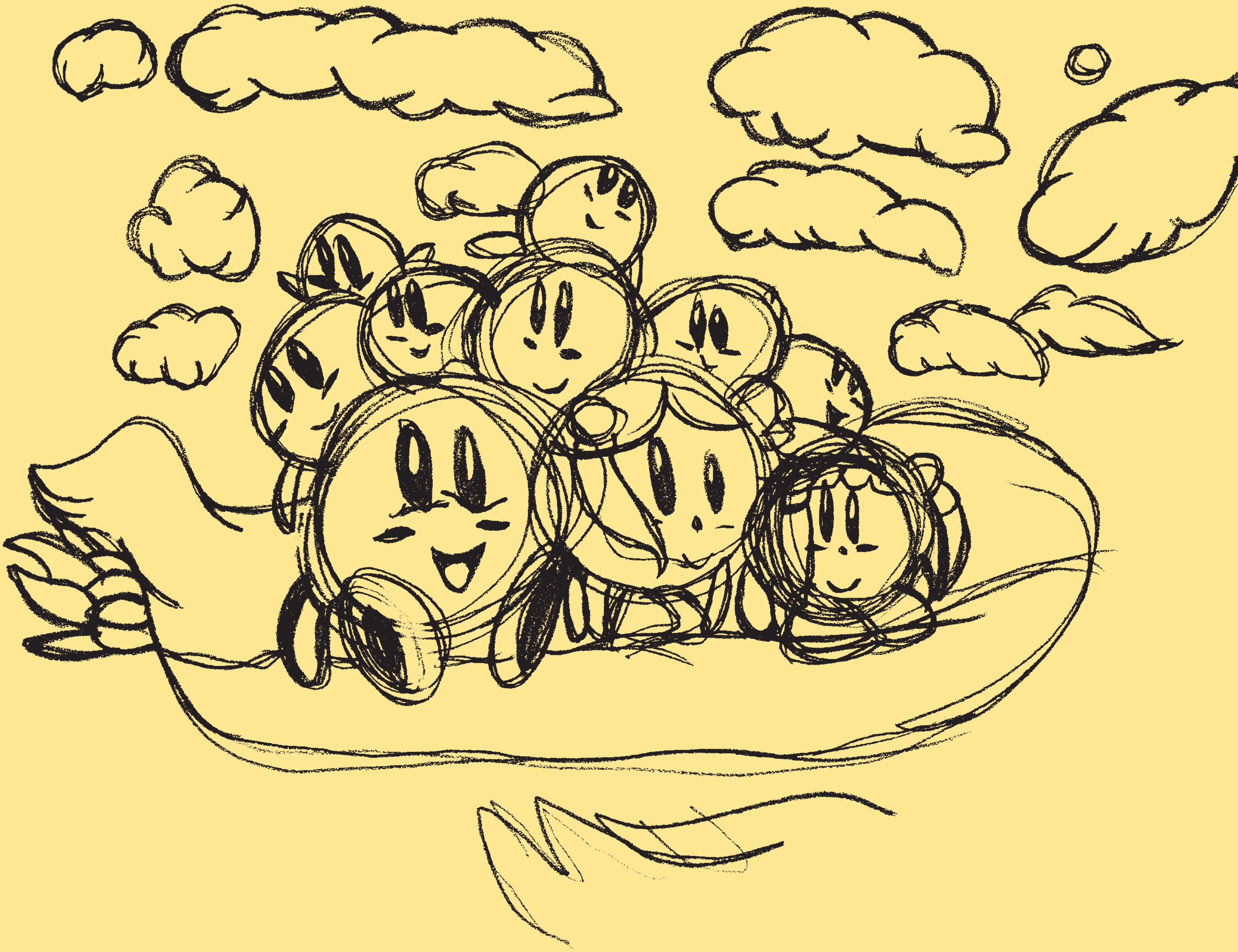
AUTISM NEWS
of Orange County
& the Rest of the World

April 2005 *Volume 2, Issue 1*



Cover illustration by Christine Jankowski

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COVER FEATURE

We are pleased to feature one of our local artists, Christine Jankowski. Read more about Christine on page 4.

Mission Statement

Autism News Orange County *& the Rest of the World* is a collaborative publication for parents and professionals dedicated to sharing research-based strategies, innovative educational approaches, best practices and experiences in the area of autism.

Submission Policy

The Autism News of Orange County *RW* is available free of charge to parents and professionals of children with autism. The opinions expressed in the newsletter do not necessarily represent the official view of the agencies involved.

Contributions from teachers, therapists, researchers and relatives/children of/with autism are welcome. The editors select articles and make necessary changes.

Please submit articles in Microsoft Word using font size 12, double spaced, and no more than four pages in length (2600 words). Photos are encouraged and when submitted with articles the permission to include is assumed.

Please email all correspondence to:
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Please visit our website: www.autismnewsoc.org

Editorial

By Vera Bernard-Opitz

The positive and enthusiastic feedback about our last newsletter has been very much appreciated, and we hope that the present issue will be equally well-received. This newsletter is the first in a new series of special issues focusing on recent trends in research, diagnosis, therapy and education. Besides reporting new breakthroughs, trend-setting findings, and the experiences of parents and teachers, controversial topics will be discussed.

Some of the topics in autism, which have become highly sensitive, are the expansion of the autism diagnosis, the so-called "epidemic of autism" and its reasons, the need to balance services for low-level and high-level children, and the choice of teaching environments and treatment methods parents are often faced with. In this issue, and those in the future, we will try to provide our readers with a balanced selection of evidence and opinions so that informed choices can be made.

This current issue focuses on the question of the broadening diagnosis of autism and increase in rate, and we are happy that an internationally recognized team of specialists has contributed their work. Looking at people with ASD in Germany, the UK and India, it becomes obvious that the trends in diagnosis noted in the US are not universal and that cultural factors need to be considered. Research on cross-cultural comparisons is therefore highly necessary.

In our ***Education and Parent*** section, teachers and parents remind us that an open mind, creative problem-solving, flexibility and dedication can make a huge difference to the individuals with autism and their families.

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As always, we encourage parents, family members, teachers and other professionals to keep sharing their experiences and innovative ideas. Our ongoing agenda is to improve our understanding of and help for children, adolescents and adults with Autism Spectrum Disorders (ASD). Since we deal with a wide spectrum of disorders, complex answers and evidence-based methods are more likely to meet the heterogeneous needs of individuals than simplistic ones.

In this issue, the following topics are discussed:

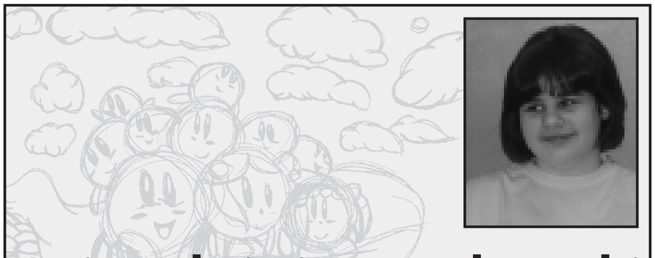
1) **Fritz Poustka and Sven Bolte** (University of Frankfurt, Germany) describe the international trend in widening of the diagnosis of autism and the relative stability of the number of children with autism in Germany. They raise the crucial question of whether there is an increase in autism or an increase in the diagnosis of autism.
2) **Tamara Daley** (University of California, Los Angeles) alerts us to the situation of autism in countries such as India, where diagnostic features, attitudes about autism and beliefs about helpful interventions are different from Western models. This article makes it obvious that more knowledge and sensitivity to cultural backgrounds could also benefit local children from different ethnic groups.
3) In her eye-opening article, **Rita Jordan** (University of Birmingham, UK) discusses the varied functions of the autism diagnosis. Different stakeholders, such as people with Autism Spectrum Disorders, their families and diagnosticians, legal, financial, educational and therapeutic specialists, all have their own agendas which need to be considered and possibly integrated in some way.
4) Integrative projects, as described by **Sarah Barrett** (Anaheim City School District) in the article "Friday Friends", deserve more than a Disney award! The article demonstrates that one person can affect change, independent of policies or funding. We hope that this article inspires others to test their visions and to share them with our readers.

