*Keynote Presenter*

**Dr. Danielle Previ**

# GPS

**Guide to Providing Services to Deaf and Hard-of-Hearing infants and toddlers**

**A workshop addressing the early intervention programming needs of deaf and hard-of-hearing infants and toddlers**

Monday
**November 3, 2025**
8:30 AM - 3:45 PM

Scan to register

THE LEARNING CENTER FOR THE DEAF

**tlcdeaf.org**

848 Central Street
Framingham, MA 01701

# Psychological Assessment and Therapy Services for Neurodivergent Children

Danielle Previ, PhD
Clinical Psychologist
Gallaudet University Psychology Clinic

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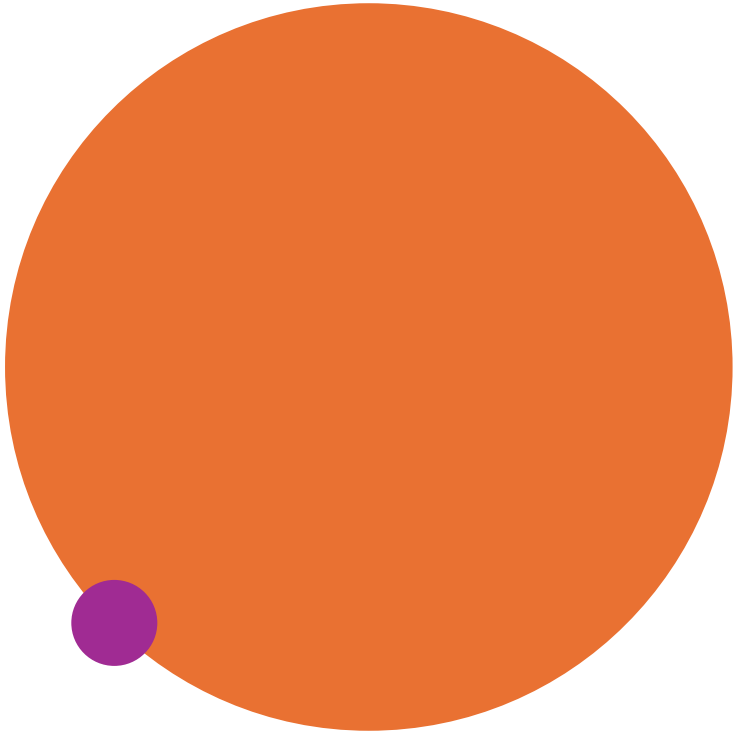
# Learning Objectives

1) Audience will learn more about current factors that may help or interfere with timely diagnosis of ASD, ADHD and additional diagnoses.

2) Audience will leave with more knowledge about what is included in the decision making process when appropriately diagnosing DHH children.

3) Audience will learn more about how to navigate and advocate for the appropriate resources tailored to the DHH child's unique needs



- Danielle Previ, PhD
  - Clinical Director of Gallaudet University Psychology Clinic
  - Training at Kennedy Krieger Institute and Johns Hopkins School of Medicine
  - Predominantly conduct neuropsychological assessments for deaf and hard of hearing children
    - Expanding work to adults
    - Common referrals
    - Neurodiversity and neurodivergence

# Neurodiversity

- “Neurodiversity refers to both the diversity of human minds and to the variation in neurocognitive functioning that shapes each person’s learning strengths, sociability, emotions, and other traits. It is most often used in reference to individuals with Autism Spectrum Disorder, Attention-Deficit/Hyperactivity Disorder (ADHD), Obsessive Compulsive Disorder (OCD), learning disabilities, and other neurodevelopmental conditions”-Cornell Health

- Coined in late 1990s by Australian Activist, Judy Singer

# Neurodivergent individuals and students

- **Strengths Based**
  - Intellectual abilities
  - Open mindedness, creativity, love of learning
  - Expertise in areas of special interests
- **Areas for Support**
  - Social and Communication Difficulties
  - Executive Function skills
  - Challenges related to flexibility skills
  - Sensory difficulties
  - Higher rates of anxiety, depression, and other mental health issues

# Evolution of IQ testing

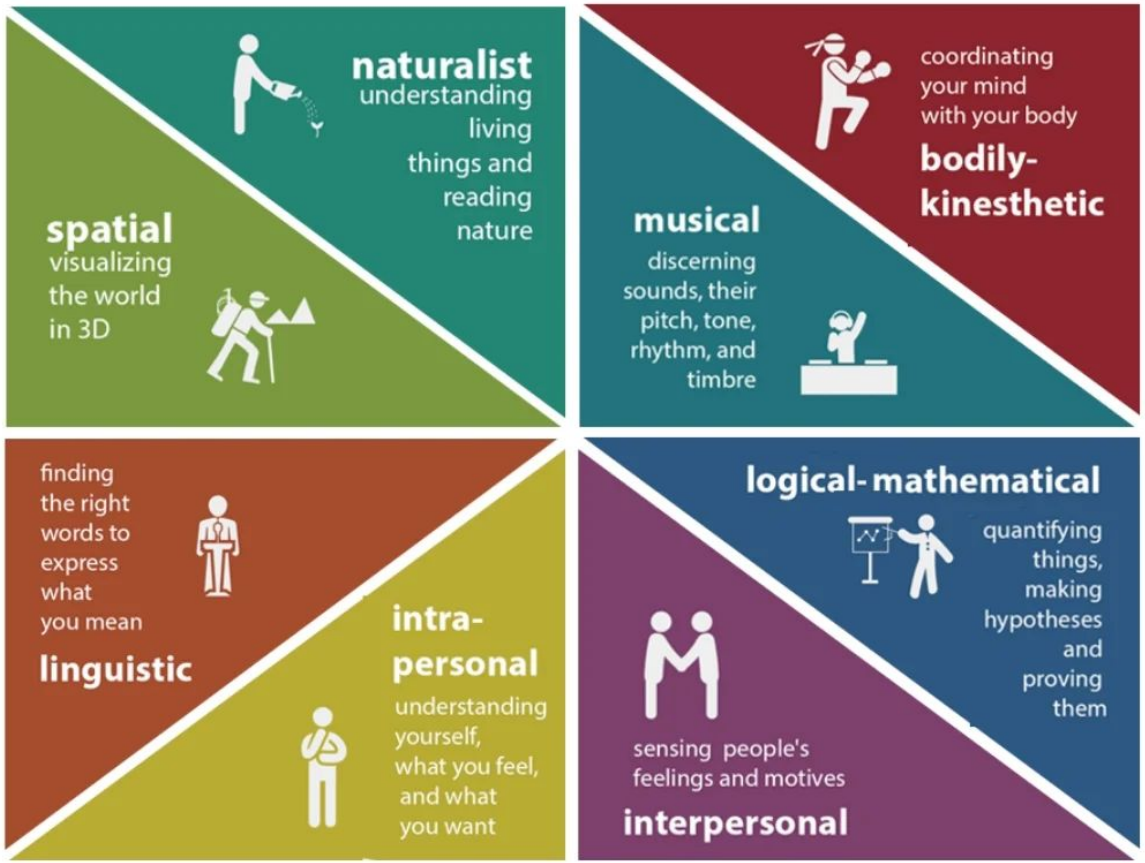
- Ancient Civilizations (e.g., Egypt and Greece)
- Aristotle (4th Century BC) wrote about reasoning and scholars during Hans Dynasty used civil service exams
- Phrenology (1800) linked skull shape with mental ability
- Sir Francis Galton (1900)  coined the term mental ability
- Alred Binet and Theodore Simon (1905) Binet-Simon Scale for children who needed extra support
- Lewis Terman developed Intelligence Quotient (IQ)
- Charles Spearman (1904) General Intelligence factor

# Evolution of IQ testing

- David Wechsler (1939) developed Wechsler test for adults and children that included verbal and performance subscales to move away from “mental age”
- Raymond Cattell (1940s) Fluid and Crystalized Intelligence
- Gardner (1983) Theory of Multiple Intelligence
- Robert Sternberg (1980s) Triarchic Theory
- 21st century
  - Genetics, environment, culture are considered
  - Cultural bias in IQ testing
  - Expansion to executive functioning and adaptive behavior scales

# Official Definition of IQ testing

- American Psychological Association 2023
  - Determines person’s level of intelligence by measuring their ability to solve problems, form concepts, reason, acquire details
  - Visual spatial abilities, language, attention, working memory, and visual processing speed


naturalist
understanding living things and reading nature
spatial
visualizing the world in 3D
coordinating your mind with your body
bodily-kinesthetic
musical
discerning sounds, their pitch, tone, rhythm, and timbre
finding the right words to express what you mean
linguistic
intra-personal
understanding yourself, what you feel, and what you want
logical-mathematical
quantifying things, making hypotheses and proving them
sensing people's feelings and motives
interpersonal

# Positive Psychology (Hart &Sasso, 2011)

- Virtues, character strengths, positive personality traits and related attributes and abilities, and talents
- Phenomena indicative of happiness, positive emotional well-being, subjective sense of fulfillment, and satisfaction with the quality of life
- Developmental process of becoming, growth, fulfillment of capacities, actualization of potential, and development of the highest/authentic self

# Chickering's Seven Vectors of Development (1993)

- developing competence
- managing emotions
- moving through autonomy toward interdependence
- developing mature interpersonal relationships
- establishing identity
- developing purpose
- developing integrity

# Autism Spectrum Disorder

## Behaviorally defined disordered characterized by:

| | | |
|---|---|---|
| Impairments in social and communication skills | Presence of Restricted and Repetitive patterns of behavior | Symptoms present in early developmental period (or may not fully manifest until social demands exceed an individual's capacities) |

## About 1 in 31 autism prevalence (CDC, 2023)

| | | |
|---|---|---|
| Rising prevalence - multiple contributing factors<br>• Shifting definition of autism and terminology (i.e., DSM changes)<br>• Improved screening efforts and access to screening tools | Shifting demographics of children identified with autism | Prevalence remains higher in boys vs girls |

# Just a millennial that loves quotes

“If you’ve met one person with autism, you’ve met ONE person with autism.” –Dr. Stephen Shore

# Autism Spectrum Disorder and differential diagnosis

Higher risk for for Autism Spectrum Disorder across many pediatric neurological conditions including deafness

Infants more likely to survive complicated medical conditions leading to increasing rate of ASD

Challenges associated with phenotypic heterogeneity of ASD

Impacts of medical factors on cognitive, physical and behavioral functioning

Roberts et al (2020)

- Symptoms of ASD MUST be independent from other conditions in clinical picture.

