

Autism Spectrum Disorder at a Glance

Autism Spectrum Disorder (ASD) is characterized by difficulties in social communication, repetitive behaviors and restrictive interests, according to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5). ASD can be associated with intellectual disability, difficulties in motor coordination, sensory integration, attention, and physical health issues, such as sleep and gastrointestinal disturbances. Some individuals with ASD excel in visual skills, music, math and art.

The strong genetic component in autism is becoming better understood and is the reason for the inclusion of autism in this listing of genetic conditions. ASD can also occur as part of another syndrome, some of which are listed below.

Individuals with ASD may also have medical issues such as seizures, or gastrointestinal issues which may be part of an underlying syndrome or occurring coincidentally with the autism. Physical differences may also be present, such as differences in facial features, a small or a larger than average head size and/or brain structure malformation.



Meet Logan and MJ on page 15.

Diagnostic criteria

The diagnosis of autism has been defined in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (known as DSM-5). The DSM-5 is the 2013 update of the DSM-4. There were significant changes made to the diagnostic criteria and categories.

- DSM-5 no longer includes the diagnoses of Autistic Disorder, Asperger syndrome, Pervasive Developmental Disorder Not Otherwise Specified (or PDD-NOS), and Childhood Disintegrative Disorder. The diagnosis for all is now Autism Spectrum Disorder (ASD) with no separate sub-diagnoses.
- The three areas of symptoms from DSM-4 (social reciprocity, communicative intent, and restrictive and repetitive behaviors) were reduced to only two areas:

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- **Social communication/interaction**
- **Restrictive and repetitive behaviors**

In the area of **social communication/interaction**, the challenges must be persistent and occur across contexts for a diagnosis of ASD. They must include all the following symptoms:

- Problems with establishing and/or maintaining **back-and-forth conversations** and interactions; inability to initiate interactions; problems sharing attention, emotions or interests with others.
- Significant problems **maintaining relationships**; includes inability to engage in pretend play as a child, or age-appropriate social activities; problems adjusting to different social expectations.
- Problems with **nonverbal communications**, such as eye contact, facial expressions, tone of voice and gestures

In the area of **restricted and repetitive behavior**, the diagnosis of Autism Spectrum Disorder (ASD) requires two of the following four symptoms:

- Stereotyped or repetitive speech, motor movements or use of objects.
- Excessive adherence to routines and resistance to change; ritualized patterns of behavior, either verbal or nonverbal
- Abnormal intensity and focus on extremely restricted interests
- Over or under reaction to sensory input; or, unusual interests in sensory inputs from the environment

Symptoms must be present in early childhood but may not become fully evident until social demands exceed the child's capacities. Symptoms need to be *functionally impairing* and not better described by another DSM-5 diagnosis.

The new DSM-5 criteria also established a new symptom structure that recognizes differences in pattern of onset of symptoms as well as co-occurring symptoms such as Attention Deficit Hyperactivity Disorder (ADHD), anxiety, mood disorders; and co-occurring medical conditions such as seizure disorders, other general medical conditions such as diabetes or celiac disease. The severity of symptoms within each of the two areas of diagnostic criteria is also defined based on the level of support required for each symptom.

Finally, the DSM-5 criteria established a Social Communication Disorder for individuals with deficits in the social use of language, but do not have the restricted interests or repetitive behavior you see in autism spectrum disorders.

Genetics of Autism Spectrum Disorder

ASD can be diagnosed as part of other genetic syndromes, including Fragile X syndrome, Rett syndrome, tuberous sclerosis, neurofibromatosis, and 22q deletion (read more about these conditions at www.gemssforschools.org); also PTEN hamartoma tumor syndrome (read more at <http://www.chop.edu/conditions-diseases/pten-hamartoma-tumor-syndrome#.VrpLpPkrLcs>). Individuals with these conditions usually present with other symptoms and the diagnosis can be confirmed by testing one gene. Individuals who have ASD without other symptoms are referred to as having isolated ASD. Studies have shown that the genes identified as being highly associated with isolated ASD fall into two main functional categories:

- One category includes the genes related to the development and regulation or function of synapses (the connections between nerves).
- The other category includes genes related to chromatin (a DNA-protein complex) that is involved in the regulation of gene expression.

