Deciphering and Alleviating Difficulties

The everyday guide

Sensory meltdowns · sleep · selective eating ·
visual routines · safety · you, the parent

A practical guide for families with an autistic child

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FREE GUIDE

Foreword

This guide is for you, the parent. Not for the professional who follows your child, not for those around you, not for your mother-in-law. For you.

You will find concrete protocols, printable charts, things to say. Everything here has been lived, tested and adjusted. My son Sasha was diagnosed autistic at 19 months, in 2015. We built a team around him — the Miracle Workers — for 5 years and 7 months. Today he leads an ordinary life. That doesn't mean "cured". It means he is moving forward, at his own pace, with the tools we taught him.

There is no miracle method in this guide. No promises. Just what works, most of the time, to help an autistic child live their day-to-day better — and to help you breathe a little easier.

Three rules before we begin:

- Your child is not their condition. They are doing the best they can with what they have.
- You are not responsible for the autism. You are responsible for the support — and you are already doing a great deal.
- No tool in this guide replaces the advice of a doctor, psychologist or therapist. Always check with a professional before any major medical, dietary or behavioural change.

> **How to use this guide** You don't have to read it all. Go straight to the part that is burning today. Print the charts, routines and checklists. Stick them on the fridge. Come back in 3 months, 6 months — your child will have changed, and so will you. Share this guide. It is free. It is meant to circulate.

Part 1 — Sensory meltdowns

What happens in the brain

When an autistic child has a sensory meltdown, they are not "having a tantrum". Their brain is in overload. Here is what happens, simply.

The human brain constantly sorts information coming from the five senses, plus two internal ones: proprioception (where my limbs are) and the vestibular system (balance). In most people, a filter suppresses 99% of useless signals. You don't hear the hum of the fridge. You don't feel the label of your T-shirt. In many autistic children this filter works differently: either it lets everything through — the child is hypersensitive — or it blocks too much — the child is hyposensitive and seeks strong stimulation. Often both, depending on the channel.

When the accumulation passes a certain point — the sensory alert threshold — the amygdala (the fear centre) takes over. The prefrontal cortex, which handles reason and control, is switched off. The child no longer has access to language, logic or the memory of rules. They are in survival mode. This is what is called a *meltdown*. It is not a choice. It is not aimed at you.

Three neurobiological phases

- **Phase 1 — Build-up:** The child has been absorbing stimuli for minutes, sometimes hours. They may seem fine. This is the window where prevention works.
- **Phase 2 — Tipping point:** The threshold is crossed. Screaming, crying, aggression, fleeing, withdrawal, intense repetitive movements. Duration: 5 to 45 minutes.
- **Phase 3 — Recovery:** The cortex slowly reconnects. The child is exhausted, sometimes ashamed, sometimes smiling. Duration: 30 minutes to several hours.

Meltdown, anger or tantrum: the assessment grid

This is the question everyone asks you. Including yourself, at 3 a.m. Here is a grid to help you decide.

Criterion	Sensory meltdown	Anger	Tantrum
Trigger	Sensory stimulus or break in routine	Identifiable frustration (toy refused, etc.)	An unmet demand in a social context
Audience	Same alone or in public	Same alone or in public	Often stops with no audience
Self-control	None	Partial	Total
Response to negotiation	None. Makes it worse.	Possible	Strong
Duration	5 to 45 minutes	2 to 10 minutes	Variable; fades if not answered
Afterwards	Deep exhaustion	Quick calming	Normal resumption
Memory	Often hazy	Clear	Very clear
Advice	Make safe, wait, low stimulation	Name it, validate, offer an alternative	Hold the limit, don’t give in

> **A professional’s opinion is needed** This grid is a guide, not a diagnosis. If you are unsure between a sensory meltdown, unspoken physical pain and a behavioural difficulty, ask your paediatrician or your child’s psychologist. An ear infection, a stomach ache or a cavity can trigger behaviours identical to a sensory meltdown.

The 6 main triggers

Most sensory meltdowns have one of these six causes — often several combined.

1. **Noise.** The first trigger, by far. Vacuum cleaners, public hand-dryers, school bells, applause, other children crying, background music, the buzz of lighting. Everything you no longer hear, they hear all the time.
2. **Light.** Strip lights, screens, flicker, direct sun, reflections on water or glass. Pulsed artificial light is invisible to most people but experienced as an exhausting flicker by many autistic children.
3. **Crowds and the social unexpected.** The first day of school, a birthday party, the supermarket on a Saturday, a school trip, public transport. Too many faces, too much movement, too many smells, too many overlapping voices.

