A FOUR-SESSION WORKSHOP FOR PARENTS OF CHILDREN WITH AUTISM: UNDERSTANDING AND MANAGING CHALLENGING BEHAVIORS, AND SUPPORTING THE DEVELOPMENT OF CHILDREN WITH ASD

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A FOUR-SESSION WORKSHOP FOR PARENTS OF CHILDREN WITH AUTISM: UNDERSTANDING AND MANAGING CHALLENGING BEHAVIORS, AND SUPPORTING THE DEVELOPMENT OF CHILDREN WITH ASD

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Child Development

by
Vanessa Huizar
December 2020
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ABSTRACT

Research studies continue to show that being a parent of a child with autism spectrum disorder (ASD) presents unique challenges for many families including understanding ASD deficits and behaviors, and identifying effective ways to manage these behaviors. Because ASD interventions generally take a behaviorally-based approach, parents tend to lack an understanding of child development, positive child guidance practices, ways to build strong parent-child relationships, and methods to engage in enrichment activities that will support their child’s overall development. The purpose of the current project was to create a parent workshop to help parents of children with ASD: 1) understand the underlying factors related to the challenging behaviors of children with ASD, 2) teach parents how to combine ABA with “positive child guidance” strategies to assist them in managing their child’s ASD behaviors, and 3) enhance parents’ knowledge of child development, ways to build strong parent-child relationships, and methods to engage with their child in enrichment activities. Pre-post workshop assessment scores showed an increase in participants’ knowledge and confidence in these three project goals. Future trainings should include other caregivers and professionals working with children with ASD to empower them with the skills needed to effectively manage challenging behaviors and at the same time support children’s overall development.
ACKNOWLEDGEMENTS

First and foremost, I want to thank God for giving me the strength and perseverance to complete this project and be the first one in my family to earn their master’s degree. I couldn’t have done it without him.

To my advisor Dr. Laura Kamptner, I thank you for your support throughout this process. Your time, words of encouragement, and endless amount of advice were very helpful.

To Dr. Amanda Wilcox and Dr. Kelly Campbell, my committee members. I thank them for their time and valuable feedback during the process of drafting my project proposal.

To my family, friends, and boyfriend, I want to say thank you for your continuous support and words of encouragement. Thank you for believing in me and being part of this accomplishment.

Lastly, I want to thank Alexandria Driscoll for being such a great support system and continuously answering my questions, hearing out my ideas, and giving me advice whenever I felt lost in this process. I am thankful that we had each other.
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CHAPTER ONE
INTRODUCTION

Being a parent of a child with autism spectrum disorder (ASD) presents unique challenges for many families including understanding ASD deficits and behaviors, and identifying ways to effectively manage these behaviors. Although Applied Behavior Analysis (ABA) has been the primary form of therapeutic intervention for children with ASD, minimal parent training is provided by ABA agencies and parents continue to lack an understanding of when and how to implement strategies that behavioral therapists use (“Applied Behaviour Analysis and Autism”, 2016; Moore & Symons, 2011; Preece, 2014). Further, parents tend to lack an understanding of child development, positive child guidance practices, and how to build strong parent-child relationships that may help to effectively manage ASD-related behaviors (Sivaratnam, Newman, Tonge, & Rinehard, 2015; “Zero to Three”, 1999). Finally, engaging in enriching activities helps support children’s development but many parents of young children with ASD do not know how to effectively create meaningful learning opportunities (Crowell, Keluskar, & Gorecki, 2018). The purpose of the current project is to create a parent workshop that: 1) helps parents understand the underlying factors related to the challenging behaviors of children with ASD, 2) teaches parents how to combine ABA with “positive child guidance” strategies to assist them in managing their child’s ASD behaviors, and 3) enhances parents’
knowledge of child development, ways to build strong parent-child relationships, and methods to engage with their child in enrichment activities.

Autism Spectrum Disorder

In the past decade, autism spectrum disorder (ASD) has become one of the most prevalent disabilities affecting young children (Pottie & Ingram, 2008). In 2007, 1 in every 149 children had an autism diagnosis compared to 1 in every 54 children in 2016 (“Data & Statistics on Autism Spectrum Disorder,” n.d.; Pottie & Ingram, 2008). According to the Center for Disease Control and Prevention (CDC) website, boys are four times more likely to get diagnosed with ASD compared to girls, and it affects children of all races and socioeconomic backgrounds (“Data & Statistics on Autism,” n.d.). ASD is considered a neurodevelopmental disability, and each child who is diagnosed has different skills and deficits that vary in severity (“What is Autism?,” n.d.). According to the DSM-5 (American Psychiatric Association, 2013), the diagnostic criteria for ASD is “persistent deficits in social communication and social interaction across multiple contexts and restrictive, repetitive patterns of behaviors, interests, or activities. These symptoms should be present in the early developmental period, must be severe enough to cause clinically significant impairment in social, occupational, or other important areas of functioning, and the symptoms would not be better explained by intellectual disability or global developmental delay” (p.50).
There are three levels of severity for ASD which include the following:
Level 1 = requiring support, Level 2 = requiring substantial support, and Level 3 = requiring very substantial support (“DSM-5 Criteria”, n.d.). An individual who requires support (Level 1) is one who can communicate and speak in full sentences but is unsuccessful in initiating and maintaining a conversation with others, has difficulty making friends, and may have difficulty transitioning from one activity to the next. When individuals require substantial support (Level 2), they may have deficits in verbal and nonverbal communication skills, limited social interactions and interest in others, difficulty coping with change, restricted or repetitive behaviors that hinder their daily functioning, and difficulty with changing their focus (“DSM-5 Criteria”, n.d.). Lastly, individuals who require very substantial support (Level 3) have severe deficits in social communication, rarely initiate social interactions, and they typically experience extreme difficulty changing their focus and coping with change which may result in maladaptive behaviors or in restricted/repetitive behaviors that affect their daily functioning (“DSM-5 Criteria”, n.d.).

Moreover, many children are not being diagnosed with ASD as early as they could be; the average age of diagnosis is 5 years old (Neimy, Pelaez, Carrow, Monlux, & Tarbox, 2017). Because of this, it has been recommended that parents and caregivers become familiar with the typical developmental milestones of children so they can better identify the early signs of ASD (“CDC’s Developmental Milestones”, n.d.). Some early signs of ASD may include limited
or no eye contact by 6 months, little or no babbling, no back-and-forth gestures or responding to their name by 12 months, and repetitive patterns, differences in play, and differences in feeding habits by 24 months (Bolton, Golding, Emond, & Steer, 2012; “Learn the Signs”, n.d.). In general, parents should consider signs of ASD if their young child is unable to establish warmth and intimacy with them, does not exchange emotional gestures and expressions, and does not use words with meaningful and emotional intentions (Greenspan & Wieder, 2009). Therefore, identifying early signs and precursors can be beneficial for the child’s developmental progress as an early diagnosis can lead to receiving early interventions that target the child’s deficits (Neimy et al., 2017; Sicile-Kira, 2014).

