

Special Education Needs 特殊教育需要

Categories of Special Educational Needs

(1) Specific Learning Difficulties (SpLD) 特殊學習困難 (讀寫困難/讀寫障礙)

(2) Intellectual Disability (ID) 智力障礙

In comparison with their peers, the global development of students with ID is delayed and they have marked difficulties in cognitive functioning in the following areas:

- reasoning is relatively concrete, weak in abstract and logical thinking;
- weak in memory;
- have short attention span and are easily distracted;
- have weak language expression, limited vocabulary, or articulation defects;
- weak in gross motor and eye-hand co-ordination which affect their daily self-care; and
- have weak social skills.

(3) Autism Spectrum Disorders (ASD) 自閉症譜系

These children show marked disabilities in social development, language communication and behaviour adjustment.

(4) Attention Deficit/Hyperactivity Disorder (AD/HD) 注意力不足／過度活躍症

These children are usually inattentive, hyperactive and impulsive.

(5) Physical Disability (PD) 肢體傷殘

(6) Visual Impairment (VI) 視覺障礙

VI can be classified as total blindness and low vision.

(7) Hearing Impairment (HI) 聽力障礙

A disorder in any part of the auditory system will affect the hearing ability, thus affecting the speech and communication abilities.

(8) Speech and Language Impairments (SLI) 言語障礙

(9) Mental Illness (MI) 精神病

6. Mistakes

Children with ADHD have difficulty following instructions that require planning or executing a plan. This can then lead to careless mistakes, but it doesn't indicate laziness or a lack of intelligence.

7. Daydreams

Children with ADHD aren't always rambunctious and loud. Another sign of ADHD is being quieter and less involved than other kids. A child with ADHD may stare into space, daydream, and ignore what's going on around them.

8. Forgetful about daily activities

Children with ADHD often forget things, for example, forget bringing textbook, forms signed by parents and homework; forget an appointment with teachers etc.



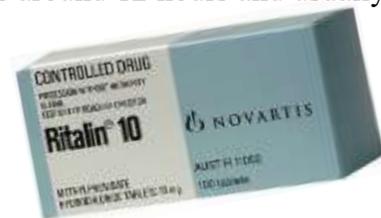
Treatment

ADHD is treatable. If a child is diagnosed with ADHD, review all of the treatment options. Then, set up a time to meet with a doctor or psychologist to determine the best course of action.

Methylphenidate is the common type of medicine used to treat ADHD. The two types of Methylphenidate are Ritalin (利他林) and (專注達). Duration of Ritalin is around 3-4 hours and usually needs 2-3 doses per day whereas that of Concerta is around 12 hours and usually needs single daily dose.

Some common side effects of medication include:

- sleep problems
- decreased appetite
- delayed growth
- headaches and stomachaches
- tics
- moodiness and irritability



When side effects become a problem, doctor usually try to change the dosage, the release formula, or the type of medication the child is taking.

甚麼是專注力不足/過度活躍症（ADHD）？

專注力不足 / 過度活躍症的主要徵狀包括專注力弱、過度活躍和行為較衝動。這些徵狀造成學習或社交上的困難，並可能導致情緒問題或自我形象低落，令患者在生活適應上出現重大問題。

專注力不足/過度活躍症（ADHD）常見特徵

1. 過度活躍

- 在座位經常扭動身體，手腳經常擺動，無法安坐
- 經常離開座位
- 「無時停」，好像「開著摩打」似的
- 在不適當的時候，經常亂跑或爬高爬低
- 說話過多，不能保持安靜



2. 衝動

- 經常按捺不住打擾別人對話
- 不能耐心排隊或輪候
- 挫折承受力弱
- 問題還沒有問完便搶答

3. 專注力弱

- 難以集中精神，需要很長的時間做功課，甚至未能完成功課
- 不能貫徹地執行指示
- 別人對他說話好像沒有聽見
- 經常忽略細節，經常粗心大意犯錯
- 健忘
- 組織力不足，做事欠條理
- 逃避需要思考的工作



專注力不足/過度活躍症 (ADHD) 的治療方案

1. 藥物治療

藥物幫助改善腦部多巴胺及去甲腎上腺素的不平衡，從而改善腦部對衝動、過份好動及專注力的控制。常用的藥物為哌醋甲酯(Methylphenidate)。哌醋甲酯有兩種配方，包括短藥效的利達林(Ritalin)及長藥效的專注達(Concerta)。短藥效與長藥效的分別在於前者藥力只能維持 3-4 小時，而後者則能維持 12 小時。故兒童患者需要每天服用短效藥 2-3 次，而服用長效藥只需一天一次便可。