# Deaf related etiologies

- Non-Syndromic versus syndromic
- Children with CMV infection may have increased chances of intellectual disabilities, seizures, and additional medical concerns (Fletcher et al., 2018)
- CHARGE syndrome rate of autism spectrum disorder is estimated to be at 30% (Richards et al., 2015)
- Deaf and hard of hearing children are likely to be diagnosed with ASD on average 3 years later than their peers (Szarkowski, Flynn, Clark, 2014)
    - National autism diagnosis=38 months of age (Van't Hof, 2020)

# Diagnostic Overshadowing

- Type 1 and Type 2 errors
  - Type 1 = false negative
  - Type 2  = false positive
- VandenBos (2007)
  - 1) misdiagnosis of ASD when symptoms are attributed to ASD, but symptoms are better explained by the impact of medical condition
  - 2) a missed diagnosis of ASD when symptoms are attributed to the medical condition, but best explained by an ASD diagnosis

# Examples of diagnostic overshadowing

- Example 1: 18 month old toddler with history of cerebral palsy may present with reduced social interest consistent with a true diagnosis of ASD, and the diagnosis is deferred as the clinician misattributed social challenges as secondary to motor concerns

# More examples

- Example 2: 13 year old Deaf female with history of HA use, primarily ASL user referred for evaluation, no prior autism diagnosis. Previous psychological evaluations indicated deafness and depression. Significant social reciprocity challenges present since early childhood and current bullying

# Comorbidities (Soke et al., 2010)

## Children who tend to be diagnosed at an earlier age:

- Developmental regressions
- Cognitive impairments
- Self-injurious behaviors
- Behavioral dysregulation

## Children who tend to be diagnosed at a later age

- History of ADHD
- Anxiety
- Oppositional Defiant Disorder
- Aggressive Behaviors

# Soke et al., 2010

- Presence of comorbidities increases phenotype heterogeneity
- Those with developmental or medical comorbidities such as deafness and epilepsy tend to lose their ASD diagnosis

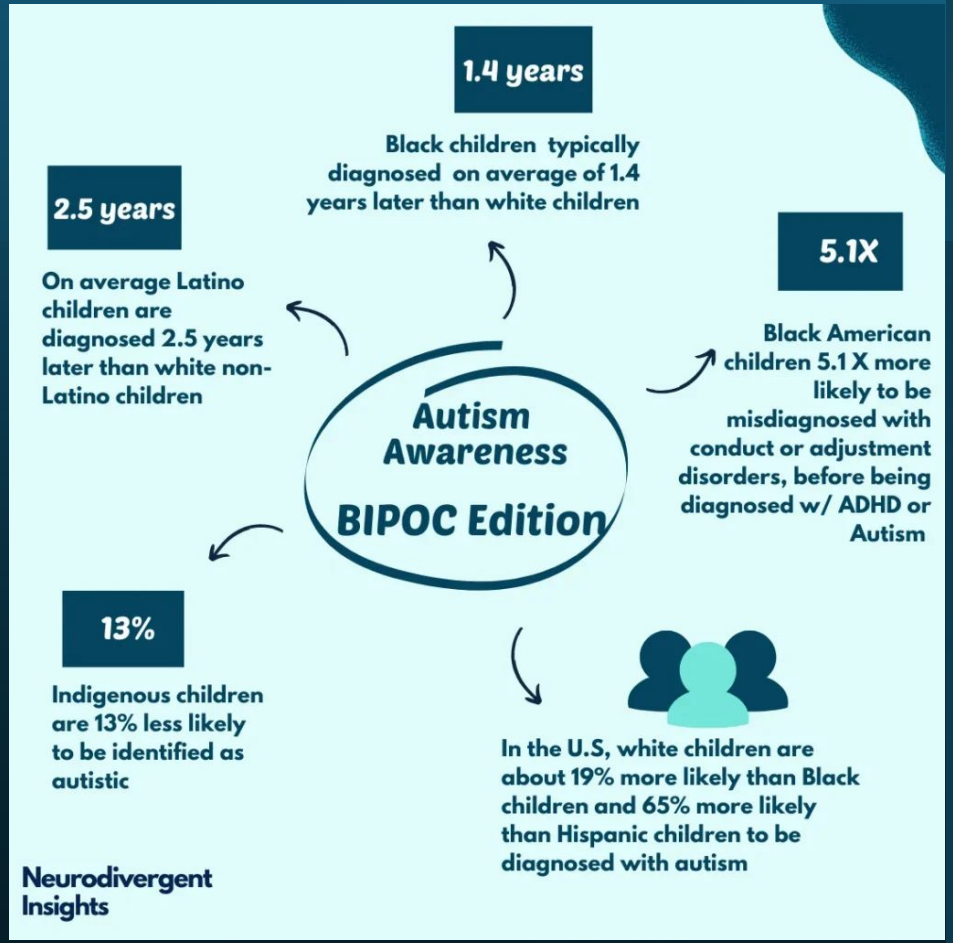
# Attention Deficit and Hyperactivity Disorder/Learning Disabilities

- Attention-deficit/hyperactivity disorder (ADHD) and learning disabilities are the most commonly diagnosed neurodevelopmental disorders in children and often coexist with other disabilities

# National Health Interview Survey 2016-18

In 2016–2018, nearly 14% of children aged 3–17 years were reported as ever having been diagnosed with either attention-deficit/hyperactivity disorder (ADHD) or a learning disability; non-Hispanic black children were the most likely to be diagnosed (16.9%)

Children living in families at less than 100% of the federal poverty level (18.7%) were more likely to be diagnosed with ADHD or a learning disability compared with children living in families at 100% or more of the federal poverty level (12.7%).


1.4 years
Black children typically diagnosed on average of 1.4 years later than white children
2.5 years
On average Latino children are diagnosed 2.5 years later than white non-Latino children
5.1X
Black American children 5.1 X more likely to be misdiagnosed with conduct or adjustment disorders, before being diagnosed w/ ADHD or Autism
Autism Awareness
BIPOC Edition
13%
Indigenous children are 13% less likely to be identified as autistic
In the U.S, white children are about 19% more likely than Black children and 65% more likely than Hispanic children to be diagnosed with autism
Neurodivergent Insights

# Disparities

**Access and Health Care utilization**

**Socio-economic factors**

**Cultural Factors/stigma**

**Bias/differential interpretation**

Seen as disciplinary issue versus neurodevelopmental concerns

**Screening tools available**

# Autism and Attention Deficit Hyperactivity Disorder (ADHD)

- DSM-IV-TR had limitations on dual diagnosis of ADHD and Autism Spectrum Disorder
- DSM-5 ***removed*** the exclusionary criteria that prevented combined diagnosis
  - Dual diagnosis allowed more tailored and effective treatments
  - 37-85% of children with ASD exhibit comorbid ADHD symptoms (Leitner, 2014)
  - ASD like symptoms are reported in children with ADHD
    - Social cognition
    - Language development issues

# Autism and Attention Deficit and Hyperactivity Disorder

- Challenges with differential diagnosis (Groom et al., 2017)
  - Recognizing gaze direction
  - Recognizing emotional expressions
  - Toddlers with ADHD and ASD may show atypical eye contacts
- American Academy of Pediatrics (AAP)
  - Difficulty with diagnosing ADHD in children at young age unless symptoms are persistent

# Autism Spectrum Disorder in females

- Biological sex and gender differences are being actively researched to reduce potential male prevalence bias
  - 3 to 4 males to every 1 female being diagnosed (Loomes et al., 2017)
  - Sampling techniques in prospective and large scale population based studies (loomes et al., 2017)
  - Danish National Registry (2014)
    - Reduction in male majority from 5:1 to 3:1 over 15 years
    - Underscores the need to research female ASD phenotypes
- Hormonal and neurobiological factors
  - Fetal Testosterone (Ferri, Abel & Brodkin, 2018)
  - Reduced connectivity area related to social comprehension for males (Kirkovski et al, 2016)

# ASD female phenotype

Clinical perspectives

- Mixed findings re: cognitive skills and females w/ASD (see Howe, et al 2016)
- Interviews and evaluation around intense interests may need to take into account different interests and how these manifest
- Greater ‘camouflaging’ skills
- More subtle difficulties, though continuing to interfere if reaching diagnostic threshold
- May experience greater clinician bias to diagnosis when strong language skills
- What is the picture in your head when you imagine a child with autism?

# Female Phenotype

- Mean ADOS-2 scores of the Social Interaction and RRB domains were significant lower for girls compared with boys
- Increased internalizing issues due to camouflaging
  - Depression
  - Low self esteem
  - Self injuries
  - Suicidal thoughts (Tubio et al., 2021)
- Girls RRB similar to neurotypicals (Lai, 2015)
  - Animals
  - Soap operas
  - Celebrities
  - Pop music
  - Increased imaginative play compared with boys
  - Presence of Intellectual Disability

# Females and ASD

- Generally recommended for girls with suspected ASD to continue to be followed up over the years to ensure they are receiving appropriate interventions.
- More diagnostic tools tailored to umask camouflaging is needed.
- Many ASD measures are not normed to include gender differences
- Frequent Differential diagnosis:
  - Anxiety
  - Depression
  - Eating disorders/ restrictive eating patterns
  - Borderline Personality Disorder
  - Post Traumatic Stress Disorder
- Concept of “autistic traits” when threshold may not be met

# Adoption History and Autism Diagnosis

- Adoption history can complicate some diagnostic decision-making
- Impact of early experience and early trauma history
- Reliability of early developmental history prior to adoption
- Accessibility of language for D/HH children

# “A Disorder without Borders”

- Socio-Cultural Influences and geographical regions
- Socio-Economic Status (SES)
- Earlier diagnosis of ASD is associated with higher SES (Hyman et al., 2020)
    - African American and Hispanic children likely to diagnosed later
    - Higher maternal education associated with earlier ASD diagnosis (Accordino et al., 2017)
    - Some cultures eye contact is considered impolite
    - Cultures that ritualize greetings which leads to parent report of child’s appropriate greetings of others

# Diagnostic Process

- Diagnosis based on:
  - Child developmental history
  - Behavioral Observations (Objective and Subjective)
  - Cognitive Functioning
  - Clinical Judgement and Diagnostic Tools
  - Parent and teacher reports
- Two of the most heavily researched tools for ASD
  - Autism Diagnostic Observation Schedule (ADOS)
  - Autism Diagnostic Interview-Revised (ADI-R)
- Adaptations made to ADOS-2 for DHH children (e.g., Phillips, 2022)

# Language Experience

- Hearing children with ASD may exhibit language delays despite language being accessible to them
- Neurotypical DHH children at risk for language deprivation
- Quantity and quality of language DHH children have been exposed to should be considered as part of evaluation
- “Home signs” versus unconventional signs used by child persistently despite appropriate language instruction
- Repetitive behaviors versus communication frustration

# Language related considerations

| | | |
|---|---|---|
| Joint attention | Vision difficulties (e.g., Amblyopia) | Facial Expressions |
| Motor skills | Pointing and gesturing | Visual Perspective taking deficits in ASD (Shield et al., 2016) |

# Therapy for Autism spectrum disorder

- Functional communication skills
  - Signs that are functional
  - Augmentative Communication System
  - Picture Exchange communication system
  - Behavior reinforcement/contingency/token system
  - But what about social connection and interactive academic opportunities