In addition to the specific genes that are being identified, advances in genetic testing have identified very tiny deletions and duplications in genes as being associated with autism. These deletions and duplications involve multiple genes and often occur in the child alone and are not carried by either parent (de novo or “new” mutation).

- The more common de novo deletion/duplications include: 2q37, 7q11, 15q11-13, 16p11, 22q11.2 and 22q13.3.
- The most common recurring changes are deletions and duplications of 7q11, 15q11.2-13.3 and 16p11.2.

These genetic differences may occur in family members without ASD and are thought to cause an increased chance of ASD. See Genetics Home Reference for more information (<http://ghr.nlm.nih.gov/>).

Prevalence

The Autism and Developmental Disabilities Monitoring (ADDM) Network

(<https://www.cdc.gov/ncbddd/autism/addm.html>) is a collaborative network that is part of the Centers for Disease Control & Prevention (CDC) and serves to track the number and characteristics of children with autism spectrum disorder (ASD) in multiple communities in the United States.

From the data from the 11 communities tracked by the ADDM in 2018, the following conclusions were made:

- About 1 in 44 (or 2.3%) children were identified with ASD in 2018
- ASD occurs across all racial, ethnic, and socioeconomic groups
- Boys were more than 4X as likely to be identified with ASD than girls among 8-year-olds
- Children born in 2014 were 50% more likely to receive an ASD diagnosis by 48 months than children born in 2010
- About one third (35.2%) of 8-year-olds with ASD also had intellectual disability

Common questions related to diagnosis of ASD using DSM-5 Criteria

What does Functional Impairment mean?

This means that the child has difficulty in an area of development that impacts his ability to function easily with his peers. Symptoms may be present in early childhood but may not become evident until social demands on the child exceed his or her capacities. For example, the child can function socially in a preschool setting (where demands may be lower) but is then unable to cope with the social demands of a kindergarten classroom. Symptoms must impair how the child functions in the world and not be better described by another DSM-5 diagnosis.

Is Rett syndrome still considered part of ASD?

No, Rett syndrome is a neurologic disorder that is no longer a sub-diagnosis under ASD, although patients with Rett syndrome may have ASD.

Is there a need for re-diagnosis?

Because almost all children with DSM-4 confirmed autistic disorder or Asperger syndrome also meet diagnostic criteria under DSM-5, **re-diagnosis is not necessary**. Referral for reassessment should be based on clinical concern. Children given a PDD-NOS diagnosis who had few DSM-IV

symptoms of autism or who were given the diagnosis as a “placeholder” might be considered for more specific diagnostic evaluation.

Will some already diagnosed with Asperger syndrome keep the label of Asperger syndrome?

Peoples may wish to continue to self-identify as having Asperger syndrome, although the DSM-5 diagnostic category will be ASD.

Should Speech and Language still be evaluated?

Yes, clinicians should note that children with ASD also should be evaluated for a speech and language diagnosis in addition to the ASD to inform appropriate therapy.

What is a Social Communication Disorder?

The DSM-5 includes a new diagnostic category called Social Communication Disorder. Children with social communication disorder may have social difficulty with understanding, producing and being aware of conversational norms. This difference is not caused by delayed cognition or other language delays. It may be a distinct diagnosis or may occur in addition to other conditions, such as autism spectrum disorder. For more detail, see American Society of Human Genetics (www.ashg.org).

Things to think about

1. Medical/Dietary Needs

What you need to know

Medical:

- Children with autism may have medical conditions that are part of an underlying syndrome or that exist in combination with autism. It is important to treat underlying medical conditions, while considering the unique needs of a child who has autism.
 - For example, if the child has seizures, they may require medication and an emergency plan for seizures. Or, they may need to know “the plan” in advance of

blood work or a visit to the school nurse. It is important to work closely with families and doctors to learn about the child's individualized medical needs.