4. **A change of routine.** A teacher away, the usual park closed, a favourite garment in the wash, a different route. For a child who relies on predictability to feel safe, the smallest deviation can feel like a threat.
5. **Tiredness and hunger.** Often underestimated. An autistic child tires faster because their brain spends a lot of energy managing stimuli. Hunger is sometimes poorly felt (weak interoception) and erupts as aggression.
6. **Frustration and the inability to communicate.** They know what they want; they don't know how to say it. Or they say it and aren't understood. The resulting rage is legitimate.

> **Tip: keep a meltdown log for 2 weeks** Note the time, the place, what happened just before, who was there, what your child ate, drank, slept. After two weeks, patterns leap out. It is the most powerful and cheapest tool for preventing 70% of meltdowns.

Prevention: adapting the environment

Five audit checklists to print and tick. The aim is not perfection. It is to remove 3 to 5 irritants per place. That changes everything.

Checklist 1 — The home

Check	Action if it's a problem
Strip lights / spotlights too strong	Replace with warm LEDs (2700 K), add a dimmer
Background noise (TV, radio, fridge)	Switch off if possible; reduce simultaneous sources
Clothing labels	Cut out all labels; prefer soft, seamless cotton
An identified safe corner	Set up a calm spot: a tent, under the stairs, cushions
Ringtones (phone, oven, doorbell)	Set to minimum, or vibrate
Strong smells (perfume, air freshener)	Ban air fresheners; use neutral cleaning products
Visual clutter (toys on show)	Store in opaque boxes; one activity out at a time
Temperature	Keep 19–21°C; air the room early
Morning light	Open the blinds on waking to set the body clock

Checklist 2 — The car

Check	Action if it's a problem
Direct sun in the eyes	Suction sun-shade + cap
Unpredictable radio	A fixed, familiar playlist; always the same songs
Air conditioning too strong	Set to 22°C, fan on minimum
Car-air-freshener smell	Remove all diffusers

Check	Action if it’s a problem
Long journey with no landmarks	Announce the stages: “In 10 minutes we turn. In 20 we arrive.”
A sibling messing about	Separate if possible; noise-cancelling headphones for the sensitive one
Unexpected traffic jam	Always carry an emergency bag: water, familiar biscuits, a familiar object

Checklist 3 — The restaurant

Check	Action if it’s a problem
Noise level	Choose a quiet slot (11:30 or 14:30); avoid Saturday evening
Seating	Ask for a corner, back to the wall, away from kitchen and toilets
Unknown menu	Check it online beforehand; choose the dish with the child
Waiting for the order	Bring a small notebook, felt-tips, a familiar object
Strong smells	Ask for a table away from the thoroughfare
Staff who talk fast	Tell the server: “My child is autistic and needs calm.”

Checklist 4 — School

Check	Action if it’s a problem
Break-time bell	Ask for a light signal or a 1-minute warning
Noisy canteen	A staggered slot, headphones, or a packed lunch in class
Classroom strip lights	Ask to switch off half if possible
A substitute teacher	A photo of the substitute sent the day before
Break time (crowds)	An identified calm space, a support assistant available
Changing rooms (pool/gym)	Arrive 10 minutes early or late to avoid the crush
Unexpected school trips	Ask to be told at least a week ahead
Emotion that can’t be put into words	A “I need a break” picture card in the pencil case

Checklist 5 — The supermarket

Check	Action if it’s a problem
Busy times	A weekday morning, 9:30. Never Saturday
Strip lights	Peaked cap + sunglasses
Noise (music, announcements)	Noise-cancelling headphones or earplugs
Long checkout queue	Self-checkout, or a priority till
Sweets at the till	Prepare a distraction: a favourite object in the pocket
A list to stick to	An illustrated tick-list with the child (they become an actor)
An unpredictable exit	A 3-step plan: we go in, we fill up, we leave

During the meltdown: 5 protocols

Five scenarios by age and profile. Choose the one that fits your child. Always keep the same line of conduct: safety first, low stimulation, calm presence, no lessons during the meltdown.

Protocol A — Child aged 2–5, auditory hypersensitive. *(Meltdown in the middle of a supermarket; screaming, throwing themselves to the floor.)* 1) Make safe: crouch to their level, a hand on the back if touch is accepted, check they can’t hurt themselves. 2) Cut the stimuli: leave the aisle, find a quiet corner, headphones on if you have them, leave the trolley. 3) Don’t talk. Really — no lesson, no question, no “calm down”. Language overloads them further. 4) Low position: sit on the floor beside them, not facing them; breathe slowly and audibly. 5) Water: when the strongest phase passes, offer a sip from their usual cup — no sweets, no reward. 6) One short sentence, quietly: “I’m here. It’s nearly over.” 7) Leave: when they have recovered 50%, leave the shop. No need to finish the shopping.