5) **Christina Conner** (Orange County Department of Education) shares her pioneering work on using yoga to relax her students with autism, attending a S.U.C.S.E.S.S. class. Positive indicators for stress reduction were noted, a result, which should be investigated further with larger groups of children.

6) In her fascinating article, "My Child Can Walk", **Carol Pohlen** brings us back to the reality of living with children whose small steps are major breakthroughs, which need to be celebrated. Articles like this remind us that the majority of children with autism are not on the high-end of the spectrum and continue to need our attention, shared visions and support.

We hope that the present ANOC issue will contribute to further improve our understanding of autism, and to broaden the spectrum of helpful methods for this population. The next ANOC issue will be looking at various treatment approaches, and we especially welcome local articles on this topic.

Vera Bernard-Opitz, Ph.D.
Clin. Psych., Editor
http://verabernard.org ♥



Artist: Christine Jankowski

By Maria Jankowski, Tasha Brooks and Sharon Marshall

Christine Jankowsi began sketching and drawing when she was 5 years old. For as long as we could remember she used drawing as a therapeutic outlet to express her perfectionist tendencies. The first things she drew were the Power Puff Girls, Veggie Tales characters, and any Nintendo characters (mostly Kirby). She watches the animators' portion of the "extras" section of DVDs (over and over and over again), studies their techniques, and applies them to her work. She also watches television artists who sketch and paint and seems very entertained by their calm demeanor.

When it comes to art, names, sounds, procedures, numbers, and sequences, Christine has a photographic memory. She surprises us with her unexpected ability to display emotions on her characters' faces. She brings her personal touches into the home by taping her artwork all over the house. She has blessed us with her art, not only on paper, but also on phone books, class schedules, yearbooks, envelopes in the back of a car, and basically anything made from a tree. She draws to all the genres of music she listens to, including Christian rock and country music. Her latest projects comprise: learning to write in cursive, and writing about the children in her class along with the emotions they express.

Christine's artwork improves exponentially as the days go by. There's no telling what's in store for her. Her family hopes that one day she'll be able to use her talents to make a living for herself. We are so proud of our little "Tink."

Christine is now ten years old and is in Sharon Marshall's class at Reilly Elementary in Mission Viejo. She is very creative with her drawings and loves all kinds of art activities.

Maria Jankowski and Tasha Brooks
(Christine's mother and sister)

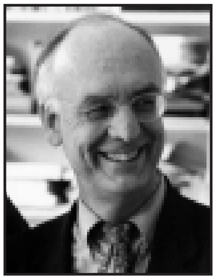
Sharon Marshall, Orange County Department of Education Special Schools Program teacher ♥

Are We Facing an Autism Epidemic?

By Sven Bölte and Fritz Poustka

For a long time, Kanner's (1943) description of the clinical picture of autism dominated the concept of the disorder. In practice this meant that autism was considered a severe and rare diagnosis and the differentiation of autism and normality was clear-cut. Asperger's 1944 report, which comprises cases of milder autistic behavior, was widely neglected until picked-up by Wing and Gould (1979), who combined it with their own studies' results to coin the notion of *the spectrum of autism*. This spectrum concept indicated that the typical triad of autism features: namely, impairments in social interaction, communication and imagination (narrow range of activities or interests) might appear at a broad level of function and severity. Thus, a markedly lower threshold was introduced for clinically relevant autism and autism-like conditions. In 1980 the American Psychiatric Association (APA) published the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), in which autism was replaced by pervasive developmental disorder, also indicating a major extension of the diagnostic framework for autistic behaviour. Today, in terms of DSM-IV-TR (APA, 2000) and ICD-10 (World Health Organization, 1992), the autism spectrum includes autism, Asperger syndrome and pervasive developmental disorder not otherwise classified (PDD-NOS & atypical autism). Whether Asperger's syndrome is distinct from autism is still debated, but most colleagues believe it is part of the spectrum.

Sven Bölte



Fritz Poustka

Twenty-three prevalence (frequency of autism in the total population) studies carried-out before the year 2000 showed a median rate of 5.2/10,000 for autism and 18.7/10,000 for the entire spectrum (Fombonne, 1999). For a long time most experts agreed on these figures. Nevertheless, some studies also found strikingly higher rates, which raised the question whether autism was diagnosed increasingly or actually rising (Gillberg et al., 1991). Indeed, prevalence studies of the 90s tended to reveal higher frequencies for autism than previous estimations. However, due to the methodological problem of comparing the 90's data to earlier prevalence studies, higher rates in these studies received little attention. Nevertheless, something like a new era of published prevalence rates began around the year 2000, as almost all studies since then suggest significantly

Prevalence (frequency) of autism and the autism spectrum disorders according to older and more recent studies

	Older studies	More recent studies
AUTISM	~ 0.05%	~ 0.2%
AUTISM SPECTRM (incl. autism)	~ 0.19%	~ 0.6%

The concept of autism and related disorders has been broadened through the years

Kanner (1943)
Autistic disturbances of affective contact

Asperger (1944)
Autistic psychopathy

Wing & Gould (1979)
Spectrum of autistic disorders

DSM-III (1980)
Pervasive developmental disorder (PDD)

DSM-IV (1994) / ICD-10 (1992)
PDD, including Asperger syndrome and PDD-NOS

higher rates of autism and the whole spectrum. According to the newer studies particularly from the UK and the USA the prevalence of autism is approximately 20/10,000 and it is 60/10,000 for the spectrum (Fombonne, 2003).

The awareness that autism and associated conditions are more prevalent than formerly presumed generated a need for explanations. No one doubts that there must be a reason for the consistently higher prevalence rates and that something must have happened which can account for the new situation. However, the pivotal question to answer is whether we are facing an epidemic of autism (secular increase) or rather an “epidemic” of diagnosing autism (broadening of diagnostic concepts), both having dramatically different roots and implications. At the moment the scientific efforts to find answers seem to clash with other processes (e.g. social policy, funding, interests, power, emotions) which are, perhaps, not a fruitful basis for objectivity. However, compared to California, where the debate is boiling, in Germany the situation is still somewhat calmer. For instance, there has not yet been a study or statistic published for this country indicating we actually are confronted with increased prevalence rates of autism over here. Although we assume that the new prevalence data from other countries applies to Germany, there is no evidence for it. In clinical practice we certainly experience an increase in the number of patients referred with autism, but this may be because we are well known autism experts in Germany. Furthermore, we do also experience a general increase of referrals at our department. Based upon discussions with colleagues from other parts of Germany, we believe the situation with regard to autism in Germany has slightly changed, but not drastically. Our aim in this article is to describe what we think regarding the epidemic of autism versus “epidemic” of diagnosing autism issue and why we think the way we do.

Why we think there is not an epidemic of autism

To conclude that we are dealing with an epidemic of autism we need to observe a true increase in the prevalence of the disorder over time and identify an environmental factor that caused the increase. At the moment, there is not hard evidence for either. Although, the prevalence estimates are higher for more recent studies than for older ones, the studies are simply incomparable. Particularly, the concept of autism used in each study and the way individuals were assessed may account for a large proportion of the differences of reported prevalence rates. To draw conclusions from prevalence studies in terms of a true increase, the methodology must be held constant over birth years.