Although a clear cause for ASD has not been determined, risks for developing ASD include a combination of genetic and environmental factors (Lyall, Schmidt, & Hertz-Picciotto, 2014). Having a child at an advanced parental age, having pregnancies spaced less than a year apart, and having complications during pregnancy are some of the minor risk factors that can influence the possibility of having a child with ASD (Sandin, Schendel, Magnusson, Hultman, Suren, Susser, & Reichenberg, 2015; “What Causes Autism?”, n.d.). A study on maternal infections during pregnancy and the risk of having children with ASD found that those mothers who were diagnosed with bacterial infections such as a urinary tract infection were at an increased risk of having a child who was diagnosed with ASD. Having multiple infections during pregnancy was also associated with ASD (Zerbo, Qian, Yoshida, Grether, Van...
de Water, & Croen, 2013). In addition, according to the CDC website, children who have a genetic or chromosomal condition such as fragile X syndrome or Down syndrome are diagnosed with ASD more often compared to those without these syndromes (“Data & Statistics on Autism Spectrum Disorder”, n.d.). Furthermore, research has found that children with ASD have some irregularities in the development of their brain. Neurobiological research using functional magnetic resonance imaging (fMRI) and structural magnetic resonance imaging (sMRI) have demonstrated a correlation between increased head circumference and the development of ASD as rapid brain overgrowth has been a key identifier of ASD in early childhood (Hall & Graff, 2012; Stigler, McDonald, Anand, Saykin, & McDougle, 2011). Children with ASD have been found to have difficulty with social cognitive processes such as attention focusing, inhibitory control, perspective-taking, and problem-solving. This can be associated with studies that have found abnormalities in cortical gray and white matter volumes in children with ASD, i.e., cortical networks that are both important for these higher-order functions (Hall & Graff, 2012; Stigler et al., 2011).

Environmental factors such as mothers living close to freeways and being exposed to automotive exhaust have been found to increase the likelihood of having a child with ASD (Sicile-Kira, 2014). Consistent research has found that perinatal exposure to air pollutants such as metals, diesel, and mercury are associated with increased risk of ASD (Lyall et al., 2014). Regarding vaccinations and ASD, it has been confirmed that vaccinations do not cause
ASD. However, this debate continues as it may be possible that some children can be more susceptible to vaccines if they have a weak immune system and if their mothers experience some of the possible risks during their pregnancy such as those mentioned above (Sicile-Kira, 2014).

Challenges of Raising a Child with ASD

Parents of children with ASD have reported higher levels of stress compared to parents of typically-developing children (Benson, 2006; Hayes & Watson, 2012). The stress surrounding parenting a child with ASD has been linked to the severity of the child’s impairments and challenging behaviors (Benson, 2006; Pozo, Sarria, & Brioso, 2013). Studies show that aggressive and self-injurious behaviors are the most significant contributors to parents’ high levels of stress (Pozo et al., 2013). A lack of parent preparedness of how to adequately manage challenging behaviors adds to this stress since parent training in this area is rarely provided (Preece, 2014). Helping parents understand their child’s challenging behaviors and what options are available to help manage them may therefore be beneficial to increasing parental efficacy and decreasing parental stress.

Some challenging behaviors that children with ASD often display include: lack of social communication, restrictive and repetitive behaviors, sensory sensitivities, and maladaptive behaviors (e.g., tantrums, aggression, self-stimulatory and irritable behaviors) (Harrop, Gulsrud & Kasari, 2015; Kirby, Boyd, Williams, Faldowski, & Baranek, 2017; Sicile-Kira, 2014). Each of these
behaviors is described in turn below along with some suggestions to help parents manage these behaviors.

**Lack of Social Communication**

Individuals with ASD typically have significant deficits in verbal and nonverbal communication. About one-third of the ASD population are nonverbal and have difficulty communicating their needs, feelings, and thoughts to others ("Autism Spectrum Disorder," 2018; "What Are the Symptoms of Autism?", n.d.). Children with minimal nonverbal conversation skills cannot understand the meaning or usage of gestures and often avoid making eye contact with others during conversations. Therefore, children become frustrated when they are unable to communicate with others causing them to engage in maladaptive behaviors such as tantrums, protests, hyperactivity, or aggressive behaviors as their form of communication ("Autism Spectrum Disorder," 2018; Sicile-Kira, 2014). Additionally, some children with ASD have limited vocal skills while others have a rich vocabulary but may engage in repetitive or rigid language. For example, some children may say things that are not related to the topic of conversation or that simply have no meaning. Others may engage in echolalia, a condition where a child constantly repeats words or sentences they have previously heard ("Autism Spectrum Disorder," 2018).

When children have such speech and language problems, parents of children with ASD would benefit from knowing about the variety of options available to them. Doctors will often refer them to speech-language pathologists
or other specialists who will determine the appropriate treatment such as communication treatment. This treatment focuses on teaching children single words and phrases, helping them understand the meaning of words, and teaching them how to appropriately engage in conversation with others by taking turns and staying on topic ("Autism Spectrum Disorder," 2018). Picture exchange communication system (PECS), sign language, and other speech-generating devices are other ways to help children communicate their needs through the use of pictures and symbols ("Autism Spectrum Disorder," 2018; Sicile-Kira, 2014). For parents of infants and young children, it is recommended that they pay attention to their child’s pre-language skills and identify whether they can make eye contact, imitate actions, babble as a form of communication, and use gestures such as pointing ("Autism Spectrum Disorder," 2018).

Restrictive and Repetitive Behaviors

Restrictive and repetitive behaviors are core symptoms of children with ASD. These behaviors include repetitive body movements such as hand-flapping, body rocking, fixation on certain items or parts of items, ritualistic behaviors and routines, as well as sensory sensitivities (Harrop, Gulsrud, & Kasari, 2015). These behaviors are categorized as “lower order behaviors” and “higher order behaviors”. Lower order behaviors include repetitive motor actions, movements, sensory manipulation of objects, and some self-injurious behaviors. Higher order behaviors are cognitive behaviors such as specific rituals and
routines, insistence on sameness, and restricted interests (Harrop, Gulsud, & Kasari, 2015; Kirby et al., 2017).

Although many of these behaviors are seen in typically-developing children, it is the frequent repetitiveness and the interference of these behaviors in children’s learning and their daily lives that make it a core symptom of ASD (Harrop, Gulsrud & Kasari, 2015). Research indicates that boys and girls under the age of five who have ASD have similar restrictive and repetitive patterns. However, once they are older, girls tend to have fewer of these behaviors compared to boys (Harrop, Gulsrud & Kasari, 2015). Because girls have fewer atypical restrictive and repetitive behaviors and are less interested in objects, it has been suggested that the lack of these core symptoms could be one of the reasons why girls are often diagnosed with ASD at a later age than boys (Harrop, Gulsrud & Kasari, 2015). The repetitive use of objects, atypical sensory behaviors, and self-aggression have been associated with children’s communication deficits and overall developmental delays. These behaviors are also said to be influenced by contextual factors such as when children are in unfamiliar spaces, are unable to interact with others, or receive reinforcement of their repetitive behaviors (Harrop, Gulsrud & Kasari, 2015; Kirby et al., 2017). More research is needed to further investigate the development and etiology of these sensory and repetitive behaviors as observational research and parent-report measures have only helped to identify the contextual occurrences of these
behaviors but not the biological explanations (Harrop, Gulsrud & Kasari, 2015; Harrop, McConachie, Emsley, Leadbitter & Green, 2013).

Some typical interventions that parents of children with ASD would benefit from knowing about and utilizing for low order repetitive behaviors such as self-injury and other stereotypies include: physically or vocally blocking the behavior, removing reinforcement of the problematic behavior and reinforcing any other positive behavior, teaching the child to appropriately communicate their needs, using visual or verbal cues to help the child with transitions, engaging in physical exercise before activities which have been associated with the behavior, teaching the child more adaptive skills, and providing non-contingent access to more appropriate objects or activities (Boyd, McDonough, & Bodfish, 2011). Existing interventions for high order repetitive behaviors such as obsessions and compulsions, restrictive interests, specific routines and rituals, and the insistence on sameness include the following: cognitive reframing exercises, reinforcing behaviors immediately after an appropriate behavior, engaging in activities where the child can engage in those restrictive interests to increase their motivation, and using visual schedules or video-based technologies to help children with transitions or changes in their routines (Boyd, McDonough, & Bodfish, 2011). The end goal is not just to stop the repetitive and restrictive behaviors but to find other appropriate replacement behaviors or activities that serve the same function and are reinforcing to the child.
Sensory Sensitivities

Children with ASD who have sensory sensitivities have atypical reactions to noise, texture, smell, touch, and temperature (Sarris, 2016). The overall explanation for sensory processing problems is that the brain has trouble receiving and responding to information that comes in through the senses (Arky, n.d.). As a result, children may develop unusual behaviors as their body responds negatively to certain sensitivities.