副作用則有以下 9 種：

- 食慾不振 — 藥物可令孩子胃口下降，尤其是當劑量高及服藥初期。家長應給多高熱量的食物，及於藥效過後，增加食物的份量。
- 腸胃不適 — 通常出現於服藥初期(剛服藥不久)，隨著兒童患者身體適應藥物後，副作用會消失。於飽肚下服藥亦可減低不適的情況。
- 頭痛
- 失眠 — 服藥後較遲才能入睡。避免晚上服藥，提早最後服藥時間以減低劑量對睡眠的影響。
- 肌肉抽搐 — 此藥可能導致少部份有抽搐徵狀的兒童患者情況惡化。但近年的研究顯示服用此藥對此類兒童患者是安全的。
- 情緒變得緊張、低落或煩躁 — 此副作用較為少見，部份兒童患者於減藥(劑量減少)或轉用長效藥後會有所改善。
- 此藥有可能增加患有羊癇症兒童患者病發的機會。
- 此藥不適用於同時患有青光眼、思覺失調的患者。

中樞神經刺激劑的副作用是輕微及暫時性的。通常於減藥及改變用藥時間後會得到改善。

有些家長於假期時讓孩子停藥，所謂藥物假期(Drug Holiday)。此安排的確可減去副作用之影響，但亦會使某些兒童患者的病徵及行為表現惡化。

2. 行為治療

有系統的管教方法可改善兒童的行為問題。

針對患者需求而設的治療方案對患者最為有利。大部分專注力不足/過度活躍症的兒童患者將在青少年期安定下來，不少亦能夠跟上學習進度、改善其學習表現並和結交朋友。

B. Dyslexia

Dyslexia is a language-based learning disability. It refers to a cluster of symptoms, which result in people having difficulties with specific language skills, particularly reading. Students with dyslexia usually experience difficulties with other language skills such as spelling, writing, and pronouncing words.

Common signs of dyslexia include:

1. Taking a very long time to finish assignment that requires reading and avoid reading out in class. This is because sounding out or “decoding” words is difficult with dyslexia, which slows down the reading process.
2. Having difficulty saying the right word and use words that sound similar but have different meanings (eg. “distinct” instead of “extinct”). This is because it is hard for
3. Struggling with writing assignments and has difficulty expressing ideas in an organized way and with proper spelling, grammar and punctuation.
4. Struggling with Math. Have problem with numbers and calculations involving adding, subtracting and time tables. Feel confused by similar-looking mathematical signs and may reverse numbers and transpose numbers.

Medicines and counseling usually aren't used to treat dyslexia.



Special arrangement given by HKEAA

HKEAA provide special services for candidates who meet the diagnostic criteria of Dyslexia, depending on the nature and severity of their disability, their history of special provisions in school, and recommendations from the psychologist and school, special examination arrangements may be made as appropriate. These may include:

1. Additional examination time may be allowed if supporting evidence is provided. Normally, a 25% extended time allowance will be granted for written papers and 15% for multiple-choice papers.

2. Supervised breaks will be given to candidates with time allowance. Depending on individual needs, schools /candidates may choose whether or not to have breaks. Supervised breaks are only applicable to examinations lasting 90 minutes or more. Normally, a 5-minute break for every 45 minutes of examination will be given. Additional breaks may be permitted only in exceptional cases with justifications.
3. Question papers with one-sided printing or enlarged print (black and white), or ivory-colour question papers may be provided to candidates.
4. Candidates may be permitted to present their answers in a special manner, such as writing on alternate lines or pages of an answer book, circling the multiple-choice answers on a question paper instead of filling in the boxes on an answer sheet. Special answer sheets with wider line spacing may be provided upon request at special centres.
5. Candidates with special examination arrangements will be allocated to special centres. Special examination centres are normally set up in secondary schools (mostly classrooms with a few school halls). Depending on the special needs of the candidate, he / she may also be assigned special seating (e.g. near the front or back of the examination room). Depending on the supply of special centres in various districts, candidates may not be arranged to take the examination in their chosen examination district.
6. Use of a screen reader. If the word reading ability of a candidate with SLD in the first language has been assessed on a standardised test with relevant norm by a professional and the test results indicate that he / she has severe word reading difficulties, he / she may be allowed to use a screen reader in designated examinations to read out the question papers. This arrangement is not applicable to examinations testing candidates' reading comprehension skills or correct pronunciation. The school should provide exam venue and computer facilities (including the text-to-speech software) for the candidate in the public examination. Private candidates have to provide their own computer with the relevant software.