Protocol B — Child aged 6–10, verbal, visually and socially hypersensitive. *(Meltdown leaving school; screaming in the car.)* Stop the car safely — don’t drive mid-meltdown. Lower everything: interior light, radio off, window ajar for fresh air. Anchor phrase, once: “You are safe. I’ll wait with you.” Let them discharge — crying, harsh words; it is not aimed at you, don’t answer provocation. Offer a closed binary choice: “Shall we wait here, or go to the park next door?” Two options, not three. When they answer, validate: “Okay.” Then silence. Defer the discussion to a calm time this evening, with a visual support.

Protocol C — Non-verbal child, any age. *(Meltdown at home; banging their head against the wall.)* Physical safety first: a cushion between head and wall; no restraint unless there is a danger to life. Low stimulation: dim light, sounds off, siblings away. Bodily presence: sit beside them, without touching if they refuse, but visible. Deep pressure if tolerated: a weighted blanket, a large cushion on the lap. A communication tool: picture cards for “I’m in pain”, “I’m scared”, “I’m hungry”, “too loud”. Allow 20–30 minutes mentally — don’t expect a quick end. When the discharge eases, offer the “refuge”: a tent, under a blanket, a warm bath.

Protocol D — Autistic teenager (summary). Respect their privacy. Don’t comment.

Leave them an enclosed space (their room). Check from a distance (every 10–15 minutes). Have water and soft light available. Defer the conversation for several hours. No lesson in the moment.

Protocol E — Meltdown in public with no retreat. Plane, train, packed transport. Noise-cancelling headphones, hood, a sensory eye-mask. Sit beside them, forming a screen. If people judge you, ignore them. If an adult tries to intervene: “My child is autistic. Please leave us; it will pass.”

Safety: when to call emergency services If the child injures themselves badly, or puts others in immediate danger, or if the meltdown lasts more than 60 minutes without easing, or if they become confused, drowsy or feverish, or no longer recognise those around them, call your local emergency number. Say “autistic child in a prolonged sensory crisis” and ask for a doctor familiar with autism. You have the right to ask.

After the meltdown: the recovery phase

The first 30 minutes: low light, zero noise; no questions, no “why”; water, soft fruit, a blanket; silent presence, quiet reading or familiar gentle music; a cuddle if asked for, distance if refused. **The following 2 hours:** a simple, familiar activity (puzzle, drawing, a familiar video); no new screen, no visitors, no learning; a light, favourite meal. **That evening or the next day:** revisit the event with a visual support; name what happened without judging (“You were in the red zone. It happened.”); identify the trigger together if possible; build a plan for next time (“Next time we hear the vacuum cleaner, we put the headphones on.”).

10 classic mistakes (and the alternative)

Mistake	Alternative
1. “Calm down!”	Silence + presence. The brain no longer processes orders during a meltdown
2. Smacking or shouting	Step out for 2 minutes to calm yourself in the next room
3. Promising sweets to make it stop	Never reward the meltdown. Reward the return to calm
4. Lecturing during the meltdown	Postpone the discussion by several hours
5. Forcing a cuddle	Presence at a distance. A cuddle only if asked for
6. Preventing self-stimulation (flapping, rocking)	Allow it. These are self-regulation valves
7. Insisting on finishing the activity	Abandon it. Go home. The golden rule: protect the brain
8. Comparing to a sibling or cousin	Never. In front of the child or anyone else
9. Apologising in front of everyone afterwards	A private conversation, when calm

Mistake	Alternative
10. Feeling guilty long afterwards	Let it go. You did your best with what you had that day

Valentine's story — My worst meltdown with Sasha It was in a supermarket, one Saturday in December 2015. Sasha was two and a half. He had been diagnosed three weeks earlier. I knew nothing. He threw himself to the floor in the toy aisle — not for a toy, but for the Christmas music playing on a loop, mixed with the PA announcements, mixed with the rattle of a lady's trolley behind us. I tried to lift him. Mistake. I tried to talk to him. Mistake. I tried to show him a toy. Mistake. I ended up shouting myself. A huge mistake. A woman of about 60 stopped and said: "Madam, your child is badly brought up." I collapsed in tears in the middle of the aisle. A store security guard came over. He had an autistic son. He told me three things I have never forgotten. First: "Leave the trolley, it doesn't matter." Second: "Carry him to the car park, open the car doors, wait." Third: "Come back when you're on your own." What I learned that day, and what carried me for eleven years: a meltdown is not a parenting failure. It is information. It tells you where the child's limits are at that moment. My job that day was to protect his brain — not to finish my shopping, not to prove to the lady that I was a good mother. Just to protect. Today Sasha goes to the shop on his own with his list, at 13. But between that Saturday and today there were 5 years and 7 months of work — and that man, whose name I never knew, who taught me the first rule.