Feeding and mealtimes can be difficult for parents of children with ASD as some children are very selective with their food and often prefer eating the same food or food with the same texture (Chistol, Bandini, Must, Phillips, Cermak, & Curtin, 2017; Sicile-Kira, 2014). Although selective eating is common among young typically-developing children, food selectivity is more pronounced among children with ASD and is thought to be related to oral sensory sensitivity which means that children have extreme sensitivity in and around the mouth. A study on food selectivity among children with ASD found that the three main factors that influenced what children ate included the food’s texture, appearance, and taste (Cermak, Curtin, & Bandini, 2010). In general, children with oral sensitivities will often avoid tasting or smelling certain foods, will limit themselves to eating only certain textures, and crave only the specific foods they are used to eating (Chistol et al., 2017).

Similarly, children with oral sensory sensitivity often have poor oral health as they have difficulty tolerating the feeling of a toothbrush in the mouth or the
taste of toothpaste. In a study interviewing parents of children with ASD, about 50% of parents reported that they had difficulty with their child’s daily oral care at home and about 50% reported that their child’s sensory processing difficulties interfered with oral care at the dentist’s office (Stein, Polido, Mailloux, Coleman, & Cermak, 2011). To help with these oral sensitivities in the home, dentists have suggested that parents experiment with different kinds of toothpaste that are different in taste and smell to see which one the child may prefer, as well as trying out different toothbrushes with different bristles. It is also suggested that parents try giving their child an oral massage with a washcloth first, so they can become used to the sensory experience before using a toothbrush (Stein et al., 2011). However, the challenges experienced at a dentist’s office not only have to do with the child’s oral sensitivities but also with the overall environment of dental offices with bright lights and loud unfamiliar noises from the tools being used (Stein et al., 2011). Therefore, it is helpful for dental professionals to also be aware of these sensory sensitivities caused by the environment of their dental office and possibly make the effort to minimize the anxious and maladaptive behaviors of children by using dim lighting and calming auditory stimulation (Stein et al., 2011).

Furthermore, children with ASD have auditory sensory processing difficulties and may often cover their ears to block certain sounds or not respond when their name is being called (“Autism and Auditory Sensory Processing”, 2018; Sicile-Kira, 2014). Children with ASD who have auditory sensory
processing difficulties often find themselves in unsafe situations by running away, hiding, or hurting themselves as a way to escape the triggering sounds (Sarris, 2016). While some parents give their children headphones or earbuds to cancel out uncomfortable noises, others simply try to avoid the sounds that trigger their children. Difficulties in processing sound have been suggested to be brain-related and not always related to hearing impairment. However, research is still being conducted to identify brain-activity patterns related to sound hypersensitivities and social communication (“Autism and Auditory Sensory Processing”, 2018). Therefore, there is a need for interventions that can help children who are sensitive to noises without limiting them from partaking in family, school, or community activities (Sarris, 2016).

Many children with ASD also have tactile sensitivities and either dislike certain feelings and textures or they have an unusual need for touching people, objects, or surfaces (Leekam, Nieto, Libby, Wing & Gould, 2006). As a result, some children like to remove their clothes and shoes to avoid the uncomfortable textures on their skin, scratch the skin that has been touched, react negatively to gentle or firm touches, and dislike any grooming activities such as brushing or cutting their hair, brushing their teeth, taking a shower, or cutting their nails (Sicile-Kira, 2014; Leekam et al., 2006). When children are unable to explain their distress regarding certain sensory sensitivities, it can lead to aggressive behaviors that can create more parental stress. It can also be extremely difficult for parents not to be able to express their love physically if their child is sensitive
to touch and dislikes getting hugs or being kissed (Leekam et al., 2006). Thus, it is important to identify the specific sources of these sensory sensitivities to develop individualized techniques and programs that will help to minimize or avoid these sensitivities (Leekam et al., 2006).

**Maladaptive Behaviors**

Children with ASD typically display maladaptive behaviors such as tantrums, aggression towards self or others, destructive behaviors, and self-stimulatory behaviors that interfere with their daily routine (Hagopian & Graham, 2009; Hall & Graff, 2012). Some biological factors that influence these maladaptive behaviors include deficits in communication, sensory sensitivities, sleeping problems, and having other disorders such as anxiety, ADHD, and intellectual disability ("Autism Spectrum Disorder," 2018; Hall & Graff, 2012; Maskey, Warnell, Parr, Couteur, & McConachie, 2012). Research studies have demonstrated that individuals with an intellectual disability who also have an ASD diagnosis have higher levels of maladaptive behaviors such as aggression and self-injury compared to children with only an ASD diagnosis (Woodman, Smith, Greenber, & Mailick, 2014). Therefore, aggressive and challenging behaviors are reported to be more prevalent in low functioning individuals with ASD (Maskey et al., 2012). Tantrums and screaming often emerge as a result of environmental factors such as parents prohibiting access to preferred items or placing demands on children to do non-preferred activities (Hagopian & Graham, 2009). In addition, maladaptive behaviors often occur because children are not
able to communicate their needs, express their preferences, or they don’t understand or respond to others’ social cues (Hagopian & Graham, 2009). To change maladaptive behaviors, it is important for parents to first be able to identify a replacement behavior that serves the same function and that is also socially appropriate (Borgmeier, Loman, Hara, & Rodriguez, 2014). For example, Facilitated Communication (FC) and Picture Exchange Communication System (PECS) are two methods that assist non-vocal individuals with ASD in communicating their wants and needs by typing on a keyboard or giving others a picture of the desired object or activity. These methods teach individuals with ASD to communicate their needs and express themselves to others instead of screaming, crying, or engaging in aggressive behaviors when they become frustrated (Sicile-Kira, 2014). Physical containment is also used as an immediate method to stop children from engaging in self-injurious behaviors or in behaviors that are harmful towards others (Greenspan & Wieder, 2009). Overall, these behaviors often create high levels of parental stress leading many desperate parents to rely on therapies or treatments that are not-evidenced based (Hall & Graff, 2012).

In addition to the above challenging behaviors that parents of children with ASD navigate, another challenge of raising a child with ASD is the lack of parent preparedness for this role, as discussed below.
Lack of Parent Preparedness and Training for Raising a Child with ASD

Although many of the current interventions for children with ASD aim to teach parents how to independently manage their child’s maladaptive behaviors, parents continue to report a lack of understanding of when and how to implement the intervention strategies taught (Moore & Symons, 2011). Additionally, some parents of children with ASD report low parental self-efficacy and view their parenting as being ineffective (Crowell, Keluskar, & Gorecki, 2019).