- School age children with ASD may have multiple doctor and specialist visits to monitor medical conditions.
- *Medications:* There are no medications that can cure ASD or treat the core symptoms. However, there are medications that can help some people with ASD function better. Children with autism may have high energy levels, inability to focus, depression, or seizures. For those children, medication might be considered or be part of an existing plan.

Dietary Approaches:

- Some dietary treatments have been developed by reliable therapists. Many of these treatments do not have the scientific support needed for widespread recommendation. An unproven treatment might help one child but may not help another.
- Many biomedical interventions call for changes in diet. Such changes include removing certain types of foods from a child's diet and using vitamin or mineral supplements. Dietary treatments are based on the idea that food allergies or lack of vitamins and minerals cause symptoms of ASD. Some parents feel that dietary changes make a difference in how their child acts or feels.
- If a parent is thinking about changing a child's diet, they should talk to the child's doctor first. Parents can also talk with a nutritionist to be sure the child is getting important vitamins and minerals.

What you can do

- Be supportive of the parent's wishes as far as dietary adjustments and their effect on their child's behavior or condition.
- Consult a dietician on texture of foods and their effect on the child's dietary intake if there are issues related to diet and texture of foods. An occupational therapist or speech therapist may be helpful with sensory issues related to food.
- Be aware if the child has seizures and if a seizure protocol is in place. Make sure the seizures are considered before field trips and during physical activity.
- A yearly check-up and studies as needed should occur in the child's Medical Home.

- Be aware of any changes in behavior or mood that seem out of line with the situation and notify the parents.
- It is important to be aware of any academic changes. Contact parents when any differences are noticed.

2. Education Supports

It is important to have HIGH LEARNING EXPECTATIONS for children who have ASD. Encourage use of the core educational curriculum and modify it in order to meet the individual needs of the child.

What you need to know

General Information

ASD covers a large continuum of skills that differ from child to child.

- Not all signs or traits listed apply to every individual.
- It is important to identify a child's strengths and challenges.

Complete developmental and educational assessments (including speech and language evaluation and occupational/physical therapy evaluation) are recommended for planning.

- A multidisciplinary/interdisciplinary team approach is helpful.
- Open communication with the special education team is critical if a child in the classroom is showing behavioral signs of Autism Spectrum Disorder.

Communication

All children with ASD have individual communicative needs. For children with ASD, communication often comes slower and differently. Some children never acquire expressive language, while others are well spoken and have high linguistic abilities. However, the common theme across ASD is differences in social communication.

- ASD has been associated with delays in social skills and social communication. Often, children with Autism have difficulty initiating conversations, turn taking in conversations, and/or maintaining a conversation.

- They may have difficulty “reading between the lines”. Understanding humor may also be difficult, often due to their focus on literal interpretations. Many children with Autism have difficulties telling understandable stories, role playing, and using imaginative play.
- In some cases, children with ASD will display a general lack of eye contact, have reduced emotion, and include imitations of environmental sounds (echolalia) in their communication.

What you can do

General strategies to consider

- Integrated teaching approach
 - Incorporates multiple subjects, which are usually taught separately, in an interdisciplinary method of teaching
 - Goal is to help students remain engaged and draw from multiple sets of skills, experiences and sources to aid and accelerate the learning process.
- Support for developing friends; direct modeling and instruction for developing social relationships
- Occupational therapy and speech therapy evaluation and ongoing therapy as needed
 - May provide individual support
 - Can work together to design programs such as social-motor groups.
- Special education and anticipatory management. For example, avoiding too much stimulation may prevent behaviors.
- Goals that emphasize the child’s learning style and strengths
- Concrete, high interest examples and materials
- Recognize need for individual attention
 - Small class size
 - May need 1:1 support or floating classroom assistant
- Avoidance of sudden change
- Modeling and imitation for both behavioral and communication goals
- Highly structured, predictable routines with visual cues for changes in expected events
- Inclusion of functional skills, along with the academic skills
- Self-help goals integrated with language and motor skills (i.e. eating, dressing, toileting).
- Occupational therapists ensure appropriate settings and equipment for a calm, structured learning environment. Use of special chairs, postural supports, etc. may be helpful.
- Positive Behavioral Supports (PBS) are often effective in working with a child with Autism. The idea behind PBS is to understand the function of behavior, teach more effective methods, and change the behavior of adults. It includes an effective support