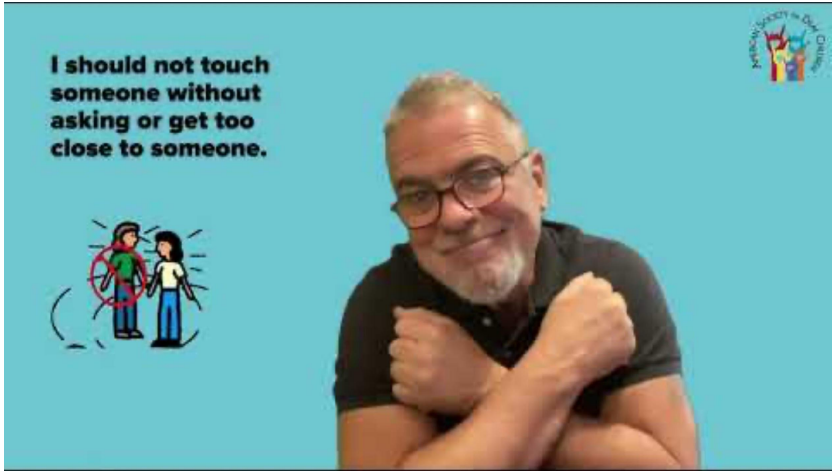
# Therapy for Autism Spectrum Disorder

- Video Modeling
- Visual Schedules
- Social Stories written from child's perspective
  - Supports development of theory of mind; understanding other's perspectives; mental rotation)
    - Ordering food at restaurants
    - Turn taking skills across multiple situations
    - Social and behavioral regulation skills
    - Can include text, images, videos (e.g., Book Creator)

# Therapy for Autism Spectrum Disorder

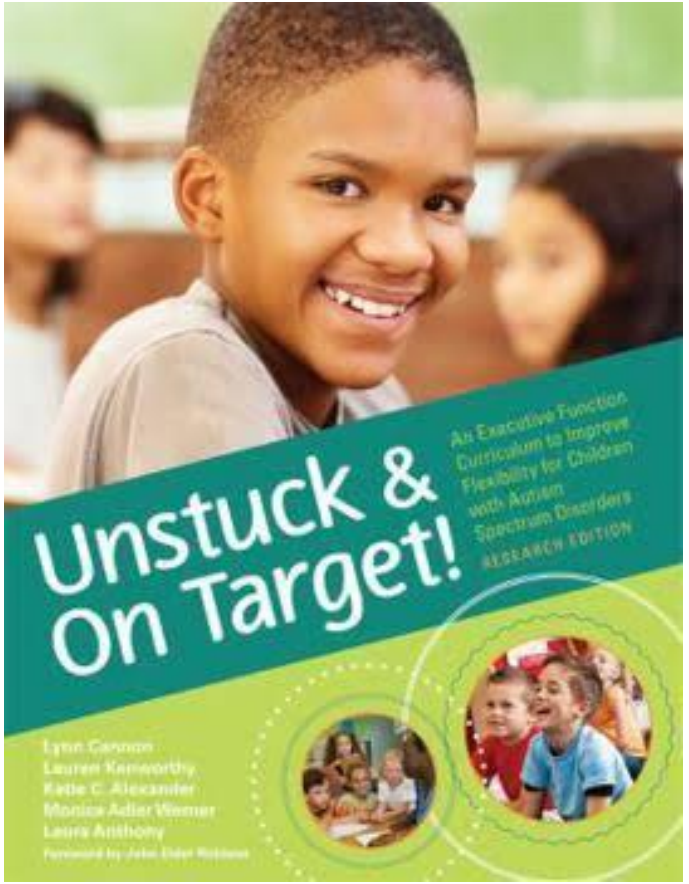
- Circles Complete (James Stanfield)
- Zones of Regulation
- Social Skills  training
- Evidenced based approaches (ABA, SLP, and OT)
- CDC's "Complementary and Alternative" treatments

# Social Stories Example (American Society for Deaf Children)

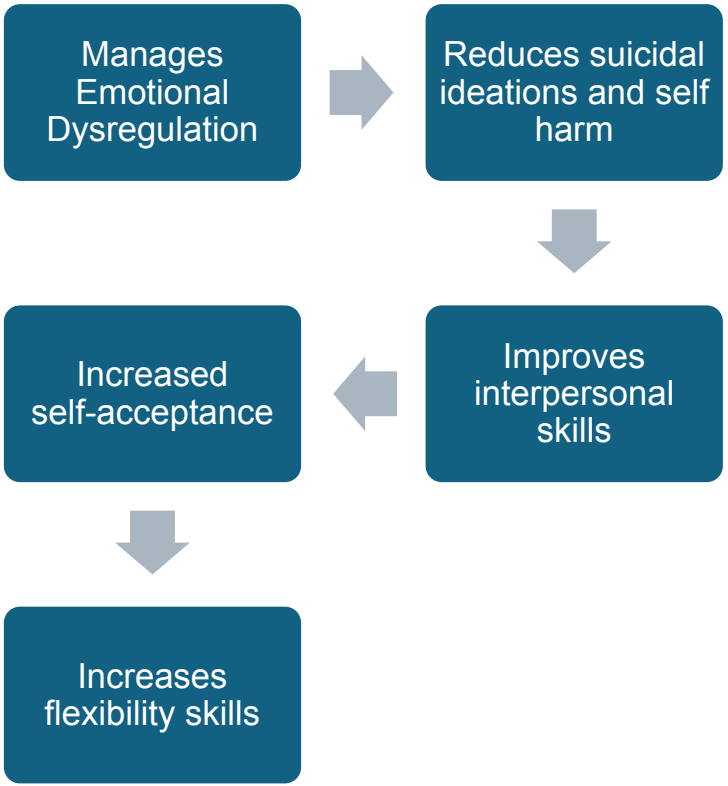



# Executive Functioning skills

- Cognitive flexibility
- Problem solving skills
- Coping Skills
- Organizational Skills
- Ideal for ASD , ADHD and Anxiety



# Dialectal Behavioral Therapy (DBT)



# Therapy for ADHD

- Parent Child Interaction Therapy (PCIT)
- Biofeedback
- Behavioral management
- Psychotropic Medications
- Lifestyle changes

# Summary


Discussion regarding neurodiversity language is ongoing
The use of Gardner's theory is encouraged
Clinicians encouraged to use more positive psychology concepts
Educators encouraged to cultivate inclusion and tailored support to neurodivergent individuals

# Resources & Readings


Fisher, E.L., Thibodaux, L.T., Previ, D., & Reesman, J. (2021). Impact of communication modality on caregiver ratings for deaf and hard of hearing children. *Applied Neuropsychology: Child* https://doi.org/10.1080/21622965.2021.1916495

Miller, M.S., Thomas-Presswood, T.N., Metz, K., & Lukomski, J. (2015). Psychological and Psychoeducational Assessment of Deaf and Hard of Hearing Children and Adolescents. *Gallaudet University Press.*

Morere, D. A. (2013). Methodological issues associated with sign-based neuropsychological assessment. *Sign Language Studies*, *14*(1), 8-20.

Reesman, J. H., Day, L. A., Szymanski, C. A., Hughes-Wheatland, R., Witkin, G. A., Kalback, S. R., & Brice, P. J. (2014). Review of intellectual assessment measures for children who are deaf or hard of hearing. *Rehabilitation psychology*, *59*(1), 99.

Ludwig, N. N., Jashar, D. T., Sheperd, K., Pineda, J. L., Previ, D., Reesman, J., … Gerner, G. J. (2021). Considerations for the identification of autism spectrum disorder in children with vision or hearing impairment: A critical review of the literature and recommendations for practice. *The Clinical Neuropsychologist*, *36*(5), 1049–1068. https://doi.org/10.1080/13854046.2021.2002933

Szarkowski, A., Mood, D., Shield, A., Wiley, S., & Yoshinaga-Itano, C. (2014). A Summary of Current Understanding Regarding Children with Autism Spectrum Disorder Who Are Deaf or Hard of Hearing. Seminars in Speech and Language, 35(04), 241–259. https://doi.org/10.1055/S-0034-1389097

# Therapy for Autism Spectrum Disorder

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# Q&A

Thank you!

# Real Life Perspectives Panel

GPS Conference, November 3, 2025

# Introduction


Emilia Doudt

# Q1:

How has your experience as a Deaf/ HoH neurodivergent individual or parent of a Deaf/ HoH neurodivergent child shaped your perspective on early intervention services?


BLOCK
COUNTABLOCK
SPACEBLOCK
ALPHABLOCK
FARMBLOCK
Around the Farm
Yoga Pretzels
Busy Bug Book
Colors
Opposites
SHAPES

# Q2:

What are some common misconceptions or assumptions you've encountered from professionals about Deaf/ HoH neurodivergent children, and how can interventionists avoid them?


BLOCK
COUNTBLOCK
SPACEBLOCK
ALPHABLOCK
FARMBLOCK
Yoga Pre
Baby Bug Book
Colors
Opposites
SHAPES
the farm

# Q3:

Can you share examples of how communication preferences and access (e.g., ASL, AAC, visual supports) have been honored—or overlooked—in your early intervention experience?


ALPHABLOCK
FARMBLOCK
Busy Bug Book
Colors
SHAPES
the farm

# Q4:

How can early interventionists build trust and collaborative relationships with families while respecting cultural, linguistic, and neurodiversity identities?


COUNTABLOCK
SPACEBLOCK
ALPHABLOCK
FARMBLOCK
Busy Bug Book
Colors
SHAPES

# Q5:

What advice would you give to early intervention professionals who are just beginning to work with Deaf/ HoH neurodivergent infants and toddlers and their families?


COUNTABLOCK
SPACEBLOCK
ALPHABLOCK
FARMBLOCK
Colors
SHAPES
the farm
LAST STOP ON MARKET STREET

# Q & A

# Thank you for listening and learning!

Continue to advocate, reflect, and grow in your practice.

# A Strengths-Based Approach to Neurodivergence in Early Childhood

Ronald E. Becker, MD
Developmental-Behavioral Pediatrician
Developmental Medicine Center
Boston Children's Hospital

November 3, 2025

# Learning Objectives

- The learner will be able to identify strategies for recognizing individual strengths and capacities in the developing child and understand the link with resiliency and capacity.
- The learner will be able to identify individual pitfalls that can interfere with success for children with neurodivergence.
- The learner will be aware of the "right to exceptionality" and the ways in which we can support this across environments.

**Disclosures:**
I have no financial or non-financial disclosures relevant to this topic.

# Strengths-Based Approach

- Complementary to a “deficits-based” approach
- Neurological differences viewed as variations rather than deficits
- Focus is on talents and interests rather than challenges
  - Build confidence
  - Improve motivation
  - Support well-being
- Catalog capacities along with challenges (balanced approach)
  - Supporting each can help reduce challenges
- Help children and caregivers understand how their brain works and leverage it for ongoing progress

# Neurodiversity/Neurodivergence

- Arguably defined as “thinking differently”
  - Different does not necessarily mean bad or wrong or even problematic
  - Examples of different thinkers can include artists/entertainers/discoverers
  - Consider that an IQ over 130 is “abnormal.”

