Autism Interventions and Strategies in the Classroom

A Paper

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Abstract

Today one out of 110 children have an autism spectrum disorder. There are five different diagnoses under the Autism heading in the DSM IV-TR. All of the diagnoses require early intervention treatment programs to ensure the child is successful throughout their life. There are several successful research based treatments, picking a treatment for a child should be a combination of the child’s medical staff and family members. The increased number of children being diagnoses on the autism spectrum has affected the general education classroom. With the raise of the ASD diagnosis educators and administrators are in need of ASD specific strategies, techniques, and interventions. Children with ASD typically struggle with sensory abnormalities, motor planning delays, and may lack theory of mind and perspective taking skills. Typical consequences in a school don’t apply to children with ASD. Educators need strategies that they understand and feel comfortable with and ones that the child with ASD will respond to in multiple high stress situations. This review investigates why children with ASD struggle in a general education classroom and what effective techniques and strategies educators can do to prevent meltdowns and encourage success of their student.
Diagnosing Autism

Autism is on the rise: today one out of 110 children have an autism spectrum disorder. This number has changed even within the last ten years. In 2001, one out of 166 children had an autism spectrum disorder. With this growing number came a rise in research, data collection, theories, and findings on autism. Just in the last ten years researchers have found more about autism and the spectrum many individuals fall on. Still not much is known about this disorder including the direct cause of autism. Many theories have circulated on what causes autism these theories range of mercury in vaccines, lack of vitamin D, and autoimmune diseases, and the old refrigerator mother theory strongly believed and accepted for decades. According to St. David’s Child and Family Development center and clinic, approximately 10% of current incidences are now believed to be genetically-based due to abnormalities in chromosomes (Internship Manuel St. David’s Center for Child and Family Development 2009). From this intense research multiple treatments have developed, all claiming that they are the best method to treat autism. This can be confusing for parents and an added stress to their already stressful lives. This review will define what autism is, what most common research based treatments are currently on the market, how sensory abnormalities affect children with autism, and strategies and interventions for classroom teachers and treatment room practitioners.

People don’t know what autism is, in spite of the plentiful research data that is available or the differences on the autism spectrum. Autism is a social and communication disorder. According to the DSM-IV-TR the diagnostic criteria for Autistic Disorder includes three areas; qualitative impairment in social interactions, this includes impairment in eye to eye gaze, facial expression, body postures and gestures to regulate social interaction, lack of spontaneous shared enjoyment, interest or achievements, lack of social reciprocity. The second area is qualitative
impairments in communication, which includes delay or total lack of spoken language, having adequate speech with impairment in ability to initiate or sustain conversation, and a lack of spontaneous make believe or social imitative play. The third area includes restricted/stereotyped patterns of behavior. This area includes a preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus, inflexible adherence to specific, nonfunctional routines or rituals, stereotyped and repetitive motor mannerisms, and persistent preoccupation with parts of objects.

**Different Types of Autism and Related Disorders**

Autism is a spectrum disorder involving different ranges of severity and symptoms of autism. The types of autism include Autistic Disorder, Autism Spectrum Disorder (ASD) Pervasive Developmental Disorder (PDD-NOS) and Asperger’s syndrome. Other rarely diagnosed developmental disorders under the Autism heading include Rhett’s Syndrome and Childhood Disintegrative Disorder (CDD). All of these are liable to change in the next few years with the new publication of the DSM. According to the DSM- IV-TR, ASD occurs because the individual can have a variety of symptoms under each three areas and the severity of the symptoms will vary depending on the individual.

Pervasive Developmental Disorder- Not Otherwise Specified (PDD-NOS) according to the DSM-IV-TR is characterized by severe and pervasive impairment in several areas of development which includes reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interest, and activities. In order to be diagnosed with PDD-NOS symptoms do not exactly fit into the diagnostic criteria of Autistic Disorder and the onset will be after the age of three.
Asperger’s Syndrome is a form of ASD that is often identified later meaning after age three and is associated with the social symptoms of autism and some repetitive interest or behaviors. However individuals with Asperger’s syndrome do not have language delays or mental retardation (Lord, 2007).

Rhett’s syndrome differs from Autistic disorder in a few ways. According to the DSM-IV-TR, Rett’s disorder has only been diagnosed in females while Autistic disorder is more common in males. The symptoms become apparent later in the child’s life commonly between the ages of one and two but as early as five months and as late as five years. The symptoms include loss of purposeful hand skills and motor skills along with a loss of social engagement. Rett’s is often accompanied with Severe or Profound Mental Retardation.