Applied behavior analysis (ABA) has been the primary form of therapy for children with ASD since the 1960s in the United States (“Applied Behaviour Analysis and Autism”, 2016). ABA is an evidence-based approach that is widely recognized and used to address problematic behaviors and to teach a variety of skills (Hagopian & Graham, 2009; Sicile-Kira, 2014). When focusing on problem behaviors, ABA emphasizes the importance of knowing what happened before the behavior occurred (antecedent) and what happened immediately after the behavior was exhibited (consequence) (Sicile-Kira, 2014). A functional behavioral assessment (FBA) is done prior to the child receiving ABA services so that the function of their behaviors is established, and effective interventions are used. The four functions of behavior include attention, access to preferred items, escape from demands, and sensory reinforcement/self-stimulation (Hagopian & Graham, 2009). To extinguish maladaptive behaviors, ABA-based interventions reinforce and provide access to preferred items or activities when the child engages in a more appropriate alternative behavior instead of the maladaptive
behavior. For example, the child can be taught functional communication skills to appropriately ask for preferred items or communicate their needs instead of engaging in problematic behaviors such as crying and screaming (Hagopian & Graham, 2009). Because most ABA services are provided by trained behavior technicians, such strategies may not always be taught to parents due to the minimal parent training that is provided by many ABA agencies (Raulston, Hieneman, Caraway, Pennefather, & Bhana, 2018). If any parent training is provided, parents are primarily taught ABA strategies so that they can support their child’s learned skills during everyday activities (“Applied Behaviour Analysis and Autism”, n.d). However, parents complain that they have difficulty understanding when and how to implement the strategies that are taught (Moore & Symons, 2011; Raulston et al., 2018). ABA has been criticized for its regimented form of teaching and its behavioral methodology (Devita-Raeburn, 2016). Parents would prefer their children to be able to transfer what they learn in therapy to a natural environment, and for the therapist to teach them to understand the reason behind their child’s maladaptive behaviors instead of trying to make their kids act “normal” (Devita-Raeburn, 2016). Although ABA has been one of the primary interventions used for children with ASD, research studies indicate that parents demonstrate poor adherence to treatment as well as

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1 Applied Behavior Analysis was developed by clinical psychologist Dr. Ole’ Ivaar Lovass in the 1960s. Designed as an intervention that would help children with ASD avoid being institutionalized, it has been modified somewhat throughout the years including the removal of aversive reinforcement methods. One of the main criticisms has been the lack of focus on children’s social emotional development. (For more information see “The Controversy”, 2019; “Dr. Ole Ivar”, 2020).
poor understanding of recommended strategies to implement with their children (Moore & Symons, 2011; Raulston et al., 2018). Therefore, parents may continue to struggle not only in understanding their child’s behavior but also in understanding the interventions that are put in place.

Summary

In sum, parenting a child with ASD can be challenging and stressful. Although existing interventions strive to decrease children’s challenging behavior, they often fail at educating parents about, and preparing them to manage these behaviors themselves. Therefore, empowering parents with an understanding of, and techniques for managing challenging behaviors may help increase their self-efficacy in parenting a child with ASD and decrease their levels of stress.

Supporting Parents in Raising a Child with ASD

In addition to helping parents of children with ASD understand the intervention options described above, helping parents to understand children’s typical developmental milestones, positive child guidance practices, how to build strong parent-child relationships, and ways to support and enrich their child’s development through enrichment activities may also empower them with skills to support them in this challenging role and at the same time support their child’s overall development. Although these practices are not specific to parents of children with ASD, they are helpful parenting practices that support children’s development.
Understanding Child Development Milestones

A national survey conducted in the U.S. on what parents know about child development found that many parents lack accurate knowledge about the development of children and often overestimate their child’s abilities (“Zero to Three”, 1999). When parents have adequate knowledge of child development, they have a better understanding of children’s normative developmental milestones and what they are capable of at different ages (“Child Development Basics”, n.d.; Smith, 2001). This can greatly benefit parents of children with ASD as knowing developmental milestones can assist in identifying early signs of developmental delays (“Child Development Basics”, n.d.; Smith, 2001).

Understanding the developmental milestones of children at different ages can give parents an idea of what to expect as their children grow up. Developmental milestones are a guide to help parents understand the normal sequence of the growth and development of children based on when different skills and abilities develop according to the child’s age (“Child Development Basics”, n.d). Parents can use the developmental milestones checklist to track their child’s development and share any concerns with their doctor if their child is not meeting their milestones. Children can be screened for general development at 9, 18, and 24 or 30 months and 18 and 24 months for autism (“Concerned About Your Child’s Development?”, n.d). This information is crucial for parents to know as identifying early signs of ASD and starting interventions early can make a significant impact on the child’s subsequent development (Sicile-Kira, 2014).
addition, the developmental milestones checklist also serves as a guide for parents to have age-appropriate expectations of their child’s abilities in different developmental domains (“Child Development Basics”, n.d.).

Parents may also benefit from understanding that even typically-developing children have “big emotions” during their early years because they are right-brain dominant and the right side of the brain specializes in receiving and interpreting emotional and nonverbal information (Siegel & Bryson, 2012). Therefore, children who are 3 years old or younger are typically unable to verbally communicate their feelings or be logical thinkers (Siegel & Bryson, 2012). This is crucial information for parents of children with ASD as sometimes their child’s difficult behaviors (e.g., tantrums, biting, yelling) can be typical behaviors of children in the early years (Siegel & Bryson, 2012). After identifying the reason behind a child’s behavior, parents can appropriately respond to the child’s internal emotional state with warm and nurturing relationships by being empathetic and active listeners (Miller, 2016; Sicile-Kira, 2014; Siegel & Bryson, 2012). Being a sensitive and caring parent will support positive developmental outcomes as children’s learning and behavior will improve over time (Miller, 2016).

Understanding Positive Child Guidance

Using developmentally-appropriate positive child guidance practices that meet children’s basic needs and guide their behavior have been found to promote positive child outcomes which may also be effective with children with
ASD (“Child Development Basics”, n.d.; Rikhy, Tough, Trute, Benzies, Kehler & Johnston, 2010). The purpose of positive child guidance is to meet the developmental needs of children through effective problem solving, honest communication, and assertiveness as well as to support children’s development and life skills without the use of punishment strategies (Kamptner, 2018). Positive child guidance helps children develop a sense of responsibility, confidence, and self-control as they grow up (Miller, 2016). Authoritative parenting, which is characterized as being responsive to a child’s emotional needs, being warm and nurturing, and setting limits and expectations, is a parenting style that is associated with positive child outcomes (Marion, 2015). Children feel safe and secure, learn to take responsibility for their actions, and learn to regulate their behaviors when parents are sensitively-attuned, responsive, set limits and consequences, and use reasons and explanations to redirect behavior (Marion, 2015; Siegel & Bryson, 2012). Parents can teach children appropriate behaviors by providing them with positive feedback about why their behaviors are healthy, responsible, and respectful. Parents can also establish potential consequences and provide rational explanations of why some behaviors are unsafe or inappropriate (Miller, 2016). Children learn to feel valued, respected, and understood when their parents create an emotionally-positive environment and acknowledge their feelings (Siegel & Bryson, 2012).
Building Strong Parent-Child Relationships

Building strong parent-child relationships is significant for children’s social and emotional development. To build strong parent-child relationships, parents need to meet their child’s basic psychological needs by being responsive, emotionally available, sensitively-attuned, supportive, and provide their children with a sense of closeness, autonomy, and overall secure attachment (Davies, 2011; Kamptner, 2005; O’Connor et al., 2016). Strong parent-child relationships also consist of reciprocal interactions, modeling, teaching, and providing children with different learning opportunities (O’Connor et al., 2016). These parental behaviors can help parents develop a close connection with their child and can result in a reduction of difficult behaviors (Kamptner, 2005). In addition, parents of children with ASD can support their child’s development and strengthen their parent-child relationship by providing their children with a secure attachment and using the Floortime approach as described below as part of their child’s treatment.