Part 2 — Sleep

Why 80% of autistic children have sleep difficulties

The figures have been stable for 20 years: 50 to 80% of autistic children have at least one sleep difficulty, against 25–30% of non-autistic children. Why? Several combined reasons: many autistic children produce less melatonin, or produce it at the wrong point in the cycle; the body clock is more fragile and more sensitive to artificial light, screens and the changing seasons; sensory hyper-arousal keeps the filter active at bedtime (the fridge, labels, headlights in the street — everything wakes them); anxiety (the unknown of tomorrow, rumination, fear of the dark, fear of a parent's absence); and co-occurring conditions (digestive problems, reflux, sleep apnoea, epilepsy, ADHD) that must be screened for.

A professional's opinion is needed Before any sleep protocol, ask for a medical check-up: an ENT exam (adenoids, apnoea), a digestive review, blood tests (ferritin, vitamin D). Many sleep difficulties in autistic children partly resolve once an underlying medical cause is treated.

Bedtime routine: 7 steps ready to print

Display in the bathroom and the bedroom. Repeat every evening, in the same order, at the same time (±15 minutes). Consistency is the main medicine.

Step	Example time	Duration	Detail
1. Light evening snack	18:30	15 min	Banana, cheese, warm milk (tryptophan foods)
2. Calm play	19:00	30 min	Building blocks, drawing, puzzle. No screen
3. Warm bath (34–36°C)	19:30	10–15 min	Soft light. Not cold, not too hot
4. Pyjamas + teeth	19:45	10 min	Always the same gestures, same order
5. Story or gentle music	20:00	15 min	Quiet voice. Always the same chair/bed
6. Light to minimum	20:15	5 min	Red or amber nightlight. No blue
7. Ritual phrase + leave	20:20	1 min	“Goodnight. I’m next door. See you in the morning.”

Setting up the bedroom: sensory checklist

Change one thing at a time. **Mattress and bedding:** a medium-firm, memory-foam mattress; organic cotton fitted sheet washed without scented softener; a light duvet or a weighted blanket (2 to 10% of the child’s weight — see the warning below); a flat pillow, or none before age 4. **Light:** blackout blinds or curtains (complete darkness); a red or amber nightlight (it filters the blue light that suppresses melatonin); no clock displaying the time in blue; no screen in the room. **Sound:** white or pink noise (a fan, a rain app); insulate from the hallway; parents’ phones on silent from 20:00. **Temperature:** 18–19°C is ideal; check with a thermometer, don’t rely on an adult’s feeling. **Smell:** no perfume, candle or essential oils before age 7; bed linen washed with the same detergent each time; possibly a comfort object carrying the parent’s scent (a worn T-shirt).

Melatonin: what the science says

Melatonin is one of the best-documented tools. In several countries, prolonged-release melatonin is approved for autistic children aged 2 and over with persistent sleep problems, after behavioural and environmental measures have failed. **Indicative dosing — must be confirmed by a doctor:**

Age	Starting dose	Usual max	Timing
2–5 years	1 mg	2 mg	30–45 min before bed
6–11 years	2 mg	5 mg	30–45 min before bed
12+ years	2–3 mg	10 mg	30–45 min before bed

Interactions and precautions: do not combine without medical advice with SSRI antidepressants, fluvoxamine or immunosuppressants; caution with epilepsy (it may alter the seizure threshold in some profiles); no combination with alcohol (teens) or sedatives; over-the-counter melatonin supplements do not have the same purity guarantee as a prescription — prefer a prescription.

A professional's opinion is needed Melatonin is not a sweet. Always get a prescription from the paediatrician, neurologist or child psychiatrist. Trial it for 4 to 8 weeks, then review. Do not increase the dose on your own. More is not better: too high a dose can actually disturb sleep.

Waking at 3 a.m.: 4 scenarios

1 — They wake and stay calm in bed. Don't intervene. Watch from a distance. This is a normal awakening; they will often fall back asleep alone. If you go in, you fully wake their brain. **2 — They get up and come to your room.** Take them back calmly, no bright light, no discussion. One phrase: "It's night-time, we sleep." Tuck them in. Leave. Repeat without losing your temper — sometimes 5 times a night for a week, then it fades. **3 — They are in meltdown, screaming, won't settle.** Make safe. Minimal (amber) light. Sit beside them. No screen, no sugary drink — water only. White noise. Wait. Often, 30–60 minutes later, they sink back. Plan a lighter day after. **4 — They wake at 3 and don't fall back asleep at all.** If this happens 3 or more nights a week for over 2 weeks, seek advice. Possible cause: apnoea, reflux, mis-dosed melatonin, late screens, school anxiety, digestive trouble.