Childhood Disintegrative Disorder (CDD) is defined in the DSM-IV-TR as a significant loss of acquired skills before the age of ten in two of the following areas 1) expressive or receptive language 2) social skills or adaptive behavior 3) bowel or bladder control 4) play 5) motor skills along with abnormal functioning in social interaction, communication, and restricted, repetitive, or stereotyped behavior. CDD has many similar symptoms but the onset of CDD is later in a child’s life compared to ASD were the symptoms are present in infancy.

This paper focuses on the ASD population including Asperger’s not including Autistic Disorder, Rhett’s Syndrome, or CDD. ASD it is the most prevalent and the most research in the last five years has been based on ASD and Asperger’s syndrome. For the remainder of this paper the acronym ASD will included Asperger’s syndrome as most clinics and centers include Asperger’s in the ASD heading.
Treatments for ASD

There are many treatments for ASD ranging in diets and holistic approaches to strict research based models. This paper focuses on four treatments currently on the market and widely available to parents. These four are all research based and have been implemented all over the country. The treatments include Applied Behavior Analysis (ABA), Floortime (DIR), TEACCH, SCERTS, and additional supports including Occupational Therapy, Speech Therapy, sensory diets, and food diets.

Applied Behavior Analysis (ABA) is an intensive behavioral therapy. Behavior analysis was originally described by B.F. Skinner in the 1930’s but it was Ivar Lovaas in the 1987 that developed ABA a type of behavior therapy for the treatment of childhood autism (Hillman, 2006). ABA therapy consists of all skills being broke down into small steps and learners are provided with many repeated opportunities to learn and practice skills in a variety of settings. The skills are done repetitively and positively reinforced, usually with food (Hillman, 2006). ABA is conducted in a highly controlled environment and done with the supervision or planning of a BSC. ABA therapy is customized for each individual and is performed by a board-certified behavior analyst (BSC) the BSC typically trains and supervises other individuals including therapeutic support staff to conduct the majority of treatment (Hillman, 2006). ABA therapy is the most widely used treatment for ASD and currently has the most research supporting its use. The Division 33 of the American Psychological Association (1989), the American Academy of Pediatrics (2001), and the New York State Department of Health Early Intervention Program (1999) have all recommended intensive behavior therapy such as ABA as a primary, evidenced-based treatment for autism. The Surgeon General’s Office of the United States has called for 30-
40 hr a week in a number for multiple states and many have identified ABA as a basic entitlement for children with autism (Hillman, 2006).

Despite the volume of ABA research and positive results, some limitations I discovered with ABA include the lack of a connection with the child and little if any parent and family support. ABA can also be financially expensive if a family following the Surgeon General’s guidelines of having 30-40 hrs a week of ABA 1:1 therapy with a certified BSC could run a family $40,000 a year.

Floortime is a specific therapeutic technique based on Developmental Individual Difference Relationship Model (DIR). Floortime was developed by Dr. Stanley Greenspan in the 1980’s (Mclntosh, 1999). The Floortime model emphasizes emotional development through intensive one-on-one engagement (Stacey, 2003). The goal of this therapy is to assist a child to reach six developmental milestones that contribute to their growth. These include self-regulation, intimacy, two-way communication, complex communication, emotional ideas, and emotional thinking. In Floortime the parent or therapist engages the child at the level the child is currently at and moves the child towards increasingly complex interactions, a process known as “circles of communication” (Mclntosh, 1999, p. 29). DIR uses community resources such as speech, occupational therapy, counselors, parental support groups, and special needs classes. DIR focus is for emotional development and the desired outcome is for flexibility, emotional range, creativity and richness of the child’s inner life (Mclntosh, 1999).

Developed in 1971 by Eric Schopler at the University of North Carolina, and the Young Autism Project is Treatment and Education of Autistic and Communication Handicapped Children (TEACCH). TEACCH emphasizes a structured environment using a one-on-one teaching that provides visual cues on how to complete tasks (Mclntosh, 1999). Children work in
a highly structured environmental setting where the physical organization of a room is of high importance. This includes the organization of the furniture, clearly delineated activity areas, picture based schedules and work systems. TEACCH encourages children to be more independent by teaching them new skills rather than using already mastered skills to encourage more learning. Positives related to the TEACCH model includes designing an environment for the child, appreciating autistic culture, having specialized trained special education teachers and trained psychologist providing care, and emphasizing the strengths of the child. Some downfalls to the TEACCH program include geography. The TEACCH center is located in North Carolina and finding a trained individual may be difficult in one’s area, even though the TEACCH model is used throughout the country. The economic cost for a family wanting individual services in-home can be expensive to hire one’s own TEACCH psychologist.