Early interactions between caregivers and their children that are warm, sensitively-attuned, and responsive create a close, emotional, and secure attachment that is significant for the child’s development and the quality of relationships that are established later in life (Davies, 2011). Attachment refers to the strong emotional bond between the caregiver and the child which develops over time and provides the child with a sense of security (Davies, 2011; Honig, 2002). Being warm means that caregivers show their affection through close
bodily contact, gentle care, and that they soothe the child when the child is in a state of distress. When caregivers are sensitively-attuned, they are aware of the child’s emotional state and respond to their physical and emotional needs (Davies, 2011; Sroufe & Siegel 2011). In addition, a responsive caregiver is one who is attentive, predictable, emotionally available, and responds quickly to the child’s needs (Davies, 2011; Sroufe & Siegel 2011). These key parental behaviors toward children help promote self-regulation, self-esteem, social and emotional competence, resiliency and empathy, and they result in fewer behavior problems (Sroufe, 2005). In addition, securely-attached children feel safe to explore their environment, express their feelings, and are more open to learning because they are confident that their caregiver will be responsive to their needs (Davies, 2011). Parent-child relationships that are securely attached have also been found to moderate the impact of difficult experiences such as family stress and marital conflict as early parental behaviors such as warmth and emotional support have been linked to children’s resiliency and psychological well-being (Sroufe, Duggal, Weinfield, & Carson, 2000). Thus, establishing a positive parent-child relationship early on can result in positive developmental outcomes, behaviors, and social relationships.

Many children with ASD often have emotion-processing deficits that can frustrate parents as it becomes difficult to connect with their child and develop a close parent-child relationship (Sivaratnam, Newman, Tonge, & Rinehard, 2015). Studies show that many children with ASD are less securely attached to their
parents compared to typically-developing children or other children with developmental delays (Sivaratnam et al., 2015). Although children with ASD are capable of forming secure attachment relationships, these relationships are often not formed due to the lack of reciprocal interactions between the parent and child (Sivaratnam et al., 2015). Parents should not become discouraged by the lack of emotional responsivity or reciprocal interactions from their child. Instead, they can try different positive child guidance practices such as the Floortime approach to have one-on-one time with their child and follow their lead on what they find of interest (Greenspan & Wieder, 2009). As parents build on their child’s interest and are responsive to the child’s emotional signals, children may be more securely attached and make progress in shared attention, two-way communication, and problem-solving (Greenspan & Wieder, 2009; Siveratnam et al., 2015).

The Developmental, Individual-difference, Relationship-based approach (DIR) is a method of treatment for children with ASD that creates comprehensive programs tailored to a child’s developmental level (Greenspan & Wieder, 2009). This model has been found to improve children’s social and emotional intelligence as they learn to relate to others through warm, intimate, and meaningful interactions (Greenspan & Wieder, 2009). The Floortime component of the DIR model creates meaningful one-on-one interactions as the caregiver gets down on the floor and spends uninterrupted time interacting with their child during play activities (Greenspan & Wieder, 2009; Mercer, 2017). One of the
main goals of Floortime is that caregivers follow the child’s lead by engaging in activities that interest the child while also elaborating on their ideas and actions (Greenspan & Wieder, 2009; Mercer, 2017). This brings the child a feeling of connectedness and closeness with their parent which creates opportunities for parents to broaden their child’s interests and abilities (Greenspan & Wieder, 2009). For example, a parent can assist their child in recognizing different sensations through careful observations and see how the child responds to sounds, touch, smells, and sights. Once a baseline is established, it becomes easier for parents to understand their child’s behavior, join them in play, and slowly attempt new challenges (Greenspan & Wieder, 2009).

The four main goals that parents and therapists focus on during Floortime and that can also be implemented into ABA programs include: encouraging attention and intimacy, engaging in two-way communication, encouraging their child to express their ideas and emotions, and using logical thinking (Sicile-Kira, 2014). The circle-of-communication game can facilitate purposeful emotional interactions between parents and children of a wide range of ages. The purpose of this game is simply for parents to try and get as many back-and-forth interactions with their child as they can, based on their responses. For example, a parent can see how many times their child will smile or laugh if they make silly faces or how many times the child attempts to open their parents’ fist when they see something hidden in their hand (Greenspan & Wieder, 2009). The Floortime approach also prioritizes developmentally-appropriate practices and interactions.
where therapists and parents elicit interactions and activities that are of interest to the child but that are also meaningful based on the child’s functional capacities (Greenspan & Wieder, 2009). Overall, this approach helps to improve parent-child relationships through intimacy, closeness, and creativity during uninterrupted play activities (Greenspan & Wieder, 2009).

**Engaging in Developmentally-Appropriate and Enriching Activities**

Interventions for children with ASD are typically behaviorally-based and result in minimal gains in children’s social-emotional, cognitive, and language development (Greenspan & Wieder, 2009). Taking a more developmentally-appropriate approach through spontaneous interactions and developmentally appropriate activities can be combined with ABA interventions to help create meaningful learning opportunities that support children’s interactive and thinking skills (Greenspan & Wieder, 2009). Many parents of young children with ASD want to support their child’s overall development, including their social-emotional development, but may feel unable to do so because they don’t know how (Crowell, Keluskar, & Gorecki, 2018). Parents can create meaningful learning opportunities with their children in various settings that can positively impact all areas of development (Steward-Henry & Friesen, 2018). For example, NAECY’s Powerful Interactions framework has been primarily used by early childhood educators to create opportunities to interact with their students. This framework encourages all parents to create opportunities to interact with their children during everyday activities (e.g., bath time, getting ready for school, playtime) as it
can get difficult to create one-on-one time when parents have work or other children to attend to (Steward-Henry & Friesen, 2018). Parents can expand their child’s skills by taking the time to be present and watch their child at play, connect with them by having the child tell them about the activity, and extend their learning by adding new information regarding the game or activity in which the child is engaging in (Steward-Henry & Friesen, 2018). Creating opportunities for children to play and explore should also come with social interactions where parents follow their child’s lead and encourage back-and-forth communication, the creative use of ideas, and problem-solving interactions (Greenspan & Wieder, 2009). When children see their parents taking an interest in and becoming engaged with them in their activities instead of forcing them to do as they want, children are more likely to acknowledge their parent’s presence, value their relationship, and have a natural desire to interact with them and share their world (Greenspan & Wieder, 2009; Siegel & Bryson, 2012).

Significantly, language development can also be fostered through creating a rich language environment where parents start interactions with their children regarding things that they find of interest (Suskind, 2015). Some of the easiest and most important activities that parents can do to support language development are to talk, read, and sing to their children (Suskind, 2015). The more children are exposed to speech and different sounds, the more they absorb these language skills and develop a larger vocabulary during their first three years of life (“Read from the Start”, n.d.; Suskind, 2015). Parents can use natural
opportunities to talk and explain the environment in a grocery store, at the park, during bath time, or any daily routine activities. This will help the child learn language in relation to their everyday environment and how their daily routines are organized throughout the day (Suskind, 2015). Getting down to a child’s eye level, describing and narrating what both the child and the parent are doing, repeating statements that the child says, and asking open-ended questions are all tips that parents can do to encourage the child to speak more and feel listened to (Suskind, 2015; “The Parent’s Role”, n.d.).

Summary

Having knowledge of children’s normal growth and development can help parents understand their child’s behavior better and have age-appropriate expectations. The use of positive child guidance strategies such as using positive feedback, problem solving, and assertiveness can teach children appropriate behaviors and meet their developmental needs. Having this knowledge and using these strategies can also support strong parent-child relationships where parents provide children with different learning opportunities and meaningful one-on-one interactions that make children feel understood and close to their parents. Significantly, parents can engage in enriching activities where they expand their child’s knowledge through spontaneous interactions and natural opportunities. This information will support parents of children with ASD to better understand their child’s behaviors and manage them in a more positive
and effective way that will help bring about the best developmental outcomes for their children while simultaneously helping to decrease challenging behaviors.