Co-sleeping: yes, no, it depends

A loaded question. A realistic approach: before 6 months, room-sharing with a separate cot is recommended for the prevention of sudden infant death — no debate. From 6 months to 3 years it is variable: if the whole family sleeps better together, that is valid; if anyone sleeps worse, separate gradually. Beyond 3–4 years, sleep autonomy becomes a goal to work towards (for school, sleepovers, nights at the grandparents') — not guilt-inducing, just a project to open at the right time. The trap is co-sleeping installed out of exhaustion (the child arrives at 3 a.m. and you give in), not by conscious choice. A possible transition: a mattress on the floor in the parents' room → a mattress on the floor in their room → their bed. Step by step, over several weeks.

Valentine's story — The night I understood Sasha slept 4 hours a night, on average, for 2 years and 8 months. I had stopped sleeping; so had my husband. We tried everything: herbal teas, big cuddles, the controlled-comforting method, a bed in our room, a bed out of our room. Nothing. One day the paediatrician ran a full work-up. Ferritin: 19. Crushed. The norm for a child is between 30 and 140. Sasha had a deep iron deficiency, which massively worsened his sleep (restless-legs in children is often linked to low ferritin). Three months of iron supplementation, plus melatonin at 2 mg prescribed by a child psychiatrist, plus the 7-step bedtime protocol I'm giving you here. After 4 months, Sasha was sleeping 10 hours a night. Not every day perfect, but a stable average. What I wish someone had told me sooner: it is not just a behavioural problem. An autistic child's sleep is also medical. Do the tests. Insist on them.

Part 3 — Selective eating

Why so many autistic children eat so few things

Between 70 and 90% of autistic children have selective eating at one point or another in childhood. Four main reasons combine: **the sensory** (texture, temperature, colour, smell, the sound of crunch — one intolerable dimension is enough); **the need for control** (in an unpredictable world, always eating the same thing is reassuring — a self-regulation strategy, not a whim); **cognitive rigidity** (the pasta in the green box — change the box and it is no longer the same pasta); and **fragile interoception** (detecting hunger, fullness and thirst requires an internal signal many autistic children perceive poorly).

The 4 eating profiles

Profile	Signs	Main strategy
1. Sensory-selective	Refuses certain textures, colours or smells	Graded exposure to the new texture, with no pressure to eat
2. Texture-selective	Eats only liquid, or only dry solids, or finely mashed	Oral-motor work with a professional (a speech/feeding therapist)
3. Controller	Wants to master everything: brand, plate, order, place, person	Reinforce predictability; give framed choice
4. Mechanical	Eats little, as a function. Lacks food pleasure	Medical work-up (deficiencies, pain), then food-pleasure work

An 8-step widening plan

A progressive, clinically validated approach (based on the SOS Approach to Feeding). Adapt it with a professional. Allow several months per food.

1. Tolerate the food in the room (on the table, in their plate or someone else's).
2. Tolerate the food in their own plate (no obligation to touch it).
3. Touch it with a utensil (fork, spoon, skewer).
4. Touch it with the fingers.
5. Bring it to the lips (smell it, kiss it).
6. Taste with the tip of the tongue (lick it).
7. Bite and spit out if they want.
8. Swallow a mouthful. Gradually increase the amount.

Golden rule: each step lasts several presentations, sometimes 10 to 20, without pressure. Only move on after visible comfort.

What works

- **Graded exposure** (the 8 steps above).

- **Sensory play away from meals**: painting with mashed vegetables, modelling, stamping with halved cherry tomatoes.
- **Food chaining**: start from an accepted food and evolve it by micro-modifications (shop nuggets → home-made nuggets, same shape → different shapes → a breaded cutlet → a plain cutlet).
- **Cooking together**: involve the child in choosing, preparing and plating. They often eat what they have touched.
- **Parental modelling**: eat together, the same menu, with no comment on what they do or don't eat.
- **The "mirror" plate**: half the plate familiar, reassuring foods, half a novelty.
- **Rhythm**: 3 meals + 2 snacks, same times, same table, same cutlery.

What does NOT work

Forcing a taste (reinforces the fear, can create a lasting food phobia); negotiating ("one more mouthful and you'll get a sweet"); rewarding with sugar; guilt-tripping; hiding foods (mashed spinach in the sauce — it works short-term, but long-term the child loses trust in food); comparing to another child; punishing by withholding dessert.

A professional's opinion is needed If your child eats fewer than 15–20 different foods in total, or loses weight, or refuses an entire category (all proteins, all vegetables), seek help without delay. Ask for a feeding/oral-motor assessment and paediatric dietary follow-up. Your paediatrician will refer you.