plan. Autism Speaks (insert hyperlink) summarizes PBS here:

https://www.autismspeaks.org/sites/default/files/section_5.pdf. Key components of creating an effective plan for implementing PBS are clarity, consistency, simplicity, and continuation.

Communication strategies

- Keep distractions to a minimum
- Use visual and tactile aids
- Provide periodic sensory breaks
- Teach using several short periods of time
- Help with organization
- Present information in concrete manner
- Repetition will help children remember basic facts
- Individuals may learn better when material is presented as a whole rather than in sequence
- Visual cues, including logos, pictures, and sign language are helpful
- Break down word problems to help with reading
- Help children apply information they have learned to new situations
- Use concrete examples

The following evidence-based practice communication programs have been implemented with individuals with Autism and proven successful, or have in some way benefited the individual's communication:

Functional Communication Training (FCT):

- Functional Communication Training
<http://autismpdc.fpg.unc.edu/sites/autismpdc.fpg.unc.edu/files/imce/documents/Functional-Communication-Training-Complete10-2010.pdf>
- Using Functional Behavior Training to Replace Challenging Behavior (*parent friendly*)
<http://csefel.vanderbilt.edu/briefs/wwb11.pdf>

Picture Exchange Communication System (PECS):

- Picture Exchange Communication System
http://autismpdc.fpg.unc.edu/sites/autismpdc.fpg.unc.edu/files/imce/documents/PECS_Complete.pdf

- What is PECS (*parent friendly*)
<http://www.iidc.indiana.edu/pages/What-is-the-Picture-Exchange-Communication-System-or-PECS>

Peer Mediated Instruction and Intervention (PMII):

- Peer Mediated Instruction and Intervention
<http://afirm.fpg.unc.edu/node/2>
- Peer-Mediated Support Strategies (*parent friendly*)
<http://vkc.mc.vanderbilt.edu/RTI2B/wp-content/uploads/2013/05/Peer-MediatedStrategies.pdf>

Pivotal Response Treatment:

- Pivotal Response Treatment
<https://www.autismspeaks.org/what-autism/treatment/pivotal-response-therapy-prt>

3. Behavioral and Sensory Support

What you need to know

Functional behavioral assessments are important for many individuals with Autism Spectrum Disorder. They can help determine the presence of concentration/attention problems, anxiety, and other differences in behavior. They can also determine possible triggers of the behavior and increase understanding of the purpose or function of behavior. From that information, a support plan can be created.

Children with Autism Spectrum Disorder may have some issues with:

- Tactile defensiveness
- Eye contact
- Perseverative speech
- Impulse control
- Distractibility

- Fidgety or overactive
- Postural control
- Self-control
- Sensory defensiveness
- Task avoidance
- Understanding of expectations

Students with ASD may present with a variety of sensory differences. Sensory differences are individual to each student. Supports should be tailored to their needs in order to maximize their integration with their peers. Examples of sensory differences might include:

Over-reactive sensory systems:

- Reluctant to touch things
- Reaches to parents for comfort
- Hypersensitivity to tactile and auditory input
- Displays abnormal reactions to normal sensory input. For example, putting hands over ears during periods of normal environmental sounds.

Under-reactive sensory systems:

- Not responding to name
- Child appears as though they are hearing impaired
- Does not respond to social stimuli
- Decreased receptive language and social reciprocity

Unusual Sensory Interests

- Rubbing of surfaces
- Staring at refracted light, such as a rainbow from a prism

Emotional Regulation

- Abnormal responses to the demands of their surroundings
- Does not seek caretaker comfort
- Responds with self-stimulating behaviors to soothe oneself

Difficulty transitioning from one situation to the next

Development of ritualistic patterns, such as needing to touch certain items in order

What you can do

Careful evaluation by an Occupational and Physical Therapist will help identify the right support for a child's specific motoric and sensory needs. Children with ASD often have difficulty processing everyday sensory information such as sounds, sights, textures, balance, tastes and smells (from the Autism Research Institute, www.autism.com).

