Chapter 1

Who Are the Children?

Marlon was a cranky infant. He didn't like to be cuddled and didn't respond to his parents' voices or faces. His parents thought Marlon might be deaf, but he would wake at the least little sound. He never learned to talk and would spend hours looking at the dust in rays of sunlight streaming in the window.

Eugene was a bouncy, happy youngster who met all of his early milestones. He even had a few words when he was a year old. Between 18 months and 2 years of age, he lost those words. Though Eugene was affectionate with his parents, he seemed to lose interest in other people. At playgroup he wouldn't join other children, but he would walk around the periphery of the room touching the walls.

Brianna was an active, busy child, but she insisted on doing things her own way. She would only wear her brother's clothes, insisting that she was a boy. She had frequent tantrums when her routine was changed. Though she could talk, her language was mostly about what she wanted or didn't want. Brianna couldn't really carry on a conversation, but she loved other children.

Josh was a bright, quiet boy who learned to read and write when he was 3. He was very sensitive to negative feedback and insisted on being first at everything. Josh developed strong interests in NASCAR and certain DVDs and devised creative games with complicated rules that everyone had to follow.

Katherine was homeschooled for much of her elementary and high school careers. Although she received As in honors English and creative writing classes at school, she just couldn't handle the pressures of school all day. Katherine was hopeless in math, but she was a talented poet and writer. She enjoyed trips with her parents, but she had no friends her age. Katherine was working on broadening her horizons by taking some college classes outside of her usual interests. Although she earned good grades, her interactions with other students remained polite and superficial.

All of these young people have been diagnosed with autism spectrum disorder (ASD), a neurological disorder that affects the way the brain functions. The symptoms of this disorder vary across individuals and are present in different degrees of severity, hence the descriptor *spectrum*. ASD is a complex developmental disability that usually becomes evident by age 3, though some symptoms may be noticed earlier or later. It is a lifelong disability, but improvement and reduction in symptoms can occur with treatment and further development.

Certain characteristics are common in children with ASD; however, not every child with ASD presents with all the characteristics. ASD affects a child's behavior, social functioning, ability to communicate effectively, academic performance, and understanding of and response to the environment.

Chapter 2

Learning Styles in Children With ASD

In children with ASD, neural organization affects the manner and sequence of learning in the areas of language, academics, and social communication. Typical children differ from one another in personality, and we all have strengths and weaknesses coded in our DNA that are influenced by environment and education. Within a range, however, most humans follow similar developmental sequences, and teaching methods are therefore geared toward the "typical" learner. While it is clear that most children with ASD can develop and learn, their sequence of development and learning styles may vary. They often need to be directly taught language, concepts, and interactions that other children pick up naturally.

Language Learning

> It was one of those lightbulb moments. I had been working with children with autism for a number of years, but I never understood why my therapy was (or was not) effective or how the children learned language. In 1982, Barry Prizant published an article in *Topics in Language Disorders*, "Gestalt Language and Gestalt Processing in Autism," that immediately resonated with my observations. It would not be an exaggeration to say that each of my therapy sessions with children with ASD, to this day, is guided by the concepts put forth in that article.

Gestalt vs. Analytic Processing

What did Prizant say that was so illuminating? He looked at the linguistic research of Peters (1977) and others and saw that typical children acquire and use language via two modalities: analytic and gestalt. In the analytic mode, the basic unit is the word (or morpheme). As children mature, they combine words to create phrases and sentences. In the gestalt mode, the basic unit may be a word, multiword phrase, or sentence that is understood and spoken by the child as a whole unit, or a gestalt.

When a child processes words analytically, she is able to combine them flexibly in a number of ways. Note the following examples of analytic processing:

"Bye-bye."

"Go bye-bye."

"Daddy go bye-bye."

"Go bye-bye Daddy."

"Daddy go."

"Bye-bye Daddy."

Chapter 3

Intervention Strategies Begin With the Child

There are many issues to think about when developing strategies for working with children with ASD. The problems are complex and the choices are not always straightforward. There are many treatment options for children with ASD. How can parents, SLPs, teachers, and therapists choose strategies and develop tactics for a particular child with ASD? It is not an easy task.

Starting with the child may seem obvious, but when a child is diagnosed with ASD, the immediate reaction is "What can we do about it?" Knowing that early intervention is important, families are eager to find treatments. Using the Internet, parents quickly get up to speed on intervention programs and begin to search for therapists and practitioners. While it is true that treatment can begin before the child is thoroughly assessed, it is best to stop, take a breath, and take a good look at the child. Since this is a spectrum disorder, by definition children do not all have the same presentation. Each child has a unique set of strengths and weaknesses. Symptoms may be mild or severe. Behaviors may occur with varying rates of frequency. Comorbid symptoms may be present or absent. Remember that this is a child with ASD who is in many ways the same as any other child his age. Characteristics of ASD may be problematic, but they are human characteristics, often recognizable in some form in all of us.

The Child's Family

Many parents divide their child's life and their own lives into two sections: before and after the ASD diagnosis. For some parents, their reaction to a diagnosis is relief. They finally have a name for their child's puzzling behaviors. In their heart of hearts they knew that something was not right. Now that their suspicions are confirmed, they know they have not caused the behaviors and they are not inept parents. They can get to work developing intervention strategies. For other parents, the news is devastating. They recognized the difficulties but hoped their child would grow out of them. They mourn the loss of their dreams for a healthy, typical child. They too begin to develop intervention strategies, but their mission is often to find that elusive cure.