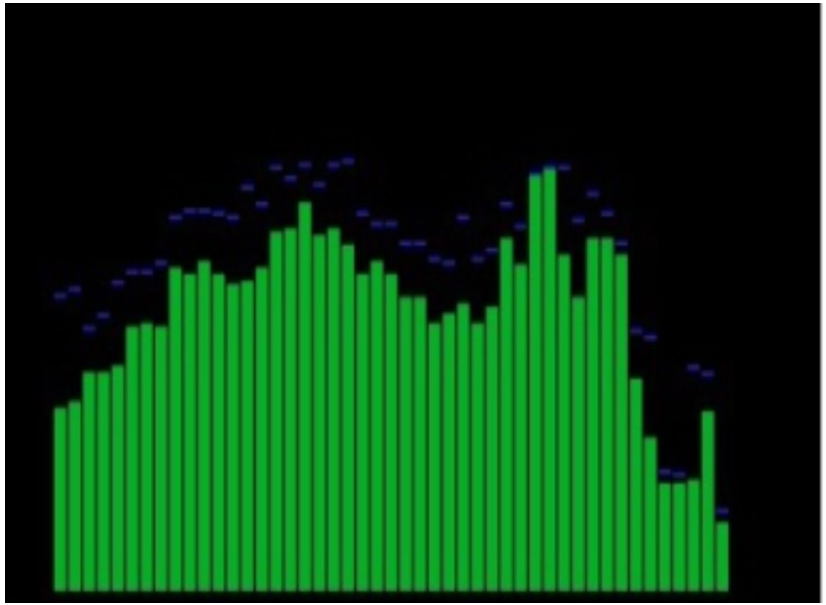
- Autism and related disorders
- ADHD
- Learning disabilities, cognitive disabilites
- Mood/Mental health (notably bipolar disorder/hypomania).

- Sensory perception differences
  - Perfect pitch
  - Sensitive taste buds
  - Challenges in crowds

# Developmental Trajectory

- Defines both strengths and challenges
  - Both may be assessed according to expectation for age
- Requires regular reassessment to best serve the child
- Prognosis can be uncertain
  - The trajectory may also be atypical
  - Skills may appear out of the typical chronology

# Spectrum v. Spectra



- Most all forms of neurodivergence can be seen as falling along a spectrum of impact on the individual
- With any diagnosis the individual may have relative strengths and weaknesses
- The diagnosis of an Autism Spectrum Disorder does not include measure of cognitive potential
- Children with an ADHD diagnosis can vary in the degree to which organizational skills are impacted

# Formal Diagnosis

- Pros:
  - Starting point for understanding challenges and strengths
  - Information about outcomes, pitfalls and successful therapies
  - Access to certain services/accommodations (payment)
  - Closure

- Cons:
  - Stigma
  - Limiting of future view
  - Future concerns (insurability, military service, job)

# DSM 5 TR (Diagnostic and Statistical Manual)

- DSM first published in 1952
  - Focused on inpatient and needs for VA hospitals after WWII.
  - Psychoanalytic influence
  - Based on longstanding need to collect statistical information
- DSM-III published in 1980
  - Major expansion and reworking
  - First mention of Autism as separate diagnosis
  - First mention of ADHD  as diagnosis (DSM-II referenced “hyperkinetic” disorder)
- DSM-5 published 2013
  - Consolidation of separate pervasive developmental disorders under one term.
  - Symptoms primarily based on a deficit model

# Social Media :  Pros and Cons

- Pros
  - Easy access to most individuals
  - Normalizing presentation (or uplifting)
  - Engenders a social grouping and sense of belonging

- Cons
  - Not always accurate diagnosis
    - May blur or misassign a diagnosis
    - May impact society
      - Raising the bar for diagnosis for others
      - “Dilutes” the meaning of a diagnosis
  - Risk of victimization by those with bad motivation
  - Risk of seeking inappropriate or dangerous care/services/treatment

  - “Standard” media can also engender false expectations (e.g. “Sheldon” character)

# Strengths

- Strengths rather than platitudes (e.g. “loveable”)
  - Consider the function of the strength that is identified
  - Example:  Temperament, can impact access to learning

- Strengths rather than areas of interest
  - Areas of interest are important, but a separate matter.
  - Expertise can be a strength

- Turning a symptom into a strength
  - “able to focus for long times” from “overfocusing on areas of interest.”
  - “perfect pitch” from “sensitive to certain sounds”

# Strengths

- Strengths that are “built-in” to a neurodivergent profile
  - Attention to detail
  - Sense of justice
  - Heightened creativity (attributed to ADHD)
  - Different view/perspective on problem solving
  - Exceptional memory
  - Logical/analytical thinking
  - Visual-spatial skills (attributed to dyslexia)

- Strengths anyone might have
  - Cognitive abilities
  - Fine motor skills
  - Athleticism
  - Empathy and sensitivity

# Strengths

- "Strengths" external to the child
  - Having a supportive and caring family/community
  - Having access to resources (an equity issue)

# Identifying individuals' strengths

- On standard testing
  - Cognitive, language, visual-spatial measures

- Parent (or self) report
  - Ask about the positives
  - Use preset questionnaires
    - Survey of Autistic Strengths, Skills and Interests (SASSI)
      - *See next slide*
    - Child and Adolescent Needs and Strengths (CANS)
      - Currently built into MBHI process, all ages, free to access
      - Small section related to strengths
      - Requires training to complete
    - Behavioral and Emotional Rating Scale (BERS-3)
      - Not free to use (PAR publishing)

# SASSI

- Long answer prompts
- Child and Teen/Adult versions (5 and up)

Sensory

1. Do you think that your child experiences heightened awareness of certain aspects of sensory stimuli (e.g., sights, sounds, smells, tastes, textures)?
2. Does your child seem to appreciate certain sensory experiences in a way that other people cannot?
3. What types of sensory experiences seem to bring your child joy?
4. Does your child have a unique way of experiencing the world that helps in creative, musical, or artistic activities? Can you think of examples?
5. Did you ever think your child might have perfect pitch?

Woods SEO, Estes A. Toward a more comprehensive autism assessment: the survey of autistic strengths, skills, and interests. Front Psychiatry. 2023 Oct 6;14:1264516. doi: 10.3389/fpsyt.2023.1264516. PMID: 37867767; PMCID: PMC10587489.

# Informal and Observational Methods

- Developmental observations
- Success portfolios
  - Collect a variety of items that demonstrate the child's accomplishments.
- Appreciative inquiry
  - Focus on what is working well for the child (e.g. at IEP meetings)
  - Shift the focus from deficits to strengths, hopes, and interests.
- Activity-based discovery
  - Engage the child in a wide range of activities to uncover abilities
- Keeping a journal or log
  - Noting specific behaviors, interests, and moments of engagement
  - Identify patterns and pinpoint what motivates the child

# Counterpoint

Considering evidence of just how different the brain of an autistic individual may be, and how differently it develops, are we comparing apples and oranges when we measure autistic strengths (and even weaknesses) in neurotypical terms? Perhaps completely separate ways of looking at strengths and weaknesses which accounts for neurodiversity is not feasible or possibly even desirable.

Maybe it doesn't even matter whether a strength or deficit is defined as such by neurotypical or neurodivergent standards, what matters is that an autistic child feels valued, confident in his/her unique strengths and contributions to the world, with as much control as is possible over his/her environment.

Yolande Loftus, BA, LLB
https://www.autismparentingmagazine.com/autismstrengths/?srsltid=AfmBOopRmCrRbFZoJifJPhywyY9qd9eITVSGN1YpACci3URR0M7evUDk
*(Accessed October 2025)*

# Strengths and Challenges : not always a clear definition

- Echolalia
  - Atypical language pattern
  - (In ASL can be observed in signs being directed inward)
  - Can be interpreted as a communication attempt, and leveraged

- Socialization
  - Not absent in individuals who are neurodiverse
  - May appear differently and may require interpretation
  - Can be supported with positive responses

- Sensory Hypersensitivity
  - May increase enjoyment of some activities
  - May pose challenge in daily activities (crossing a busy street).

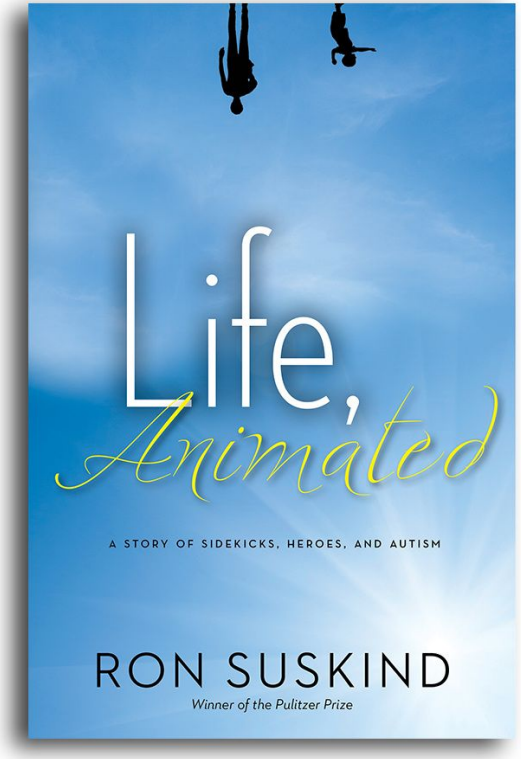
# Strengths and Challenges : not always a clear definition (2)

- Mischief
  - Negative behaviors that are intended to spark a reaction
  - May be social in nature

- Inner motivation
  - Very hard to quantify
  - High motivation (success-seeking) may be seen as a strength
  - The counterpoint is frustration, which can be a reflection of motivation

# General strategies for a strength-based approach

- **Identify strengths early**
- **Use affirming language:**
  - Frame neurodivergent traits as differences rather than disorders
- **Incorporate special interests:**
  - Integrate the child's passions into learning, therapy, and daily routines.
  - Needs to be with caution if overfocus is present and may cause distress
  - Balanced with opportunities to explore non-preferred topics
- **Tailor the environment:**
  - Reasonably accommodate a child's sensory needs
  - Adapt lesson/service delivery to students' strengths and learning style
- Promote self-advocacy
  - Help children understand their own strengths and needs
- **Give specific, positive feedback:**
  - Move beyond generic praise




# Example of leveraging interests

- "Life Animated"
  - A Book and subsequent Movie
  - Ron Suskind about his son Owen Suskind

- High interest in Disney characters
- Developed broader communication

# Adult Authors of Interest

- Steve Silberman – *NeuroTribes*
- Temple Grandin – Many Books, *Thinking in Pictures*
- John Elder Robinson – *Look Me In the Eye* and *Be Different*

- Barry M. Prizant – *Uniquely Human*

# Young children

- Identify strengths early on
  - Recognize that they may change over time
- Identify interests early on
  - These can be supported mindfully as part of the teaching model
  - These also may change with time
- Progress fuels the motivation for future intervention!
  - Build successes early on

- Developing an IEP that includes strengths
  - At transition to age 3
  - IEP Narrative is often a good place
  - The IEP is not otherwise “strengths friendly”
  - Consider inclusion of long-range goals that will be met much later on

# Integrated placement *as versus* substantially separate

- Access to tasks that may not otherwise be presented
- Creates social pressure – and potential for growth
- Reduction of stigma, increasing community awareness, increasing positive attitudes
- For success we need teaching of peers to help prevent bullying
  - Neurotypical children may hold inaccurate beliefs or understanding of autism

- Older children may benefit from self-identification and self advocacy
  - A child is <u>not</u> responsible for teaching peers (but)
  - Self-identification and advocacy can signal openness to discussion

# Strength-Based Goal Setting

- In young childhood this can be shaped by a “future adult” view
  - Immediate goals
  - Goals to reach by adulthood

- Self-advocacy
- Role in society, workplace, interpersonally
- Maximizing independence
- Safety

# Resilience

- The ability to cope when things don't go as expected, to handle adversity
- Children are supported by
  - Being self-aware
  - Recognizing their strengths (and not assuming incompetence)
  - Being able to recall past successes / self-esteem
  - Having trusting relationships

- Parents/teachers/caregivers can
  - Offer positive messages
  - Avoid overprotection (which diminishes confidence and self-agency)
  - Help child learn from mistakes in non-judgmental way

# Right to neurodiversity/exceptionalism

Recognition and respect for the unique abilities, perspectives, and needs of people with neurodivergent conditions,

- **Tailored Support and Accommodations**:
  - Appropriate support in educational and workplace settings. This can include personalized learning plans, assistive technologies, and flexible working arrangements.
- **Challenging Normative Standards**:
  - Broader understanding of what it means to contribute meaningfully to society.
  - Traditional measures may not always capture the value brought by neurodiverse individuals.
- **Ethical and Moral Considerations**:
  - Advocates argue for the moral obligation to respect and enhance the lives of neurodiverse individuals, ensuring they are not marginalized or discriminated against due to cognitive or behavioral differences.
- **Critiques and Challenges**:
  - The emphasis on recognition only for exceptional talents (as for “twice exceptional.”)
  - All individuals, regardless of abilities, are valued and supported.