Older and newer studies on the frequency of autism cannot be compared

If we look at some studies this way (e.g. Fombonne et al., 1997; Yeargin-Allsopp et al., 2003; Lingam et al., 2003), we fail to detect a true increase or conclude that the increase was likely to be connected to better recognition and improved services, rather than to an environmental factor. Where increase was found, the rate of autism plateaued in more recent years, implying a stabilization or end of a process of any kind. The latter would be unlikely for an (ongoing) epidemic. While referral statistics from governmental centers (i.e., California Department of Developmental Services (CDDS)) appear to show a true increase, conclusions are limited, since the statistics do not take into account changes in diagnostic practice over the years. Earlier CDDS reports also suffered from additional scientific shortcomings, such as a lack of controlling for a markedly increase in the population of California in the last decades (Fombonne, 2001). Moreover, their current referral statistics (number of persons with autism, other PDDs and suspected autism in 12/2002) are still in line with population-based prevalence studies. Besides, it seems absolutely possible that increased autism referrals are interpreted in very different ways (e.g. not in terms of a true increase) depending on the institution that registered it (Baker, 2002). On balance, the possibility of a true increase of autism to a certain extent cannot be ruled out on the basis of existing research.

A true increase in the frequency of autism spectrum disorders has not been identified

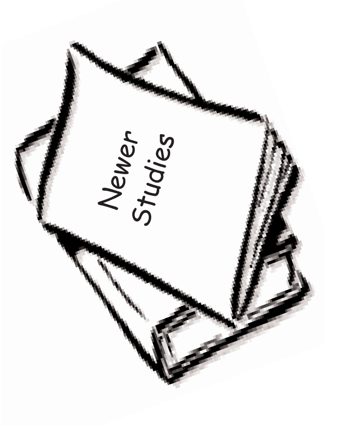
Even without sufficient evidence for a real autism epidemic, there have been numerous theories concerning possible environmental factors causing increased referrals. One of them, the combined measles, mumps and rubella vaccine (MMR) has risen the greatest concern. The assumption of MMR causing or triggering a new variant of (regressive) autism related to bowel symptoms was brought up by Wakefield et al. (1998). Fortunately, research has responded swiftly and the alleged association has been examined quite carefully in the last years. So far studies have found no trends in MMR intake and the frequency of autism nor clustering of autism-onsets after vaccination or autism-onset and bowel symptoms (e.g. Fombonne & Chakrabarti, 2001; Taylor et al., 1999, 2002; DeWilde et al., 2001). A huge population-based study in Denmark (Madsen et al., 2002) compared 440,655 vaccinated and 96,648 unvaccinated children (birth years 1991 to 1998) regarding the prevalence of autism spectrum disorders. The difference in rates of autism and related disorders between the groups (14/10,000 vs. 12/10,000) was negligible.

Why we think there is an "epidemic" of diagnosing autism

As mentioned above, the history of autism is also a history of its broadening definition. Among experts it is generally agreed that the diagnostic concept has been considerably extended. During the 90s, DSM-IV and ICD-10 were launched and their diagnostic concepts have been used consequently in the following. Especially in recent years, higher functioning cases of autism and milder forms of autism spectrum disorders are increasingly diagnosed. In addition, (early) detection of autism has been significantly improved and services for affected children and their families have been expanded. Thus, we believe, changes in diagnostic practices and availability of professional help are mainly responsible for the higher prevalence data.

The broadening of the diagnostic concept of autism probably accounts for the increase in frequency rates

Although, this may seem to be an insufficient explanation for the higher prevalence data, the history of psychiatry is filled of comparable events. As long as there are no 100% reliable psychological or biological markers for mental disorders we will always have to deal with these processes. For instance, recently, Harpaz-Rotem and Roseneck (2004) published a study showing that not only the frequency of autism diagnoses, but also those of bipolar disorder, anxiety disorder and attention-deficit-hyperactivity disorder have increased during the 90s, while oppositional disorders and substance abuse diagnoses decreased. Recent autism prevalence studies' results are likely to particularly reflect strict and exhaustive usage of the diagnostic frame of DSM-IV-TR and ICD-10. Previous research was based on narrower descriptions of autism or criteria were interpreted less inclusively. The rates of 0.2% for autism and 0.6% for the entire spectrum in the general population are probably good (or "true") estimates of the disorders when the current classification systems are applied systematically. If this is true, then the prevalence rates should remain relatively stable now. The plateauing of the frequency of diagnosis mentioned earlier could be a clue that this might be the case.



The frequency of other child psychiatric diagnoses has changed as well

The risk for a real epidemic of diagnosing autism

While autism spectrum disorders apparently have been under-diagnosed before, we are somewhat concerned that right now there is a certain hazard for over-diagnosing the conditions. We have noted that the new prevalence data has shaped an atmosphere for diagnostic routines where the threshold for giving an autism spectrum label is probably too low. We do not believe that the problem is that children formerly diagnosed as mentally retarded now receive a label of autism (Croen et al. 2002; Blaxill et al., 2003), but rather that other children showing milder mental problems, who are not pervasively disordered in terms of autism, are receiving a diagnosis of higher functioning autism or Asperger syndrome (Eagle, 2004). This may initiate a self-sufficient prophecy, fuelling the discussion of an epidemic, which hopefully does not exist.

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The complete list of references can be requested from the Editor at vbernard@ocde.us

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APRIL IS AUTISM AWARENESS MONTH!

Autism Awareness Wristbands

The Autism Society of America has announced the launch of its autism awareness wristbands. Each band is individually packaged carrying ASA’s 40th anniversary logo and its mission statement, and is ready for delivery in time for National Autism Awareness Month (NAAM), April 2005. Proceeds benefit ASA’s mission to promote lifelong access and opportunity for all individuals within the autism spectrum, and their families. You can pre-order wristbands at http://www.autism-society.org/wristband.

For general information about the Autism Society of America, please contact

http://www.autism-society.org

For the local chapter, please contact

http://www.asaoc.org/contact.html

Autism in a Cross-Cultural Perspective

By Tamara Daley

> *The overall incidence of autism is consistent around the globe, but is four times more prevalent in boys than girls. Autism knows no racial, ethnic, or social boundaries, and family income, lifestyle, and educational levels do not affect the chance of autism's occurrence.*
>
> **(From Autism Society of America, "What is Autism?" brochure.)**

For over a decade, the Autism Society of America has included a version of this statement in their description of the disorder. Many people first learning about autism are likely to take these statements as facts. However, for researchers interested in the intersection of culture, development, and disability, the prevalence of and possible cultural differences in autism are actually issues that remain unexplored. What is known about autism in other parts of the world, especially in developing countries? Does autism even exist in other countries, and if so, does it "look" the same as it does in the United States? Does it occur at the same rate? How is it diagnosed and treated? Is the prognosis the same for children everywhere?

These are just a few of the questions that researchers are beginning to explore more thoroughly. For the past several decades, cultural issues and socioeconomic factors have largely been ignored in the field of autism. Some researchers have claimed that autism is rare in non-Western countries (e.g. Sanua, 1984; Varma & Chakraborti, 1995), while others have argued that it doesn't vary at all in either symptoms or prevalence (Campbell, 1996; Cuccaro et al, 1996). The truth is that there is very little research related to cultural factors relative to what we know about autism in general. A few studies have attempted a comparative approach or explicitly addressed cultural factors, *but no major epidemiological studies have been conducted in developing countries*, and we simply do not know whether autism occurs at the same rate throughout the world. If the commonly used figure that 1 in 250 people is affected by autism is applied to the two most populous countries in the world, India and China, this would suggest a prevalence of **over 9 million** people with autism in these two countries alone.