Students must apply for special arrangement according to the Application Guide.

http://www.hkeaa.edu.hk/en/Candidates/special_needs_candidates/hkdse.html

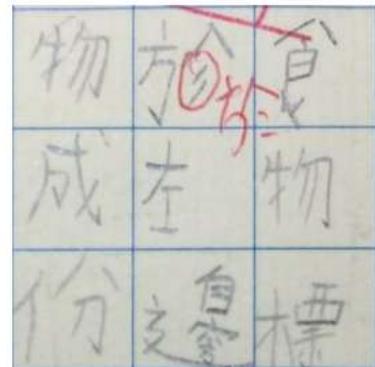
特殊學習障礙

特殊學習障礙英文是 **Specific Learning Disabilities**（簡稱學障或 **SLD**），它是：

- 腦部發展異常情況所造成：這種中央腦神經系統失調而引起的核心障礙，導致學障學生未能準確流暢地自動辨別和記憶個別的文字
- 一種「隱性障礙」，表面沒有明顯特徵
- 與智力不足無關，學障學生智力絕對正常，甚至是資優
- 不能醫治，因為它本身不是「病」，而是一種「障礙」、「缺陷」。假若學障學生能及早識別及接受有效的訓練（如學習技巧、輔導課程、視覺空間感知訓練、言語治療等）和協助，情況會有所改善。

「特殊學習障礙」的類別可分以下五類，當中以讀寫障礙最為普遍，佔其中八成半，亦有研究估計全球約有多至一成的人口有不同程度的讀寫障礙。

- 閱讀障礙（讀寫障礙）
- 特殊語言障礙
- 發展性協調障礙
- 特殊數學運算障礙
- 視覺空間感知障礙



學障學生可單一或按不同程度同時存在以上五種類別，亦可能同時有「專注力失調」和「社交發展遲緩」、「自閉症」等等。

（一）讀寫障礙（Developmental Dyslexia）

• 原因

腦部處理文字的「硬件」有與生俱來的差異，導致掌握文字的聲音、外形和意義之間的聯繫出現困難。這種情形往往有遺傳因素，而男性比女性的個案為多。

• 主要特徵

1. 每個字都要重複溫習多次方可牢記，但轉眼又會忘記。認字、默字、串字都成為他們的大問題。
2. 由於認字方面出現困難，故此無法理解題目。老師或家長若將題目讀出來，他們便可對答如流。
3. 閱讀障礙的嚴重程度不一，可由輕微到非常嚴重。相應地，出現問題的兒童年齡可以由一、二年級至高小不等。

(二) 特殊語言障礙 (Specific Language Impairment)

• 原因

不少幼童在早期語言發展可能比較遲緩，但經指導和學校教育，大部分均能慢慢地趕上，可是有少數患者卻有持續的語言障礙，這是由於負責語言發展的腦部組織未能擔任理想的功能，孩子的語言能力因此就相應地出現障礙，以至最終語言能力發展未如理想。

• 主要特徵

1. 說話句子組織能力弱，表達和理解方面都甚差。
2. 複述事情時顯得混亂，對方難以明白。
3. 非語言能力明顯較好，令老師覺得孩子表現不平均。

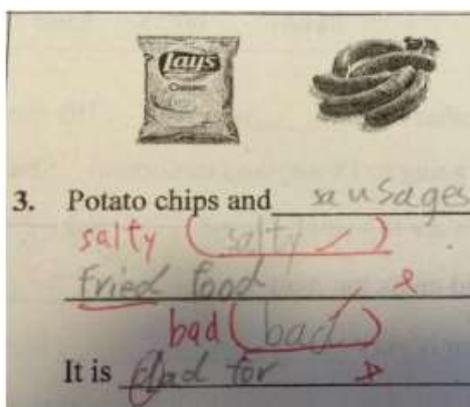
(三) 發展性協調障礙 (Developmental Coordination Disorder)

• 原因

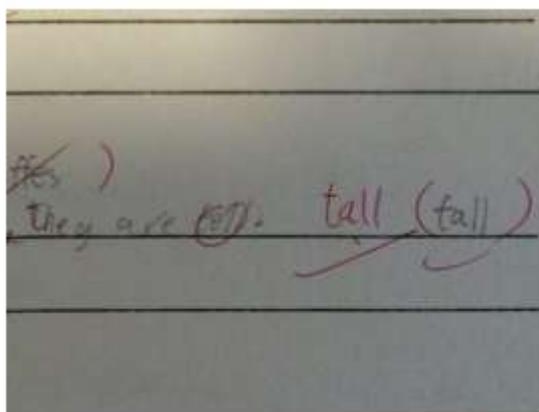
人體內的中樞神經系統聯同其他控制平衡、姿勢、動作計劃和協調的各神經系統部位，是負責保持一個人肌肉功能的靈活操作。有發展性協調障礙的兒童，往往因這些系統未能協調地運作，引致大小肌肉上的不協調，所以他們時常出現不靈活的現象，而坐立不安的情形也可能是因為孩子取不到重心平衡，而並非是好動、頑皮的表現，可惜這些孩子往往被誤會為過度活躍、搗蛋。

• 主要特徵

1. 寫字欠佳又吃力，手腳不靈活。
2. 身體平衡感較差，經常因為笨拙而引致自己或他人發生意外。
3. 字體的大小多超越所指定的格或行的範圍。



「b」與「d」混淆



「a」與「e」混淆

(四) 特殊數學運算障礙 (Specific Learning Disability in Mathematics)

- 原因

數學運算是需要不同認知的配合方能成功處理，包括長期記憶（例如記公式、乘數表）；運作記憶（如腦部運算上的暫時記憶）；語文能力（用於推理時的思考和文字題的理解）；手眼協調（書寫需保持一定工整才不會引致不小心的錯誤）；專注力控制。