Regardless of where parents begin, they are on the ASD journey. Along the way there will be frustrations and triumphs, tears and laughter, and an emotional roller coaster involving their circle of family and friends. The most important thing to remember is that their child is just the same the day after the diagnosis as he was the day before the diagnosis. The child does not know or care that there is now a diagnosis and a label. That child has the same toothy grin, the same sleepy smell, the same furious temper, and the same special rituals. It is time for parents to chart their course and assemble their crew.

A Team Approach

During or after the ASD diagnosis process, parents seek out advice, counsel, evaluations, and treatment from a variety of professionals. Within the first year, most families have had at least three consultations in addition to evaluations by early intervention programs or by their school district.

Chapter 4

Intervention Tactics

Once you've established goals and objectives and the strategies to reach the objectives, it's time to select tactics. This chapter covers intervention tactics in detail. Tactics are used to implement the strategies to reach the objectives.

The challenge in suggesting tactics for children with ASD is the children's wide range of abilities. A tactic dealing with nonverbal communication, for example, would be quite different for a preverbal or nonverbal child as compared to the tactic for a verbal child. Even something as specific as teaching *what* questions varies from very simple to complex. To make this chapter usable and practical for SLPs, teachers, and parents working with particular children with ASD, tactics are divided into eight groups—basic skills, language, classroom, reading, writing, math, thinking, and social skills.

In each group of tactics, individual tactics are numbered. For many tactics, three levels of examples for activities are provided. Keep in mind that a particular child may need tactics between the levels suggested. Many of the tactics are interrelated. The Appendix to this chapter contains a summary chart listing all of the tactics in the first column and related tactics in the second column.

The suggestions in this chapter are intended as jumping-off points rather than prescriptions. Many of the tactics are based on the principle of using strengths to address weaknesses. The content of activities should be based on each child's unique interests and on what is required in the child's life.

Here is an example of how to choose tactics to achieve a particular goal and objective:

Goal: Charlie will write a logical narrative.

Objective 1: Charlie will write a logical paragraph.

Under *Language,* choose these tactics:

Language 14	Teach sequencing.
Language 15	Teach about attributes and descriptors.
Language 16	Teach explaining and describing.
Language 17	Teach how to create narratives and dialogues.

Under *Writing,* choose these tactics:

Writing 1	Decrease blank-page anxiety.
Writing 3	Use guided writing.
Writing 4	Demonstrate story organization.

Under *Basic,* consider these tactics:

Basic 1	Use visual patterns.
Basic 6	Follow the child.

After incorporating particular activities suggested under the tactics, the objective "Charlie will write a logical paragraph" would include:

Sequencing prewritten sentence strips (Language 14b)

Using adjectives in describing activities (Language 15b)

Chapter 5

ASD Through the Lifespan

The birth of a child evokes myriad emotions: joy and elation, hope and fear, and overwhelming responsibility and awe. Parents can never be fully prepared for what is to come as they watch their child grow and develop, fuss and cry, and wake and sleep. Parents slowly learn about this new little person. Does the baby like to be cuddled and rocked? Does he like music? What makes him smile? Each child is unique, and parents search for ways to integrate their son or daughter into their family life. When families begin to realize that there is something different about their child's development, the search begins to take them down a different path. As the path twists and turns, they come to a place they'd never imagined they would be.

This chapter covers how clinicians can interact with families at various places along the path of life. It describes life stages and typical reactions at each one, as well as family priorities and concerns. For each stage, the priorities and concerns are listed in order of importance for that time. Many priorities and concerns are the same, but the order of their importance changes through the lifespan. It is important that as clinicians, we respect the families' priorities as we manage treatment for them and their children.

> I have been very lucky in my professional life. Since I have stayed in one place for more than 35 years, I have been privileged to stay in contact with many families who brought in their toddlers before they could talk. I worked with them as they entered school and stayed with them as they became adults. These families have enriched my life in unexpected ways, and they have taught me how to help them. As a speech–language pathologist, I learned that my work was not limited to the child. I learned that as the child grows, the family develops different priorities. I learned to listen to the concerns of the entire family and to provide the kind of support and intervention that was needed at each stage of life.

Coping

All parents who raise children experience stress, and they develop strategies to cope with that stress. Parents of children with ASD encounter stressful challenges far more frequently. There is the stress of coming to terms with their child's condition and limitations, finding and funding providers of services, finding community resources, and planning for the future (Glidden, Billings, & Jobe, 2006). In addition, their lives may be complicated by financial or medical worries, job-related stresses, and the myriad societal problems associated with living in the modern world.

Mackintosh, Myers, and Goin-Kochel (2005) found that lower-income parents used fewer information sources and reported fewer supports than middle- or upper-income parents. In particular, lower-income parents were less likely to attend group gatherings around autism issues.

Coping is defined as the process of response to threats of stress. Coping strategies are often grouped into two general clusters. *Emotion-focused coping* includes strategies that aim to reduce or manage the feelings of distress. *Problem-focused coping* includes strategies that aim to solve the problem or take some action to change the source of stress (Smith, Seltzer, Tager-Flusberg, Greenberg, & Carter, 2008). Parents of children with ASD may cope in different ways. Coping strategies may