Autism is on the rise. Unfortunately, recent studies have estimated that somewhere between 1 in 500 to 1 in 166 children are affected by this potentially debilitating disorder which impacts a child’s social functioning, communication, and behavior (Centers for Disease Control and Prevention, 2005). Researchers and professionals alike have speculated with growing concern as to the cause of this drastic jump in prevalence rates. Certainly, part of this increase may be due to our enhanced ability to recognize the signs and symptoms of autism earlier in childhood, and to diagnose with greater precision and accuracy.

Yet many speculate that due to our expanded understanding of autism, we are now including in the diagnosis a wider range of symptoms, thereby transforming what we once knew as “classic” autism into a range or spectrum. Indeed the face of autism has changed. We have learned that there exists a tremendous diversity within the disorder – no two children with the same diagnosis are alike. Many children that were previously labeled as “socially odd”, or as being “disruptive” or “oppositional” are often now identified as suffering from a milder form of the same disorder. This has led to the term “Autism Spectrum Disorder” (ASD) in order to include those with milder disabilities such as Asperger’s Disorder or Pervasive Developmental Disorder, NOS (not otherwise specified).

Many of these children suffer similar impairments as their autistic counterparts, but are far more difficult to identify, especially in early childhood. They may not exhibit the classic symptoms that lend themselves to prompt identification, such as a lack of speech or absence of eye contact. Due to their mild presentation, they are often simply missed during brief visits with their pediatrician, and can go unnoticed in preschool or other group environments. Although two thirds of children with autism have a developmental delay in other areas such as mental or motor development, one third of these children are developmentally on target with their peers.

How on earth, you may ask, can we possibly identify children who are milder in their symptoms, or who, upon observation, appear to be keeping up with their peers in their mental and motor development? As it turns out, this is a very critical question. We now know that early intervention, such as behavioral therapies, speech/language therapy, and social skills training yield the most positive outcome. This is especially true for those children who are on the milder end of the spectrum. In fact, those children who are at par with their peers in their mental development show the most gains from early intervention (Powers, 2000).

Fortunately there is an answer: learn to recognize the diverse social and emotional signs of autism spectrum disorder that can emerge in the critical years of birth through three. Carry with you this knowledge in order to identify these children early on and make appropriate referrals for further evaluation. It is important to remember that there will not be any one “telltale” sign, just as a runny nose alone does not necessarily mean you have a cold. However, if you make yourself familiar with some social and emotional
symptoms a child with ASD might be exhibiting, you could be the one person that catches what others have missed: this child isn’t “disruptive” or “odd”, he may have an autism spectrum disorder.

**Birth To 12 Months**

Currently, we are simply not able to diagnose ASD at this age. Yet when parents of children who have been diagnosed are asked to recall their child’s behavior in infancy, some do say they remember social/emotional differences. Normally, the social/emotional development in infancy is fairly predictable. As early as 8 weeks, an infant demonstrates a social smile when viewing a human face and begins tracking their caregiver when he/she moves about the room. At 4 months, infants smile spontaneously at others, enjoy company, and are aware of (and seek to touch and explore) other infants. At 8 months, infants begin to enjoy social games such as “peekaboo”, and have become so socially adept that they are able to distinguish mother from others, and exhibit “stranger anxiety”. At 10 months, infants seek to imitate others, either with vocalizations, or in non-verbal ways such as waving “bye-bye”. Separation from their caregivers can spur significant anxiety, and the predominant mode of play is solitary in nature.

Some of the signs of ASD which mothers have reported retrospectively is that their infants simply preferred focusing on inanimate objects such as mobiles or toys rather than on their mother’s face. Eye contact may not necessarily have been noted to be poor, but some parents do describe eye contact as fleeting or inconsistent. Parents often recall temperament which they feel was unusual. They either recall the infant as overly passive or “too good” yet there are others who found their baby irritable or extremely difficult to soothe. Facial expressions and social smiles may have also been intermittent. A baby may have needed considerable tactile stimulation (such as touching or tickling) before rendering a social smile or may have giggled despite the parents’ report that nothing prompted this reaction.

