Part 1

Autism & Evidence-Based Practices for Assessment

A Strengths Based Approach

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BEST BUDDIES

LOS ANGELES UNIFIED — READY FOR THE WORLD

A Message from the President

A Marathon...and a Sprint

By Dr. Jeannine Topalian, PsyD.

Jeannine Topalian

For nine months we have endured the challenges of the Covid-19 pandemic in our personal and professional lives. These challenges remind me of running. I used to be a short distance runner who never imagined she would be able to run long distance - specifically, a few marathons. After six months of training at 4am, five days a week, in March 2013 I ran my first marathon in Los Angeles.

The course for the marathon seemed easier than my hill training, until I encountered a phenomenon I had not accounted for – 90° heat in March. I had trained early in the morning when the air was comfortable, even rather chilly. I got a good, steady, start in the marathon, but at the seventh mile with the sun beating down on me doubt crept in. The crew I trained with was there for support and with their encouragement I made it to the 13th mile. It was there that I saw our best runner on the sidelines in pain – sitting it out. The fear that I also might not reach the finish line slowed me even more than the relentless heat.

I am a very positive person, but, just like everyone else, there have been times during the Covid-19 pandemic when life gets me down. Like trying to get organized

> *Sprinting the last 500 feet - after staggering the last 7 miles - seemed impossible... until it wasn't.*

and complete my to-do lists while yearning to go back to "normal." Of course, going back became an unrealistic expectation when cases surged and my school district paused the transition to in-person learning.

And yet, as the year 2020 is coming to an end and we see a light at the end of the tunnel, I am reminded that each of us has the power to make changes. The theme of School Psychology Week this year was Power of Possibility "which conveys hope, growth, resilience and renewal. Possibility suggests that even something as small as a seed can grow into something magnificent" (NASP, 2020). We have all grown and been resilient as we try to hold on to the old ordinary while accepting the new reality. Life in our new reality may not be normal, but we can still navigate our goals, our interests, and our positive growth into something magnificent.

One positive in this new reality that has helped me navigate is the good work we are doing at CASP to support our students, parents, and school communities. Our first virtual Convention was a success. Of course, we would have preferred to see everyone in person, but the stakes were too high. Thank you attendees and presenters for your support and flexibility as we transitioned to the virtual platform for professional development. I am also heartened by our successful advocacy work at the local and state level; we are participating in

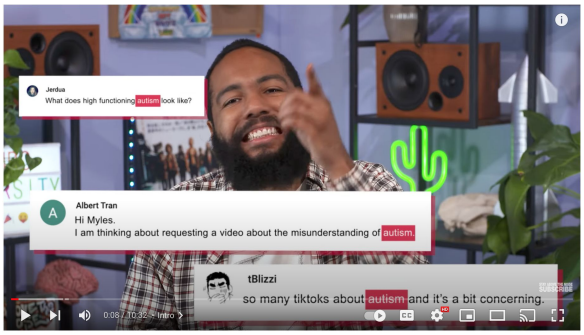
continued on page 11

Agenda

- ➔ Rationale/Prevalence
- ➔ Setting the stage for assessment
  - ◆ Logistics around ASD Assessment
- ➔ Evidence-Based Practice
  - ◆ Components of best practice ASD assessment
  - ◆ Assessment data interpretation
- ➔ Ethical Considerations
- ➔ Resources

*Part 2 - Autism & EBP's to Support Mental Health

Rationale



#autism

Is Autism A Disorder Or A Difference To Be Celebrated?

Person-first language

"I am a person with autism"

Identity-first language

"I am autistic"

7

A Note About Language

You will notice that the terminology used to describe students in this edition of *"You've Going to Love This Kid!"* has largely changed from person first (e.g., "a student with autism") to identity first (e.g., "an autistic student"). This change has been made to reflect the preferences of many autistic people who have shared that, although they understand that person-first language emerged to support and honor disabled people and combat stereotypes and one-dimensional views of autism (Brown, 2011; Dwyer, 2022), this way of speaking and writing can actually be harmful as it problematically separates autism from the individual (Botha et al., 2021; Brown, 2011; Okundaye, 2021; Sequenzia, 2016; Sinclair 1999).

To some, person-first language also communicates that autism is something negative that should be diminished or downplayed as in, "He has autism, but he is so much more than his autism." According to many advocates and self-advocates in the field of autism, this mindset is not only potentially hurtful, but also misleading. In fact, Jim Sinclair noted in his landmark 1999 essay on the topic that autism is so essential to his being that it cannot be understood as just one piece of him. Instead, he explains, autism is integrated into all that he is:

> Saying "person with autism" suggests that even if autism is part of the person, it isn't a very important part. Characteristics that are recognized as central to a person's identity are appropriately stated as adjectives, and may even be used as nouns to describe people: We talk about "male" and "female" people, and even about "men" and "women" and "boys" and "girls," not about "people with maleness" and "people with femaleness." . . . We describe important aspects of people's personalities in terms such as "generous" or "outgoing," [not as] "person with generosity" or "person with extroversion." [Autism] affects how we relate to others and how we find places in society. It even affects how we relate to our own bodies. If I did not have an autistic brain, the person that I am would not exist.

This view of autism and corresponding terminology change may be new to some, but it is not new. It has, however, gained a lot of traction in the last few years. In fact, in a survey of language conducted by the Organization for Autism Research (2020), more than 80% of the respondents (e.g., self-advocates, parents, professionals) indicated that they preferred identity-first language over person-first language.

Having shared all of that, it should be noted that autistic people are individuals. Therefore, their language preferences are not uniform. Some still do prefer the use of person-first language or other ways of describing their diagnosis, identity, or uniqueness (Bury et al, 2020; Dwyer, 2022). Therefore, you will see that although identity-first language is used frequently in these pages, you will also find some uses of person-first language. Some uses of the term "on the spectrum" instead of "autism" have also been included to further acknowledge these diverse preferences.

This book was created with the intention to listen to autistic voices and develop strategies around their recommendations. A shift in language, therefore, was a necessary and important update to this third edition.

8

autism in california

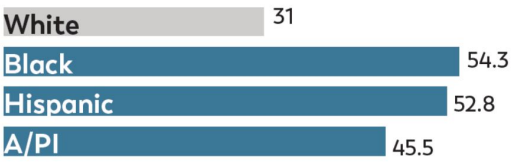
- What percent of students with disabilities in CA have autism? (enter your guess in the chat!)
  - **15.1%**
  - (Around **11%** nationwide)
- **149,925** students with autism in CA
- **Autism 3rd most common** disability category in CA schools
  - 2nd speech/language impairments
  - 1st specific learning disabilities

9

early diagnosis matters...

- Better outcomes in many areas including language, mental health, and social skills
- African American children have a later age of diagnosis

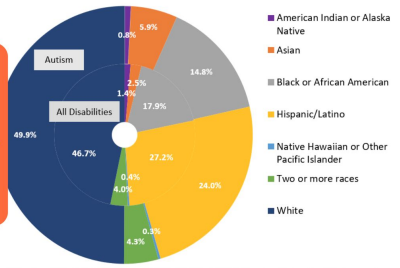
White 4-year-old children were less likely to be identified with ASD than other races and/or ethnicities.



Values indicate prevalence per 1000.

Percentage of Students with Disabilities, Ages 6 to 21, by Race and Ethnicity, Served Under IDEA, Part B, in the US, Outlying Areas, and Freely Associated States: SY 2018-19

In school year 2018-19, Black or African American and Hispanic /Latino students were less likely to be identified with autism and Asian students were more likely to be identified with autism when compared to all students with disabilities.



Source: U.S. Department of Education, EDFacts Data Warehouse (EDW): "IDEA Part B Child Count and Educational Environments Collection," 2018-19. https://go.usa.gov/xdp4T

Early diagnosis matters…

- ASD can be reliably diagnosed by age 2
- Current average age of eligibility is between 4-5 years
- ESDM, an evidence-based intervention, is designed to be delivered prior to age 5…

13

Training

14

Delivery matters…

- School psychologist for 19 years
- Sat in several IEP meetings where we deliver some hard news
- Had my original training in 2001 via NASP
- Neurodiversity perspective

15

Previous trainings

SACRAMENTO STATE

UC SANTA BARBARA
The Gevirtz School

MIND INSTITUTE

SAN JOAQUIN COUNTY OFFICE OF EDUCATION
Troy A. Brown, Ed.D., County Superintendent of Schools

Semel Institute for
Neuroscience and Human Behavior

TikTok

Quick poll

- For the specific training you received, please share:
  - What did this involve?
  - How long was it?
  - Who delivered it?
  - What was most helpful?