While we do not know whether this figure is accurate, we know for certain that the diagnostic category of "autism" has certainly traveled around the globe. National autism organizations now exist in over 85 different countries, in countries as diverse as Swaziland, Lebanon, Serbia, Ecuador, and Nepal.

We can infer that, at the very least, a set of behaviors has been identified as "autism" in each of these countries. Yet much about the disorder can vary from one culture to the next, and an open question is to what degree the clinical presentation of autism is consistent across cultures. In addition to the two overarching questions of symptom presentation and prevalence, there are at least seven other areas that are likely to differ from one culture to another:

- **Awareness and Concepts of Illness:** When is a symptom perceived, by whom, and what behaviors are perceived as problematic?
- **Help-seeking Behavior:** At what age are children with autism first taken to a doctor or specialist, and what kind of help is sought?
- **The Process of Diagnosis:** What criteria are used to differentiate autism from other disorders? Does a child receive a diagnosis at all? What information is told to parents and what interventions or referrals are made?
- **Treatment:** What options for treatment are available? Are they specific to the problem? What alternative and non-Western practices are used? Are any treatments effective, and does treatment occur at all?
- **Family Functioning:** Who provides care for a

child with autism? What type of social support is available and used, and how does a child with autism impact other members of the family?

- **Community and Legal Issues:** What level of awareness and acceptance of autism exists among the general population and what legislation is available to enhance the lives of people with autism?
- **Socialization:** How are parental values instilled in children with autism and which aspects of culture are selected for transmission to children with autism?

Merry Barua founded the Indian organization Action for Autism

Over the past decade, a number of these issues have been examined in India– a country with a population of over one billion people. In contrast to many other developing countries, India has a long history of research interest in autism. Autism was first noted in scientific Indian journals as early as 1962, and dozens of journal articles have been written in the years following (Daley, 2004). Similar to many non-Western and less industrialized nations, the more applied side is still very young in India. The autism movement really did not begin until 1991, when the National Autism Society of India, Action for Autism, was founded.

This organization has worked to raise awareness, gain legal recognition, support research of the disorder in India, and provide services to thousands of families. However, this task is extremely challenging, given the lack of awareness of the disorder, lack of funding, and lack of trained professionals (Daley & Sigman, 2002). It wasn't until 2000 that the government of India legally recognized autism, allowing parents of children with autism the same benefits as parents of children with other disabilities, such as tax concessions and reduced travel costs. This recognition also impacted services for children with autism. Before 2000, a school for children with autism could not receive government funding, since the logic of the government was that it was not possible to operate a school for a disorder that did not exist.

Directions for research

From this brief description of the state of autism in India, one can begin to see several directions for future research in India as well as other countries around the world. One area of research would be to investigate which aspects of the disorder differ between cultures, and how these differences relate to **linguistic differences**, socialization goals and practices, and other culturally mediated processes. For example, does a trait such as pronominal reversal occur in other languages? When a language does not contain pronouns, are there other identifiable idiosyncrasies of communication? Given that autism is often thought of as a disorder of communication, how does multilingualism shape the communication aspects of the disorder? In India, as in many countries in the world, bilingualism is the norm rather than the exception. Researching autism in these settings could help us better understand many of the social communicative aspects of autism in a much more sophisticated way than we currently do and could shatter some assumptions we currently hold about language capability.

Speech therapists in a culturally diverse area such as Southern California are increasingly encountering bilingual autistic children and must make recommendations about language use.

Another example of this line of research relates to the **social impairments** evident in people with autism. In a culture in which childhood sociability is less emphasized, does such aloofness not appear as central a symptom or as much of a problem? Are autistic children just seen as "mature" or well behaved, rather than odd and unusual? Cultural practices related to socialization could also impact prevalence.

In India **arranged marriages** are still the norm. Perhaps more high functioning men with autism are getting married and having children of their own, since one's social skills are not as much of a prerequisite for marriage as they are in the U.S. **Intermarriage** between relatives is also very common in certain parts of India. Given the high influence of genetic factors in autism, both of these cultural practices are clear examples of how the prevalence of autism could in fact differ from one culture to another.

Mothers and their children use the AFA premises to work independently for at least two hours per day.

Studying autism in developing countries could give us a clearer idea of what the untreated course of autism looks like.

Still another interesting issue is the extent to which differences in symptoms can be linked to treatment, or the absence of treatment. In the U.S., we do not have a clear idea of what the untreated course of autism looks like, since most children in the United States attend school at the very minimum. Yet in developing countries many children with autism (and other disabilities) receive literally no intervention beyond the care of their family.

Perhaps the most compelling reason to conduct autism research in countries around the world stems from the notion that the treatment needs of children and families may differ substantially from one country to another.

This may seem like an obvious statement; after all, parents intuitively know that their own child's needs are unique. Yet Morgan (1996) has argued that not only are the same behavior patterns seen around the world, but also "the problems of the individuals and their families are virtually the same, and the required responses are quite similar" (p. 9). Regardless of the similarity or dissimilarity in symptoms across cultures, treatment in the U.S. is always based on the individual characteristics of the child.

An effective intervention for children in Southern California may be culturally inappropriate in another country.

An effective intervention for children in Southern California may be culturally inappropriate or simply prohibitively expensive in another country. Given this issue, part of the rationale to research autism in non-Western contexts surely must be to help develop and promote methods of treatment that are options for children with autism in other countries, just as we would want access to effective treatments developed outside the U.S.

In summary, research on the pervasive developmental disorders within a cultural context and in

The mother-child program is a workshop incorporating elements of different interaction-based interventions.

developing countries has received limited attention to date. The major questions of whether the prevalence and symptom presentation of the disorder are the same throughout the world remain unanswered. Autism has been identified in over 85 countries, and communication about the disorder continues to rapidly increase via the internet and extensive parent networks. Ultimately, developing an appreciation of the experience of autism in these diverse cultures will help us better understand the disorder here at home.

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For a complete list of national autism organizations, visit www.autism-society.org

Diagnosis and the Identification of Special Educational Needs for Children at the 'Able' End of the Autism Spectrum: Reflections on Social and Cultural Influences

By Rita Jordan

1. The conceptual basis of autism

In the past, autism was considered a well-defined constellation of behavioral 'symptoms' based on clear descriptions of Kanner. It was recognized as a specific disorder within the then current systems of medical classification. This enabled its differentiation from both general intellectual impairment and mental illness (primarily schizophrenia). Researchers tried to establish its biological base and to counter the damaging assertions of a psychogenic origin.

The definition of autism used for classificatory systems was based on the influential work of Wing and her colleagues (Wing, 1996). Wing established that autism could be associated with severe learning disabilities and/or mental retardation. She also introduced the work of Asperger to the English-speaking world and with it the recognition of a far more intellectually and linguistically able group. Nevertheless these individuals shared a common 'triad of impairments' with others within an 'autistic spectrum of disorders' (ASD). The 4th edition of DSM (DSM-IV: APA, 1994) and the 10th edition of ICD (ICD-10: WHO, 1993) introduced the further category of 'Asperger's Syndrome/Disorder'. Much research interest in the 1990s was concerned with distinguishing Asperger Syndrome from autism, with most researchers concurring that no clear distinction could be justified (Prior, 2003). Only recently has research focused on differentiating categories at the **'borderlands' of autism,** i.e. the point where individuals might be distinguished from persons with language disorders or non-pathological variations of human development – the 'eccentric and unusual'.