# The End

# Behavior is a Clue

## Behavior Is a Clue: Neurodiversity-Affirming Behavior Supports for Deaf and Hard of Hearing Children in Early Education

Kathleen Steele MA, BCBA, LABA

A little about me…

- Behavior Is a Clue: Neurodiversity-Affirming Behavior Supports for Deaf and Hard of Hearing Children in Early Education.
    - **Regulation-first**
      **Communication-first**
      **Connection-first**
- Behavior is communication
    - our role is to understand it’s message

# Agenda

1. Welcome & Framing

2. Foundations of Safety & Predictability

3. Reinforcement & Interpretation

4. Emotional Literacy & Regulation

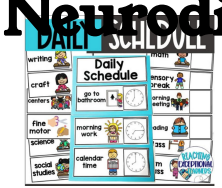
5. Practical Classroom Strategies

6. Reflection & Closing

# Main Goals for Behavior Support
# Instructional and Participation Supports

1. ## Increase Communication Supports
    a. Expand use of **ASL, AAC, and all functional communication methods** across the student's day.
    b. Ensure every activity includes opportunities for expressive and receptive communication.
2. ## Participation in Learning
    a. Continue active engagement in **academics and skill-building activities.**
    b. Encourage involvement in **all group activities** with necessary supports (visuals, peers, staff prompts).
3. ## Structured Work Systems
    a. Use **FIRST/THEN visual schedules** with icons for daily tasks and transitions.
    b. Provide **1:1 work sessions with a token board** to support motivation and track reinforcement.
4. ## Skill Expansion
    a. Teach and reinforce skills through **repetition, routines, and predictable practice.**
    b. Generalize skills across settings while keeping routines consistent.
5. ## Predictable Functional Routines
    a. Build and maintain **clear, consistent, and functional daily routines** that reduce uncertainty and increase independence.

# Why Social & Communication Demands Can Be Hard for Neurodiverse Students




## 1. People are unpredictable

a. Social environments change constantly.

b. Others may move around, shift routines, or act in ways that feel confusing.


## 2. Emotions are hard to read

a. People show different emotions that may not make sense or may feel overwhelming.

b. Misreading emotions can lead to stress, withdrawal, or challenging behavior.


## 3. Language can be unclear

a. Many words are abstract or figurative (not concrete/literal).

b. This can make directions, conversations, and schoolwork harder to understand.

## 4. Adult requests feel confusing

a. Directions often rely on perspective-taking (understanding what the adult means, not just what they say).

b. This can feel less predictable and harder to follow.

c. Better approach: use structures that clearly indicate a demand (e.g., visual task lists, FIRST/THEN boards, checklists).

# Creating Safety Through Systems and Routines


## 1. Predictability

a. Keep routines consistent and predictable across the day.

b. Aim for “as boring as possible” so transitions and activities are not surprising or overwhelming.

i. Example transition sequence: **Light signal → prompt to visual → seated chant → class moves together as a group.**


## 2. Daily Routines

a. Establish set routines for **work time, breaks, class activities, and lunch.**

b. Ensure routines are used the same way every day to promote a sense of safety and familiarity.

## 3. Communication

a. Use **simple, clear, concrete language** paired with **visuals** (pictures, symbols, objects) to make expectations understandable and reduce uncertainty.



## 4. Soothing Structures

a. Provide access to **favorite toys or comfort items.**

b. Organize play in predictable, structured ways — this can feel calming and help regulate emotions.

# SIGNALS OF SAFETY

## Safe Adult

- Present as **steady, calm, grounded, and positive.**
- Model emotional regulation;  tone, facial expression, and body language should signal *safety, not stress.*

## Predictability

- Maintain the **same clear routines and rules every day.**
- Consistency across staff creates trust and security.

## Movement & Pacing

- Use **slow, deliberate movements** and allow extra **wait time** for processing.
- Only move quickly in emergencies.

# SIGNALS OF SAFETY

## Teaching & Redirection

- **Redirect unsafe behavior first**, then reinforce alternative/appropriate behavior.
- Keep interactions instructional rather than punitive.

## Communication

- Provide **clear language for approach and avoidance** (e.g., “safe hands,” “take space”).
- Pair verbal language with visuals, ASL, or AAC.

## Emotional Coaching

- **Label feelings** the student may be experiencing.
- Respond with **empathy and validation** (“I see you’re frustrated, that’s hard.”).

## Safety & Boundaries

- **Block unsafe behavior** calmly and neutrally when needed.
- Prioritize safety while preserving dignity and connection.

# Reinforcement Defined

**A reinforcer is anything that increases the likelihood a behavior will happen again.**

It is defined by its effect — not by what adults *intend* to be motivating.

- A reinforcer is not a reward
- It is anything the child experiences as regulating, meaningful, or motivating
- You know it is a reinforcer *only if the behavior increases after access*

Reinforcer = something that strengthens behavior because it meets a need

# Reinforcer Detective

- Observe: What lights them up? What calms their body?
- Join in play: Imitate + narrate + label
- Redirect inappropriate behavior: Same need, safer form
- Play as an assessment of what are student needs and what do they need to learn.

# Behavior Is a Clue

- Behavior is an early communication system
- Children show needs with their body before they can use language
- The “behavior” is not the problem the unmet need is

Ask: What is the message behind the behavior?

Ask: What help is this child asking for?

# Function vs. Needs

- Function = the *what*.  We identify which category is the reinforcer (attention, escape, tangible, sensory)

- Need = the *why* (safety, connection, predictability, autonomy, regulation)

- Behavior does not fully stop until the **need** is met
- Behavior can be redirected by replacing challenging behavior with alternatives that are of the same function

# Want vs. Don’t Want
# Early Advocacy and Assessing Well Being

- “Don’t want” = communication, not defiance
- Preference is early self-advocacy
- Want = ready

Don’t want = overwhelmed / not yet available

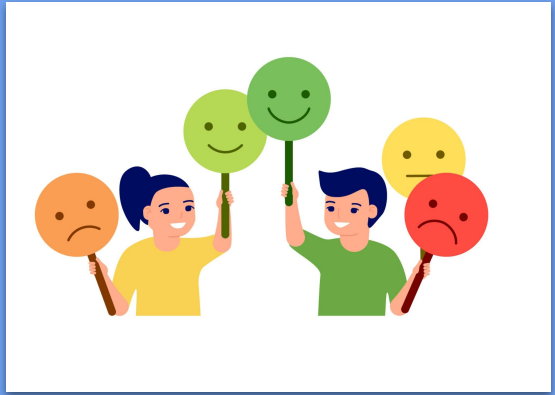
# Body Language = Communication

- Early communication is expressed through **proximity, orientation, and motor behavior**
- Moving closer, reaching, or leaning in = **bid for co-regulation / connection**
- Turning away, hiding, pulling back, or pushing = **bid for space / reduced stimulation**
- These are **functional signals**, not “noncompliance” or “attention-seeking”
- When we respond to low-magnitude signals, escalation is less likely

Behavior escalation = stronger communication attempt

# Emotional Literacy

- Emotional awareness is a **taught skill**, not assumed
- Instruction begins with **observable body cues** (tight hands, hiding face, pacing)
- Adults can model labeling emotion paired with the cue
- Taught during **regulated moments** so the skill can contact reinforcement
- Two separate skills;  Identifying emotions in others and in self



**Instructional Focus:**
Pair body cue → label → coping action

# Coping Skills

- Children regulate through movement, rest, connection, or space
- Breaks are **predictable**, not earned
- Staff read the body for need signals
- Regulation is support, not reward

Always looking for those beginning cues to teach coping skills rather than waiting for escalation.

# Child-led play

## Free Play Approach

- Allow **child-led play**: follow Students lead during free play.
- The goal is to **make play with people enjoyable** by pairing staff/peers with reinforcers.


## Skills to Embed in Play

- **Joint Attention**:
  - Copy Students  actions.
  - Point out interesting things and direct his attention (“Look!”).
- **Imitation**:
  - Copy Student’s actions, then invite him to copy yours.
  - Keep it playful and fun.
- **Language Practice**:
  - Label items and actions naturally during play.
  - Model and practice language for **avoidance** (e.g., “no thank you,” “all done”) and **approach** (e.g., “more please,” “let’s play”).
  - Encourage **feeling labels** in context.

Child-led play sequence adapted from the Early Start Denver Model (Rogers & Dawson, 2010)

# Child-led play

## Building Social Reinforcement

- The purpose is to **connect people with reinforcers** so that **staff/peers become reinforcing.**
- Staff should consistently pair themselves with fun, preferred activities and items.

## Respecting Alone Time

- Student signals he wants to be alone:
    - Allow up to **2 minutes alone**.
    - Return afterward and gently re-engage in play.

## Reinforcer Detective Work

- Observe and note students preferred items, activities, and social interactions.
- If allowed in the classroom, **store highly preferred items in his backpack** for use as motivators during instruction and transitions.

Child-led play sequence adapted from the Early Start Denver Model (Rogers & Dawson, 2010)

# Using Reinforcers

## Upgrades

- Also consistent with Hanley's approach: when a child successfully completes a task or responds appropriately, the reinforcer can be **enhanced or "upgraded."**
- This makes reinforcement dynamic and motivating — it grows when effort and cooperation grow.
- Example: After a successful "watch me" → "your turn," staff might shift from a small token to a larger preferred activity.

## Clear Teaching Sequence

- Use **simple social cues**:
  - *"Watch me."* (model)
  - *"Your turn."* (opportunity to respond)
  - Reinforce or provide an upgrade if the response is safe/appropriate.

Based on Hanley et al., Practical Functional Assessment & Skill-Based Treatment model (2014–present).