17

RESEARCH-BASED PRACTICE

Comprehensive Autism Evaluations: Research and Reality

By Zachary A. Bella

Volume 51 Issue 4, pp. 1, 15–17

Early detection of autism spectrum disorder (ASD) is an important event for children and their families or caregivers when considering positive developmental outcomes. A breadth of literature establishes positive associations between early detection of ASD and subsequent proximal and distal benefits for the child and family (see for example Anderson et al., 2014; Koegel et al., 2014). Early detection of ASD can occur in both health settings and educational settings in different but "parallel" processes (Esler et al., 2022). Early identification/detection of ASD allows for clinical intervention through mental health and behavioral health supports, as well as potentially providing individualized services/supports in the educational setting.

18

ASD trainings

- Varies widely state to state
- Many states do not mandate the use of standardized autism evaluation measures
- A **majority** of school psychologists reported **never** using either the ADOS or ADI-R

19

Logistics of ASD Assessment

20

Assessment
IDEA vs DSM-5

Table 2: Comparison of IDEA Definition of Autism and DSM-5 Diagnostic Criteria

IDEA Definition	Similarities with DSM-5	Differences from DSM-5
"Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects a child's educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. A child who manifests the characteristics of autism after age three could be identified as having autism if the aforementioned criteria are satisfied. Autism does not apply if a child's educational performance is adversely affected primarily because the child has an emotional disturbance, as defined in paragraph (c)(4) of IDEA."	• Both definitions include symptoms in the areas of social interactions, nonverbal communication, repetitive activities, stereotyped movements, resistance to change, and unusual sensory responses. • Both definitions indicate that symptoms need not be apparent before age 3.	• IDEA uses the classification of 'autism,' while DSM-5 uses the classification of 'autism spectrum disorder (ASD).' • DSM-5 presents more detailed behavioral descriptions for each symptom. • DSM-5 provides an algorithm for how many symptoms in each behavioral domain are required for a diagnosis. • IDEA provides more detailed description for stereotyped activities than for social impairments, suggesting an emphasis on the former. • IDEA specifies that the symptoms must adversely affect the child's educational performance, while DSM-5 requires impairment in social, occupational, or other important areas of functioning. • DSM-5 requires the specification of severity levels for the two behavioral domains. • DSM-5 uses "specifiers" to describe co-morbidities, such as language and intellectual impairment.

(Harker & Stone, 2014)

21

Purpose of the Assessment

- Assess in the area of suspected eligibility
- Identify students patterns of strength and challenges/weaknesses in communication, socialization, and cognition/learning.
- Identifying evidence-based interventions and supports

Challenges of Assessing Children with Autism

- Difficulty establishing rapport with examiner
- Lack of motivation to please examiner
- Limited flexibility and/or overly reliant on nonfunctional routines or rituals
- Difficulty understanding and following instructions and generating verbal responses due to language deficits
- Unique learning profiles
  - Stimulus overselectivity (such as attending to irrelevant stimuli, difficulty switching between tasks, and a desire to use materials in unique or unusual ways)
  - Attending to materials, and persisting in completing tasks
  - Inconsistent responding across items on a task
  - Inability to demonstrate skills that child can do at home (generalization problems)
- Interfering and challenging behaviors

FIGURE 2.1 Characteristics of Students with ASD That Affect the Evaluation Process

(Durocher, 2011)

Challenges of Assessing Children with Autism

Considerations for Assessment	
The student might have difficulties understanding directions or how to respond.	He could lack the communication skills to answer "yes" or "no."
A student with autism might lack motivation because she does not understand the importance of trying to do her best in a testing situation.	A student with autism might suffer from anxiety and will not function well in an unfamiliar situation with an unfamiliar adult.
Distractibility and disorganization are often associated with autism and can make performing on cue difficult.	The student's ability to respond and communicate can vary a great deal from one day to the next, making it difficult to get an accurate measure.
There can also be significant discrepancies from one skill to the next. A student with high functioning autism might appear to have a well-developed expressive vocabulary, while his receptive language skills are limited.	The testing situation is different from everyday life. How the student interacts in the classroom or at home may not be reflected in the assessment setting, where interactions take place in a one-on-one, organized format.
During an assessment, the student is given more time to process language than during typical everyday exchanges.	In the typical assessment, the clinician directs activities and communication. The ability to initiate communication (a common problem with autism) is often not evaluated.
An evaluation sometimes ignores critical nonverbal and pragmatic language skills.	

(VCU,2023)

Challenges of Assessing Children with Autism

- Autism exists in all racial, ethnic, and socioeconomic groups around the world and the core deficits are the same in all cultures.
- However, the symptoms/characteristics and developmental course may not be the same and are shaped by the cultural context in which the child lives (Barton, Harris, & Leech, 2016).
- Children who are higher functioning may present with better linguistic abilities, imagination and pretend play (mostly nonreciprocal and overly structured). However, their ability to understand and take someone else's perspective ,as they grow older, may be impacted.

(VCU,2023)

"Test The Limits" During the Assessment

1. Be flexible in the order of presentation of subtests and subtest items:
   - Administer subscales in a different order to maximize cooperation.
   - Begin with a task that you know the child likes (puzzles).
   - Intersperse easy and more difficult items (behavioral momentum).
   - Present tasks so that stressful language items are balanced by more enjoyable visual motor tasks.
   - Start at the beginning of a particular subscale (easiest item) rather than the age-suggested start point.
   - Repeat tasks the person enjoyed following some frustrating task, prior to a break.
2. Change the manner in which instructions are given:
   - Use a multiple-choice or fill-in-the-blank format rather than an open-ended style.
   - Paraphrase instructions and/or simplify language to match the child's language level.
   - Use phrases that are more familiar to the child (e.g., "match" vs. "find me another one just like this").
   - Use generic verbal prompts. For example, for a picture vocabulary task, we may ask: "What is this? This is a _____."
   - Use visual supports to aid in the comprehension of instructions.
3. Modify the response and presentation formats:
   - Allow untimed responses.
   - Allow different modes of responding, including nonverbal (pointing, gestures), etc.
   - Administer task with different materials, which may be more familiar, motivating, or interesting.
   - Administer items in naturalistic settings and/or on another day.
   - Use dynamic assessment/diagnostic teaching approaches (teach the task).

(Perry, Condillac, & Freeman ,2002)

Best Practice ASD Assessment

- **Formal Assessment Approach**
  - Standardized tests/norm-referenced
- **Informal Assessment Approach**
  - Non-standardized/curriculum-based measures/work sample analysis/portfolio assessment

Best Practice ASD Assessment

- Record review
- Developmental & medical history
- Medical screening &/or evaluation
- Parent/caregiver/student interview
- Direct child observation-structured/unstructured
- Parent/teacher/student ratings of social competence
- Cognitive/intellectual assessment
- Academic Assessment
- Communication & Language assessment
- Social, Emotional and Behavioral Assessment (Restricted & Repetitive Behavior)
- Adaptive Behavior Assessment
- Transition/Postsecondary Assessment

TABLE 3.1 MEASURES FOR ASSESSING THE CORE DOMAINS OF ASD

Measure	Format	Age Range	Time
Direct Observation			
ADOS-2	Direct Testing	12 months to adult	40 to 60 min
CARS-2	Observation	2 years to adult	5 to 10 min
Parent/Teacher Report			
ADI-R	Interview	2 years to adult	1.5 to 2.5 hrs
ASRS	Questionnaire	6 to 18 years	5 to 20 min
SCQ	Questionnaire	4 years to adult	10 to 15 min
SRS-2	Questionnaire	4 to 18 years	10 to 15 min
Academic Achievement			
KTEA-3	Direct Testing	4 years to adult	15 to 85 min
WIAT-III	Direct Testing	4 years to adult	45 to 104 min
WJ IV ACH	Direct Testing	2 years to adult	40 to 50 min
Cognitive/Intellectual			
DAS-II	Direct Testing	2.6 to 17 years	45 to 60 min
SB-5	Direct Testing	2 to 85 years	45 to 75 min
WISC-V	Direct Testing	6 to 16 years	48 to 65 min
Social Communication			
CASL	Direct Testing	3 to 21 years	30 to 45 min
CCC-2	Questionnaire	4 to 16 years	10 to 15 min
PLSI	Questionnaire	5 to 12 years	5 to 10 min
SLDT-E	Direct Testing	6 to 12 years	45 min
TOPL-2	Direct Testing	6 to 18 years	45 to 60 min
Restricted and Repetitive Behavior (RRB)			
RBS-R	Questionnaire	6 to 17 years	20 min
RBQ-2	Questionnaire	2 years to Adult	30 min
Adaptive Behavior			
ABAS-3	Questionnaire	Birth to Adult	15 to 20 min
DP-3	Interview	Birth to 12 years	20 to 40 min
VABS-II	Interview	Birth to 18 years	20 to 60 min