任何一項以上的認知能力如有所欠缺，數學運算能力就相應受到嚴重影響。

- 主要特徵

1. 數學上的能力與其他能力不相符。以孩子一般表現，常常作出「驚人」的運算和邏輯上的錯誤。
2. 這些孩子很多都有不同程度的閱讀障礙，令學習困難更加嚴重。

(五) 視覺空間感知障礙 (Visual Spatial Perceptual Disorder)

- 原因

雖然孩子的視力正常，但因左腦的視覺感知區域發生障礙，以致對空間辨別、主體背景辨別及視覺恆常的能力有所影響，他們卻被人誤會為「視」而不見，不留心學習的孩子。

- 主要特徵

1. 對於任何空間的辨識有困難，未能組合「字」的不同部份，看起來像「散」開一般。
2. 寫字的筆劃長短經常出錯，常有加多或減少筆劃。
3. 未能辨認形狀相似的字，例如：日→目；春→看；土→士

C. Autism Spectrum Disorder (ASD)

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder, characterized by different degrees of impairment and deviance in the development of social communication, cognition and emotions, and presence of restricted, repetitive patterns of behaviours and interests as well as sensory processing problems. The symptoms fall into a spectrum of severity with associated intellectual, language, and neurodevelopmental impairment. With new diagnostic criteria in recent years, categories of Autistic Disorder, Asperger's Disorder, High Functioning Autism, Autistic Features, Atypical Autism and Pervasive Developmental Disorder Not Otherwise Specified are subsumed under the new diagnosis of "Autism Spectrum Disorder" (ASD) as one disorder.

The behavioural manifestation of the core features of children with ASD can vary greatly, with the following common clinical presentations:



(1) Deficits in social interaction:

Social interaction difficulties may vary from being aloof, passive to over-passionate, or odd mannered behaviours. Some of the very young children with ASD may only approach adults for addressing physical or biological needs, such as getting food or toys. For these, they may use others as mechanical aids to get what they need. Some may show aversion to physical contact and stiffen when held. They may show limited social relatedness and attachment with parents or close care-takers, and prefer to play alone and with little or no spontaneous sharing of interest, enjoyment and achievements. Older children may fail to initiate appropriate social signalling to others (e.g. socially directed smiles, eye to eye gaze), and lack response to others' signals in social situations. For those who have developed useful verbal language, communication is still often used for instrumental rather than social purposes. Apart from aloofness, some may attempt to socially relate as instructed by adults but with low social volition, while others with higher social intention may appear odd, over-passionate and self-centered.

(2) Deficits in non-verbal communication:

Children with ASD are weak in the use of non-verbal communication. Very young children with ASD may have difficulty indicating needs through pointing and eye-gazing. Limited facial expression and poor eye contact may render them to be seemingly rude, uninterested or inattentive in social interactions. Some may speak with high-pitched voices, strange prosody or with robot-like monotone. Older children may have difficulty in understanding social cues from body language and tone of voice. The overall integration of verbal and non-verbal communication is weak.

(3) Deficits in relationship and friendship building:

Children with ASD lack adequate social skills to develop friendships with others. Many children with ASD have speech and language difficulties, such as weak fund of vocabularies, pronominal reversals, which affect their ability to converse effectively with peers and in friendship building. Even for those with intact language and who are eager to make friends, the weakness in empathy to understand others' thoughts and feelings creates a range of challenges. These include difficulties in processing complex social cues and understanding implicit social rules, regulating behaviour to match specific social context, following rules of the communication context, and understanding non-literal languages including jokes, idioms and metaphors. Friendships are often one-sided or based solely on shared special interests. Inappropriate attempts at social interchange are often interpreted as aggressive or disruptive behaviour as they may be socially immature, mechanical, awkward or overly passionate.

(4) Stereotyped or repetitive motor movement or use of objects/ speech:

Restricted and ritualized patterns of verbal or nonverbal behaviours are common during early and middle childhood. During early childhood, common examples of non-verbal restricted and ritualized patterns of behaviour include lining of objects and repetitive opening and closing doors. Stereotyped body movements (stereotypies) such as flapping of hands, running back and forth, head banging, rocking of body, self-spinning, finger movements and grimacing may be present when these children become excited, distressed or agitated, and diminished through structured environments. Some children may repeatedly watch the same movie or read the same story book. Stereotyped verbal language

may be rote and repetitive, lacking in functional communicative intent. The unusual speech pattern may include stereotyped words or phrases which are out of the context, immediate or delayed echolalia, repetitive questioning, and greeting rituals, and for some older children pedantic speech with vocabularies or phrase that are unusual for age or social group may be seen.