# Do-Overs

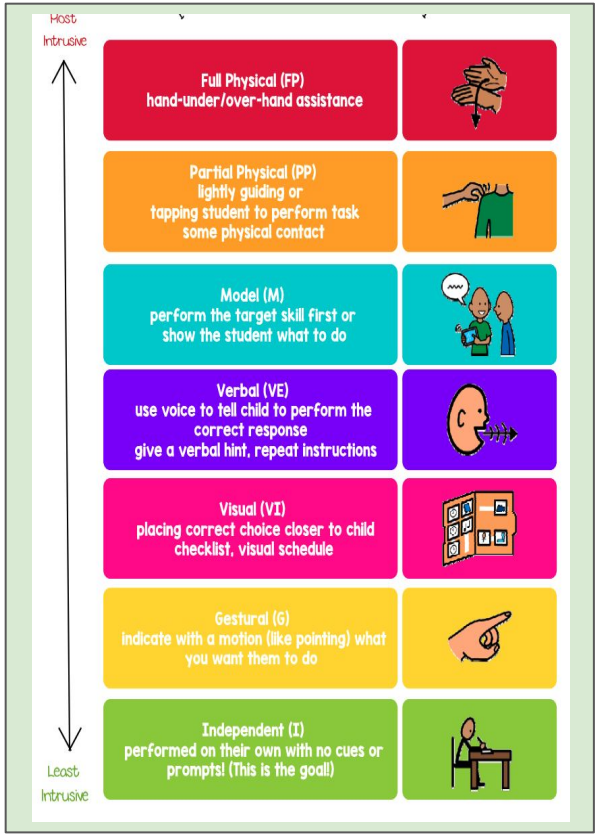
- **Avoid accidental reinforcement of unsafe/dangerous behavior.**
    - Reinforcement should be delivered for **safe, appropriate responding**, not immediately after a high-risk behavior.
    - If unsafe behavior occurs, calmly block and reset the demand — don't pair the behavior with a preferred outcome.
- **Do-Overs**
    - From Greg Hanley's work (often referenced in *practical functional assessment* and *skills-based treatment*).
    - A "do-over" is simply giving the child another chance to practice the correct/expected behavior and then earn reinforcement.
    - Example: If a direction is ignored or done unsafely, say **"Let's try again"** → prompt the safe response → then reinforce.

Based on Hanley et al., Practical Functional Assessment & Skill-Based Treatment model (2014–present).

# Teaching Strategies

Prompt Hierarchy

- **Use the least intrusive prompt possible** for success.
- **Fade quickly** once the student shows progress.
- **Reinforce independence**, not just prompted responses.
- **Mix in natural opportunities** so skills generalize.
- **Be consistent** — if one staff uses full physical and another uses only verbal, the student gets confused.




1. **Full Physical Prompt** – Hand-under/over-hand guidance.
2. **Partial Physical Prompt** – Light touch or guidance.
3. **Model Prompt** – Teacher demonstrates the behavior.
4. **Verbal Prompt** – Saying part of or all of the instruction ("Say 'water'").
    - Can be *direct* ("Say hello") or *indirect* ("What do you say?").
5. **Visual Prompt** – Picture, written, or environmental cue.
6. **Gestural Prompt** – Pointing, nodding, or motioning.
7. **Independant** No extra help; just the environment or task demand.

# Challenging Behavior

- Challenging behavior = unmet need + missing skill
  1. What is the need here?  What do they need to learn?
- Support order:
  1. Safety
  2. Regulation
  3. Teaching
- We don’t remove the need — we teach a safer form

# Practical Strategies

Proactive supports prevent overwhelm. Communication supports prevent the body from having to shout. Sensory/regulation supports protect capacity. Redirecting by **function** means we do not take away the need we teach a safer way to meet it. Prevention is the intervention.

# Response strategies

1.
    - Stay calm and predictable
    - Use neutral affect and low-demand presence
2.
    - Prompt or model a safer alternative response
    - Provide *measured* access to regulating input without reinforcing unsafe topographies
3.
    - Embed coping strategies already in the child's repertoire
    - Pair with simple feeling-identification or need-labeling

# Response strategies when upset

4. [illegible]
   - Use clear contingencies (First/Then, visual sequence)
   - Reduce verbal load and keep expectations concrete
5. 
   - Access/preferred items follow safe and expected behavior
   - Still honor the original demand once ready
6. 
   - Block unsafe behavior neutrally
   - Protect autonomy whenever possible

## Core Principles of Neurodiversity-Affirming Behavior Support

- Behavior is communication, not defiance
- Interpretation comes before intervention
- Meet the need first, then teach the skill
- Regulation is a right, not something earned
- The message is valid even when the form is unsafe
- Prevention is the intervention

# Reflection

**1. If behavior is communication, what might a child be telling us through their actions, especially when they don't yet have full access to language or regulation tools?**

A. They are intentionally trying to get attention or disrupt the classroom.

B. They are expressing, coping with, or communicating an unmet need.

C. They are testing boundaries to see what they can get away with.

D. They are refusing to follow directions and need stricter consequences.

# Reflection

**2. What does it mean to be a “reinforcer detective,” and how can cross-disciplinary collaboration (with Deaf educators, SLPs, OTs, and families) help us identify and honor what truly motivates and regulates each child?**

# Multiple Modalities for DHH Children: Supporting Language Development Through AAC

By Taryn Carlson, MS, CCC-SLP and Mary Grace Hamme, MS, CCC-SLP

## Mary Grace Hamme
## Support Services Coordinator
## Speech-Language Pathologist

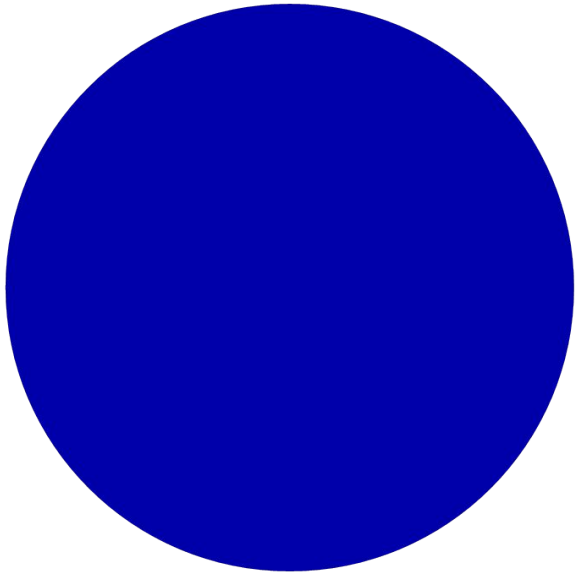
*Mary Grace Hamme, MS, CCC-SLP is a salaried employee of The Learning Center for the Deaf. She is also a contract employee of The Informed SLP. Mary Grace Hamme has no non-financial disclosures to provide.*

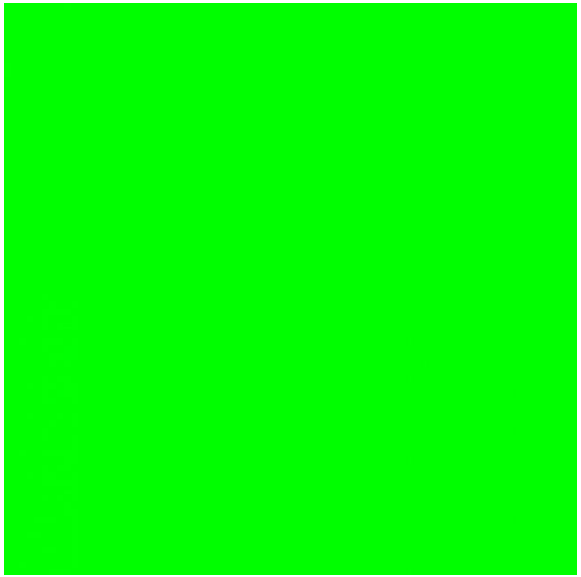
## Taryn Carlson
## Speech-Language Pathologist

*Taryn Carlson, M.S., CCC-SLP is a salaried employee of The Learning Center for the Deaf. She also provides per diem outpatient services through OTA Kids. Taryn Carlson has no non-financial disclosures to provide.*

# Outline

- Introductions
- Language vs. Communication
- Typical Language Milestones for DHH Children
- What is AAC?
- AAC as an Additional Modality to Support Language Development
- Strategies for Success
- Myths, Facts, and Considerations for AAC Use
- Communication Rights
- Q&A and Hands on Practice

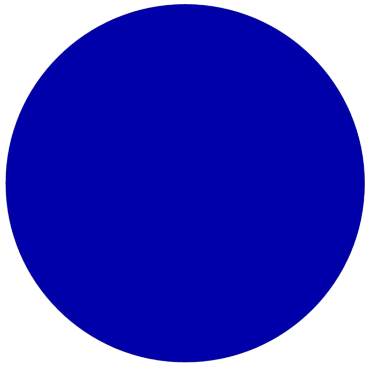




# Question:

Have you worked with children who utilize AAC before?

Yes



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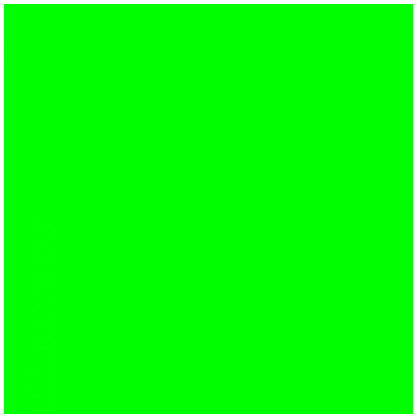


# Language vs Communication

*How are they the same? How are they different?*

# Language

Language is a rule based system with its own vocabulary, grammar, and social use

Languages can be signed, written, or spoken

Examples:

- **Signed**: American Sign Language, British Sign Language, Auslan
- **Spoken/Written**: English, Spanish, Mandarin

# Communication

Communication is an act in which a message is *sent* and *received*

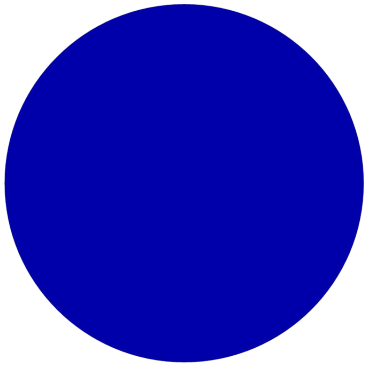
Examples: facial expressions, body language, gestures, pointing, yelling

Language is a form of communication, but communication does not need to be language

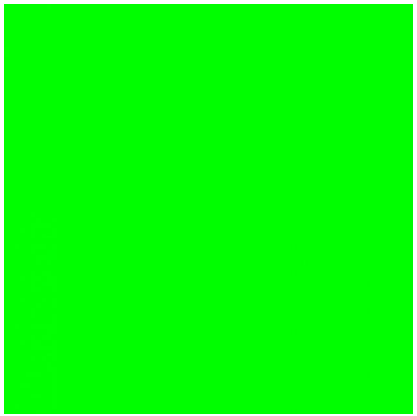
# Question:

Crying is a form of:

Language



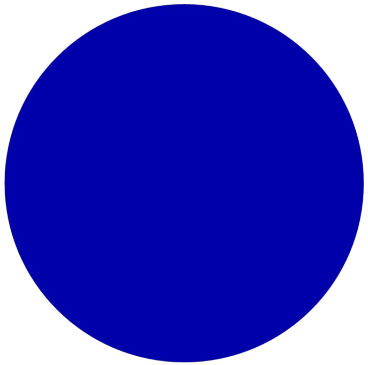
Communication



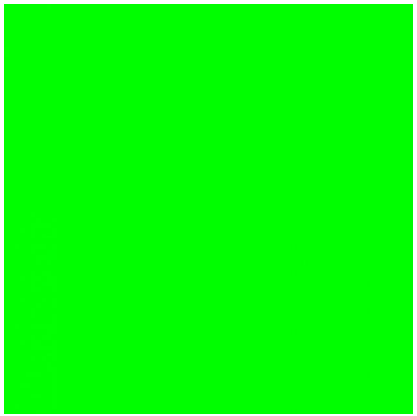
# Question:

Pointing is a form of:

Language



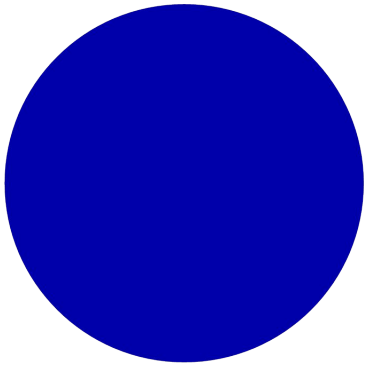
Communication



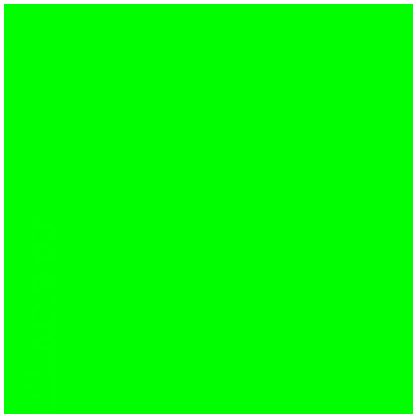
# Question:

Signing or saying MAMA or DADA is:

Language



Communication



# Typical Language Milestones for Deaf and Hard of Hearing Children

# SB 210 Language Development Milestones

Examples of linguistic milestones included in the checklist:

- 4-6 months: babies begin to babble with hands and/or voices; babies will respond when name is signed or spoken (e.g., through looking and/or vocalizing)
- 7-12 months: babies express first signed or spoken words; babies understand common things in their environment (e.g., toys, food)
- 2-3 years old: child answers questions with yes or no; child uses intelligible words about 80% of the time

Receptive language enters brain through visual or auditory system

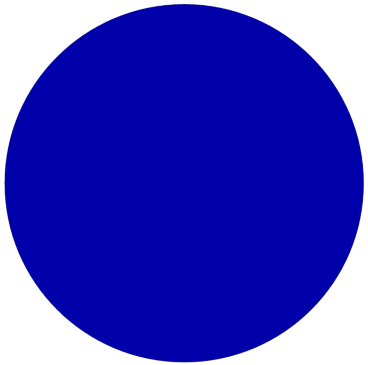
Expressive language is produced through the hands or mouth,

depending on modality

# Question:

Can language delays and disorders present in Deaf and Hard of Hearing children?

Yes



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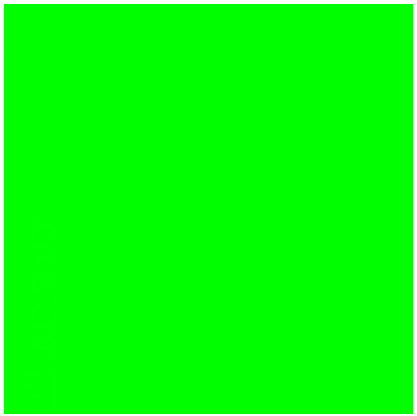


**It is estimated that about 20-40% of deaf children have additional disabilities (Cupples et al., 2016).**

# Additional diagnoses in the DeafDisabled community:

- Autism
- Down Syndrome
- Intellectual Disabilities
- Cerebral Palsy

Receptive language

Expressive language

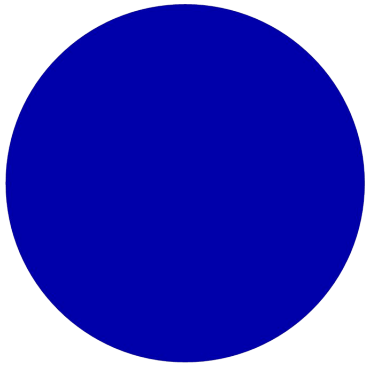
Receptive language

Expressive language

# Question:

If a Deaf/Hard of Hearing child is not developing ASL expressively, should we automatically recommend they learn how to speak?

Yes



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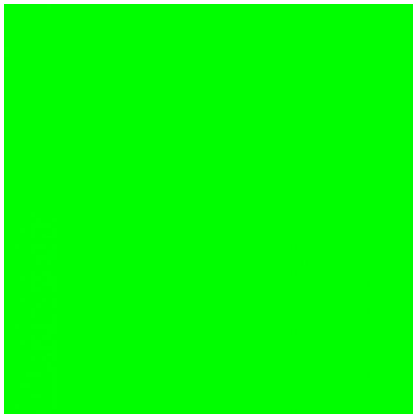


# What is AAC?

# Augmentative and Alternative Communication (AAC)

ASHA refers to AAC as communication that is not spoken; *it is our stance that as ASL is a natural language, AAC is communication that is not spoken* ***or signed****.*

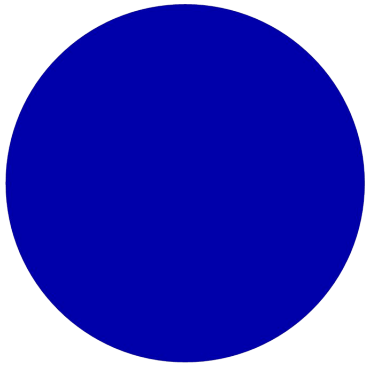
**Augmentative** - communication approaches adding to speech or sign

**Alternative** - communication approaches being used in place of speech or sign

# Question:

Are children with disabilities the only people who use AAC?

Yes



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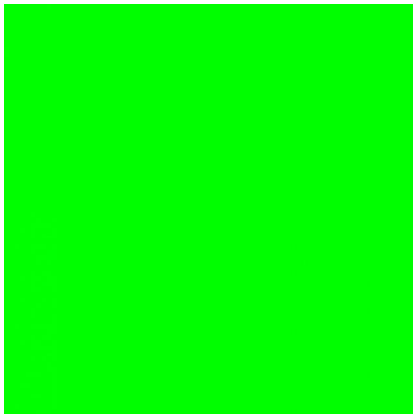


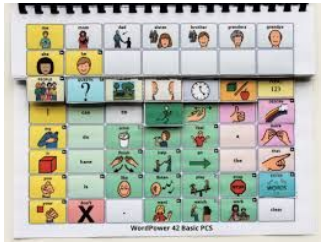
# Types of AAC

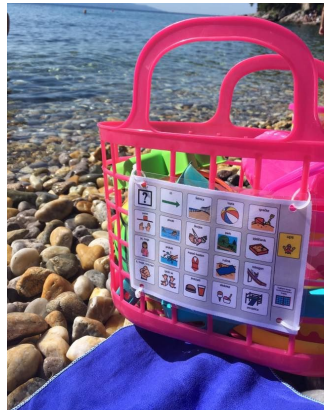
## Unaided AAC:

An augmentative or alternative communication that does not use a tool (e.g., eye gaze, pointing, facial expressions and body language

## Aided AAC:

An augmentative or alternative communication that uses a tool (e.g., a device with speech-generating software, pictures to show someone else)





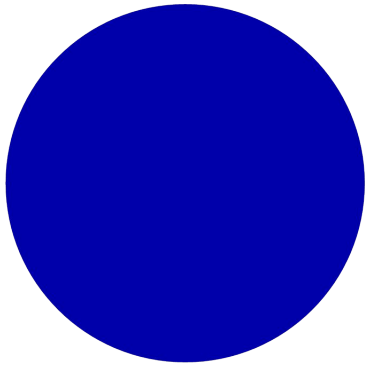
## AAC classification

- Lite-tech
- Mid-tech
- High-tech

# Question:

Should only high-tech devices be used?

Yes



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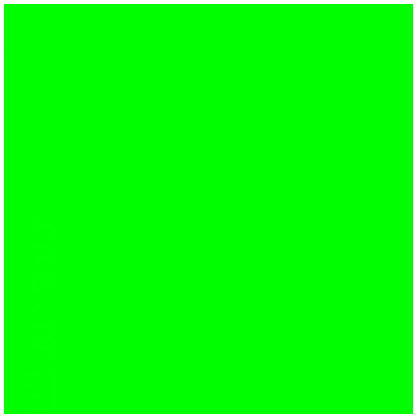
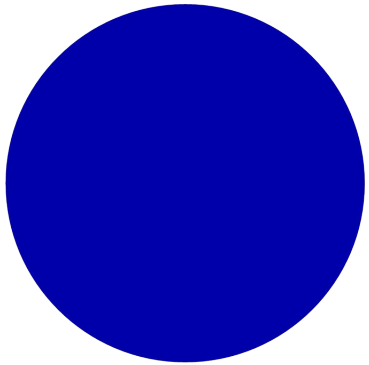


# Question:

If a Deaf or Hard of Hearing child is not developing the ability to express themselves through spoken English, we should automatically qualify them for AAC.

Yes



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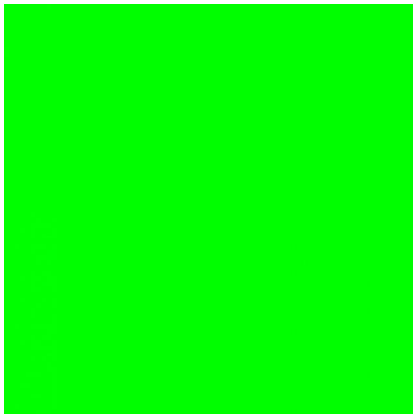
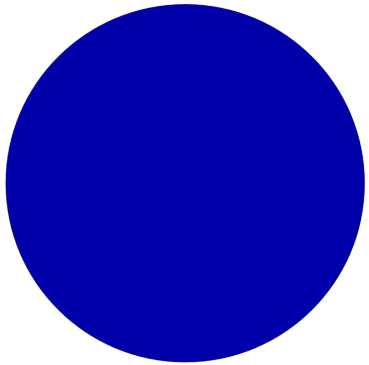


# AAC as an Additional Modality to Support Language Development

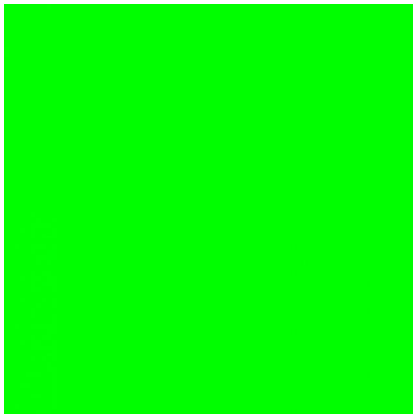
# True or False:

Children automatically know how to use AAC.

True



False



# Children learn to use AAC through AAC use being modeled for them

Some techniques:

- **Aided language stimulation** - modeling language through either speech or sign while also using a form of AAC simultaneously
- **“Sandwiching”** - say or sign a message, repeat it through AAC, say or sign it again

“The average 18-month-old has been exposed to 4,380 hours of oral language at a rate of 8 hours/day from birth. A child who has a communication system (AAC) and receives speech/language therapy 2 times/week for 20-30 minutes will reach the same amount of language exposure (in their AAC language) in 84 years.”