Assessment Procedures:
Record Review, HDQ, & Medical/Health Screening

- All students assessed for ASD should receive medical/health screening to identify any associated medical conditions.
- MANY co-occurring conditions associated with ASD:
  - Vision/hearing impairments,
  - Fragile X,
  - Tuberous Sclerosis,
  - Epilepsy/Seizures,
  - Other genetic disorders

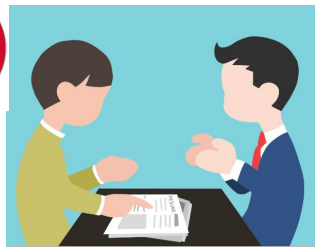
Assessment Procedures:
Record Review, HDQ, & Medical Screening

step 1

- What do you do if parents don't return the HDQ?
- What types of screenings are you familiar with?
- How does your school support staff collaborate on this step? (Nurse, speech therapist, OT?)

Assessment Procedures:
Record Review, HDQ, & Medical Screening

step 1



Record Review

- School
- Medical/Health /Developmental History
- Outside agency/provider reports

Interviews

- Parent *(Developmental /Medical History*)*
- Student *(see handouts for example)*
- Teacher and other school staff
- Behavior Support provider
- Schoolbased /outside and/or non-public agency/ mental health providers

Assessment Procedures:
Record Review, HDQ, & Medical Screening
(added this to previous slide so we can delete-thoughts?

- **Record Review**
  - School
  - Medical/Health /Developmental History
  - Outside agency/provider reports
- **Interviews**
  - Parent (*Developmental /Medical History**)
  - Student *(see handouts for example)*
  - Teacher and other school staff
  - Behavior Support provider
  - Schoolbased /outside agency mental health providers

HDQ- example

https://www.csus.edu/indiv/b/brocks/courses/eds%20243/Reader%20Material/Autism/Autism%20Diagnostic%20Evaluation%20Questionnaire.pdf

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

COLLEGE OF EDUCATION
DEPARTMENT OF SPECIAL EDUCATION, REHABILITATION AND SCHOOL PSYCHOLOGY

School Psychology Diagnostic Clinic
6000 J Street
Sacramento, California 95819-6079

AUTISM DIAGNOSTIC EVALUATION
HEALTH, FAMILY, DEVELOPMENTAL, & BEHAVIORAL HISTORY INTERVIEW FORM

Child's Name: _____ Birth date: _____
School: _____ Grade: _____
Parent(s): _____ E-mail: _____
Home phone: _____ Alt. Phone: _____
Languages spoken in the home: _____
Siblings and their ages: _____
Other adults living in the home: _____

Referring concern: _____

At what age did the referring concerns first emerge? _____

Health History (Perinatal Factors)

1. General obstetric status (circle one): Optimal Adequate Poor
2. Mothers age time of the pregnancy (list): _____
3. Length of pregnancy (circle/list): Full term Premature @ _____weeks
4. Was there threatened miscarriage (circle)? YES NO If YES describe below:
5. Maternal illnesses during the pregnancy (circle all that apply/list when illness occurred): Measles _____ Mumps _____ Rubella _____ Influenza _____ Syphilis _____ Herpes _____ HIV _____ Cytomegalovirus _____ Other (list): _____

34

Autism Diagnostic Interview-Revised (ADI-R)
A WPS TEST REPORT by Am Le Couteur, M.B.B.S., Catherine Lord, Ph.D., Michael Rutter, M.D., F.R.S.

www.wpspublish.com
Version 1.210

Diagnostic Algorithm
Subjects Aged 4 Years, 0 months or more

Name of Subject: Donal
Date of Birth: Not Entered
Chronological Age: 12 year(s) 0 month(s)
Name of Respondent: Not Entered
Clinician Name: Not Entered
School/Clinic: Not Entered

Subject ID: Sample
Date of Interview: 05/10/06
Gender: Male
Relation to Subject: Not Entered
Date Processed: 05/10/06

Subject is Verbal (Item 30 = 0)

A: Qualitative Abnormalities in Reciprocal Social Interaction
Codes are "Most Abnormal 4.05.0" for all items in A1 to A4 (except 51, 58, and 65).

		Code	Score
A1: Failure to use nonverbal behaviors to regulate social interaction			
Direct Gaze	(50)	2	2
Social Smiling	(51)	3	2
Range of Facial Expressions Used to Communicate	(57)	2	2
	Total A1		6
A2: Failure to develop peer relationships			
Imaginative Play With Peers	(49)	2	2
Interest in Children	(62)	2	2
Response to Approaches of Other Children	(63)	2	2
Group Play with Peers (score if 4.0 to 9.11 years)	(64)	2	
OR (score either 64 or 65, depending on age of subject)			2
Friendships (score if 10.0 years or older)			
"Most Abnormal 10.0 - 15.0"	(65)	2	
	Total A2		8
A3: Lack of shared enjoyment			
Showing and Directing Attention	(52)	3	2
Offering to Share	(53)	2	2
Seeking to Share Enjoyment With Others	(54)	2	2
	Total A3		6
A4: Lack of socioemotional reciprocity			
Use of Other's Body to Communicate (Score "Ever")	(31)	0	0
Offering Comfort	(55)	2	2
Quality of Social Overtures	(56)	2	2
Inappropriate Facial Expressions (Score "Ever")	(58)	2	2

35

TABLE 2.1 SCREENING MEASURES FOR AUTISM SPECTRUM DISORDER

Measure	Age Range	Format	Sensitivity	Specificity	Time to Complete
ASRS	6:0 - 18:0	Questionnaire	.94	.92	5-15 Minutes
ASSQ	6:0 - 17:0	Questionnaire	.91	.86	10 Minutes
SCQ	4:0 - Adult	Questionnaire	.96	.80	10 Minutes
SRS-2	4:0 - 18:0	Questionnaire	.92	.92	10-20 Minutes

Note. ASRS – Autism Spectrum Rating Scales; ASSQ – Autism Spectrum Screening Questionnaire; SCQ – Social Communication Questionnaire; SRS-2 – Social Responsiveness Scale, Second Edition (School-Age Form).

36

Assessment Procedures:
ASD Targeted Observations

Assessment Procedures:
ASD Targeted Observations

Observations in the natural setting (structured/ unstructured)

- **Facial expression** *(appropriate facial features for situation; eye contact/gaze (inconsistent or fleeting) to initiate , sustain, or guide social interactions)*
- **Gestures** *(differences in body posture- mechanical, awkward, body space, and gait);*
- **Voice/speech quality** (pitch, intonation, rate, volume; prosody);
- **Spoken language** *(non-verbal/verbal (mumbling, grunting, delays, sophisticated), repeating the same word for everything; stereotyped/repetitive/idiosyncratic language; talking about a specific topic incessantly/out of context; overly sophisticated use of words or expressions; repeating TV/movie/song lines; language directed towards others and for what purpose)*
- **Pragmatics** *(initiating, maintaining, and ending conversations; recognizing / responding to social cues; changing language according to the needs of the listener (classroom vs. playground); monologue vs conversation; understanding non-literal language; understanding humor; perspective taking; social or emotional reciprocity*)*

Assessment Procedures:
ASD Targeted Observations

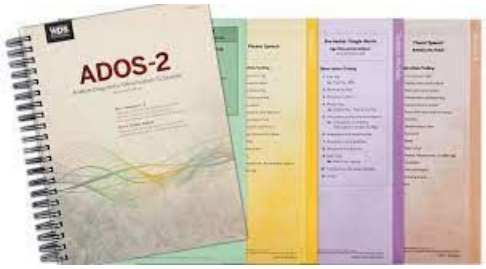
- **Social or emotional reciprocity** *(inferring the feelings of others, following social conventions; predicting how others feel or think; response to someone else's pain or distress; making sense of ambiguous social norms; understanding how their behavior impacts others)*
- **Friendships** *(watching, responding, initiating & maintaining interaction with others; showing/ bringing things to others to express interest; shared enjoyment in interactions; interest in other children; recognizing unfriendly acts);*
- **Play Skills** *(solitary/social play; reciprocal/joint interactive play; immature/appropriate play behaviors compared to same age peers; spontaneous pretend play with toys; perseverative play/conversation topics)*