Current Family Interventions for Children with ASD

Although traditional therapeutic interventions for children with ASD have focused almost solely on Applied Behavioral Analysis, there are a few programs that currently exist which support parents of children with ASD in other ways as well. These programs strive to improve parent-child relationships and reduce parental stress and children’s challenging behaviors through developmentally-appropriate practices compared to what has been available in the past (Ginn et al., 2017; Koegel, Symon, & Koegel, 2002; Stadnick, Stahmer, & Brookman-Frazee, 2015). The programs described below are not an exhaustive list of the many interventions that have been created, but they provide a sampling of those that either teach parents to implement a standard treatment protocol that is not individualized to the child’s specific needs or that are not generally available (“Bridge Collaborative”, n.d.; “PEERS”, 2018).

Parent-Child Interaction Therapy (PCIT) is an evidence-based intervention treatment that has been widely used with young children ages 2-7 with behavior problems. PCIT aims to reduce problem behaviors and improve parent-child interactions using positive reinforcement (French, Yates, & Fowles, 2018; Wallace, Quetsch, Robinson, McCoy, & McNeil, 2018). The focus is to teach caregivers a balance between being warm, attentive, and responsive while also being firm and setting limits. This treatment includes two phases: Child-
Directed Interaction (CDI) and Parent-Directed Interaction (PDI). The primary focus of the CDI phase is to coach parents to follow their child’s lead in interactions and to reinforce their child’s appropriate behaviors (Wallace et al., 2018). In PDI, parents are taught to use consistent discipline and place appropriate demands to increase children’s compliance and reduce negative behaviors. PCIT is based on attachment theory, social learning theory, and coercion theory as the strategies taught reflect the importance of being warm and responsive to a child, reinforcing positive behavior, and setting limits and consequences for children’s behaviors (French et al., 2018). Studies on the efficacy of PCIT with children on the autism spectrum and with disruptive behaviors have shown positive results in the improvement of parent-child interactions, including an increase in the child’s compliance and a decrease in disruptive behaviors and parental stress after 8-10 weeks of treatment (Ginn et al., 2017). Although PCIT should be considered by parents of children with ASD, PCIT may not benefit all children with ASD. It has been noted that PCIT may not be appropriate for children who have difficulty understanding simple instructions and require substantial support (Masse, McNeil, Wagner, & Quetsch, 2016).

Second, Project imPACT (Improving Parents as Communication Teachers) is a 12-week, parent-mediated intervention that teaches parents of primarily 12-24 month old’s to use a naturalistic approach to promote children’s social communication skills through play and other daily activities (Ingersoll & Wainer, 2013; Stadnick, Stahmer, & Brookman-Frazee, 2015). Developmental
techniques are first taught and modeled by a therapist to help parents improve responsiveness and reciprocity with their child and naturalistic behavioral techniques are then taught to increase children’s language, imitation, and play behaviors (“Autism Discovery Institute”, n.d.). Parents are also interviewed and work together with the therapist to develop goals for the child and use ABA strategies as a guide to teach communication skills (“Bridge Collaborative”, n.d). This intervention has been shown to effectively increase children’s social engagement, language, imitation, and play skills (Ingersoll & Wainer, 2013; Stadnick et al., 2015). However, Project imPACT is a pilot program that is being tested only in Southern California and will be available to the public when research is completed (“Bridge Collaborative”, n.d.).

Finally, the **UCLA PEERS program** is an evidence-based social skills intervention program for young children, adolescents, and young adults with ASD who have challenges in making friendships and interacting with peers (“PEERS”, 2018). This 16-week program includes parent training where parents are taught strategies through role-playing on how to help their children make and keep friends and they also receive performance feedback. This program is effective in improving the social functioning of children, teens, and young adults with ASD when implemented in school and clinic settings (Laugeson, Ellingsen, Sanderson, Tucci, & Bates, 2014). Although research studies have demonstrated the effectiveness of this program, a barrier for families is that sessions primarily take place at the UCLA clinic with costly fees. Otherwise,
professionals and educators who want to implement the PEERS program as an intervention have to attend training seminars and become certified by UCLA PEERS staff ("PEERS," 2018).

Overall, the programs mentioned above strive to improve parent-child relationships and reduce parental stress and children’s challenging behaviors through developmentally appropriate practices. However, they are either not generally available to families who might be interested in them or their treatment practices are not individualized for the needs of each child. In addition, none of these interventions focus on helping parents understand the reason behind their child’s maladaptive behaviors. The current project aims to rectify these shortcomings including integrating and teaching ABA strategies and developmentally-appropriate practices to parents of children with ASD.

Summary and Purpose of Project

Raising a child with ASD presents unique challenges for many families including understanding ASD deficits and behaviors, and identifying effective ways to manage these behaviors. Parents of children with ASD experience higher levels of stress compared to parents of typically-developing children due to their child’s challenging behaviors (Benson, 2006; Hayes & Watson, 2012; Pozo et al., 2014). Although some strategies and suggestions of what parents can do to address these behaviors are known to and used by ABA therapists, many parents are unaware of this information. This can be due to a lack of parent training provided by ABA agencies and a failure to prepare them to
understand and manage ASD-related behaviors (Moore & Symons, 2011; Raulston et al., 2018). Because ASD interventions generally take a behaviorally-based approach and parents continue to lack an understanding of the causes of their child’s ASD behaviors and how to manage them, there is a need for an intervention that combines ABA with positive child guidance strategies that enhances parents’ knowledge of child development, ways parents can build strong parent-child relationships, and methods to engage in enrichment activities that will support their child’s overall development.

The purpose of this project was to address these shortcomings by creating a parenting workshop that supports parents and caregivers of young children with ASD. Goals included the following: 1) help parents understand the underlying factors related to the challenging behaviors of children with ASD; 2) teach parents to combine ABA with positive child guidance strategies to assist them in managing their child’s ASD behaviors; and 3) enhance parents’ knowledge of child development, ways to build strong parent-child relationships, and methods to engage with their child in enrichment activities that will support their child’s overall development. It was expected that after four workshop sessions, parents and caregivers would have a better understanding of challenging ASD behaviors and their underlying factors, be better able to manage their child’s challenging ASD behaviors using a combination of ABA and positive child guidance strategies, and have greater knowledge on child development, ways to build strong parent-child relationships, and methods to
engage in enrichment activities with their child to support their overall development.
CHAPTER TWO

METHOD

Overview

The purpose of this project was to create a parenting workshop for parents and caregivers of young children with autism in order to help them better understand the underlying factors related to the challenging behaviors of children with ASD and how to combine ABA with positive child guidance strategies to help them manage their child’s ASD behaviors. A third goal was to enhance parents’ knowledge of child development, how to build strong parent-child relationships, and how to engage with their child in enrichment activities that will support their child’s overall development. Eight topics were discussed over the course of four sessions, with each session in the program lasting approximately two hours (Table 1). Each session concluded with an enrichment activity for parents to create meaningful learning opportunities with their child.
Table 1. Summary of Sessions and Session Topics