SCERTS is an educational model for children with ASD and their families SC= Social Communication, ER= Emotional Regulation, TS= Transactional Support (Prizant, Wetherby, Rubin, Laurent, 2003, p.296). Social communication includes the development of spontaneous, functional communication, emotional expression, and development of secure and trusting relationships. Emotional regulation includes developing the ability to have a well-regulated emotional state. Transactional support are the supports developed to help parents respond to the child’s needs and interests, and provide tools to assist child’s learning along with providing emotional support to families and teamwork among professionals. “The SCERTS model is derived from over two decades of empirical and clinical work…” (Prizant & Wetherby, 2003, p. 298). SCERTS provides a comprehensive framework, evolves a multidisciplinary team including speech therapy and occupational therapy along with clinical psychologist, family therapist, and special education teachers. This multidisciplinary approach enhances
communication and socioemotional abilities. The SCERTS model is child centered, activity based, developmentally grounded, family centered, and relationship based model (Prizant & Wetherby, 2003).

A positive difference the SCERTS model has is the inclusion of family therapy. This model includes supporting the family by educating, providing tools and strategies, and by support them emotionally to ensure the families overall well being. A down fall of the SCERTS model is that it has to be center based through a certified school, clinic, or center. A family can not hire a SCERTS expert to come in-home. In order for this model to work the child has to be enrolled in a program to ensure proper outcome.

Additional Supports

In 2001 the National Research Council concluded that a number of approaches have demonstrated positive outcomes, meaning combining certain treatments can create the best outcome for a child. Remember not all children benefit from any one approach (Prizant & Wetherby, 2003). This combining of treatments can include services like speech therapy, occupational therapy, Gluten – Casein free diets, sensory diets, and other sensory integration therapies. According to the DSM-IV-TR in order for a child to be diagnosed with ASD they must have communication impairments. These impairments include development of spoken language, adequate speech, impairments with ability to sustain conversation, and repetitive use of language. All of which a speech pathologist can work on with a child. Children with ASD often have difficulties with fine motor skills. Occupational therapy address coping skills, fine motor skills, play skills, self help skills, among others to increase awareness in the body and lead to a production life. Additional things to incorporate in the treatment of ASD could be a diet free in gluten and casein which has helped regulate bowel habits, sleep activity, and other behaviors. As
well as a sensory diet which includes the integration of touch, hearing, sight, taste/smell, and body awareness. A sensory diet can include therapeutic listening, deep pressure and heavy activities, food science, and proprioceptive techniques.

**How Autism Affects Children in the Classroom**

Individuals with Autism Spectrum Disorders are impacted in all areas of their lives including “... deficits in language, social behavior, and intellectual abilities as well as the development of repetitive behaviors that can greatly restrict access to the community and quality of life” (Leaf, Taubamn, McEachin, Tsuji, 2011, p. 259). According to the All Handicapped Children Act of 1975 a feudal law passed for the first time to ensure that all children who were handicapped had a right to a proper education, which is now know as the Individuals with Disabilities Education Act (IDEA, 2004) all children with autism have the right to not only to an education but availability to general education curriculum (Moores-Abodool, 2010).

Some of the common characteristics of ASD significantly impact learning and behavior…Persons with ASD frequently experience underlying communication problems, sensory issues, limitations of attention, skills defects, modulation and regulatory challenges and motor planning difficulties that can interfere with learning and may be manifested as unacceptable behavior. (Wheeler, 2002, p.1)

For the reasons just listed having a child with autism in a general education classroom can be distracting, difficult, and frustrating. It is typical for the student with autism to blurt more often in class, talk loudly, have uncontrollable sensory outburst, ask questions repeatedly, have a lack of social understanding, and social awareness. A common reason why children with autism seem distracting in multiple settings is due to their sensory processing and motor planning. “Over 90% of children with autism had sensory abnormalities...” (Leekam, 2006, p. 896) According to
Baranek’s study on *Efficacy of Sensory and Motor Interventions for Children with Autism* (2002) “…highly functioning children with autism spectrum disorders, ages 5 to 19 years, had intact movement execution but atypical movement preparation” (p. 399). Poor motor planning is usually mistaken for clumsiness or laziness when in reality the child cannot control their body. The lack of motor skills in a developing child can create difficulties for the child’s future according to Baranek (2002) “…during early foundational years, motor skills provide a means for learning important skills in other domains…including social skills and academics” (p.398). Therefore motor related difficulties need to be addressed early in an educational or therapy setting.