Assessment Procedures:
ASD Targeted Observations

- **Restricted, Stereotyped movements and repetitive activities:** *(odd hand or body movements (hand flapping); tiptoe walking; playing with parts of an object (wheels of a toy car); intensely preoccupied / interested in a topic/object) wearing s specific clothing item for a specific day/activity; rigid ,specific sequence in routines; self-imposed rules; transition; unstructured time; response to changes in routine)*
- **Sensory response:** *(Reaction to sensory stimuli (mouthing, smelling, touching); rocking/ lunging; self-injurious behaviors (head-banging, hand biting, excessive self-rubbing)*

Direct & Indirect Observations

step 2



ADOS-2 Trainings can be costly & hard to find…

- Online
- CASP
- UC Davis MIND Institute LEND Program

Playground Observation of Peer Engagement

Int	State	Chi Initiations Gen = I, Peer R = +, Peer NR = -	Chi Responses App Res = + Miss opp = -	Comments (note affect, activity, atypical behavior, who the child engages with (aide, adult, peers) and anything of importance or interest)	
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
STATES		S = Solitary	O = Onlooker	PA = Parallel Aware	G = Games with Rules
		X = Proximity	P = Parallel Play	JE = Joint Engage	

Child Behavior Rating

Amount:

___ Initiated to another Child
___ Responded to another Child
___ Engaged in a Conversation (4+ exchanges) with another Child

Measurement Tools

- MIGDAS-2
  - Strengths-based
  - Views sensory, language, & social needs as 'differences' not deficits

wps
unlocking potential

MIGDAS-2
Examples of Sensory-Based Materials

The MIGDAS-2 interviews require the use of common sensory-based toys and materials (not included in the MIGDAS-2 Kit purchase). The use of these materials and suggestions for building a sensory-based materials kit are described in the MIGDAS-2 Manual. This document describes examples of sensory-based materials and offers suggestions for where to obtain such materials. The items described herein are examples only; it is not necessary to use these specific items as long as a range of materials with sensory properties (visual, tactile, movement, auditory) is provided during the interview. The suggested materials are recommended based on the consistent level of interest they generate in individuals with ASD in the sensory-based interview setting. Having multiples of the materials is recommended (e.g., two "thunder tubes," multiple spinning light-up toys, and several magnetic building materials), as this allows the evaluator to mirror the actions of the individual being evaluated as he or she explores the sensory properties of the materials. It also allows for a natural way to probe for differences in the individual's ability to shift from object-focused play to shared play and flexible exploration of materials.

Materials With Visual Movement Properties:
Examples of materials with visual movement properties include spinning light-up toys, water toys, wind-up toys (e.g., caterpillar, dinosaur, flipping ladybug, flipping frog), and transforming balls such as the Phlat Ball. To find examples of these items, use Internet search terms such as "LED Changing Pattern Spinner Wands," "handheld water games" (such as "TOMY Waterful"), "wind-up toys," and "Phlat Ball."

Materials With Tactile Properties:
Examples of materials with tactile properties include expanding spheres, GeoFlux, and assorted sensory stress balls, as well as magnetic building materials such as the X-Ball and Ball of Whacks. To find examples of these items, use Internet search terms such as "Hoberman Mini Sphere," "GeoFlux kinetic sculpture ring," "sensory stress balls," "Roger Von Oech's X-Ball," "Roger Von Oech's Star Ball," and "Roger Von Oech's Ball of Whacks."

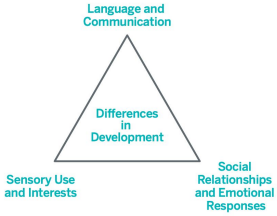
Materials With Auditory Properties:
Examples of materials with auditory properties include a "thunder tube" percussion instrument and cause-and-effect sound objects, such as a record talking button and sound effects machines. To find examples of these items, use Internet search terms such as "thunder tube percussion instrument," "record talking button," and "Sound Machine Cartoon Special Sound Effects."

Materials for Emotions and Social Probes:
Examples of materials that are useful when administering emotions and social probes include feelings cards, a magic wand, and a small compact mirror. To find examples of these items, use Internet search terms such as "feelings cards," "mini spiral glitter wand," and "compact folding mirror."

Materials for the Game of Catch:
Examples of materials that are useful for the game of catch include a Velcro ball and mitts, a ball that transforms from one configuration to another when thrown, and an expanding disc. To find examples of these items, use Internet search terms such as "Velcro ball and mitt," "Switch Pitch," and "Hoberman Flight Ring."

The Visual Framework for Autism Spectrum Disorder
The Descriptive Triangle

This framework helps you:
Understand the Autism Worldview
Take the Perspective of the Child
Describe Behavior Patterns Instead of Using Labels
Start with Strengths and Then Describe Differences
Link the Student's Autism Behavior Profile to Practical Interventions and Educational Supports



Marilyn J. Monteiro, Ph.D.
marilynmonteiro.com

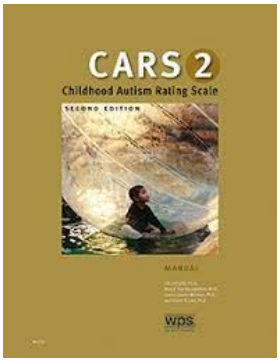
MIGDAS Example

Instead of saying student is nonverbal…

MIGDAS Example

In the area of **language and communication**, Student showed limited verbal fluency, however he showed a strong desire to communicate. **Strengths** for Student included his desire to request preferred items from his grandmother. For example, he would often ask for 'hot pockets' or 'McDonald's.' He was also able to repeat some phrases after his grandmother said them. During testing, Student's was able to look through a book and turn the pages. He was also able to label a fruit in my office (said apple when he saw some tangerines on the table). Student's used the most language when he was able to initiate or request as opposed to responding when I asked him questions. Student's made some noises while testing, but they were minimal and pretty quiet. He also had great eye contact during communication with his grandmother and when I talked to him.

- Language and communication differences for Student's included difficulty with responding to questions. He responded best to questions when I paired a verbal question with a visual or manipulative for him to respond with.

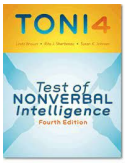


Indirect Observation Tools

Direct Testing

step 3

KBIT-2 REVISED

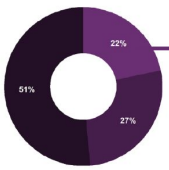


IQ data available for 87%

Of children identified with ASD by the CA-ADDM Project

IQ SCORE
- ≤ 70
- 71 - 85
- > 85

IQ = Intelligence Quotient
Intellectual disability = IQ ≤ 70



22% had Intellectual Disability

Assessment Procedures: Direct Testing

step 3

Please refer to your District guidance and procedures regarding which tools to utilize to assess for Cognitive/intellectual ability; psychological processing and language.

Assessment Procedures: Direct Testing

step 3

Reading Vulnerability Hypothesis

- The social communication impairments that characterize ASD overlap with the cognitive demands of Learning reading comprehension, writing and math.
- **If so, vulnerability to academic reading comprehension learning disability may part of the phenotype for many school aged children with ASD.**
  – Ricketts, 2011; Randi et al. 2010; Nation, 2006.

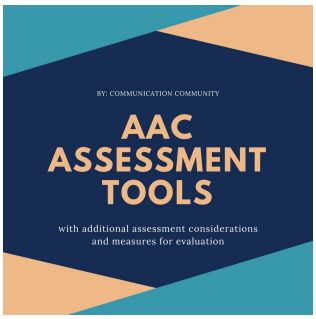
Assessment Procedures: Direct Testing

step 3

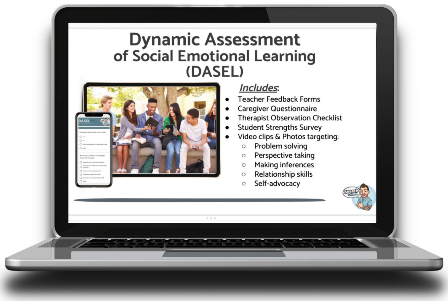
25 YRS! Social Thinking

Assessment Procedures: Direct Testing

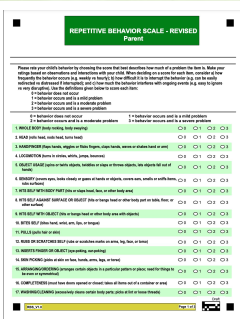
step 3

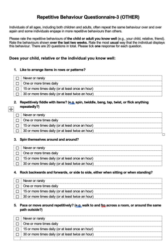


Introducing
The DASEL!