Specific supports

- Increase use of visual supports
- Provide warnings or schedules so they can be prepared for check-ins.
- Decrease visual distractions
- Use ear plugs or headphones to decrease noise; create a quiet work station
- Use sensory breaks for students to apply deep pressure, engage in pleasurable tactile experiences (ex. Running hands through rice bucket)
- Consult a dietician or occupational therapist to learn about methods used with feeding children with sensitivities to food textures
- Avoid strong perfumes, cleaning products, or other strong scents
- With an Occupational Therapist, encourage practice of balance activities
- Consider using a sensory diet (strategies to help child cope with sensory challenges that are distributed throughout the day to prevent difficulties) to help add sensory supports during the day to help the child be most ready to learn.

4. Physical Activity, Trips, Events

What you need to know

Children with an ASD may have a hard time with change and transition. They may be challenged in situations where there are excessive stimuli.

What you can do

- Pre-plan the schedule. If unexpected changes are made, make sure to let the student know the reason. Provide support for the anxiety that might result.
 - Remind the student that changes in schedule may occur.
- Review itinerary often before upcoming trips
- Discuss expected behaviors of the student while at the event
- Use written schedules with pictures whenever possible

- Work with parents and team to anticipate any sensory effects of the new environment and make a plan for dealing with them.
- Consider any dietary restrictions
- Consider the seizure protocol if there is one.
 - Ensure seizure meds are available for the child if necessary.
- Acquire emergency contact information from parents

5. School Absences and Fatigue

What you need to know

Absences:

Children with an ASD should not have an abnormal amount of absences.

Fatigue:

- A child's sleep cycle may be affected. This could cause hyperactivity or drowsiness at school.
- Absences for doctor's appointments should be anticipated
- Fatigue not only affects children, but their caretakers as well.
- Insomnia may be present. Careful observation of sleep patterns and special attention to triggers of hyperactivity may provide helpful information in regulating sleep.

What you can do

- Provide a daily routine to promote regularity in awake and sleep cycles
- Consult a nutritionist in order to maximize nutritional intake to promote energy as well as inhibit it during inappropriate times.
- Contact parents/school nurse/educators if changes are noted
- Consult with the child's special education team at the start of the school year to set in place an agreement regarding excused absences.
- Encourage parents to carefully consider and schedule medical appointments around their child's education whenever possible.

6. Emergency Planning:

What you need to know

Emergencies are not predictable and can interrupt the schedule of a child with ASD. This disturbance in routine can often trigger confusion and unexpected behaviors.

Create a seizure plan or protocol if needed.

What you can do

- Create a plan of action should there be an emergency. Introduce the child to this plan ahead of time.
- Encourage the child to ask questions. Try to anticipate anything that might go differently during an emergency
- An emergency kit should include items that the child finds soothing/comforting.
- Make sure seizure drugs go with the child if applicable.

7. Resources

The Centers for Disease Control and Prevention

Offers an overview of Autism and provides screening and diagnostic information, research, scientific articles, and statistic information

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

National Center for Pyramid Model Innovations (NCPMI)

Provides supports for state systems and local programs to help improve the social-emotional outcomes of young children who are at risk for developmental delays and/or disabilities

<https://challengingbehavior.cbcs.usf.edu/>

The Center on the Emotional and Emotional Foundation for Early Learning (CSEFEL)

Promotes the social emotional development and school readiness for children birth to age 5

<http://csefel.vanderbilt.edu/>

The Center for Community Inclusion and Disabilities Studies

“Growing ideas, tip sheets and resources for guiding early childhood practices-social emotional development”

<http://ccids.umaine.edu/resources/ec-growingideas/social-emotional-development/>

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The Hanen Center

Provides knowledge and training geared to aid those working with children with or at risk for language delays and those with developmental challenges such as ASD

<http://www.hanen.org/Home.aspx>

The American Speech-Language- Hearing Association

Provides information of social skills, communication skills, and common behaviors in individuals with ASD, and explain how a Speech-language pathologist may be able to help a child with ASD

<http://www.asha.org/public/speech/disorders/Autism/>

A Guide to Moving with Children Who Have Autism

A thoughtful guide on how to help ease some of the stress of moving for children with autism.