**Sensory Processing and Motor Planning**

Areas affected by sensory processing abnormalities and motor planning include visual spatial skills, the vestibular system (movement), oral, olfactory (smell), proximal, and auditory.

Examples of sensory items from Leekam’s (2006) *Sensory Profile* used as an indicator of hyporesponsiveness and hyperresponsiveness for a sensory disorder include the following.

- **Auditory:** distressed by sounds that do not affect others, unusual fascination with certain sounds, unusually acute hearing. Their responds may include covering their ears
- **Visual:** unusual interest in bright lights, shiny objects, twists, flicks, or spins objects near eye
- **Proximal:** unusual interest in certain surfaces, scratches surfaces, negative reaction to touch...
- **Smell/taste:** unusual tendency to smells objects and people, small range of food...
- **Oral:** tends to put everything in mouth, refuses to eat certain textures of food...
- **Kinesthetic:** enjoys spinning, seeks continues movement...
- **Other:** plays with saliva, urinates, smears feces, self-injures, repeated tearing of objects, over breathing (p. 897)
Some of the areas affected by poor motor planning according to Baranek (2002) include low muscle tone, oral-motor functioning and repetitive motor movements, for example the flapping of one’s arms.

One of the reasons why students with autism can be distracting in class is their Hyporesponsiveness or their Hyperresponsiveness to sensory stimuli.

“Hyporesponsiveness is characterized by an absence of the expected response to a stimulus, a delayed response, or a higher response threshold. A Hyperresponsiveness is characterized by an exaggerated behavioral reaction, aversive response, or effort to avoid a sensory stimulus.” (Watson, Patten, Baranek, Boyd, Freuler, & Lorenzi, 2011, p. 1563)

According to Leekam, Libby, Wing, and Gould in their study Describing the Sensory Abnormalities of Children and Adults with Autism, 2006 their studies found “… over 90% of children with autism had sensory abnormalities and had sensory symptoms in multiple sensory domains…” (p. 894). Leekam (2006) concluded that “… children with autism had more sensory symptoms than typical children.” (p. 894) Leekam’s (2006) study also discovered that the high functioning autism group, the group most commonly seen in general education classrooms, had the most frequent and intense sensory symptoms. When a student is Hyperresponsive or Hyporesponsiveness to sensory stimuli they commonly present stereotypical responsive to sensory stimulation. One of the defining characteristics of autism is the presence of stereotypic behavior (American Psychiatric Association, 2000). A stereotypy behavior “… is repetitive, does not appear to serve a purpose, and appears inappropriate for the environment. Stereotypic self-stimulatory behaviors may interfere with a student’s ability to attend, communicate, learn, and
interact…” (Mays, Alvarez, Jolivette, 2011, p.46). Stereotypic behaviors are usually caused by sensory abnormalities.

**Causes and Triggers**

Sensory processing abilities and abnormalities appear uneven and different with each child with autism. “These aberrant sensory reactions are thought to reflect poor sensory integration and/or arousal modulation in the central nervous system, although the underlying nature of these symptoms remains speculation.” (Baranek, 2002, p. 398) Areas of the brain that may be affected by autism and create an abnormality include the neurological structures and systems involving the cerebellum, limbic system, and the cortical mechanisms. While abnormalities in the brain and in the genetic makeup of an individual may cause one’s initial sensory and motor abnormalities, one’s environment plays a major role. Our world is a sensory stimulus in itself and living in a sensory driven world can make it difficult for individuals with autism to function. The conventional education classroom or environment is sensory complicated and unpredictable which can generate an immense amount of anxiety in students with autism. Just the way the classroom is set up can drastically affect a student’s success.