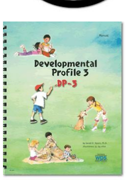


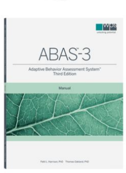
Assessment Procedures:
Direct Testing





Assessment Procedures:
Direct Testing





Assessment Procedures: Direct Testing-EF

step 3

Direct Testing: EF

step 3

Goals and Executive Functions

Diagnostic Centers

Direct Testing: EF

step 3

UNSTUCK AND ON TARGET

FREE *Unstuck* Elementary Educator Training

Do you want to learn about *Unstuck* or how to implement it with your students? We have created a training to help you do that!

To get started, create an account with the University of Maryland Baltimore's Institute for Innovation and Implementation. Decide whether you'd like to earn CEUs for this training and click the appropriate link below to create your account.

Yes, I'd love to earn CEUs!
No thanks, I don't need CEUs

Click below to view portions of the training.

Direct Testing

step 3

- Sensory Processing (OT)
- Motor Skills (PT)
- Behavioral/Emotional Problems (will be reviewed in second half of the day)
- Assistive Technology (AT)

Direct Testing: EF

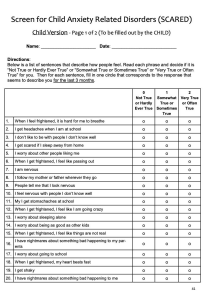
step 3

Goals and Executive Functions

Diagnostic Centers

Direct Testing

step 3



Screen for Child Anxiety Related Disorders (SCARED)

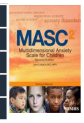
Child Version - Page 1 of 2 (To be filled out by the CHILD)

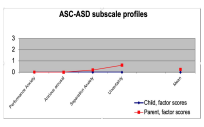
Name: _____ Date: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1.	When I feel frightened, it is hard for me to breathe	o	o	o
2.	I get headaches when I am at school	o	o	o
3.	I don't like to be with people I don't know well	o	o	o
4.	I get scared if I sleep away from home	o	o	o
5.	I worry about other people liking me	o	o	o
6.	When I get frightened, I feel like passing out	o	o	o
7.	I am nervous	o	o	o
8.	I follow my mother or father wherever they go	o	o	o
9.	People tell me that I look nervous	o	o	o
10.	I feel nervous with people I don't know well	o	o	o
11.	My I get stomachaches at school	o	o	o
12.	When I get frightened, I feel like I am going crazy	o	o	o
13.	I worry about sleeping alone	o	o	o
14.	I worry about being as good as other kids	o	o	o
15.	When I get frightened, I feel like things are not real	o	o	o
16.	I have nightmares about something bad happening to my parents	o	o	o
17.	I worry about going to school	o	o	o
18.	When I get frightened, my heart beats fast	o	o	o
19.	I get shaky	o	o	o
20.	I have nightmares about something bad happening to me	o	o	o

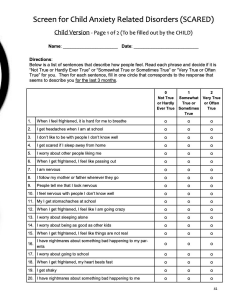
A Achenbach
S System of
E Empirically
B Based
A Assessment





Direct Testing

step 3



Screen for Child Anxiety Related Disorders (SCARED)

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5.	I worry about other people liking me	o	o	o
6.	When I get frightened, I feel like passing out	o	o	o
7.	I am nervous	o	o	o
8.	I follow my mother or father wherever they go	o	o	o
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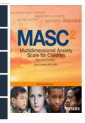
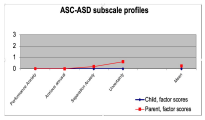
18.	When I get frightened, my heart beats fast	o	o	o
19.	I get shaky	o	o	o
20.	I have nightmares about something bad happening to me	o	o	o

41

A Achenbach
S System of
E Empirically
B Based
A Assessment





Direct Testing

step 3

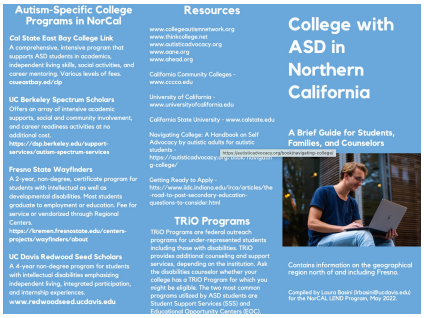
- Autism Comorbidity Interview - Present and Lifetime (ACI-PL)
- Anxiety Disorders Interview Schedule - Autism Spectrum Addendum (ADIS-ASA)
- Emotion Regulation and Social Skills Questionnaire (ERSSQ-P)

Direct Testing

step 3

- Children's Interview for Psychiatric Syndromes - Parent Version (P-ChIPS)
- Child and Adolescent Symptom Inventory - 5 (CASI-5)
- Spence Children's Anxiety Scale - Parent Version (SCAS-P)
- Glasgow Anxiety Scale for People with IDD (GAS-ID) *For adults but uses Pictorial Item responses so could be good for youth with ID.

Transition and Post-Secondary Assessment



Transition and Post-Secondary Assessment

- Transition Planning Inventory - 3rd edition (TPI-3)
- Self-Determination Inventory System (SDI)
- Casey Life Skills Toolkit
- Community Based Skills Assessment: Developing a Personalized Transition Plan Toolkit from Autism Speaks (CSA)

Strengths Inventories

- VIA Strengths Survey
- CoVitality Social Emotional Health Survey
- Thrively
- Thomas Armstrong Strengths Checklist
- Strengths-Based Collective site

We all have things that make some situations easier than others.

In our work together, we learned that your brain is built in a way that makes **strengths** come easily and **challenges** much more difficult.

It turns out - you're not alone! This pattern happens a lot, and we call it **Autism**

Now that we know, our job is to maximize your amazing superpowers and find ways to build those trickier skills so that the hard part gets easier.

Let's make a plan!

IM

INCLUSIVELY MINDED

This slide show was created by: Danielle Christy, Licensed Educational Psychologist # 3165 & with resources from © Dr. Liz Angoff, blog : www.BrainBuildingBook.com

73

Assessment Data Interpretation & Educational Considerations

74

Assessment Data Interpretation

Reminder....

- Identify students patterns of strength and challenges/weaknesses in communication, socialization, and cognition/learning.

75

Assessment Data Interpretation

Reason for referral: ***operationally*** define the student's challenges.

- Provide a mental picture for your audience.
- Behavior issues versus defining what the behavior looks like in the school/home setting.

Assessment Data Interpretation

Rate the quality of the following example (score 1: detailed, clear explanation; score 2: has some details, but requires more information;

Reason for Referral:
James was referred by his mother for concerns regarding Autistic-like behaviors. Parent reports James has an outside diagnosis of Autism and has had challenges in socializing since he was 2 years old.

Assessment Data Interpretation

How would you rate this reason for referral information?

- Above Average- very detailed and no need to ask clarifying questions.
- Average- detailed information, ask parent a couple of questions.
- Low Average- some detailed information, ask teacher a couple of questions.
- Below Average- lacking details, need to ask clarifying questions.

How would you rate this reason for referral information?

- Above Average- very detailed and no need to ask clarifying questions.
- Average- detailed information, ask parent a couple of questions.
- Low Average- some detailed information, ask teacher a couple of questions.
- Below Average- lacking details, need to ask clarifying questions.

79

Assessment Data Interpretation

- Ensure both ***anecdotal*** information and ***standardized*** assessment are **analyzed** and **synthesized** in each section of the report.
  - Provide examples from observation, interviews, outside reports, school records, tools/resources used, etc.
- If the scores do not support other evidence (e.g. observations, interviews), explain why that might be the case (e.g. limits in reliability or validity).

80

Assessment Data Interpretation

- If the scores do not support other evidence (e.g. observations, interviews), explain why that might be the case (e.g. limits in reliability or validity).
- Consider the impact of the student's behaviors on test performance. Explain if the test results are valid.

81

Assessment Data Interpretation

- Consider the impact of the student's primary/native language on test performance/ during observations. ***Explain if the test results are valid.***

82

Assessment Data Interpretation

- Follow up with raters when discrepancies exist between their individual observations/rating scales/interviews, and explain why that might be the case.
- Follow up with raters when discrepancies exist between raters (parent/caregiver/teacher) -observations/rating scales/interviews, and explain why that might be the case.