<table>
<thead>
<tr>
<th>Session</th>
<th>Session Overview and Topics</th>
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</thead>
<tbody>
<tr>
<td><strong>Session #1</strong></td>
<td>● Introductions- Presenter and Parents</td>
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<td></td>
<td>o Purpose of Project</td>
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<tr>
<td></td>
<td>o Overview of 4 Sessions</td>
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<tr>
<td></td>
<td>● Administer Pre-training Assessments</td>
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<tr>
<td></td>
<td>● Overview of Autism</td>
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<tr>
<td></td>
<td>● Challenges of Raising a Child with Autism</td>
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<tr>
<td></td>
<td>o Lack of Parent Preparedness</td>
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<tr>
<td></td>
<td>o Challenging Behaviors and What Can Help</td>
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<tr>
<td></td>
<td>1. Lack of Social Communication</td>
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<td></td>
<td>2. Restrictive and Repetitive Behaviors</td>
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<tr>
<td></td>
<td>● Enrichment Activity</td>
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<tr>
<td><strong>Session #2</strong></td>
<td>● Challenges of Raising a Child with Autism (Cont.)</td>
</tr>
<tr>
<td></td>
<td>o Challenging Behaviors and What Can Help</td>
</tr>
<tr>
<td></td>
<td>3. Sensory Sensitivities</td>
</tr>
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<td></td>
<td>4. Maladaptive Behaviors</td>
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<td></td>
<td>● Parent Discussion</td>
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<td></td>
<td>● List of Resources</td>
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<tr>
<td></td>
<td>● Enrichment Activity</td>
</tr>
<tr>
<td><strong>Session #3</strong></td>
<td>● Effective Ways to Guide Children’s Challenging Behaviors</td>
</tr>
<tr>
<td></td>
<td>o Introduction to ABA &amp; Positive Child Guidance</td>
</tr>
<tr>
<td></td>
<td>o Applied Behavior Analysis: Where Challenging Behaviors Come from and How to Respond</td>
</tr>
<tr>
<td></td>
<td>o Positive Child Guidance: Definition and Explanation of Strategies for Guiding Behavior</td>
</tr>
<tr>
<td></td>
<td>● Enrichment Activity</td>
</tr>
<tr>
<td><strong>Session #4</strong></td>
<td>● Supporting Your Child’s Development</td>
</tr>
<tr>
<td></td>
<td>o Developmental Milestones</td>
</tr>
</tbody>
</table>
Participants

The workshop was targeted towards parents and caregivers of young children diagnosed with autism between the ages of 4 to 10 years old. The current project included a total of three participants. Only two of the participants were parents of children with ASD and the third participant was a daycare teacher who worked with a child with ASD. Although parents of children with ASD may experience more challenging behaviors at home, teachers also experience some of these behaviors in a school or daycare setting. Therefore, training can be beneficial for both groups to better manage challenging behaviors of children with ASD. Due to the COVID-19 pandemic, these participants were personally recruited by the facilitator.

The participants who participated in the current project were all of Hispanic ethnicity with the youngest being 25 years old and the oldest being 42 years old. One of the participants had a college degree, one had a high school diploma, and the last participant had not completed high school. The daycare teacher had previously taken child development classes and had background knowledge on developmental milestones and positive child guidance strategies.
The two parents of children with ASD have children receiving ABA therapy and were familiar with some ASD facts and terminology.

All three participants attended the four sessions of the workshop and completed the demographic survey, the pre-and post-assessments, and the class evaluation.

Table 2. Participants' 1-3 Demographic Information.

<table>
<thead>
<tr>
<th></th>
<th>Participant 1</th>
<th>Participant 2</th>
<th>Participant 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>25</td>
<td>39</td>
<td>42</td>
</tr>
<tr>
<td>Gender:</td>
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<td>Female</td>
<td>Female</td>
</tr>
<tr>
<td>Marital Status:</td>
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<td>Married</td>
</tr>
<tr>
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<td>Hispanic</td>
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<tr>
<td>Highest Education Level:</td>
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<td>Did not complete high school</td>
</tr>
<tr>
<td>Relationship:</td>
<td>Daycare teacher</td>
<td>Mother</td>
<td>Mother</td>
</tr>
<tr>
<td>Children Diagnosed with ASD:</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Age of Child:</td>
<td>4</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Level of Severity:</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Years receiving ABA:</td>
<td>1 month</td>
<td>5 years</td>
<td>4 years</td>
</tr>
</tbody>
</table>

Measures

Participants completed a pre- and post- class self-assessment created for use in this project, a demographic questionnaire, and a class evaluation.
Pre- and Post- Training Self-Assessment

A 15-item self-assessment (APPENDICES A and B) was created for this project to assess participant’s perception of their knowledge of autism-related challenging behaviors and interventions, their knowledge and confidence of ABA strategies, their knowledge and confidence of positive child guidance strategies, their knowledge of and confidence in managing children’s challenging behaviors using ABA strategies and positive child guidance, their knowledge and confidence of identifying typical child development milestones, their knowledge and confidence on how to build strong adult-child relationships, their knowledge and confidence on how to create and engage in enrichment activities with their child, their confidence in parenting their child with ASD, and their stress level on a daily basis. The participants responded on a 7-point Likert scale (1= not at all knowledgeable/confident; 7= very knowledgeable/confident). For example: How confident do you feel with managing your child’s challenging behaviors? How knowledgeable do you feel with using Applied Behavior Analysis (ABA) strategies to help manage your child’s challenging behaviors?

Demographic Questionnaire

Participants were asked to report their age, gender, relationship to the child diagnosed with ASD, current marital status, ethnicity, highest level of education, number of children in their household diagnosed with ASD, age and gender of children diagnosed with ASD, severity of ASD, services and length of services received by their child with ASD, number of children receiving services,
how long they’ve received those services for, and what their biggest challenge was at the moment in parenting a child with ASD (APPENDIX C).

Class Evaluation

At the end of the fourth workshop session, participants were asked to complete a class evaluation form (APPENDIX D) to assess their perception of the effectiveness of the workshops. The form asked participants if the workshop was beneficial to them, what information taught was the most beneficial for them, what information was the least useful, what information they believe would be important to include in future workshops, and whether they felt they would continue to implement the information they learned in their daily lives.

Procedure

A flyer (APPENDIX E) was emailed to California Psychcare families who the facilitator works with and to acquaintances of the facilitator several weeks prior to the beginning of the 4-session workshop. Due to the COVID-19 pandemic, this workshop was conducted virtually with the facilitator and participants utilizing the Zoom application. Prior to the first session, the facilitator dropped off the demographic questionnaire and the pre-training assessment to each of the participants. The participants were emailed a link prior to each Zoom session. Video and audio were utilized during each session by the facilitator and the participants with the facilitator sharing her screen to present each sessions’ PowerPoints.
At the beginning of Session 1, the presenter introduced herself and asked the participants to introduce themselves by stating their name, the age of their child with ASD, and something they enjoy doing with their children. Following introductions, the facilitator discussed the purpose of the proposed project and gave an overview of all four workshop sessions. Participants were asked to complete the pre-training self-assessment created for the use of this project as well as the demographic questionnaire.

Each of the sessions began by the facilitator providing an overview of the topic for that session and a review of the research that indicated why the information presented was relevant for parents. The facilitator asked questions during each session to facilitate a discussion among the participants. Each session ended with an enrichment activity that the participants were able to implement at home with their child. The facilitator followed up with the participants at the start of the following session to discuss how these activities went.

At the end of the last workshop session, participants were asked to complete the post-training self-assessment and a class evaluation form, which were later picked up by the facilitator from the participants’ home, along with the pre-training assessment and the demographic form.
Session 1

The purpose of Session 1 was to discuss some of the challenges that parents face in raising a child with ASD, challenging behaviors that children with ASD may display, and what parents can do to help. Participants were emailed a copy of the PowerPoint to keep as a reference and take notes as needed (APPENDIX F), a fact sheet about autism spectrum disorder (APPENDIX F-1), a fact sheet with information about communication problems in children with ASD (APPENDIX F-2), and the handout for the enrichment activity to complete with their child at home (APPENDIX F-3).

This session began with an overview of facts and statistics about ASD for participants to gain a general understanding of the prevalence, risks, diagnostic criteria, and levels of ASD severity, as every individual’s diagnosis is unique.