**Theory of Mind**

Theory of Mind (ToM) or the lack of ToM is another reason why students with ASD can create an interesting classroom environment. “Theory of Mind (ToM) is awareness of own and other people’s mental states, such as beliefs, desires, intentions, and emotions. These mental states are revealed largely through conversation and are the foundation of social understanding” (Sprung, 2010, p.204). Individuals with autism and on the autism spectrum commonly lack ToM. It is common for individuals with ASD to assume that you know what they are thinking and they themselves can read your inner thoughts as well. ToM also affects perspective taking, in typical
child development it is learned early on that just because I see you that doesn’t mean that you can see me. Individuals with autism commonly have difficulty reading people’s facial features and looking into people’s eyes. They don’t commonly look at people’s faces because it doesn’t mean anything to them. While in individuals with normal development of ToM, looking at someone’s face provides one with a lot of information. One can tell if someone is happy, sad, scared, nervous or another emotion just by looking at one’s face. This is something that individuals with autism typically have difficulty with. According to Sprung (2010) autistic individuals activate only areas in the brain associated with general problem solving. They can typically solve anything that has an equation or has a rule to follow. What they don’t have is the social-cognitive networks in the brain, when picking up on social cues. This lack of social functioning can create a difficult environment in that classroom or treatment room. Group work and participating in a large class can create misunderstanding from the individual with autism and from the individuals working with them.

Strategies and Interventions

When teachers and other mental health professionals have students with ASD in their classroom or treatment rooms it is important to have a basic understanding of what might cause a behavior and some strategies and interventions to use with that student. First it is important to observe the child and gain an understanding of what might cause certain behaviors or meltdowns, according to Rudolf Dreikurs “There are no bad children just discouraged ones.” This quote is something to keep in mind. A student with ASD may be presenting a negative behavior, it is usually a behavior caused by misunderstanding and frustration.

What can cause these behaviors in children with autism? According to Maria Bird-West Wheeler an Educational Consultant from St. David’s Center for Child and Family Development
many things can cause a child with autism to present behaviors and cause meltdowns. Autism affects each individual differently so no one is going to know everything that will set a child into a meltdown but it is good to have a basic idea of what can cause a behavior.

Characteristics of autism can impact behavior in a classroom. The characters include over or under sensitivity to sensory stimuli including sights, sounds, movement, and textures. High levels of anxiety or intensive emotionality including mental preparation time, order, reassurance; a tendency to respond to stress by developing systems of protection which include withdrawing, avoidance, and aggression; and neurobehavioral disturbances like disorganization (Wheeler 2002, p. 1).

Strategies to improve classroom behaviors are strongly dependable on organization of the teacher and preparation. If a child is typically over stimulated planning relaxing activities during the day and creating a schedule routine for relaxing will help calm the child on daily basis. If a child is typically over stimulated and the relax schedule isn’t improving, assess the classroom environment. The typical classroom has bright colors, cartoon posters, and things dangling from the ceiling. This creates an over stimulating and anxiety prone environment for a child with autism. Reorganize the classroom and illuminate visual distracters.

Other sensory interventions to use in the classroom include activities to incorporate into the student’s daily schedule. For example set a time twice a day for a sensory or motor break. Provide a safe place for the student to receive the sensory input they are requesting. This can include taking the student to a motor room to swing or jump on a trampoline; or on a smaller scale incorporate motor activities in the classroom, for example before reading everyday let the student rock in the rocking chair for ten minutes, this allows the child to reorganize the mind and get ready to focus.
If the child is seeking sensory input varied approaches work at passively providing one type of sensory stimuli.

An example of a commonly used technique is ‘deep pressure’ (i.e. firm touch pressure providing calming input,) which can be applied via therapeutic touch like massage or joint compressions, or an apparatus including a Hug Machine, pressure garments, weighted garments (Baranek, 2002, p. 409).

For teachers and professionals not trained in administering vestibular techniques and using apparatus, meeting with a pediatric Occupational Therapist is recommended. Apparatus’s including the Hug Machine which is “…a touch pressure device designed by Temple Grandin to decrease arousal and anxiety by self-administration of lateral body pressure…showed a significant reduction on a tension scale and marginally significant change in anxiety” (Baranek, 2002, p.409). These machines may look odd to some professionals but typically children enjoy them and aren’t nervous to try them.