(5) Insistence on sameness:

Children with ASD often show insistence on sameness or excessive adherence to routines. Insistence on taking the same route, maintaining same arrangement for objects, eating a narrow range of food items, adopting rigid thinking patterns are some common examples. Many respond to small changes in the environment with disproportionate distress, including change in routine, transition from one activity to another, and moving to new home/classes with changes of people and environment.

(6) Fixated interest:

Fixated or narrow interests are very common in children with ASD. Some demonstrate strong memory of information and data and fascination with numbers, bus routes, calendar and natural sciences. In early infancy and early childhood, commonly there is absent or minimal exploratory play or symbolic/fantasy play. Instead, the play is monotonous and repetitive, and lacking variation, such as spinning and lining activities. For older children, including those with high functioning, there may be limited imitation, creativity and imagination. They may have unusual preoccupation with parts of objects, or perseverative interests with particular topics, all leading to negative impact on their daily and social functioning.

(7) Sensory issues:



Some children with ASD have sensory processing problems of hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment. Some show apparent indifference to pain, heat or cold, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement (e.g. spinning objects). They may present sensory seeking or avoidance behaviours to usual auditory, tactile, or vestibular stimulation, manifested as repetitive and compulsive behaviours.

How does ASD affect children?

ASD are life-long disorders. The syndrome can cause significant impact on parent-child relationships, peer relationships and adjustment to school and society. Children with ASD vary greatly in the overall functioning depending on the individual's age, language and intellectual development, as well as other factors such as treatment history and ongoing support.

(1) Age:

Clinical features vary with age as the child's developmental repertoire changes. Symptoms are typically recognized during the second year of life (12-24 months of age) but may be seen earlier than 12 months if developmental delays are severe, or noted later than 24 months if symptoms are more subtle. Behavioural impairment appears most severe at two points throughout life: in early childhood (about 3-5 years old), and during and immediately after puberty (around 14-17 years old). Diagnostic criterion features are most obvious in early childhood while non-criterion (associated) features appear gradually later. While the rigid behaviours of an autistic child may wane, social and communication interaction may be progressively more strange and awkward in middle childhood when the social demands become more prominent. Some adolescents and adults with ASD might indulge in solitary web-based activities in order to reduce social interaction with peers. In face of challenges in daily, social, academic, and vocational life, or as a result of biological factors, some may develop symptoms of anxiety and depression which further debilitate their daily functioning.

(2) Language development:

Individuals with ASD vary in their degree of language impairment, ranging from complete lack of speech to language delay, poor comprehension, poor response to calling of own name or to speech of others, echoed speech, or stilted and overly literal language. Many children with ASD present an uneven profile of language development. For example, some children with ASD may quickly develop very strong vocabulary in a particular area of interest. They may develop strong literacy skills (e.g. reading alphabets, words or characters) at very young age, but not truly comprehend what they have read. Some have very good memory and may repeat in inappropriate contexts for what they have heard from commercials and television programmes in form of echoed speech. Some capable children may be able to deliver an in-depth "monologue" about a topic of their interest, but may not be able to hold a two-way conversation about the same topic.

(3) Intellectual development:

Recent prevalence study conducted by the Centers for Disease Control and Prevention (CDC) showed that 33% of children with ASD had intellectual disability, 24% were considered in the borderline range, while the rest were in the range of normal intelligence. Regardless of the level of general intelligence, verbal skills are usually weaker than non-verbal skills. Cognitive profile of children with ASD and average or even superior intelligence (i.e. “high functioning” individuals) is typically uneven, with difficulties in attention, complex language abilities, working memory and other executive skills, but with strengths in sensory perception, rote learning, visual-spatial problem solving and simple language skills.

Individuals with ASD usually present with rigid thinking style. They are weak in abstract thinking, organization and problem-solving skills. Some of them are weak in higher cognitive functioning, such as logical reasoning and executive functioning which lead to their deficits in self-management in daily life. Despite the well documented learning impairment in children with ASD, some individuals with ASD demonstrate superior perception, exceptional abilities and savant skills. These include a wide range of superior perceptual abilities in auditory and visuo-spatial tasks, specific knowledge in focused interests and savant abilities such as calendar calculation, hyperlexia, absolute pitch and synaesthesia.

What causes ASD?

Though the exact cause is still not fully delineated, ASD is now widely accepted to be a neurodevelopmental disorder that is highly heritable and resulting from multiple genetic and non-genetic causes. Heritability is demonstrated by the higher recurrence rate of siblings of children with ASD. About 10% of children with autism are also identified as having Down’s syndrome, fragile X syndrome, tuberous sclerosis or other genetic and chromosomal disorder. However, empirical findings have refuted poor parenting as a cause and there is overwhelmingly strong evidence that the measles, mumps, and rubella vaccine is not associated with ASD.

Mainstay of treatment for children with ASD?

The current mainstay of intervention for ASD is to improve the overall functional status of the child through behavioural and educational training, social adjustment, as well as continual parental support.