83

Assessment Data Interpretation

- Interventions and recommendations directly related to the student's needs.
- Recommend additional screenings/assessments from other related service providers.

84

Assessment Data Interpretation

Exclusionary Factors to consider....

Not primarily due to:

- • Environmental
- • Cultural or economic disadvantage
- • Limited English proficiency
- • Limited school experience
- • Poor attendance
- • Emotional disturbance
- • Intellectual disability
- • Visual, hearing or motor impairment

Reminder : Consider if the PRIMARY reason for the student's overall deficits are due to the exclusionary factors. If the deficits may/not be attributed as the PRIMARY reason, you need to analyze and synthesize the information in your report.

85

Educational Considerations

86

Guidance for IEP Teams to Consider

- Guidance for eligibility teams to consider when reviewing differential evaluation results for students who are referred for both Autism and ED/OHI (ADHD & other medical conditions) / ID /SLD eligibilities.
- The intent is to assist school IEP teams as they interpret eligibility evaluation results for that often present with overlapping criteria/co-existing conditions and to determine the most comprehensive eligibility.
- Importance to collaborate and consult with other related service providers and to conduct a thorough developmental history.
- This is guidance for team consideration only.

87

Differentiation between **Autism Spectrum Disorder** and **Specific Learning Disability**: Eligibility Consideration Guidance

- Different types of learning disorders exist, as opposed to autism's single disorder on a spectrum of severity and effects.
- Autism tends to affect the whole child (neurodevelopmental). Learning disabilities (cognitive disorder) can, too, but typically their impact is narrower, impacting the area of specific disability.
- Children with learning disabilities, their symptoms mostly (but not completely) affect their specific area of disability. On the other hand, children who have autism feel the effects of the disorder more globally and evenly rather than attached to an area of learning (educational performance which includes- academic, social, emotional, and behavioral challenges).

Differentiation between **Autism Spectrum Disorder** and **Specific Learning Disability**: Eligibility Consideration Guidance

- Children with autism are more at-risk for dyslexia, dyspraxia, and dysgraphia.
- Typically, children with Autism present with deficits in *executive functioning skills*
  - The relationship between executive dysfunction and behavioral symptoms in autism is of interest to many researchers (Shiri et al., 2020). Studies found a link between executive function and both social and non-social symptoms associated with ASD, but more research is needed to pinpoint the exact relationship (Van Eylen et al., 2015).

Differentiation between **Autism Spectrum Disorder** and **Other Health Impairment (ADHD)**: Eligibility Consideration Guidance

AU Eligibility	Shared/Differential	OHI (ADHD) Eligibility
Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects a child's educational performance. The characteristics of autism are generally evident before age three, but the child who manifests the characteristics after age three could be identified as having autism if the eligibility criteria are satisfied. Children with pervasive developmental disorders are included under the disability category of autism. Autism does not apply if the child's educational performance is adversely affected primarily because the child has an EMOTIONAL DISTURBANCE.	**Shared Characteristics** • Evident typically in childhood • Difficulties in social interactions (reacting appropriately to other's emotions/feelings) • Characteristics of inattention **Differential Characteristics** • Avoid eye contact ← Likely AU • Substantial difficulties primarily associated with hyperactivity/impulsivity → Likely ADHD • Repetitive language/behaviors (restricted, intense interests; rocking/flapping) ← Likely AU • Language/Communication disorder ← Likely AU • Unresponsive to social stimuli ← Likely AU • Impaired initiation/ response/maintenance of social interactions ← Likely AU	*OHI* means having limited strength, vitality, or alertness that adversely affects a child's educational performance. The term *health problems* includes: • Attention deficit disorder or attention deficit hyperactivity disorder The term *limited alertness* includes a heightened alertness to environmental stimuli that results in limited alertness with respect to the educational environment. SEE SPECIFIC CRITERIA FOR: INATTENTION HYPERACTIVITY/IMPULSITIVTY

Schanding, G.T. & Cheramie, G.M. (2020)

Differentiation between **Autism Spectrum Disorder** and **(OHI-medical conditions (Epilepsy) & ADHD):** Eligibility Consideration Guidance

- **Epilepsy**
  - More prevalent children with Autism.
  - Several studies suggest that epilepsy could be one cause of Autism (Besag, 2017).
  - Difficult to determine which one came first -epilepsy or Autism.
  - Both can present with:
    - Unusual tics and physical movements
    - Blank stares
    - Inattention or loss of focus
    - Unusual sensory experiences
- **ADHD**
  - Most common co-existing
  - Neurodevelopmental disorders
  - Both can present with:
    - Hyperactive, Impulsive , and inattentive behaviors
    - Challenges with self-regulation
    - Difficulty with social cues due to focus
    - Executive function difficulties
    - Passionate focus
    - Neurodivergent masking
    - Sensory differences
    - Stimming
    - Emotional maturity
    - Task-switching difficulties

Differentiation between **Autism Spectrum Disorder** and **Emotional Disturbance:** Eligibility Consideration Guidance

AU Eligibility	Shared/Differential	ED Eligibility
Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects a child's educational performance. The characteristics of autism are generally evident before age three, but the child who manifests the characteristics after age three could be identified as having autism if the eligibility criteria are satisfied. Children with pervasive developmental disorders are included under the disability category of autism. Autism does not apply if the child's educational performance is adversely affected primarily because the child has an EMOTIONAL DISTURBANCE.	**Shared Characteristics** • Inability to build or maintain satisfactory interpersonal relationships • Inappropriate types of behavior or feelings under normal circumstances **Differential Characteristics** • History/current communication disorder ← Likely AU • Depressive Characteristics → Likely ED (can be comorbid if AU primary) • Physical Symptoms (vomiting, sweaty hands, racing heartbeat) → Likely ED (can be comorbid if AU primary) • Hallucinations/delusions → Likely ED (to be comorbid, AU would have been diagnosed earlier, be primary, and hallucinations/delusions would not have been present in initial diagnosis)	*Emotional disturbance* means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects the child's educational performance: • An inability to learn that cannot be explained by intellectual, sensory, or health factors; • An inability to build or maintain satisfactory interpersonal relationships with peers and teachers; • Inappropriate types of behavior or feelings under normal circumstances; • A general pervasive mood of unhappiness or depression; or • A tendency to develop physical symptoms or fears associated with personal or school problems. Emotional disturbance does not apply to a child who is socially maladjusted, unless the child also meets the criteria for having an emotional disturbance. Emotional disturbance includes schizophrenia.

Schanding, G.T. & Cheramie, G.M. (2020)

Differentiation between **Autism Spectrum Disorder** and **Emotional Disturbance:** Eligibility Consideration Guidance

Autism vs. Anxiety Disorders

- **Social anxiety**
  - Presents differently in males than females.
  - Females are reported to be diagnosed with Social Anxiety Disorder than ASD.
  - Females are reported to struggle more socially than males.
  - People diagnosed with OCD were 4 x more likely to be diagnosed with Autism later in life .
  - Social Anxiety can exacerbate the symptoms of ASD and vice versa.
  - Challenge to differentiate between Social Anxiety and ASD.
- **OCD**
  - Rituals may resemble repetitive behaviors; however, the function is different (the function is to reduce the distressing thought/fear/anxiety), while for the child with Autism, it is more often tied to their sensory processing and is a method of self-soothing and not connected to a specific fear/obsession.

Autism vs. Schizophrenia

- Although autism has long been recognized as a separate diagnostic entity from schizophrenia, both disorders share clinical features.
- This prepsychotic developmental disorder includes deficits in communication, social relatedness, and motor development, similar to those seen in children with autism spectrum disorder.

Autism vs. PTSD

- Can Autism and PTSD co-exist?
- Are children with Autism more likely to develop PTSD in response to trauma than neurotypical children?
- What does brain based research suggest is the reason for PTSD in children with Autism?