First steps when approaching an ASD child in a meltdown is to limit your verbal communication and take a step back. If the child is feeling overwhelmed, stress, and/or anxious use visual supports to help the child calm down. Individuals with autism have a decrease auditory processing speed with high anxiety (Wheeler, 2002). According to St. David’s Center for Child and Family Development Tips for Communicating in a Meltdown include

- *Show Don’t Tell: Communicate with gestures (no words needed) for example point or use tactile prompts*
- *Say it ONCE then stop and allow time to process (remember auditory processing is slowed the more you repeat the more anxious the child becomes)*
- *Lower yourself to their eye level and take a step back*
• Use “You can..” instead of “No, Don’t do that”
• Use basic sign language for prompting the child to sit, clean up, or be all done...

When communicating with a student who is having a meltdown provide clear expectations of what’s expected. Use a ‘First- Then’ T chart, **First** clean up **Then** go outside, and don’t change your expectations if the child still refuses after a few minutes, this will only confuse the child and prevent them for doing any expectation.

Based on research within the last ten years there is a lot of information regarding interventions for children while having a meltdown. Observing and gaining an in depth knowledge of your student is recommended. Not all interventions and strategies will work for all children. Along with observing the student, observe yourself. Due to ASD’s characteristic of sensory abnormalities common actions professionals due create the child to become even more stressed which can lead to a larger problem. Assess yourself, are you talking to loud, wearing a perfume, or standing too close. The better understanding you have of your student and yourself will assist in picking out strategies that will help you both. No child with autism is the same. Children that fall under the autism heading can have a wide range of symptoms and abnormalities. Their processing is different in all areas and some will react negatively to certain things while others won’t get bothered. All children with autism need support and encouragement to ensure their success in and out of the classroom or treatment room.

**Reflection**

I gave an educational presentation and workshop on autism. The presentation included the key diagnostic features of autism, Asperger’s and other related social disorders, sensory processing abnormalities, theory of mined concept, and classroom strategies. I presented to an audience of professionals including educators, school counselors, and administration staff. Being
in education myself I noticed a need in the public schools to educate the educators on the difficulties students on the autism spectrum face daily.

There is an immense amount of information that I would like educators to know about when it comes to this diagnosis. I struggled with what to include in the presentation and what I could leave out. I decided that an overview of the diagnostic key features was important information from a medical and educational point of view. I also wanted to present on information that would appeal to their needs in the classroom. With the raise in the diagnosis educators need to come up with new ways of teaching and with new supports to help the students and themselves. Strategies and intervention/meltdown techniques were something the educators could use right away.

Overall, my presentation was a success and I feel satisfied with my power point slides and my execution of the presentation. I presented on the key diagnostic features while emphasizing key topics such as sensory stimulation and theory of mind. Both sensory stimulation and theory of mind concepts are new to educators and I believe that by making them aware of both concept it will improve future interactions with students with ASD.

I received both positive feedback and things to improve on through my evaluations from the audience. I found the evaluations to be very helpful and resourceful for future presentations I give on this topic. The positive feedback was largely focused on three areas of the presentation. The most positive feedback I received was on the presentation content. The evaluation reported that the audience learned the most new information during the sensory processing portion of the presentation. Most of the audience was unaware of this abnormality, and thought it extremely helpful to gain such knowledge. I found this information extremely helpful; this information informed me of the need to educate teachers on how students with autism process the world and
how it affects their behavior and relationships. It was also helpful to know that, that portion of my presentation was done well. In the future I will spend more time introducing the sensory processing concept. The other positive feedback I received was on the classroom strategies. The audience even commented on the placement of the strategies in the presentation, they reported that it was nice to have the strategies at the end after going through the key diagnostic features. The evaluations reported the strategies introduced in the presentation were helpful and for the most part techniques they could incorporate in a general classroom setting.

The parts of the presentation I could improve on, based on the audience elevations include slide presentation, stories, and explanation of acronyms. The slide presentation could have used aesthetic improvements, 20% of the evaluations reported there were too many words on each slide. The inclusion of more pictures and explanation of the slides and concepts would have been more helpful. The inclusion of more real life stories or examples of how to carry out strategies used in the classroom would have been beneficial, along with further explanations of the acronyms used during the diagnostic criteria.