Deficiencies to watch

Nutrient	Possible signs	Ask the doctor for
Iron (ferritin)	Fatigue, pallor, irritability, restless sleep, poor appetite	Serum ferritin + full blood count
Calcium	Cramps, growth delay, early cavities	Calcium, vitamin D
Vitamin D	Fatigue, fragile bones, lowered immunity	25-OH vitamin D (ideally twice a year)
Omega-3 (DHA)	Dry skin, fluctuating attention	Supplement if the diet is poor
Vitamin B12	Fatigue, smooth tongue, neurological signs	Serum B12 + folate
Zinc	White marks on nails, poor appetite, dry skin	Zinc (fasting morning sample)

Valentine's story — Pasta, pasta, more pasta At 3, Sasha ate 7 foods: pasta (one brand only), white rice, ham (one brand), apples (a precise variety), bananas (not too ripe), plain yoghurt (one only), white sliced bread. Every professional told me: "Force him." Or: "Starve him, he'll crack." I tried. Disaster. When we started the Miracle Workers at home, a feeding therapist took the case. First rule: stop putting pressure at meals. Create a neutral space. Play with food outside meals. For 4 months we did vegetable painting, tomato stamping, potato sculpting. Nothing new on the plate. Just contact. In the fifth month I put a radish on his table — not in his plate, beside it. He looked at it for three meals without a word. On the fourth day he touched it. On the eighth, he licked it. On the fifteenth, he bit it. On the sixteenth, he asked for more. Today Sasha eats almost everything. He loves sushi. But between the radish of day fifteen and the sushi of today there are 8 years of patience and play. No bribery. No force. Play.

Part 4 — Visual routines

Why visual works better than verbal

Spoken language is fleeting: the sentence vanishes as soon as it is said. For a brain in sensory overload, for a non-verbal child, or for a child who processes language more slowly, that is a permanent challenge. A visual support stays. It does not fade. It does not mock. It does not get annoyed. The child can consult it at their own pace, as often as they want. It is one of the most powerful tools — and it is free. Three documented benefits: it reduces the anxiety of the unexpected by showing what comes next; it supports language (seeing the word as a picture anchors it); and it builds independence (the child can act without being told).

3 types of support

Support	For whom	Advantage	Limit
Pictograms (Arasaac, PECS)	Non-verbal children or young verbal children	Universal, neutral, easy to understand	Sometimes too abstract
Real photos	All ages, especially beginners	Very concrete, personalised	Must be redone if the place changes
Written scripts / comics	Reading children (often from 5–6)	Allow complex narrative, strong autonomy	Require reading

10 routines to set up today

1 — Morning (bathroom/bedroom, 6 pictures): get out of bed · go to the toilet · get dressed (clothes laid out the night before) · breakfast · brush teeth · school bag. **2 — Bedtime**: see Part 2 (7 steps). **3 — Getting ready for school** (by the front door, 5 pictures): coat · shoes · school bag · comfort object if allowed · kiss + go. **4 — Family meal** (4 pictures): wash hands · sit in your place · eat what I can + taste the new thing (no obligation) · ask to leave the table (“I’ve finished”). **5 — Supermarket trip** (A5 card in the pocket): journey · shop entrance · illustrated tick-list (5–8 items the first times) · checkout · back to the car · reward on return (never sweets). **6 — Doctor’s visit** (prepared 24–48 h before, real photos if possible): journey · waiting room · entering, saying hello · the exam (weighing, measuring, listening to the heart, throat, ears — each gesture as a picture) · leaving + reward. **7 — Birthday / family party** (a week ahead, include the faces of those attending): photo of expected guests with names · arrival and departure times · an identified refuge on site · gift to give/receive · candles + song (warn that headphones are allowed) · a discreet exit signal if overwhelmed. **8 — Long car journey**: a simplified map · planned stops · indicative times · an emergency bag (headphones, water, familiar biscuit, familiar object, tablet with familiar content) · arrival + first ritual. **9 — Restaurant**: photo of the restaurant and menu sent the day before · dish chosen at home · reserved corner seat · an activity book for the wait · an exit phrase. **10 — The swimming pool**: bag prepared the day before with the child · photo of the place (entrance, changing room, pool) · steps (pay, changing room, compulsory shower, pool, drying, leaving) · announced duration · reward on leaving.

Free tools to create your own pictures

Tool	Type	Access
Arasaac	A free bank of 14,000+ pictograms	arasaac.org — free
Picto Selector	Software to build picture boards	pictoselector.eu — free (Windows/Mac/Linux)
Time Timer	A visual timer app	Free basic version (Android/iOS)
Sclera	High-contrast black-and-white pictograms	sclera.be — free

If the child refuses pictograms

It happens. Three frequent reasons and their solutions: **they find them babyish** (true especially for verbal children from 8 — switch to written words, to-do lists, teen planners); **you introduce them mid-meltdown** (a classic mistake — introduce them calmly, in play, several days before expecting use; make the board together, decorate it, name it); **too much information at once** (start with 3 pictures maximum; extend once mastered).