Social games such as “peekaboo” or “pattycake” may not have been of interest, or may have held the baby’s attention for very limited periods of time. Parents often describe this saying “he only played peekaboo when HE wanted to”. Other aspects of social development such as non-verbal imitation (e.g. clapping hands or waving bye-bye) may not have emerged until much later, or may have required considerable prompting on behalf of the parents in order to motivate the baby to do so. Attachment and social awareness of their caregivers also may have had distinctive qualities. They may have had little or no stranger anxiety, and may have tolerated separation exceedingly well. Others describe their infants as being extremely reactive and difficult to calm in the presence of novel adults, or with separation from the familiar caregiver.

**12 to 24 Months**

Although some children with more severe forms of autism may be diagnosed as young as 18 months, many children with ASD, due to their mild presentation, are not identified until later. This is a critical period, however, as children in this age range can begin to fall behind their peers in their social and emotional development. Although a
firm diagnosis may be a year or two off, recognizing these first signs is key in allowing prompt identification.

In terms of social development, typically-developing toddlers at this age demonstrate interest in the activities of their peers. They are, however, mostly observers, and most of their interactions are limited to an exchange (peacefully or not!) of toys. Children are developing a sense of identity and independence, and can become possessive (and persistent) in regards to their toys or activities. Play can be very interactive with their caregivers — often games such as “hide and seek” are very enjoyable. Social imitative play also emerges. Children seek to imitate and recreate actions and activities they observe, such as pretending to feed a doll or wipe off a table.

Emotionally, tantrums are not uncommon, as children’s newly discovered identity and growing independence clashes with the realities of their world and the limits placed on their behavior. It is through these tantrums, and a child’s increasing ability to regulate his emotions, that he learns to overcome feelings of anxiety, disappointment, and frustration more easily. Although children at this age are still fairly self-centered, and have not yet developed the ability to empathize, they can be noted to react to other’s emotions. For example, when seeing another child fall down and begin crying, a toddler at this age may approach this child, approach their caregiver, or demonstrate a facial expression of cautiousness or concern.

So how might a child with ASD look different? We certainly cannot expect a toddler at this age to initiate play with others, or to simply not have emotional outbursts such as tantrums. So, what can we see? This is often not so easy, but many children are already exhibiting differences.

In the social domain, if we look more closely, the ASD child may, on the surface, appear to demonstrate interest in “observing” other children’s activities. However, this may be limited to times when the toys or activities that others are involved with are inherently interesting to them. Therefore at other times, they may appear to be unaware or disinterested in what others around them are doing. Many ASD children do enjoy interactive play with adults. However, this play often needs to be initiated by the adults or caregivers rather than the child. Social contact initiated by the toddler may be more based on acquiring help or fulfilling needs. For example, tugging on Dad’s sleeve to come join his play with the toy trains can be actually less social, and more instrumental in nature — he just simply can’t put together the track without Dad’s assistance. The ASD toddler may be less likely to engage in social imitative play spontaneously. He may have acquired a few simple activities such as pushing toy cars, making toy dinosaurs “growl” or even feeding a baby doll. Yet in comparison to others, there is not significant variety in their imitative play repertoire. This can lead them to be somewhat excessive (“he just loves those toy cars”), or fleeting (“he can feed a baby doll, but after one minute, he’s onto something else”) in their attention for these activities.

Emotionally, just as their typically-developing peers, toddlers with ASD may engage in temper tantrums. However, when we look at the causes or “triggers” of the tantrums over time, a pattern often emerges. It is frequently the intrusion of others in their activities, or a transition away from a preferred toy or activity that sets them off. This requires the astute observation of a caregiver or teacher who knows the child well, as we know that all toddlers can get upset in these situations. What we are talking about here is a trend or tendency, and when we notice these patterns occur more often and with more
intensity than their same-age peers, we certainly have a cause for concern. You may hear others attributing these frequent and somewhat predictable emotional outbursts to the child’s temperament or personality. For example, “He is a very stubborn child, he’s very strong-willed”. In social interactions with the parent or caregiver, this leads the child to be more difficult (but not impossible) to direct than other children. Others may describe him as “very independent”, or “it’s his way or the highway”.