Differentiation between **Autism Spectrum Disorder** and **Intellectual Disability (ID)**: Eligibility Consideration Guidance

AU Eligibility	Shared/Differential	ID Eligibility
Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects a child's educational performance. The characteristics of autism are generally evident before age three, but the child who manifests the characteristics after age three could be identified as having autism if the eligibility criteria are satisfied. Children with pervasive developmental disorders are included under the disability category of autism. Autism does not apply if the child's educational performance is adversely affected primarily because the child has an EMOTIONAL DISTURBANCE.	**Shared Characteristics** • Difficulties with communication/social communication • Difficulties with adaptive behaviors • Difficulties in social-emotional functioning • Difficulties in safety concerns **Differential Characteristics** • Marked deficits in cognitive impairment (overall IQ) → Likely ID or comorbid AU/ID • Higher cognitive functioning, with social communication deficits ← Likely AU • Intensity of Restricted, repetitive behaviors ← Likely AU or comorbid AU/ID	*Intellectual disability* means significantly sub-average general intellectual functioning that: Is reflected in an overall test score of cognitive ability that is at least two standard deviations below the mean, when taking into consideration the standard error of measurement of the test; Exists concurrently with deficits in adaptive behavior in at least two of the following areas: • Communication • Self-Care • Home living • Social and interpersonal skills • Use of community resources • Self-direction • Functional academic skills • Work • Leisure • Health, or • Safety Is manifested during the developmental period; and Adversely affects the child's educational performance.

Schanding, G.T. & Cheramie, G.M. (2020)

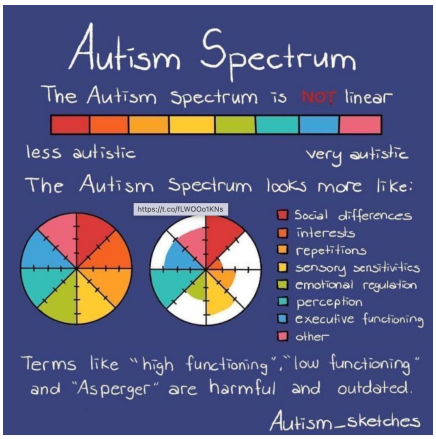
Differentiation between **Autism Spectrum Disorder** and **Intellectual Disability (ID)**: Eligibility Consideration Guidance

How to Conduct Meaningful Assessments for Students with Intellectual Disabilities

NATALIE CORONA, M.S.
SCHOOL PSYCHOLOGIST

Differentiation between **Autism Spectrum Disorder** and **Impact of COVID-19 Social Isolation**: Eligibility Consideration Guidance

- Preventative practices such as mask wearing, social distancing, and virtual meetings and classrooms may have negatively affected communication, learning and social skills in children.
- Limited / restricted social interaction due to social distancing/limited gatherings may have affected children from having meaningful, in-person interactions with peers and relatives, which is essential in language /social skills development.
- Social skills development in younger children may have been negatively impacted by mask wearing. Masks have taken away the ability for children to pick up on facial expressions and non-social cues that are imperative for the growth of pragmatic and social language development.
- Excessive screen time may have negatively impacted a child's language development. Reduced vocabulary, inability to functionally ask questions, and missed interactions with family members are just a few of the consequences of passive screen time on language development.
- English Language Learners may have faced significant obstacles in learning and improvising the English language with regard to the COVID-19 pandemic (Yerawardina, Asnur, Luhis, Hendriyani, Ramadhani, Dewi, & Darni, 2020). Significant impact in terms of language learning especially speaking skills.
- For elementary, middle, and high school students, Zoom fatigue has also led to a reduction in the amount of time most children are able to focus and pay attention.
- Behavior pattern (more frequent tantrums/increased irritability) may be result of the strange living conditions, or they may reflect stress, trauma and social isolation that many families have experienced.



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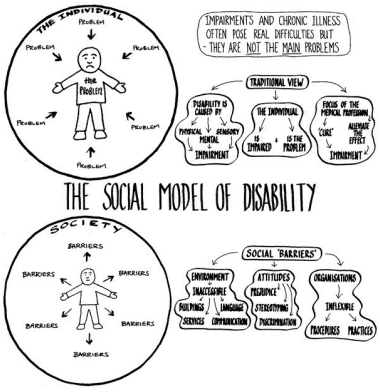
Ethical considerations

- Medical model vs. Social Model
- Culture and gender differences
- Profound Autism
- ABA therapy
- Neurodiversity, Autism & Healthcare

98

99



rates of ASD

Clinical Diagnosis of ASD	Educational Eligibility of ASD (IDEA)
1 in 36 (CDC; 2020)	1 in 91 (Barnard-Brak, 2019)
By gender: 43 per 1000 males 11 per 1000 females	By gender: 1 in 54 males 1 in 285 females

gender differences

SCIENTIFIC AMERICAN MIND

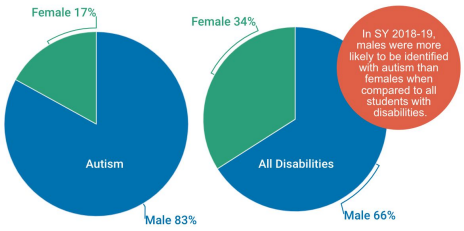
MENTAL HEALTH

Autism—It's Different in Girls

New research suggests the disorder often looks different in females, many of whom are being misdiagnosed and missing out on the support they need

By Maia Szalavitz on March 1, 2016 اعرض هذا بالقلة العربية

Percentage of Students with Disabilities, Ages 6 to 21, by Gender, Served Under IDEA, Part B, in the US, Outlying Areas, and Freely Associated States: SY 2018-19



Source: U.S. Department of Education, EDFacts Data Warehouse (EDW): "IDEA Part B Child Count and Educational Environments Collection," 2018-19. https://go.usa.gov/xdp4T

Though billions have been spent on autism research, there is still a significant lack of understanding and data on Black autistic women and girls. (GETTY IMAGES)

Race

How Black autistic women and girls are excluded from conversations on resources and research

Review > Autism. 2022 Nov;26(8):1931-1946. doi: 10.1177/13623613221113501. Epub 2022 Jul 28.

Autism presentation in female and Black populations: Examining the roles of identity, theory, and systemic inequalities

Maire Claire Diemer [1], Emily D Gerstein [1], April Regester [1]

Abstract

Although the prevalence of autism has been rising in recent years, disparities in diagnosis still remain. Female and Black populations in the United States are diagnosed later, are more likely to have an intellectual disability, and are excluded from research as well as services designed for autistic individuals. Autistic Black girls are effectively invisible in the current scientific literature. Intersectional theory, which looks at a person as a whole, examines models that are inclusive toward diverse gender, ability, and racial/ethnic backgrounds. This theory may be a useful approach to clinical and research work with autism so that practitioners may be most effective for the whole population of autistic people. The authors recommend research focusing on inclusion of autistic populations with intellectual disability and research studies that include evaluations as part of the procedure. Clinically, the authors recommend a focus on screening all young children for autism and improving provider knowledge in working with diverse autistic populations.

Camouflaging Autistic Traits Questionnaire (CAT-Q)

Instructions:

Please read each statement below and choose the answer that best fits your experiences during social interactions.

		Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Agree	Strongly Agree
1	When I am interacting with someone, I deliberately copy the body language or facial expressions...	1	2	3	4	5	6	7
2	I monitor my body language or facial expressions so that I appear relaxed.	1	2	3	4	5	6	7
3	I rarely feel the need to put on an act in order to get through a social situation.	7	6	5	4	3	2	1
4	I have developed a script to follow in social situations.	1	2	3	4	5	6	7
5	I will repeat phrases that I have heard others say in the exact same way that I first heard them.	1	2	3	4	5	6	7
6	I adjust my body language or facial expressions so that I appear interested by the person I am interacting with.	1	2	3	4	5	6	7
7	In social situations, I feel like I'm 'performing' rather than being	1	2	3	4	5	6	7
8	In my own social interactions, I use behaviours that I have learned from watching other people interacting.	1	2	3	4	5	6	7
9	I always think about the impression I make on other people.	1	2	3	4	5	6	7
10	I need the support of other people in order to socialise.	1	2	3	4	5	6	7
11	I practise my facial expressions and body language to make sure they look natural	1	2	3	4	5	6	7
12	I don't feel the need to make eye contact with other people if I don't want to.	7	6	5	4	3	2	1
13	I have to force myself to interact with people when I am in social situations.	1	2	3	4	5	6	7
14	I have tried to improve my understanding of social skills by watching other people.	1	2	3	4	5	6	7
15	I monitor my body language or facial expressions so that I appear interested by the person I am interacting with.	1	2	3	4	5	6	7
16	When in social situations, I try to find ways to avoid interacting with others.	1	2	3	4	5	6	7

Page 1 of 2

gender differences

What is masking?