Part 5 — Safety

Risks specific to autistic children

Three risks are over-represented in autistic children: wandering (running off), drowning, and a lack of awareness of danger. According to a large US study (Interactive Autism Network, 2012, taken up by the CDC in 2018): 49% of autistic children have wandered at least once after age 4 (against 9% in the general population); drowning is the leading cause of accidental death in autistic children, ahead of road accidents; the risk peaks between 4 and 7 and stays high into adolescence. None of these figures are meant to frighten you. They are here to justify the measures that follow.

Identification bracelet

Essential as soon as the child may be out of an adult's sight, even when travelling. Choose one the child can't detach themselves. **To engrave:** the child's first name, a parent's name + phone number, and the note "autistic — may not respond / may wander". Alternatives: an embroidered T-shirt, a laminated ID card in the pocket, a label sewn into the coat. Update it if you move or change number.

Home locks and safeguards

Place	Risk	Measure
Front door	Wandering	A high lock (1.80 m), chain, opening alarm
Windows	Falls	Window stops, railings if upstairs
Balcony	Falls, wandering	A sliding-door block, key hidden
Private pool	Drowning	Fencing, an immersion alarm, a rigid certified cover
Kitchen	Burns, ingestion	Hob guard, gas safety, cupboard locks
Bathroom	Drowning in the bath	Never leave alone; a high door lock
Medicines / products	Ingestion	A locked box, always up high
Garage / cellar	Tools, the car	Systematic locking, key out of reach

Child location: an overview

Tool	How it works	Pros / cons
Child GPS watch	Built-in SIM, call parent, zone alert	+ Precise, long battery − Cost + subscription
GPS tracker tag	Discreet unit, app	+ Very discreet, wander alert − Subscription required
Bluetooth tracker (sewn into the coat)	Bluetooth + a finder network	+ Cheap, long battery − No real-time tracking
Family app	Requires the child's phone	+ Free or cheap − A phone is required

A professional's opinion is needed The choice of device should be discussed with the child where possible, and with the professionals who follow them. Beyond safety, it is also a question of autonomy and privacy as the child grows. Adapt it to each age.

Wandering protocol: 5 steps

If your child disappears, act in this exact order. Print this page. Put it on the fridge.

1. **Immediately check the danger zones around you**: water (pond, pool, fountain, river), road, train tracks, large bushes. Many autistic children are drawn to water or to a specific object they have spotted.

2. **Call your local emergency number within the first 10 minutes.** Don’t wait. Say: “My autistic child has disappeared, named [first name], aged [age], wearing [clothes], does not respond to their name / may be drawn to water / may head towards [spotted place].”
3. **Mobilise neighbours and local shops within 30 minutes.** A recent photo on your phone; search on foot in a 500 m radius, several people in a star pattern.
4. **Post on social media**: local groups, neighbourhood apps. Attach the recent photo; state the place and time of disappearance + distinctive features.
5. **If found**: call the police to close the case. A medical check even if the child looks fine — many autistic children do not report pain or shock.

Prepare a template poster in advance, to print urgently: “MISSING CHILD — [NAME, AGE] — recent photo — autistic, may not respond to their name — last seen: [address, time, clothing] — call [parent number + emergency number].”

Valentine’s story — The great fear of July 2017 Sasha was 4. We were on holiday at my parents’, in a village. A family house, an enclosed garden — we thought. A kitchen door opened onto a courtyard, which opened onto an alley, which opened onto the village square. By the time I realised, I had lost sight of him for perhaps 5 minutes. We found him 18 minutes later. He had crossed the square, followed a wall, and was standing in front of the village fountain, watching the water flow, motionless. He didn’t realise we were looking for him; he didn’t realise he had left. During those 18 minutes, I thought my life was ending. That very evening, my husband fitted a high lock on every external door. The next day we bought an engraved ID bracelet. The following week we began teaching Sasha the “danger” and “stay with Mummy” pictures. What I understood: wandering in an autistic child is almost never an escape. It is an attraction — towards water, a light, a texture, a spotted object. They are not running away FROM something. They are walking TOWARDS something. And they don’t feel time pass. Keeping them safe is not over-protecting. It is simply recognising that their brain and mine do not perceive danger the same way.

Part 6 — You, the parent: survival tools

A 4-movement breathing routine

To practise during your child’s meltdown. It takes 90 seconds and resets your own prefrontal cortex so you can help your child. 1) Breathe in for 4 seconds through the nose — the belly rises, not the chest. 2) Hold for 4 seconds, lungs full; relax the shoulders. 3) Breathe out for 6 seconds through the mouth, lips pursed as if blowing out a far-off candle. 4) Hold for 2 seconds, lungs empty. Repeat 5 times. Why it works: the long out-breath activates the vagus nerve, which lowers the heart rate, which calms the amygdala, which gives you back access to your frontal cortex. You become able to think again.