Evidence-based intervention programmes:

These should focus on addressing the core deficits of ASD, including social communication, language, play skills, and adaptive behaviours. Early, intensive and sustained interventions with the use of multiple treatment modalities carried out in natural settings, and with active parental involvement, are proven to be effective. The following are treatment approaches with more evidence and efficacy:

1. Behavioural approach:

This approach is based on the learning theory that behaviour is shaped by antecedents and reinforcement. Examples of programmes included Applied Behaviour Analysis (ABA) and Picture Exchange Communication System (PECS). Behavioural interventions should be considered to address a wide range of specific behaviours in children and young people with ASD, both to reduce symptom frequency and severity and to increase the development of adaptive skills. The approach involves breaking down complex skills or behaviours into smaller steps and teaching individuals through the use of clear instructions, rewards, and repetition. On the other hand, PECS provides an alternative means of communication for children who have limited verbal language. It is a systematic process to enhance these individuals' intention and motivation of communication through the use of alternative means of communication with symbols (usually pictures).



2. Combined approach:

Some programmes have been developed using principles from both the behavioural and social/developmental approaches. Examples include: 1) TEACCH (Treatment and Education of Autistic and related Communications handicapped Children) emphasizes the use of structured environment and visual cues to enhance an ASD individual's understanding of environmental expectations and others' behaviours, in order to facilitate their learning; 2) SCERTS (Social Communication, Emotional Regulation and Transactional Support) emphasizes active engagement, environmental support in enhancing an individual's learning and communication motivation, as well as emotional regulation and problem-solving skills.

3. Relationship-based approach:

This approach is generally play-based and taught in the child's natural environment with parents playing the major roles in the intervention. Examples of this approach include Developmental, Individual Difference, Relationship-Based Model (DIR) and Relationship Development Intervention (RDI). DIR / (Floortime) focuses on promoting development by encouraging children to interact with parents and others through play in a pleasurable atmosphere. This helps to facilitate children to reach milestones in their emotional development, enhance social awareness and establish intimate interpersonal relationship as well as expanding their learning experiences.

4. Socio-cognitive approach:

Examples include: 1) Social Stories are short descriptions of a particular situation, event or activity, which include specific information about what to expect in that situation and reasons behind. These strategies help children with ASD to understand others' perspective, learn appropriate social behaviours and build social skills; 2) Social Thinking are strategies that help an individual to build up social competencies to understand and interpret social information, including the thoughts, beliefs, emotions, perspectives, motives, intentions of others, so as to make appropriate social responses or action; 3) PEERS Program is teaching of appropriate social skills in group setting which emphasizes parents' involvement and enhances their instructional skills.



自閉症譜系障礙

甚麼是自閉症譜系障礙？

自閉症譜系障礙 (Autism Spectrum Disorder, ASD) 是一種與生俱來的發展障礙，患者在社交溝通以至認知、情緒、行為方面都有不同程度的困難和發展差異。此障礙除了影響患者與人互動的表現外，其行為亦會較重複及固執不變，同時有狹隘興趣和異常感官反應等問題。而其他相關障礙也包括智力、語言及其他發展問題。以往有關自閉症在診斷的名稱上常有差異，例如自閉症、亞氏保加症、高功能自閉症、自閉症傾向、自閉症徵狀、非典型自閉症、待分類的廣泛性發展障礙等，不同的名稱可能令家長感到十分困惑。隨着診斷標準的更新，以上名稱已統稱為「自閉症譜系障礙」。每位患有自閉症譜系障礙兒童的行為表現都不相同，有時甚至很大差異。

以下是一般較常見的臨床徵狀：

(一) 社交互動能力困難：

患有自閉症譜系障礙的兒童，其社交表現可以是冷漠、被動，或過份熱情、古怪。年幼時，除了因為生理需要（例如希望得到食物、玩具）而主動接觸大人外，他們很少主動與人接觸。他們或會利用別人的身體作為達到目的工具，有些對於身體接觸或擁抱等表現抗拒。這些兒童一般較難與人，甚至父母或照顧者建立親密關係。他們較喜歡獨自玩耍，很少注意其他同伴。他們也很少自發地分享個人興趣、感受及成就。部份兒童或會按成人的指示與人交往，然而他們的主動性通常較低；另外一些兒童雖然有社交動機，但卻表現過份熱情或較自我中心。至於較年長的兒童，他們仍然難以建立恰當的社交行為（例如對人微笑、眼神接觸），亦較難察覺別人的社交訊息及情緒反應，有時可能出現不恰當的行為表現。社交溝通方面，即使兒童已有一定的語言能力，但他們不擅與別人打開或持續話題，有時又不理會別人的反應，單向地與人講述一些自己感興趣的話題，給人一種「只顧講、不愛聽」的感覺。

(二) 非語言溝通困難：

患有自閉症譜系障礙的兒童較難運用非語言溝通技巧與人交流，年幼時欠缺眼神接觸及較少指向物件以表示需要。由於缺乏面部表情和眼神接觸，他們很多時給人一種沒有禮貌和不專注的負面印象。部份兒童說話時音調較高，語氣較為刻板或古怪。兒童長大後也未能掌握別人的身體語言、語氣聲調所傳達的意思，亦難以協調及一致地用語言和非語言訊息去表達自己的意思。