I would improve three areas of my presentation based on my presentations outcome and evaluation results. After viewing my presentation I noticed that I talked with my hands frequently and said the “um..” it fill silent space. I know I talk with my hands frequently without noticing, however it may be distracting to audience members and take away from my presentation. Next time I present I need to be cautious of hand gestures and saying useless words to fill space to make my presentation less distracting. I would also slow down my presentation. Certain slides especially in the beginning were gone through fast, which made it difficult for people to understand each disorder and the acronym attached to each disorder. Slowing down certain slides would also provide me with the opportunity to explain the strategies and how to
carry out the strategies in real life. This would include telling more of my past experiences and stories related to each strategy. By providing life experiences individuals may remember the strategy and may feel more comfortable trying it out. The next improvement I would make would have been to include more visual stimulating slides. I would remove most of the slides I had written on and replace them with pictures or visual techniques and cues. Throughout the presentation I discovered that I didn’t frequently read off the slides instead I explained the main concept and summarized what the slide stated. I agree that my slides were too wordy and could have used some visual supports.

Future

Giving a presentation was a great opportunity to not only share the knowledge I gained but was a great learning opportunity for myself. Giving a short presentation on such a powerful topic seemed overwhelming at first, but once I narrowed down what I felt was most important. I received a lot of enjoyment out of planning and presenting on my topic. In the future I would like the opportunity to present this presentation again. My larger goal for the future would be to do an hour long presentation on each topic covered in my master’s project presentation. I only briefly introduced the concepts of sensory stimulation and theory of mind. Giving a presentation on each topic would provide me with more time to educator professionals on why students with ASD act certain ways. It would also provide me with the opportunity to do more in-depth research on each of the topics.

The Master’s Project was one of my favorite parts about the graduate program. There was freedom to choose a topic and a project that you were passionate about. I enjoyed the project even more knowing that what I learned I would be able to pass on to professionals. It was a great experience to do such in-depth research and be able to get passionate about one’s project.
References


Presentation

Slide 1

Autism in the Classroom
Presented by
Alexandra McCannel

Slide 2

Working in the schools this rise in autism directly affects our everyday lives. As we all know the diagnosis of autism has increased. With more students being identified with having autism this directly affects our teaching strategies and how we affectively manage our classrooms and assignments.
Slide 3

The presentation will include the following...

What to Expect

1. Brief overview of the key diagnostic features of Autism and related disorders
2. Sensory stimulation
3. Theory of Mind
4. Social and Coping Skills
5. Strategies in the Classroom

Slide 4

What is Autism/ASD/Asperger's

Autism disorder has a different ranges of severity and symptoms of autism

Slide 5

Autism

Autism is a social emotional communication disorder. The spectrum includes autism, Pervasive Developmental disorder, Rhett's Syndrome, and Childhood Disintegrative Disorder (CDD) rarely diagnosed.
There are three areas of the autism diagnosis, the first area is what many people associate with the disorder.

It is common for individuals with the autism diagnosis to have speech and language difficulty. These impairments may occur not just in the way the child speaks but in their processing of the spoken language.
Slide 9

Pervasive Developmental Disorder (PDD-NOS)

- PDD-NOS is characterized by severe pervasive impairment including reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interest, and activities.
- Onset is after the age of three, unlike other autistic disorders which occur earlier in life.

*DSM IV-TR

Slide 10

Asperger’s Syndrome

- Asperger’s Syndrome is a form of ASD that is often identified later (meaning after age three) and is associated with the social symptoms of autism and some repetitive interest or behaviors. However, individuals with Asperger’s syndrome do not have language delays or mental retardation (Lord, 2007).

Slide 11

Rhett’s Syndrome

- Rhett’s Disorder is only diagnosed in females while Autistic Disorder is more common in males.
- Symptoms include loss of purposeful hand skills and motor skills along with a loss of social engagement.
- Retarded vision, speech delay, or Profound Mental Retardation.
Childhood Disintegrative Disorder (CDD) is defined in the DSM-IV-TR as a significant loss of acquired skills. CDD has many similar symptoms but the onset of CDD is later in a child’s life compared to ASD where the symptoms are present in infancy.

What is it like to have ASD... Individuals may struggle with the following:
- Social and coping skills
- Scattered skill development and atypical learning patterns
- Inappropriate behaviors for complex reasons
- Lack of adaptation of normal consequences
- Difficulty generalizing concepts and skills across environments

Sensory Processing in Children with Autism
Slide 15

Area’s Affected by Sensory Processing
- Visual Spatial Skills
- Vestibular System
- Oral
- Olfactory
- Proximal
- Auditory

Slide 16

Individuals with ASD may have an under or over sensitivity to sensory stimuli. Examples of their sensitivity include...