***Jane Korsten (2011) QIAT Listserv April 4, 2011***

Receptive language

Expressive language

Receptive language with AAC modeling

Expressive language

Words “stay” longer - signs or spoken words exist for a moment. Modeling on AAC can make words more concrete and can anchor a message instead of disappearing in an instant. This can help with working memory or processing speed deficits.

Kids can also see how the device was used before trying themselves.

Receptive language

Expressive language supplemented with AAC

If Deaf/Hard of Hearing children are unable to produce their intended word, they may be able to select the icon that matches their message. This may be more easily understood than other unaided forms of communication.

# Strategies for Success

# Keep language fun (and functional!)

- Integrate AAC into fun and motivating activities
- Model, model, model!
- Have it be meaningful for the child (e.g., personalized vocabulary)

# Be patient and acknowledge all communication attempts

- Wait time: Give plenty of time to respond
- Accept all forms of communication (e.g., AAC device, gestures, sounds, signs)
- Celebrate every attempt and model targets in response.

# Keep AAC physically accessible

- Having AAC “within reach” makes it more likely to be used and/or utilized
- Match AAC to the environmental needs

# Ask your SLP questions

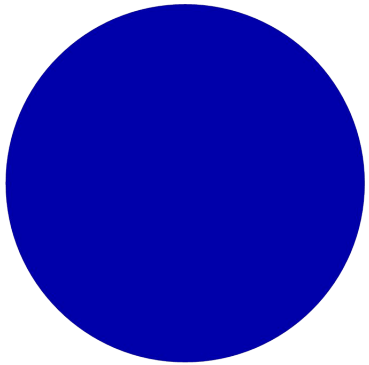
- There are no bad questions when it comes to AAC!
- Parent, caregiver, and professional “buy in” is crucial
- SLPs may have more individualized tips on what may work with a specific child

# Myths, Facts, and Considerations for AAC Use

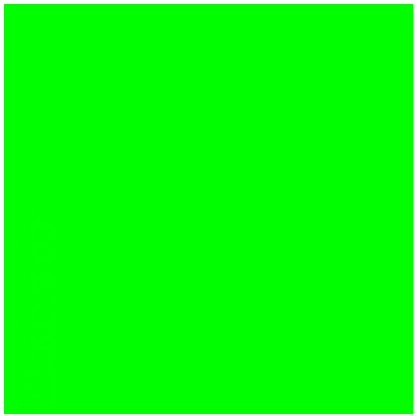
# Myth or Fact:

Early Intervention is too young to start AAC.

Fact



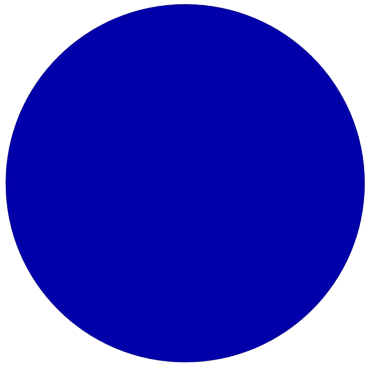
Myth



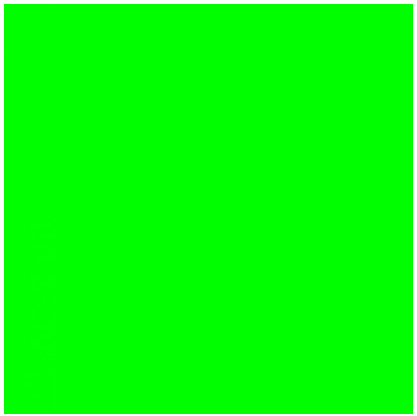
# Myth or Fact:

Using AAC will stop a child from producing a signed or spoken language.

Fact



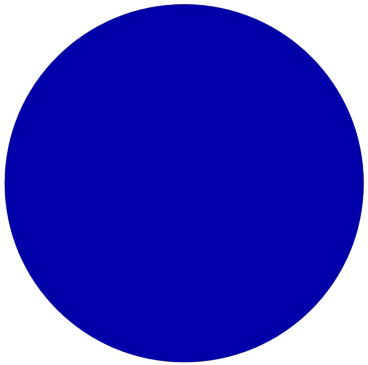
Myth



# Myth or Fact:

There are prerequisite skills that a child needs in order to be a candidate for AAC.

Fact



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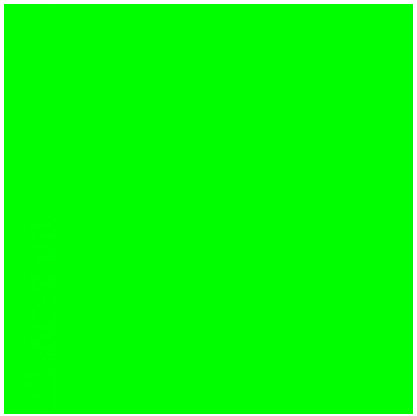
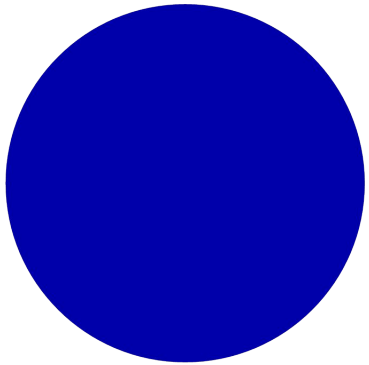


# Myth or Fact:

A child can sign MORE, they do not need AAC.

Fact



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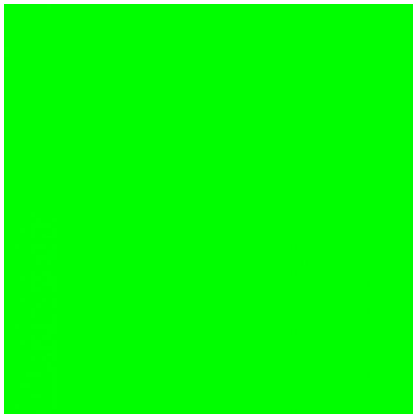
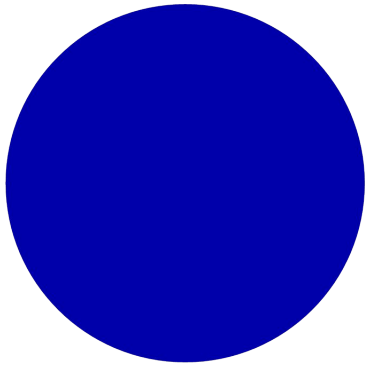


# Myth or Fact:

Early intervention providers should not recommend high-tech forms of AAC due to the adverse effects of screen time in children.

Fact



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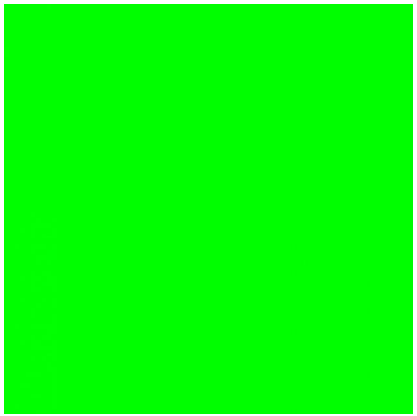
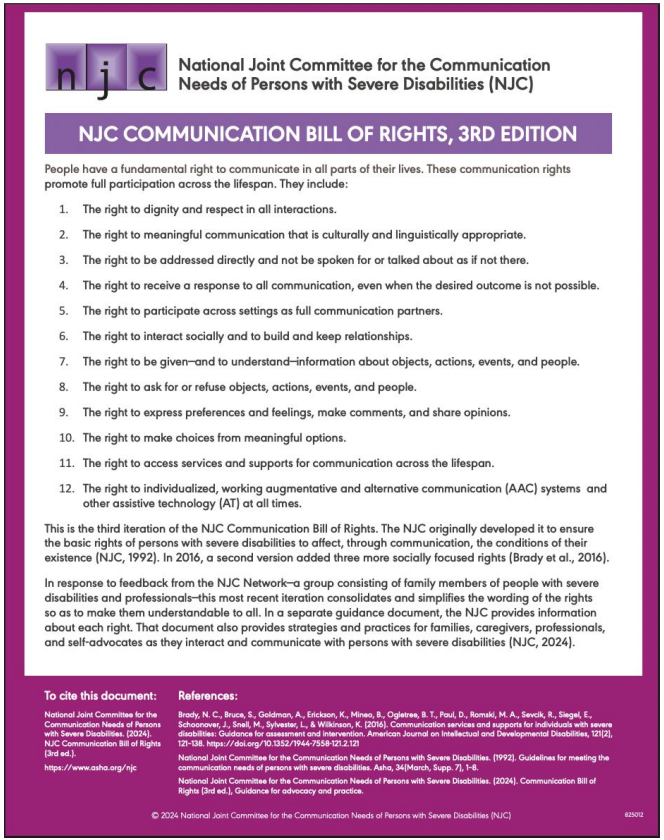


# Communication Rights

DeafDisabled individuals have fundamental communication rights, as listed by the National Joint Committee for the Communication Needs of Persons with Severe Disabilities.

Deaf/Hard of Hearing children have the right to appropriate forms of AAC.However, Deaf/Hard of Hearing children also have the right to develop language naturally (e.g., through immersion in a signing environment).

**What it comes down to is access. Can Deaf/Hard of Hearing children access language independently or do they need language to be augmented in order to best access it?**



National Joint Committee for the Communication Needs of Persons with Severe Disabilities (NJC)

## NJC COMMUNICATION BILL OF RIGHTS, 3RD EDITION

People have a fundamental right to communicate in all parts of their lives. These communication rights promote full participation across the lifespan. They include:

1. The right to dignity and respect in all interactions.
2. The right to meaningful communication that is culturally and linguistically appropriate.
3. The right to be addressed directly and not be spoken for or talked about as if not there.
4. The right to receive a response to all communication, even when the desired outcome is not possible.
5. The right to participate across settings as full communication partners.
6. The right to interact socially and to build and keep relationships.
7. The right to be given—and to understand—information about objects, actions, events, and people.
8. The right to ask for or refuse objects, actions, events, and people.
9. The right to express preferences and feelings, make comments, and share opinions.
10. The right to make choices from meaningful options.
11. The right to access services and supports for communication across the lifespan.
12. The right to individualized, working augmentative and alternative communication (AAC) systems and other assistive technology (AT) at all times.

This is the third iteration of the NJC Communication Bill of Rights. The NJC originally developed it to ensure the basic rights of persons with severe disabilities to affect, through communication, the conditions of their existence (NJC, 1992). In 2016, a second version added three more socially focused rights (Brady et al., 2016).

In response to feedback from the NJC Network—a group consisting of family members of people with severe disabilities and professionals—this most recent iteration consolidates and simplifies the wording of the rights so as to make them understandable to all. In a separate guidance document, the NJC provides information about each right. That document also provides strategies and practices for families, caregivers, professionals, and self-advocates as they interact and communicate with persons with severe disabilities (NJC, 2024).

**To cite this document:**

National Joint Committee for the Communication Needs of Persons with Severe Disabilities. (2024). NJC Communication Bill of Rights (3rd ed.). https://www.asha.org/njc

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# Q & A

# Hands on Practice

Due to time, we may be unable to role play using AAC. If you would like to see AAC in person, please find us after the presentation!

# Additional Resources


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