Masking is when an autistic person has learned to consciously or subconsciously hide or suppress some of their behaviours to 'fit in' with non-autistic people's expectations.[31] Although all autistic people might mask, masking is common particularly in women and girls.[27]
It can be exhausting for autistic people and may be associated with:

- low self-esteem
- increased emotional overload
- anxiety
- meltdowns.[32]

Many autistic people told us that they want therapists to be aware of masking. Many feel their therapists might judge them for being autistic.

This can lead someone to:

- answer questions with what they think a therapist expects of them
- suppress stimming/self-stimulating behaviour such as rocking and hand-flapping so they appear more 'normal'.

Masking can be exhausting and can give an unrealistic picture of how significant someone's mental health difficulties are, as well as make their needs less clear.

Be aware that the person you are working with may be masking. After building a rapport with them, discuss masking and ask whether they feel they are doing this in sessions. This will give you a clearer picture of their needs and the work you will do together. Displaying a good understanding of autism and offering reassurance will help your autistic client.

Key considerations:

- Do you know what masking is and why an autistic person might mask?
- Have you discussed masking with the person you are working with?
- Have you considered how autistic characteristics might be masked both inside and outside of the therapy room and the impact this can have on the person's life?

"Lots of people are undiagnosed, everyone who is autistic is different. If you want to, you can hide that you are autistic. For some people, it is very hidden or very subtle so therapists need to take time to understand us."

Autistic adult

profound autism?

THE LANCET COMMISSIONS | VOLUME 399, ISSUE 10321, P271-334, JANUARY 15, 2022

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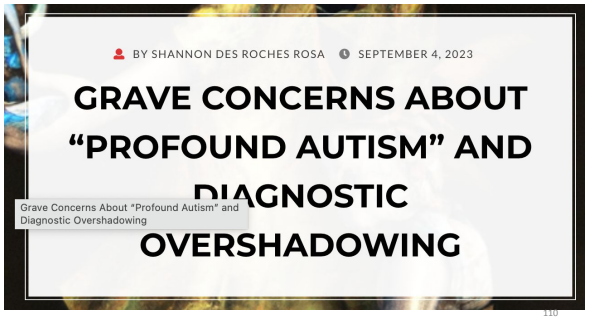
The *Lancet* Commission on the future of care and clinical research in autism

Prof Catherine Lord, PhD • Prof Tony Charman, PhD • Alexandra Havdahl, PhD • Prof Paul Carbone, MD • Prof Evdokia Anagnostou, MD • Prof Brian Boyd, PhD • et al. Show all authors • Show footnotes

Published: December 06, 2021 • DOI: https://doi.org/10.1016/S0140-6736(21)01541-5 • Check for updates

profound autism?



ABA Therapy?

Guidelines for a More Neurodiversity-Affirming Practice for Autism

By: Rebecca Rosenzweig | Autistic Self-Advocate | Barry M. Prizant, PhD, CCC-SLP | Brown University

April 1st, 2022

ABA, actually autistic, anxiety, communication, dysregulation, echolalia, eye contact, language, neurodiversity, research, sensory-processing differences, Spring 2022 Issue, stimming, training

5825 0

This article came out of discussions between the authors about guidelines for a more neurodiversity-affirming practice for autism. The training that is discussed in this article was developed by the first author (Rebecca Rosenzweig).

ASAN
AUTISTIC SELF ADVOCACY NETWORK

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For Whose Benefit?: Evidence, Ethics, and Effectiveness of Autism Interventions

For Whose Benefit?: Evidence, Ethics, and Effectiveness of Autism Interventions

There are many therapies for autism, along with a significant amount of funding for research, development, and implementation of these therapies. However, it often remains unclear whether these therapies actually help autistic people. Autistic people rarely have a voice in creating and shaping these therapies, and there is very little ethical guidance for people who practice autism therapies that accounts for the needs, experiences, and perspectives of autistic people. Autistic people should have the ultimate say in what autism services focus on. ASAN's white paper, "For Whose Benefit?: Evidence, Ethics, and Effectiveness of Autism Interventions," aims to help close this gap.

resources

CASP Publications

CASP TODAY
California Association of School Psychologists

>

Autism Acceptance Month

By **Danielle Christy, LEP #3165,** CASP Communications Co-Chair and **Mary Humphreys, M.A.**

April is Autism Awareness Month and as school psychologists, we know this population of students has been steadily increasing in our schools for many years. Nearly 15% of students with disabilities in California have Autism and it is the third most common eligibility category. As such, we wanted to include a short article with evidence-based practice updates, data about co-occurring mental health conditions, information about the growing neurodiversity movement, and resources for all of our CASP members to access.

EBP Updates: Currently, if you 'google' the word, "autism," you get approximately 696 million results! Many of us remember the days of misinformation about vaccines and battles over how many applied behavior analysis (ABA) hours children should get for early intervention. Fortunately, over the years, a few key organizations created a database of evidence-based practices. The *National Clearinghouse*

continued on page 9

CASP Publications

CASP TODAY

California Association of School Psychologists

School Psychologists are Seeing More Autism Referrals Lately: What exactly is Going On?

By **Christina Saad, Ed.S.,** NCSP
School Psychologist for Westlake Charter School Natomas (Sacramento), California

In the post-pandemic era, many school psychologists across the state have seen a rise in the number of Autism referrals for special education assessments. This is not a coincidence or even an issue specific to the state of California. In fact, worldwide, there seems to be an increase in the prevalence of Autism Spectrum Disorder (ASD) diagnosis (Chiarotti & Venerosi, 2020, p. 2). In 2020, The U.S. Department of Education reported a rise in Autism identification for Special Education services, doubling from 2008 to 2018 (Heasley, 2020). Even prior to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) update in 2013, clinicians had seen a steady rise in Autism diagnoses since the early 2000s (Zeldovich, 2018).

As school psychologists, we have seen this on the front

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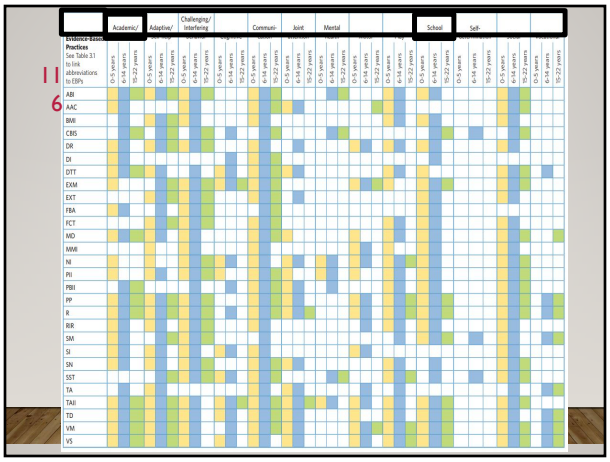

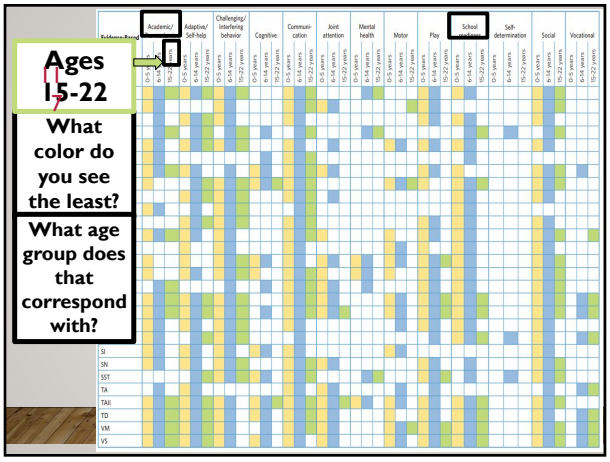

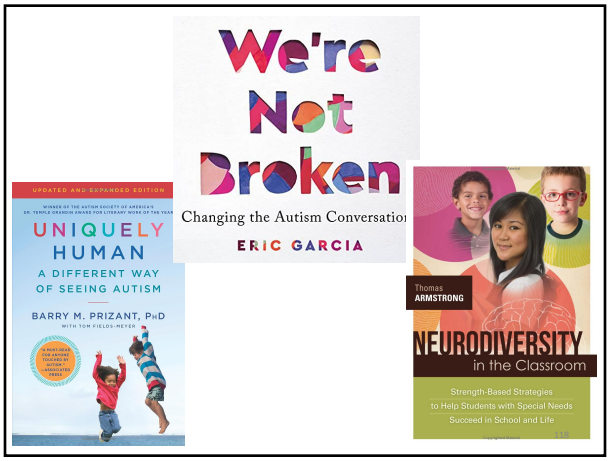

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