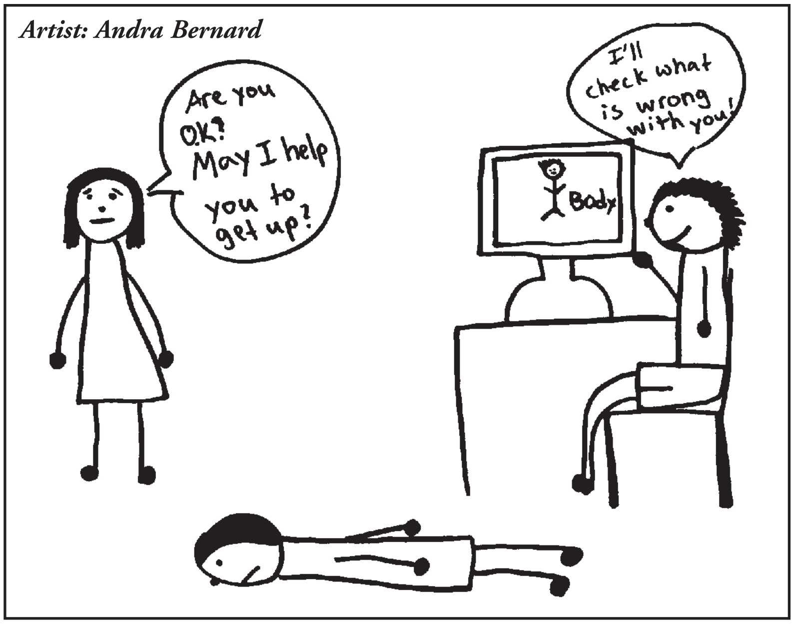
Wing (1996) makes the case for a broader view and points to the numbers of individuals and their families, therapists or teachers who are left without support if a tight medical classification is used as a 'gatekeeper' to the provision of services. In the UK, special needs are recommended as the basis for providing services, but Jordan (2005) argues that, although education has to be based on assessment of individual needs, in ASD the medical category (in its broadest terms) is necessary as a way of identifying those needs. Research is also beginning to supply evidence that certain categories (i.e. Asperger's Syndrome) are often misunderstood or inconsistently applied, and may be used to deny service, so there are research-based and pragmatic reasons for using the broader concept of ASD.

Categorical diagnoses are essential for research purposes but are not a good basis for understanding the real-life presentations of the disorder or for planning and implementing services (Volkmar, 1998).

2. A broader conceptualisation

As with other disability areas, there is a growing group of individuals with ASD, who challenge the characterisation of ASD as a 'disease' in need of a 'cure' (Dawson, 2004). The evidence of a high genetic link and a broader phenotype within families of individuals with ASD has led some researchers to make the case for the **evolutionary advantage of some traits associated with ASD.** Baron-Cohen (2004) adopts Asperger's characterisation of autism as an extreme form of maleness and argues, that these different strengths and weaknesses comprise different ways of understanding and acting on the world: **systemizers (mostly male), who process information naturally in terms of physical systems, and empathizers (mostly female), who process information in relation to its social and emotional import.**

Artist: Andra Bernard



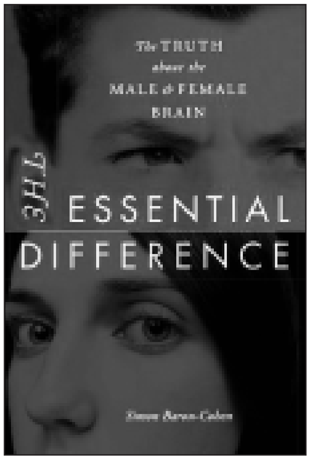
Gender differences in approaching life's problems

Baron-Cohen claims that those with ASD are at the extreme systematizing end. This theory has face validity and has been accepted readily by some individuals with ASD themselves. It has its roots in decades of research that ironically was directed at proving the categorical nature of ASD i.e. the 'Theory of Mind' (TOM) research suggesting a supposed malfunctioning of a TOM module as the core 'defect' in ASD (Frith, 1989). Yet Frith had also recognized the strengths arising from ASD and developed her theory of weak central coherence as a way of characterizing a difference in cognitive style. Happe (1994) argues that differences are seldom absolute and may just reflect cognitive preferences. Her work also highlights the advantages as well as the problems that might arise from certain cognitive preferences, adopting what might be characterized as an 'equal but different' stance with respect to the conceptualisation of ASD.

3. Different perspectives

The different positions with regard to conceptualizing ASD, then can be seen as:

- ASD are pathologies, 'diseases', or developmental disorders. Some see this as a broad single category, while others claim validity for subcategories such as 'autism', 'Asperger syndrome' and 'Pervasive Developmental Disorder – Not Otherwise Specified: PDD-NOS.
- ASD are differences in cognitive style, which are merely extreme forms of common human variation. They only represent pathologies to the extent that society does not understand and support their differences – leading to secondary problems of frustration, anxiety, depression and so on.
- Some combination of these two positions.



The different positions are to some extent associated with different 'stakeholder' views, although no one group can be said to hold a unified view.

Individuals with ASD: Those who are able to reflect on their own condition, and write about it, are a minority of individuals with ASD, so there has to be caution in accepting known views as representative of all. Most autobiographical writings in ASD take the stance of ASD as a cognitive style, yet they also give powerful accounts of the difficulties (often severe) in living with the condition. Where individuals manage to lead a 'successful' life, they do so at a cost and many suffer mental health problems in the process. Even the most successful, may themselves experience their autism as an almost intolerable burden in terms of the fear and anxiety generated simply by trying to live in society. Symptoms may apparently diminish as the person learns ways to suppress them and alternative ways of responding, but the autism may be expressed in other ways (depression perhaps or increasing obsessiveness) or there may be regression at times of extreme stress.

However, there are individuals within society who would meet a number, if not all, the criteria for an ASD, yet remain undiagnosed and apparently undisturbed by their differences. Enough is not yet known about the factors that protect an individual from needing special supports or provision, and it might be that even those who are apparently functioning well might do better if they were better understood and society was more tolerant. Nor do we know the effect of their condition on those who may be supporting them, first parents and siblings and then perhaps spouses and children. Some wives are now seeking support for their roles of living with men with ASD, who may or may not be diagnosable.

Parents: Although parents are occasionally prepared to see ASD as a spectrum of differences that may enhance life, as well as lead to problems, this is far from the typical response. Many parents have formed, or joined, pressure groups dedicated to 'cures' for ASD or to determine causation with a view to future prevention. As Dawson (2004) has pointed out, it is largely parents who have been responsible for the media representations of ASD as a 'plague' that devastates both the lives of the 'patients' themselves and of their families.

However, one cannot assume a common parental view. Many effective educational approaches to autism owe their existence to pressure or even instigation by parents. Good educational approaches use parents as co-therapists and have respect for the individual with ASD at their heart. There are approaches to ASD that are child-centred, working on helping the child understand and make sense of the world, rather than simply to conform and respond in set ways, but it is more often approaches that promise 'cures' and changing the individual to fit the system that seem most attractive to parents, whether that is through behaviour modification or some biological 'cure'.

The medical profession: Medicine is underpinned by a disease model and needs to categorize in order to proceed. Once there is clear diagnosis, this can lead to scientific research to identify causes, establish prevalence and incidence and develop effective treatments. The ideal in medical terms is to have tightly drawn diagnostic categories that are distinct from other categories (including the norm) and are homogeneous. That came close to being true of the original category of Kanner's autism but is clearly not true of the heterogeneous categories that now exist.

The argument against medical classification is that it locates all the difficulties within the individual but, if one accepts medical input as just one contribution to diagnosis and treatment, then potentially 'pathological' features would be judged alongside an analysis of the environment in which the child is functioning.