(三) 發展人際關係困難：

患有自閉症譜系障礙的兒童與朋輩相處時欠缺技巧，較難與人建立友誼。因為語言及溝通方面的困難（例如詞彙貧乏，容易將「你」、「我」等代名詞混淆使用），亦影響到他們結交朋友及與朋輩溝通相處的能力。即使他們有足夠的語言能力及興趣去結交朋友，在與人相處時，又因欠缺同理心，難以理解別人的想法和感受。他們一般較難理解「不明文」的社交常規，以至較難調節自己的行為以配合當時的處境（如面對陌生人或師長時也不懂忌諱）。他們較難明白非直接的溝通模式（如比喻、諷刺等說話），因此未能有效地與人交流。友誼建立方面也較單向，多數只與有共同興趣的人作伴。也有表現過份頑皮或暴力，給人不成熟、不自然或過份熱情的印象。

(四) 重複行為：

重複行為多見於學前或學齡期的自閉症譜系障礙患者，如排列物品、開關櫃門、轉動車輪等。他們興奮或激動時，個別會不停地拍動雙手、撞頭、搖動身體、自轉或來回走動等。有些兒童會反覆觀看同一影片 / 圖書，或重複背誦非溝通性的說話和重複詢問同一問題。部份年紀較大的兒童說話或會顯得文縷縷，甚至使用過多與其年齡及智力水平不符的專有名詞之類。

(五) 固執不變：

患有自閉症譜系障礙的兒童對常規表現固執，較難適應生活上的轉變，例如行走路線、物品位置、食物種類等，對於生活上的小改變可能會產生強烈的情緒反應。如由一項活動轉到另一項活動，或課堂上人與物的改變都可以觸發很大的脾氣。他們行為表現固執，過份堅持原則及常規，處事欠缺彈性，容易情緒激動或與人爭執。

(六) 狹隘興趣：

自閉症譜系障礙患者的興趣較狹隘，有些喜愛背誦巴士路線、交通標記、地鐵站名、地圖、日曆，或有關恐龍、太空、動植物等資料及數據。年幼時較少參與探索性或假想性遊戲（例如扮演老師或醫生等角色），他們的玩意及遊戲技巧亦比較單一、重複及欠缺變化（例如喜歡轉動錢幣或排列玩具車等）。年紀較大及能力較高的兒童，他們的遊戲仍然欠缺模仿、想像及創意，可能只對某些物件的部份顯得過分沉迷，這些過分沉迷的興趣都會對他們的生活及社交產生影響。

(七) 感官反應異常：

部份患有自閉症譜系障礙的兒童在感官方面有過高或過低的反應，例如有些兒童會對某些聲音、質感有極端的驚恐或抗拒的反應；有些對溫度及痛楚反應過低；有些則過分追求嗅某種味道、觸摸某種質感的物件或凝視某些光源及動態（如轉動的物件）。他們的感官反應不尋常，以致他們對於一些日常的感官刺激有過度追求或逃避的情況，形成重複及固執行為。

自閉症譜系障礙對兒童有甚麼影響？

自閉症譜系障礙是發展障礙的一種，它有機會伴隨兒童成長，並對其親子關係、朋輩關係、學校生活以至社區適應等方面產生深遠的影響。然而，每位自閉症譜系障礙患者的情況都不一樣，這與患者的年齡、語言、智力、過去及現在所接受的治療有著密切的關係。

1. 年齡：

當兒童年紀漸長，其自閉症譜系徵狀也因此而有所變化。一般來說，徵狀會在一至兩歲之間開始被發現，徵狀較嚴重的甚至在一歲前已被發現，而徵狀較輕微的或會在兩歲以後才被發現。較嚴重的行為問題多出現於兩個階段：幼兒期（約 3 - 5 歲）及青春期（約 14 - 17 歲）。自閉症譜系障礙的主要診斷徵狀於幼兒期較明顯，而其他附隨徵狀則在之後逐步出現。一般來說兒童的重複及固執行為隨著年紀長大可能會逐步減少，但隨著環境對其社交要求有所提升，兒童的社交及溝通問題或會變得越來越明顯。患有自閉症譜系障礙的青年或成年人，或許會花很長的時間，獨自沉醉在網絡世界或進行與其特殊興趣有關的活動，而刻意或無意地減少與朋輩接觸。面對每天來自社交、學業、就業及生理變化的挑戰，部份患者或會出現焦慮及抑鬱徵狀，進一步影響日常生活。