- Auditory: distressed by sounds that do not affect others, unusual fascination with certain sounds, unusually acute hearing.
- Visual: unusual interest in bright lights, shiny objects, twists, flicks, or spins objects near eye

Slide 17

- Smell/taste: unusual tendency to smell objects and people at all ranges.
- Proximal: unusual interest in certain surfaces, scratches surfaces, negative reaction to touch.
- Oral: tends to put everything in mouth, refuses to eat certain textures of food.
- Kinesthetic: enjoys spinning, seeks continuous movement.

All of the follow sensory stimuli occur in every classroom and affect every child on the spectrum. When a child is over or under stimulated this will directly affect their behavior and responds in the classroom.
An individual with ASD does not understand that we all think differently. They commonly believe that you know what they are thinking so why would they have to tell you. May be not understand that you don’t see them or understand why you can’t give them your solo attention. The idea that a teacher has to think about all the kids in the classroom and not just them is difficult for both the student and the teacher.

The phrase “Put yourself in someone’s shoes” takes on a whole in meaning to an individual with ASD.
The lack of social understanding can lead to some unpredictable and unacceptable behaviors in the classroom.

Students with ASD may not pick up on typical social understanding cues. The student may seem like they are demonstrating unacceptable behavior, whereas it is actually a lack of understanding.

Students with ASD may not understand simple communication or may miss content because they cannot read body language, voice inflection, facial expression, and tone.

Some of the common characteristics of ASD significantly impact learning and behavior. Persons with ASD frequently experience underlying communication problems, sensory issues, limitations of attention, skills deficits, regulation challenges, and motor planning difficulties that can interfere with learning and may be manifested as unacceptable behavior” (Wheeler, 2002).
• Encourage them to problem solve.

If they do it a way you won’t have, that’s ok.

5. This is not a reward but a mental break! (we all need one)

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Over or Under sensory stimulation, a change in the schedule, a new person.
Helpful Visual Supports

Strategies in the Classroom

- Provide a schedule of the day's plan and what to expect for the week.
- Be direct and use simple language.
- Allow for processing time.
- Say it once; the more talking (auditory input) the student receives can overwhelm them.

- Pop quiz’s, unexpected speakers, unusual activities, are all things that can through a child. If they aren’t prepared they don’t understand.

3. The student may have a high IQ but may not understand the direction. Use simple and direct language to ensure understanding.
Slide 28

Strategies in the Classroom
- Provide a fidget (hand or oral)
- Listen to music
- Provide calming and predictable activity for student (Sudoku, crossword, reading...)
- Discuss highly preferred activity (movie, book, animal...)

Slide 29

Strategies in the Classroom
- Provide choices
- Provide physical movement (ask child to get a drink and come back, rocking chair)
- Provide additional input/hand out of notes. Auditory processing can be difficult.

Slide 30

Sensory Strategies
- Yoga or Stretching
- Rocking (rocking chair)
- Swing
- Lava lamps or slow visual light
- Aromatherapy
- Chewing work (gum, mint, hard candy)
Slide 31

Sources

Slide 32

Sources
- Lytle, Rebecca; Todd, Teri; (2009) Stress and the Student with Autism Spectrum Disorders. TEACHING Exceptional Children Vol. 41 No. 4 36-42
- Google images

Presentation Handout
Classroom Strategies

- Observe the child. Is this something they can problem solve on their own.
- If they need help, ask them.
- Language: Limited to no talking, Best communication is written, keep direct
- Provide adequate processing time (2X more)
- Show Don’t Tell: Communicate with gestures (no words needed)
- Say it ONCE then stop and allow time to process
- Lower yourself to their eye level and take a step back
- Use “You can..” instead of “No, Don’t do that”
- After provide the child with a calming activity.
- Provide a print out of the weekly schedule if not posted in room
- Provide a fidget (hand or oral)
- Listen to music
- Have the student go for a walk, get a drink

Evaluation for *Introduction to Autism and Intervention Strategies in the Classroom*
Circle One

Did you gain new knowledge about Autism the Spectrum and their key diagnostic features?  Yes  No

Did you gain new knowledge about sensory stimulation related to ASD?  Yes  No

Do you feel you learn how to interact with a child during a meltdown?  Yes  No

Did you learn any helpful strategies to use with your ASD students?  Yes  No

Did you find this presentation helpful and resourceful?  Yes  No

Comments:

What was the most important piece of information from the presentation?

How could the presentation be improved?

Please write any information you would have included in the presentation?