Researchers: Researchers, whose interests lie in identifying the core characteristics of ASD at a biological, psychological or behavioural level, have much the same interest as the medical profession in clear homogeneous categories. However, failure to reach definitive conclusions from such research reflects the fact that such neat classifications do not match reality. Some have turned their attention to studying the dimensions of human difference along which ASD may be located, and this offers a new way forward. It means it will be harder to claim a 'core' deficit from which all else stems, but **ASD has perhaps suffered from premature theorizing on**

Highlight

Teachers and parents are always looking for ideas to make materials and activities for children to use… here are just a few highly recommended websites that will provide LOTS of creative things and will save you time! Have fun browsing through them – thanks to Barbara Bloomfield of the Orange-Ulster BOCES, Goshen, New York for sharing these at her February presentation for the S.U.C.S.E.S.S. Project of Orange County.

www.dltk-kids.com
www.pbskids.org
www.junctionof-ot-function.com
www.usevisualstrategies.com
www.nuttinbutkids.com
www.tinsnips.org

its nature and a period of data-driven research might provide a sounder basis for future theories.

Educationalists and service providers: The goals of individuals or groups who are selling particular interventions are not hard to determine; they have a vested interest in seeing ASD as a devastating condition requiring their particular treatment for any hope of 'rescue' or 'cure'. There is little scientific evidence to support these claims, but the appeal lies in the hope rather than the reality. At the same time, there has been a movement among educationalists and other practitioners towards more inclusive practices in all service provision and against a medical model on which to base educational need. Education is not just another 'treatment' but has a special status within most societies as a way in which culturally valued knowledge and skills are transmitted to the next generation and children are prepared for their contribution to society as adults. Most advanced societies regard universal education as the entitlement of all children, including those with ASD. Thus, parents and clinical practitioners may see the goal of treatment as eliminating or reducing autistic symptoms, whereas the goal of educationalists will be to provide access to broad and relevant curriculum opportunities.

Special educational needs may depend on diagnosed medical needs but **are not just about deficits; they are equally determined by strengths, information processing style, prior experiences, personality, motivation, emotional and behavioural barriers and features of the educational environment.** The diagnosis is important in ASD, because it is the 'lens' through which the behaviour must be interpreted (Jordan, 2005).

4. Implications for education and treatment

The original model of teaching in ASD was that developed for those with learning disabilities. The needs of those with ASD are distinct, however, and visual impairment can be regarded as a better analogy for ASD than learning disability.

In ASD also we can recognize different degrees of disability associated with the condition and that there will be compensations as well as deficits. We can learn to work with individuals to find out what is most supportive for them in their learning and life, rather than assuming that it is best for the child to learn to do what typical children do (just as the blind child would be introduced to Braille or computer aided learning rather than being forced to try to 'read' text). There has been a great change in awareness of both the number of individuals with ASD and the range of abilities and disabilities they may present. It is likely that these people have always been part of society and have contributed in both ordinary and unique ways. **An inclusive society should recognize and value the contribution of all**, and work with individuals to help them overcome any barriers that may exist that prevent them making that contribution and leading a full life.

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Rita Jordan, Ph.D., Prof.
School of Education
University of Birmingham

Friday Friends

By Sarah Barrett

Students work together to create a fun snack.

If you walked into Mrs. Barrett's preschool classroom on a Friday morning, waves of laughter and a sea of students successfully working together would immediately hit you. As a part of a program developed by fourth grade teacher, Mrs. Fugitt and preschool teacher, Mrs. Barrett, students share thirty minutes together in different activity centers. So why does this scene differ from any other peer-tutor program? Mrs. Barrett's classroom consists of eight preschool students diagnosed with autism, who arrive daily to **Benito Juarez Elementary School** in the **Anaheim City School District** to learn and grow. Usually, Mrs. Barrett's day with her students is filled with structured learning time meant to enhance developmental abilities. However, on Fridays, both Mrs. Fugitt and Mrs. Barrett's classes get a chance to discover and develop together.

Fun with glue!

About six months ago, Mrs. Fugitt approached Mrs. Barrett with an idea to integrate the two classrooms, aware that the introduction may be beneficial for both ages. Mrs. Fugitt grew up with a cousin who had special needs, and she was tired of the world looking at him for being "different". Mrs. Fugitt decided that introducing her students to children with special needs would open their hearts and teach them not to discriminate.

Students working on colors and shapes.

When the program began, both teachers were not sure what to expect, but could only imagine what was to come. The children have become close to their **"Friday Friends"** and have extended their friendship on the school campus past their structured thirty minutes together. The fourth graders are eager to say hello to their preschool friends, and the preschoolers seem to have picked up a comradery and understanding of fellowship on campus. The fourth grade students now feel a sense of pride and responsibility from their newfound duty as "Friday Friends". Many students in the fourth grade class have learned not to tease others. They also have experienced that helping someone can make them feel good about themselves.

Mrs. Fugitt's fourth graders have begun to volunteer outside of their scheduled time by asking Mrs. Barrett if she needs help before and after school, or if they can help in the morning by walking some of the preschoolers off the bus. Mrs. Barrett explains, "I believe that children need to understand how to work with people who may be different from themselves. These fourth grade students have embraced this learning experience and have learned how to treat others with kindness and respect."

On Halloween we worked together to make spider art.

When the Friday activities are completed, the students sing goodbye songs and give high fives and hugs. "Each time I watch my students smile at their new friends and give them hugs, it brings tears to my eyes. These simple gestures of acceptance that the fourth graders display will have an impact on my students' lives forever" says Mrs. Barrett.

Justin is learning to write his name.

Mrs. Fugitt states, "My kids are so kind to everyone now, are generous, willing to help, and have improved their academics. I just wanted to introduce them to something they have never been exposed to, and it has become so much more than that. I couldn't ask for anything else."

One simple idea from Mrs. Fuggit has turned into an experience both classrooms will benefit from for a lifetime. A lesson of acceptance, an understanding of differences and the creation of open mindedness has now been implanted in these children. As Mrs. Barrett and Mrs. Fuggit continue to implement the program who knows what amazing developments will be discovered next.

Sarah Barrett, Preschool Teacher
Anaheim City School District ♥

Note: This program has received a well-deserved grant of $500.00 from Disney.

Comments of some of the "Friday Friends"

Christian wrote - "Autism Kids" "Before I did not talk to the kids, because I thought they were different. Then when I got to know them I didn't make fun of them anymore. Now I feel bad about making fun of them. So I try to help as much as I can. That is how I help them."

Bibiana wrote - "Buddies" "Ever since I started going with buddies I've changed by caring more about the special needs. Because before I didn't really care them because I didn't know how to help them."

Brenda wrote - "Buddies" "I changed a lot because, they were nice and they were happy to see us and they were excited to see us. I was happy to see them and they were fun now that way I like to go to the preschoolers."

Arnoldo wrote - "Buddies" "I have changed by taking my buddies off the bus. And walking them to their class. And every Friday we go help them. I used to be mean to the people that help them. I have changed. Now I help by walking them. I have to help and it feels good when I help them. I like to with my buddies."

So Much Stress; So Little Time

By Christina Conner

Teaching and managing a special day class of children with autism is definitely a balancing act. As I am sure all of my colleagues can attest, there just never seems to be enough time to cover all the bases. My classroom is part of the **Orange County Department of Education's** Special Schools Program based upon the components of the **S.U.C.S.E.S.S.** Project (see ANOC, Volume I, January 2004). The classroom is typically a "beehive" of activity that combines me, three paraeducators, eight boisterous boys, and an integrated educational model, which includes such strategies as Intensive Behavioral Instruction, TEACCH/Structured Teaching, Positive Behavior Support, Picture Exchange Communication System, Social Stories, Links to Language, and Sensory Diets. I am proud to say my students stand as a living testament to the favorable results achieved in children with autism given consistent, systematic intervention. Still, I often feel challenged just trying to keep "all the balls in the air". How can I simultaneously **teach meaningful, lifelong skills**; **improve student behavior** to enhance social opportunities; **support the families** of my students; and, meanwhile, simply **maintain my own sanity**?