2. 語言：

患有自閉症譜系障礙的兒童，其語言能力可以有很大的差異，有些完全沒有語言，有些語言發展遲緩，有些語言理解困難，有些只能作鸚鵡式對話，有些則表達得過分文縷縷。當別人叫喚他的名字或與他說話時，他們經常不作回應。他們的語言發展可能出現不平均的情況，例如有些很快從其特殊興趣中學會很多專有的名詞，有些年幼便學會讀很多文字，但往往未能明白這些文字的意思，有些記憶力特別強，經常在不適當的場合中背誦從電視廣告或劇集中的對白。部份能力較高的兒童或會對有興趣的題目作深入的個人分享，然而他們卻難於就著同樣的題目作雙向互動的交流。

3. 智力：

根據美國疾病控制與預防中心的統計數據，約百分之三十八患有自閉症譜系障礙的兒童有智力障礙，約百分之二十四被界定為有限智能（中下至有限智能），而餘下的百分之三十八則屬正常智能範疇。不論整體智力水平如何，語言能力一般都比非語言能力為弱，擁有正常甚或優異智能（或被稱為「高功能」）的自閉症譜系障礙患者，他們的認知能力分佈也很不平均，一般於專注力、語言、工作記憶及執行功能表現較弱，但於感知、背誦、視覺空間等範疇表現較強。在思考方面，他們較難明白抽象的概念，在組織及解難能力上亦表現欠佳。他們或會在個別領域上有特殊技能，有些對文字、數理、音域、或聯覺方面有特殊興趣或非一般的才能，但在高階思維（包括邏輯思考及執行功能）方面有所欠缺，以致在計劃、組織、自我管理，及解難能力等均出現困難。

自閉症譜系障礙的成因是甚麼？

雖然仍未有確實的結論，自閉症譜系障礙的成因已被普遍認為與遺傳因素有相當大的關係，及由多項基因及環境因素相互影響。

研究普遍發現，自閉症譜系障礙的兄弟姊妹患有同一症狀的機會比一般兒童高。大約有百分之十的自閉症譜系障礙患者也同時患有其他遺傳及基因突變疾病（如唐氏綜合症、脆性 X 綜合症、結節性硬化症等等）。另外，研究已推翻父母管教方式及家庭背景是導致自閉症譜系障礙出現的原因。大量研究數據也指出接種麻疹腮腺炎德國麻疹混合疫苗與自閉症譜系障礙並沒有關聯。

如何幫助患有自閉症譜系障礙的兒童？

現時對自閉症譜系障礙兒童的最佳治療方法，主要是從教育及行為訓練著手，幫助他們建立有效的社交溝通技巧，從而加強其適應社會的能力。此外，提供家長支援亦是治療範疇中重要的一環。

實證為本的治療策略：

根據一般國際性醫學指引建議，有效的治療手法必須針對兒童的個別需要（如：社交、語言、幼年時期的遊戲技巧、社會適應行為等）而進行訓練。治療適宜於早期開始，密集及持久的訓練會對兒童更有幫助。治療及訓練亦必須配合家長的參與，以確保兒童及家長能有效地將學到的技巧延伸至日常生活及社區中應用。

實證為本的治療策略大致可分為：

(1) 行為策略：

此策略是透過分析行為出現的前因和後果，來釐定改變行為的方法。此方法可應用於處理兒童的行為情緒問題及建立新技能上，來提昇孩子的學習及生活適應能力。例如將新技能分拆成細小步驟，給予清晰的指令逐步教導兒童，再配以獎勵方法及重複練習的方式，讓兒童逐漸掌握新技巧，此訓練模式的例子有應用行為分析學 (Applied Behaviour Analysis, ABA)。此外，還有圖片交換溝通系統 (Picture Exchange Communication System, PECS)，這是一種輔助及替代性的溝通策略，多應用於語言能力較弱的孩子身上，以提昇其溝通動機、理解及表達能力。

(2) 綜合策略：

此策略包含行為理論、社交及個人發展要素。其中例子有：利用有系統的環境及視覺策略來增加孩子對環境及他人行為理解的結構化教學 (Treatment and Education of Autistic and related Communication handicapped Children, TEACCH)，以及主要針對增強社交溝通的主動性、提升情緒處理和面對困難應變能力的自閉症綜合教育模式 (Social-Communication, Emotional Regulation and Transactional Support, SCERTS)。

(3) 互動策略：

此策略多以遊戲為本，教導父母如何於日常生活中透過遊戲來與兒童產生互動，進而促進兒童的情感發展及關係建立，並吸引其對外在環境的關注，好讓孩子的學習經驗得到擴展。其中例子有以發展性個別差異、關係為本模式的 (Developmental, Individual Difference, Relationship-Based Model, DIR)、(Relationship Development Intervention, RDI) 和地板時間 (Floor Time)。

(4) 社交認知策略：

其中例子有：社交情境故事 (Social Story)：透過簡單的社交故事來演繹不同的社交情境，幫助兒童理解不同社交處境之餘，亦提升他們推測別人想法的能力，從而發展出恰當的社交行為和態度。社交思考訓練 (Social Thinking)：幫助孩子理解及推測別人的想法、感受、觀點、動機和意圖，從而主動作出合宜的回應。