10 mantras to repeat

"I'm doing my best." · "My child is not their condition." · "This meltdown will pass." · "I'm not a bad mother, I'm an exhausted one." · "I have nothing to prove to anyone." · "What I see today is not what they will be tomorrow." · "I'm allowed to ask for help." · "Other people's judgement is not my problem." · "I breathe. I'm here." · "I love my child. That is my compass."

When to ask for help: signs of parental burnout

You are at risk of parental burnout if you tick 3 or more of these for more than 3 weeks: you cry more than once a day with no clear trigger; you feel empty when your child comes home from school; you dream of leaving, of disappearing, of sleeping for 3 days; you shout more than usual and hate yourself afterwards; you have no desire left for anything — meals, friends, a shower; you make mistakes at work, forget things; you cut yourself off from friends; you have dark thoughts, even vague ones, and feel you are a burden to your family.

> **If you ticked the last point** Reach out now. Contact a suicide-prevention helpline in your country — the international directory **findahelpline.com** lists free, confidential lines available 24/7. You don't have to justify yourself. You don't have to explain that your child is autistic before you are allowed to be in pain. You are allowed to be in pain, full stop. And they will know how to listen.

Useful contacts (find the equivalent where you live)

Need	Where to turn
General autism questions, guidance, rights	Your national autism association
Suicidal thoughts, distress, need to talk	A suicide-prevention helpline — findahelpline.com
Immediate medical emergency	Your local emergency number
A disappearance / wandering	The police / local emergency number
Domestic or emotional violence	A domestic-abuse helpline in your country

Getting concrete help

Support varies from country to country, but in most places you can look for: **home help** (disability allowances and home-care schemes — your national autism association will tell you what exists and how to apply); **a trained babysitter** (via local autism associations, student networks in psychology or special education, or word of mouth through parent groups — filter for "disability experience"); and **respite** (respite platforms, organised respite stays, short temporary placements, and, in many countries, a carer's right to respite funding). Ask your national autism association: they hold the local directories.

The couple: 5 conversations to have

Autism puts a couple under pressure. These 5 conversations, held calmly and away from a crisis, can prevent many break-ups. **1 — The mental load:** “Let’s list everything each of us does for our child — not to compete, but to rebalance if needed.” **2 — Time just for us:** “How do we get 2 hours a week, just the two of us, with no child — not to talk about them, but to be a couple again?” **3 — Disagreements over methods:** “We don’t always agree on how to react to a meltdown, or which therapy comes first. That’s normal. How do we decide? Shall we try a method for 3 months, review, and adjust together?” **4 — The siblings:** “Our other children live with autism full-time too. How do we make sure they get individual time with each of us?” **5 — The future:** “What do we picture for them at 15, 25, 40? Are we on the same wavelength? When do we revisit this?”

> **Valentine’s story — The couple** In the first years after the diagnosis, my husband and I nearly separated three times. Not for lack of love. From exhaustion. We didn’t really argue. We lived side by side. He handled his job, I handled Sasha. Evenings, we talked about Sasha. Mornings, we talked about Sasha. Weekends, we talked about Sasha. The turning point was a dinner with a psychologist friend who told us: “You’ve lost your couple. You’ve become colleagues at a company called Sasha.” We put three things in place that saved us. First: every Friday evening, a night out, just the two of us, with a trained sitter. Unconditional. Even tired. Especially tired. Second: no talking about Sasha during the first hour. Third: a weekend alone, no children, every six months. It looks like a luxury. It looks selfish. It is neither. It is the survival condition of the couple — which is the survival condition of the family — which is the condition of a stable framework for the autistic child. Invest in your relationship as you invest in the therapies. It is support too, by ricochet.

Appendix — Resources

Main scientific sources

- National clinical-practice guidelines on autism spectrum disorder (warning signs, screening, diagnosis and assessment in children and adolescents).
- World Health Organization (WHO) — information on autism.
- Regulatory approvals for prolonged-release melatonin in autistic children.
- CDC (USA) — *Wandering in Children with Autism: data & prevention*, 2018.
- Meta-analyses on sleep difficulties in autistic children.
- Toomey & Ross — *SOS Approach to Feeding* (feeding-therapy reference).

Sites and tools

- **sortirdelautisme.fr** — guides, resources, testimonies.
- **Arasaac** — free pictograms — arasaac.org
- **Picto Selector** — free software — pictoselector.eu
- Your **national autism association** — guidance, rights, local directories.

To finish

This guide is free. It was written to circulate. Print it. Share it. Send it to another family just starting out. The only feedback that matters is that it is useful.

And if something in it has helped you, write to me at contact@sortirdelautisme.fr. I read everything, and I reply to a great deal. You are thousands of families. You are not alone.

Valentine Lecêtre — sortirdelautisme.fr