<https://www.mymove.com/moving/kids-and-pets/moving-children-with-autism/>

Medline Plus

Consumer-friendly information about human genetics from the U.S. National Library of Medicine

<https://medlineplus.gov/genetics/condition/autism-spectrum-disorder/>

8. Meet Siblings with Autism Spectrum Disorder

GEMSS was interested in checking in with Logan and MJ and updating their story.

Catching up with Logan and MJ in 2020

Logan is now 15 years old and in the ninth grade. MJ is 11 and is in the fifth grade. The family moved four years ago from a rural NH town to a bigger city. They and Jenn (their mother) share a home with Jenn's parents and they provide support to one another. MJ is close with her grandmother and Logan is with his grandfather - they are good friends. Logan has developed a special relationship with his grandfather and they do activities together such as heavy lifting and projects around the house. Jenn has a support system available to her, such as that provided by their local area developmental services agency and her network of friends. Their home support provider is able to take MJ and Logan into the community and work on goals in places that are natural in their lives. They are there to help the children but to also let Jenn have some space and take a break for herself. Tyco, Logan's 8 year old service dog, is getting

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older and is still a good friend to Logan. They have found that both Tyco and Logan are not safe around some dogs that are not well-trained so they have to be careful in the community.

Logan update

Jenn describes Logan as a gentle giant and says he is an expert in silent sarcasm and can be very funny. Logan often prefers to be alone, so when the family moved, his mother did a lot of work preparing him for his new class. The culture of the elementary school turned out to be very welcoming. The children welcomed him into the school and at the end of the year, the class took a trip to Boston. Jenn and Logan's aide went along to chaperone but he didn't need help from either of them. "His classmates had his back" said Jenn. The children interacted with Logan and knew exactly what to do if he needed any help.

Jenn says that Logan has a few words and that he uses a speech generating device. He uses an iPad in school along with his classmates. Logan has a one-on-one aide in school and receives speech therapy and occupational therapy both inside and out of school. Logan's speech therapist helps him in school with his communication device. The occupational therapist helps with motor skills and is starting to help with job search. Outside of school, the speech therapist and OT work together on supporting his eating and sensory issues. Logan has a limited diet and likes smooth foods or foods that can be crunched up. Therapy also helps him strengthen his core muscles.

When Logan was younger, he had a habit of ripping up paper and eating it. It was later learned that this behavior was due to an iron deficiency.

Madison (MJ) Update

MJ is described as a diva by her mother. "It is her way or the highway. If you need anything from her you need to make sure she thinks that it is her idea," says Jenn. MJ is a very good negotiator. For example, she might negotiate how many times she has to go to school before earning a day off. MJ uses words more than her brother but is also a bit hard to understand. She is good at letting people know what she means. It is easier for familiar people to understand what either one is saying.

MJ has always liked dance. The first year of recital she ran out on stage and did a circle and ran backstage. The next year the dance teachers took it upon themselves to go to her school in order to learn more about MJ and to try to figure out different ways to support her so she could have more success in dancing.

Like her brother, MJ participates in both special ed and general ed classes. Anxiety can increase because of how noisy it can get in the classroom, so both children are able to have quiet time outside of class to get refocused and concentrate on their work. MJ spends time with her classmates and even a little bit outside of school. MJ also has OT and speech therapy. Her body is always looking for stimulation but she has become very good at self-regulation. MJ is generally active and when she can't be, she invents strategies to help regulate, like playing with her fingers.