Emotionally, ASD toddlers may tend to be less reactive to the emotions of others. When adults smile and praise them, or scold and reprimand them, they may show appropriate emotional reactions (such as delight or shame) inconsistently. At times they may appear unaware of others’ reactions or are “engrossed” in their own activities. It is this apparent minimal or fleeting motivation to acquire social praise from their adult caregivers that can result in perceptions that the child is difficult to discipline. This can lead to subsequent (incorrect) assumptions that their child is oppositional in nature.

24 to 36 Months

This is the time when many ASD toddlers may be diagnosed if they have been referred to the appropriate professional. Many still may only receive a provisional, or “working” diagnosis indicating that mild symptoms are present, but it is unclear as to whether they are significantly impacting the child’s functioning.

Typically, parallel play is common at this age (i.e. two children playing side by side). Children begin to enjoy following one another’s lead, and imitating others’ behavior. Frequently children will initiate play with others and bring or show objects to caregivers in order to share their delight (e.g. “look, plane”!) This is also when self-identity and independence are at their peak, and children seek to do things without assistance. They do not like to share (the ‘mine’ stage), and have not yet learned turn-taking or other cooperative play skills. Tantrums still occur, but children are learning what is expected of them, and are acquiring skills to regulate their emotions. In addition, most children seek praise and approval from adults/caregivers. Therefore with appropriate praise and reinforcement, most demonstrate a decrease in tantrum behaviors, especially as they approach age 3.

Although the ASD child may engage in parallel play, when peers move on to other activities, he may stay with a preferred game or activity for a considerable period of time. He may require more prompting by caregivers to engage in games which require imitation or following the lead of others. ASD children may initiate play and may show or bring objects to others, but they often do so less frequently than most children. A caregiver who knows them well may notice that these children may point out objects of interest to others that are relatively narrow in scope (e.g. just cars or just trains).

Emotionally, some of these children may demonstrate tantrum behaviors which can be very extreme, described by some as “meltdowns”. ASD children may require more warnings or warm-up time during daily transitions. Attachments to adults may be noted to be different in quality or intensity from their typically-developing peers. Some ASD children appear to be indifferent to separation from their parents or caregivers. Others may have more considerable difficulty separating from parents and may be very difficult to soothe after such a separation. This apparent fear of novel situations may generalize to other new environments such as a shopping mall or grocery store. At this
time, caregivers may begin to notice their child’s preferences for familiarity and predictability in their day. This preference can often extend to social relationships. Many ASD children can look very appropriate when relating to familiar adults and siblings, but may shy away from relationships with novel adults and peers.

**What To Do When You Have Concerns**

As we can see, the social and emotional characteristics of ASD children are not clear-cut. In addition, children with other disabilities can struggle in the same areas. For example, a developmentally-delayed child will lag behind their peers in social and emotional functioning as well. This is typically where a referral for an evaluation can be helpful in order to assess whether these symptoms indicate the presence of ASD. Irregardless of whether or not a diagnosis is made, clear identification of these concerns is crucial so that an educational program suited to the child’s individual strengths and weaknesses can be developed.

If you know of a child who you think may be exhibiting signs of ASD, encourage the family to promptly consult with their pediatrician, school, or other local resource group for an appropriate referral. An evaluation should be conducted by a psychologist or other health professional that has specialized training in developmental assessment. Despite the fact that autism spectrum disorders appear to be more common than before, there is also a greater number of available resources offering early intervention services. When identified and assisted at this critical age, ASD children often show substantial improvements and can make extraordinary strides.

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