Austin & Alexander hold their "Great Triangle" position.

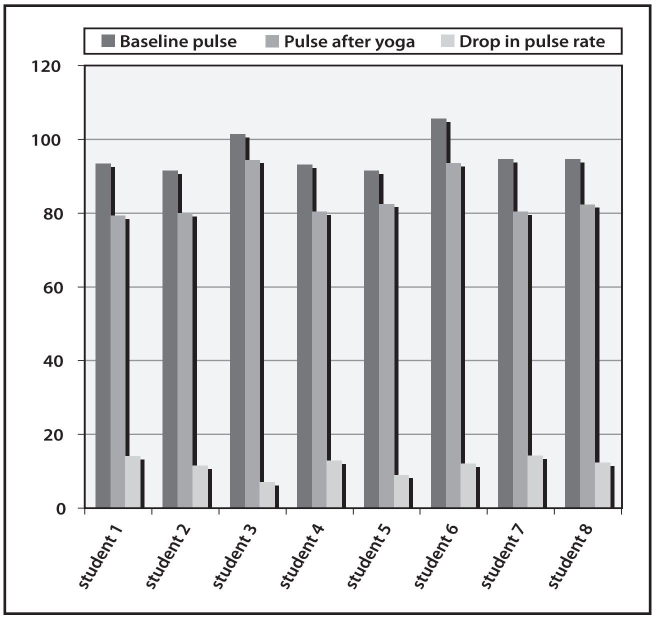
Interestingly, finding an answer to that final question unexpectedly may have supplied a means to address all the others. When I determined last summer that I personally needed to find a way to relax more, I turned to yoga as a possible solution. Not being particularly athletic, I was seeking the highest degree of calming with the lowest degree of exertion–yoga seemed ideal! My students and I had dabbled in yoga as part of their Adapted Physical Education (A.P.E.) program and, as my enthusiasm for the activity grew, I wanted to share the benefits I had experienced with my students.

Some skill areas that were addressed:

- **Attention**
- **Imitation**
- **Socialization/Working in a Group**
- **Learning to Wait/Turn Taking**
- **Receptive Language/ Following Verbal Directions**
- **Following Routines**
- **Regulating and Self-Monitoring**
- **Body Awareness/Proximity**
- **Recreation/Leisure Skills**

A "Quiet Pose" is now done by Austin, Brandon and Alexander.

Our A.P.E. Teacher, John Knitter, and I decided to devise a small research study on the physiological effects of yoga on the students in my class. We were most interested to learn if yoga could be used as a calming strategy to improve student behavior. This, however, seemed a difficult factor to isolate, since my classroom employs many tools designed to address student behavioral concerns. We decided instead to focus on strictly physiological manifestations of "calming". Ultimately, we used **resting heart rate** as a logical gauge of the success of the intervention. We took a baseline resting heart rate for each student twice daily for a period of two weeks prior to beginning the systematic introduc-



tion of our yoga program. We then began implementing 30-minute yoga sessions daily for the next three weeks, taking the children's resting heart rates immediately after yoga and again three hours later. Resting heart rates were measured with a mechanical device called an oximeter.

Our 30-minute yoga routine was comprised of some simple poses, specific breathing techniques, and periods of full relaxation at both the beginning and end of each session. The individual poses were pre-taught in isolation prior to the introduction of the complete program. When doing the complete routine, all instruction was delivered verbally, accompanied by a teacher model directed toward the entire group. Classroom lighting was turned off for the duration of the yoga session, leaving only natural light from the windows. Classical music, comprised of pieces containing 50-60 beats per minute, was also played throughout the activity.

The change in individual resting heart rate was immediate and dramatic. The average change per student was a drop of 11.6 beats per minute between the pre-intervention measurement and that taken after we had begun systematic yoga sessions. The greatest change experienced by a member of the class was -14.2 and the smallest change was -7.0 (see Table).

Even the resting heart rate readings taken later in the day showed an average drop of 3 beats per minute. The resulting change was definitely gratifying both physiologically and behaviorally. We were all feeling much more relaxed!

While our findings are certainly far from conclusive, it appears that "yoga therapy" is certainly worthy of further study. Given my present level of "inner harmony", I will happily leave more intensive research to others of a more scientific inclination. I personally am satisfied that I am well on the way to meeting my own goals for this study:

- **Lifetime skill learned:** students are able to follow a variety of simple yoga routines in a group by following a leader
- **Improve student behavior:** systematic yoga practice seems to have a positive impact on student behavior as well as reducing resting heart rate
- **Support families:** yoga is an activity families can participate in with their child or that their child can do alone for recreation as well as self-calming

Vincent tries to relax during the "Lotus" position at the end of the yoga session.

- **Last, but not least, maintain my sanity:** daily yoga practice has unquestionably helped reduce my personal stress level tremendously

Hopefully, my findings will prove useful to others who find themselves similarly challenged.

Christina Conner, Special Education Teacher
Orange County Department of Education
Culverdale Special Classes, Irvine, California ♥

My child can WALK
This is a true story... about my kid...

By Carol Pohlen

"My kid rides!" That sounds like such a simple statement. The fact is I might as well have said, "my kid can walk!" You see, my son is autistic. That is a statement hard to say out loud. Unless you have lived the nightmare personally, and I do not wish that on anyone, it may be impossible to fully understand its meaning. New parents often feel a great joy at seeing their child roll over, sit up, say his first words and even walk. These are supposed to be the highlights of our life as parents. However, my son spent his first few years spinning round and round until he fell to the floor, rocking back and forth to a soundless music I longed to hear and lining up objects in unique patterns that made no sense to anyone.

When my daughter was born with the same set of problems, I thought for a while that hope was simply a myth. Somehow I could make it, because that is what mothers do in this world. However, I helplessly watched as my husband was drained of all resolve, our parents began to wear those faces you see in bad plays, with smiles that took all their will and effort just to create. I began to seek alternatives in sheer desperation. I had put to use everything I had learned on the Internet, from a terrific place - the Regional Center and the good people of our school district, but it was not enough. A good friend I corresponded with on the Internet sent me an article regarding horses; I was skeptical, but willing to grasp at straws.

That is when I found Darlene Harman. Angels really do come in all shapes and sizes. **Her patience and perseverance put my daughter on a horse.** From a handful of words and meaningless phrases, to a chattering little girl, her sweet soul opened up. Riding in the car one day, she looked up at me and asked, "Is it horsey day?" I think that was just about the best day of my life. After that, **I knew hope again**. I continued to take her each week, and the measured changes in her attitude, behaviors and overall quality of life were enormous. Then my thoughts return back to my son. I tried to take him several times, but his fear of animals was simply too great. He was overwhelmed by the smells and noises of the too real atmosphere of the world of horses. It did not matter. Darlene continued to ask about him. She continued to try even though I had given up. Her suggestions about walking around the corrals, watching shows about animals and, above all, her own hope was like a tangible handhold on both our hearts.

Yesterday I took my son with me for the first time in several months to watch his sister ride. He showed only a vague interest in anything that was happening, that is, other than how the dirt from the corrals and open riding areas made nice clouds as he stirred it up. I wanted to cry, but I did not. I had learned not to do that, at least not in public. Darlene placed a riding helmet near where I was sitting on the bench. She smiled and suggested that he might like to wear one like his sister. I pulled myself together, used every trick in the book I had learned, and in the end, he actually had put it on. The next part is a sheer miracle for sure. At the end of my daughter's lesson, Darlene opened the gate and magically coaxed my little boy into the arena. Her two volunteer helpers, a tall veteran cowboy and a smiling earth-bound angel were ready at hand, with warm, incredible words of encouragement. I stepped back, like any parent, and let go. The tremendous beats of my heart were so loud I thought everyone would hear them. The noises he made were a combination of fear, nervousness, and to my surprise, delight and joy -- the real sound of joy! Like any child that walks for the first time, I could tell he stumbled a little in spirit and would not have stayed on the gentle beast, if it were not for the strength of Darlene's own will. The horse was moving at her command. A few steps, a few more steps, and before long my son was really riding tall in the saddle

I will never forget this precious smile!