Jenn's Advice in 2020

- The best advice Jenn would give to a **teacher** of ANY child is to *utilize peers*.
- When **teaching or supporting** children, use what they are interested in to help them learn. For example, use a movie that the children like in order to help with an assignment or therapy.

To **parents** of a child with a disability, the most important advice Jenn would give is to *trust your instincts*

Logan and MJ (2013)

Madison ("MJ") age 4 and Logan, age 8, are happy, communicative, and smart siblings who are enjoying their new dog Tyko, a trained service dog for Logan. They live in a rural town in northern New England and enjoy their family and friends and going to school. Their mother Jenn is actively involved in their school programs and is also involved in many advocacy roles in her state. The family recently made the trip to Michigan's *Paws for a Cause* to pick up Tyko with two cars and 4 adults to help and the two children, which was quite an undertaking to add this new family member!



Logan

Logan recently used his *Vantage Light Talker* (a speech-generating device) to ask his grandmother for pudding right before supper. She said 'no' as it would spoil his appetite, and he walked away. Soon, he returned with a message on his *Vantage Light Talker* that surprised them all – "I have an emergency. I need chocolate pudding now!" He got his pudding!



Logan might be found riding his Mobo Triton in his neighborhood with someone lending support. Although he has his service dog to help him navigate safely in the community, they are still working on how to bike with the dog without tangling him in the leash! Tyko recently accompanied the family to the Boston Aquarium, an adventure his mother feels wouldn't have happened without the dog's support. Tyko is proving to be a big help to the family during these community outings.

Logan was diagnosed with autism when he was 2 ½ years old but had been receiving Early Supports and Services since 18 months of age. Logan, who is a third grader, has a few good friends at school and received a marriage proposal on Valentine's Day. He is starting to say a few words and they feel the dog is helping him become more verbal. When picking up the dog in Michigan, Logan said "Fetch" very clearly for the first time.

At school, Jenn is hopeful that the team will have high expectations for him and will include him more fully. Although in a typical classroom, he is pulled out for some work on communication. He has had a 1:1 aide since starting preschool. His new aide will be able to program the Vantage Light and it will make communicating at school easier and more fluid and in-the-moment.

Both in school and at home, Logan has chores to do. At school, he does recycle and helps with the fruit and veggie program. When at home, he makes his bed, puts away silverware, and recycles with his grandfather.

Logan likes to use his trampoline or play on his inside swing. He is starting to play with Tyko and “he likes to do ribbon dancing, like in the Olympics,” says his mother, Jenn.

Logan has some sensory sensitivities, especially orally, and likes to have smooth foods. They are starting to notice that he has some OCD tendencies and they are working to see if these might be caused by a medical issue, such as seizures.

Madison (MJ)

MJ is a “take-charge” kind of girl who likes to think “she is the boss,” says Jenn. She is very verbal and, although easily understood by her mother, is working on speaking more clearly so others can understand her. “She learns so much from watching other children in their play,” says Jenn. She is fully included in her preschool, where picking up new skills is easier because of so many children who become MJ’s teachers simply by engaging in play that she watches. “She likes to tag along and copy the other children,” says Jenn.

Madison also loves their new dog and playing with children her size. She was diagnosed with autism when she was 18 months of age. Her language is coming along and she says many phrases such as “Sit down,” “Watch out,” and “Be careful.” After watching a pirate themed video, she responded to her mother’s request with a salute and “Aye-aye, Captain.”

At school, Madison gets OT and Speech therapy. She has some sensory issues and uses a weighted blanket at home. Jenn feels that she is pretty good at self-regulating.

Jenn’s Advice

Jenn hopes that both parents and teachers will feel that it is okay to ask questions and that it is a good idea to admit when you don’t know an answer. “It is okay to say, ‘I don’t get it’ and try to

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get an explanation that makes sense,” she says. She thinks parents should trust their instincts and work with teams so that everyone understands each other.

Jenn and the team communicate with daily written communication in a notebook that goes back and forth. They have face-to-face meetings once per month and Jenn also volunteers for school events and field trips.