I cannot say that this miracle will be for every child that tries. I can only share with you that Darlene Harman, owner of *Ride Your Horse* (www.rideyourhorse.com) knows a greater depth of patience and compassion than I had seen so far, in my all too many encounters in the world of Autism. She gives teaching a new definition. It is a way of life, not a job.

Carol Pohlen

We are grateful for the ongoing sponsorship of this newsletter by the following agencies:

Council for Exceptional Children Chapter 188

Council for Exceptional Children (Chapter 188) is the largest international professional organization dedicated to improving educational outcomes for individuals with exceptionalities, students with disabilities, and/or the gifted. CEC advocates for appropriate governmental policies, sets of professional standards, provides continual professional development, advocates for newly and historically underserved individuals with exceptionalities, and helps professionals obtain conditions and resources necessary for professional practice.

WILLIAM M. HABERMEHL
County Superintendent of Schools

Orange County Department of Education provides 'world-class' educational programs for over 163,000 students. These include General Education, Alternate and Correctional Education, Outdoor Science, Regional Occupational Program (ROP), and Special Education and Student Programs. OCDE partners with local school districts and community college districts, as well as local, state and federal governmental agencies. Staff Development, administrative, business, educational and support services are available.

For OC Kids

For OC Kids is a UCI-CHOC collaborative program dedicated to the earliest diagnosis and treatment of autism and related disorders. It is committed to the support, education and empowerment of families and professionals. It is supported by the Children and Families Commission of Orange County.

RC OC
REGIONAL CENTER
OF ORANGE COUNTY

The Regional Center of Orange County is a nonprofit organization that coordinates services to more than 14,000 Orange County residents who have developmental disabilities. These disabilities include mental retardation, cerebral palsy, autism, epilepsy and related conditions. The Regional Center is operated by a volunteer board of directors under contract with the State of California's Department of Developmental Services. The mission of the Regional Center is to advocate, support and provide services to people with developmental disabilities from birth through adulthood. The Regional Center receives state and federal funding to provide services to eligible individuals and families.

Upcoming Staff Development, Conferences and Parent Trainings

(Partial Listing — April to August 2005)

There are several opportunities for continuing education and support that will be offered by various organizations. The **Regional Center of Orange County** (RCOC), **For OC Kids** and the **S.U.C.S.E.S.S. Project of Orange County** strives to provide affordable fees to both families and staff. Each session has a specific focus, some pertaining to early interventions, some with more of an emphasis on the older aged student. Registrations may be limited, therefore call early!

PLEASE NOTE: The new 2005 – 2006 schedule for the S.U.C.S.E.S.S. Project of Orange County and the evening presentations at the Regional Center are currently being developed. More information will be included in the next issue.

SEE-PAC = *Support, Educate and Empowerment for Parents of Autistic Children* is a program developed in collaboration between the For OC Kids, Regional Center of Orange County. The overall project goal is to provide needed parent training to families struggling with early diagnosis and treatment of their children with autism. Information and support is pulled from best practice and families have the opportunity to develop resiliency as a direct result of the project's multidisciplinary focus toward parent empowerment through education. ***See the 2 different options available this Spring and Summer.***

Date/Time/Place	Topic/Speaker	Dev. level	Approximate Fee	Contact
April 26 to June 14 8 Tuesday sessions 6:30 – 8:00 PM O.C.D.E.	SEE-PAC - 8 sessions series	All ages	$20 material fee per family	Hedy Hansen (714) 939-6766
May 9 5:00 – 8:00 PM O.C.D.E	**Overview** 'Hidden Curriculum' *B. Smith Myles*	Older students – + 8 yrs and older	$20	S.U.C.S.E.S.S. Project (714) 966-4137
June 23 and 24 8:00 AM – 4:00 PM Orange, CA	Picture Exchange Communication System Training *PECS staff*	All ages	$345-375-Professionals Parents have a different fee rate of $235 (1) or $400 (both)	PECS staff (888) 732-7462 or website www.pecs.com
July 16 and 23 2 Saturday sessions 8:30 AM to 4:00 PM O.C.D.E.	SEE-PAC - 2 full days series	All ages	$30 per person plus $20 material fee per family	Hedy Hansen (714) 939-6766

Location O.C.D.E. = Orange County Department of Education — 200 Kalmus Dr., Costa Mesa, CA 92628

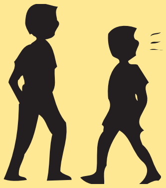
Behavior Management Workshop for Parents and Service Providers

When: Wednesday mornings (April 27th and May 4th, 11th, 18th and 25th.
Time: 10:00 am to 12:00 pm
Location: **Regional Center of Orange County West Office**
13950 Milton Ave., Suite 200
Westminster, CA
Cost: No charge!
Speaker: Julia Shaull is a Licensed Clinical Social Worker and BCBA, who is working for the Institute of Applied Behavior Analysis.
Contact: Thelma Day at 714-796-5223

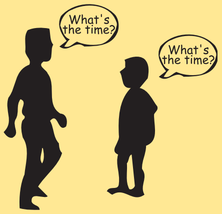
This 5 session workshop will cover the basic principles of positive behavior management. The 5th session on May 25th will focus on toilet training.

SOME EXAMPLES OF AUTISTIC BEHAVIOR

ALGUNOS EJEMPLOS DEL COMPORTAMIENTO DE PERSONAS CON AUTISMO



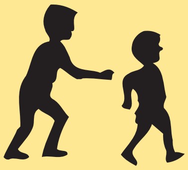
Avoids eye contact
Evita el contacto visual



Copies words like a parrot ("echolalic")
Repíte las palabras como un loro
("en forma de echo")

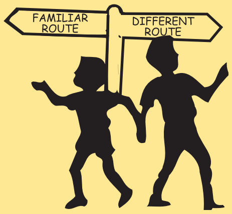
Shows preoccupation with only one topic
Demuestra preocupación/interés en solo un tema/asunto

Lacks creative "pretend" play
Carece el juego creativo

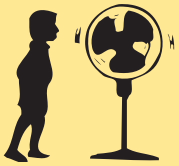


Shows indifference
Demuestra indiferéncia

Displays special abilities in music, art, memory, or manual dexterity
Demuestra capacidades especiales en musica, arte, memoria or destreza manual

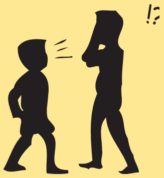


Does not like variety: it's not the spice of life
No demuestra interés en variedad



Shows fascination with spinning objects
Demuestra fascinación con objetos que gíran

Laughs or giggles inappropriately
Risa/reír inadecuadamente



Shows one-sided interaction
Demuestra interacción que es unilateral

Shows fear of, or fascination with certain sounds
Demuestra miedo de/ó fascinación con ciertos sonidos

Some Examples of Autistic Behavior

Algunos ejemplos del comportamiento de personas con autismo

- Difficulty with social interactions.
  Tienen dificultad para socializar con otras personas.
- Problems with speech.
  Tienen problemas con su lenguaje.
- Disturbed perception.
  Tienen una percepción anormal de los sucesos que acontecen a su alrededor.
- Abnormal play.
  Su forma de jugar es anormal.
- Resistance to change in routine or environment.
  Se resisten a cambios en sus actividad rutinarias ó a su medio ambiente.

Does not play with other children
No juega con otros niños