Next, the facilitator discussed challenges of raising a child with ASD. Research shows that parents of children with ASD have higher levels of stress compared to parents of typically-developing children (Benson, 2006; Hayes & Watson, 2012). This stress has been linked to the severity of the child’s impairments, their challenging behavior, and a lack of parent preparedness to effectively manage these behaviors (Benson 2006; Pozo et al., 2013; Preece 2014). To hear and understand the challenges that the participants face in raising a child with ASD, the facilitator asked the participants to share some of their experiences when raising/teaching their child with ASD.
With a lack of parent training available for parents of children with ASD to help them understand and manage challenging behaviors, two types of behaviors (i.e., lack of social communication and restrictive and repetitive behaviors) were discussed in this session. About one third of the ASD population is nonverbal and has difficulty communicating their needs. When children are unable to communicate with others or are unable to understand the meaning or usage of gestures, they often become frustrated and may engage in maladaptive behaviors such as tantrums, protest, hyperactivity, or aggressive behaviors as their form of communication (“Autism Spectrum Disorder”, 2018; Sicile-Kira, 2014; “What Are the Symptoms of Autism?”, n.d.). When children have such language and communication deficits, parents can benefit from knowing what options are available to them. Therefore, the various deficits in social communication children with ASD may have were reviewed as well as treatment options available and how parents can use some of these options at home.

Lastly, restrictive and repetitive behaviors were discussed. These behaviors are core symptoms of individuals with ASD and they often cause increased levels of family stress, pushing some parents to rely on negative parenting practices (Boyd, McDonough, & Bodfish, 2011). To help parents decrease some of the stress related to these behaviors, parents were taught about the topography of these restrictive and repetitive behaviors, what influences individuals to engage in these behaviors, and how to teach replacement behaviors that are more socially appropriate.
At the end of the first session, the facilitator modeled to parents how to engage in an enrichment activity with their child at home since one of the goals of this project was to teach parents ways to engage in enrichment activities that will support the child’s overall development. Some of the easiest and most important activities that parents can do to support language development are to talk, sing, and read to their kids (Suskind, 2015). Therefore, the enrichment activity consisted of first reading the book *The Rainbow Fish* and then decorating a rainbow fish using a fish paper cut-out and glitter. The facilitator sent the participants a YouTube link to a read-along of the book in case they didn’t have a physical copy. Participants learned how to discuss the main point of the book, how to emphasize the importance of sharing, and how to create opportunities for their child to communicate what materials they would want or need when creating their glitter fish. The handout of this activity can be found in APPENDIX F-3.

**Session 2**

The outline and PowerPoint of Session 2 can be found in APPENDIX G. The purpose of the second session was to continue discussing other challenging behaviors (i.e., sensory sensitivities and maladaptive behaviors) that individuals with ASD often display and what parents can do to help. The session began with the facilitator checking in with the participants about how the enrichment activity went with their child.

First, sensory sensitivities were discussed. Children who have sensory sensitivities have atypical reactions to noise, texture, smell, touch, and
temperature (Sarris, 2016). When children have oral sensory sensitivities, parents often struggle to feed their child a variety of foods or may struggle with brushing their teeth as many children have difficulty tolerating the feeling of a toothbrush or the taste of toothpaste (Chistol et al., 2017; Stein et al., 2011).

Auditory sensory processing difficulties were discussed next. Children with ASD who have auditory sensory processing difficulties may find themselves in unsafe situations by running away, hiding, or hurting themselves as a way to escape the triggering sounds (Sarris, 2016). Many children with ASD may also have tactile sensitivities and either dislike certain feelings and textures or they may have an unusual need for touching people, objects, or surfaces (Leekam et al., 2006). Because these sensory sensitivities may often lead to aggressive behaviors and can create parental stress (Leekam et al., 2006), they were discussed in depth with participants along with treatment options and suggestions to help minimize the triggering experiences of these sensitivities. Participants were also sent a sensory checklist to fill out that could help them understand their child’s unique sensory profile (APPENDIX G-1). School may present various challenges for children with sensory processing issues; therefore, understanding their child’s sensory sensitivities may help encourage parents to coordinate with their child’s teacher to create a safe learning space for them (Biel & Peske, 2018).

Maladaptive behaviors were then discussed. Children with ASD typically display maladaptive behaviors such as tantrums, aggression towards self or
others, destructive behaviors, and self-stimulatory behaviors that interfere with their daily routine (Hagopian & Graham, 2009; Hall & Graff, 2012). Research studies demonstrate that these behaviors often create high levels of parental stress leading many parents to rely on therapies or treatment that are not evidence-based (Hall & Graff, 2012). Therefore, it is beneficial for parents to be able to identify the function of these behaviors so they can respond with an appropriate intervention that will teach their child to communicate their needs in a more direct way. To identify the function of different behaviors, participants practiced filling out an A-B-C data sheet based on different scenarios that were presented (APPENDIX G-2). Participants understood that the “antecedent” (A) is what triggers or happens before a behavior occurs, the “behavior” (B) is what the child did in measurable terms (duration, frequency, intensity), and the “consequence” (C) is the response that happens immediately after the behavior. After scenarios were presented and the participants filled out their A-B-C data sheets, the facilitator encouraged the participants to discuss which of their child’s behaviors they had the most difficulty managing and whether they were able to identify the function of those behaviors. After this discussion, the facilitator reviewed and included a list of resources in the PowerPoint presentation for participants to look into if they wanted to learn more about the different types of ASD-related behaviors and what they can do to help.

This session ended with a sensory enrichment activity where participants learned how to make texture balloons (APPENDIX G-3). Because research
shows that providing children with sensory experiences helps to stimulate their children’s senses (Biel & Peske 2018), this activity will help both sensory avoiders and sensory-seeking children to experience different textures without directly touching the items inside the balloons. In addition, sensory balloons can also be used as stress balls which can help children regulate their body when they feel agitated.

Session 3

The outline and PowerPoint for Session 3 are in APPENDIX H. The purpose of this session was to help parents understand and practice effective ways to manage the challenging behaviors previously discussed by using a combination of ABA strategies and positive child guidance practices. After discussing with the participants how the enrichment activity went at home, a brief introduction of these two approaches was presented prior to discussing each approach in depth.

First, parents of children with ASD report a lack of understanding of when and how to implement intervention strategies (Moore & Symons, 2011; Raulston et al., 2018). To improve the participants’ understanding of when and how to implement ABA strategies, the presenter first defined and provided examples of antecedent and consequence strategies used in ABA to prevent and manage challenging behaviors. A total of six antecedent and six consequence strategies were presented. Next, participants and the facilitator role-played specific situations they’ve experienced with their child to practice how to effectively
implement the strategies taught. For example, one of the participants chose to role play with the facilitator telling her child he could only have one toy when they went to the store. The participant used the strategy of priming to tell her child (the facilitator) before going to the store that he would only be able to get one toy. When the facilitator pretended to whine about wanting another toy, the participant stated that she would use the consequence strategy of extinction by no longer giving in and buying the other toy. A handout with the strategies taught was given to the participants to review and practice at home (APPENDIX H-1).

Second, positive child guidance practices that are developmentally-appropriate were discussed. These strategies have been demonstrated to be effective in guiding children’s behavior, meeting children’s basic needs, and promoting positive child outcomes (“Child Development Basics”, n.d.; Rikhy et al., 2010). In addition, positive child outcomes have also been associated with parents that are responsive, nurturing, and set limits and expectations for their child’s behaviors (Marion, 2015). Therefore, it would be beneficial for parents of children with ASD to have some knowledge of positive child guidance practices and effective parenting skills that will support their child’s behaviors and overall development.

“Positive child guidance” was defined, and its effect on children’s behavior was discussed. Because positive child guidance practices such as setting limits and consequences, using reasons and explanations, and modeling appropriate behaviors have been found to be effective in guiding and redirecting the
behaviors of typically-developing children, they were reviewed in this session (Marion, 2015; Miller, 2016; Siegel & Bryson 2012). Children feel safe and secure, learn to take responsibility for their actions, and learn to regulate their behaviors when parents are responsive, set limits and consequences, and use reasons and explanations to redirect behavior (Marion, 2015; Siegel & Bryson, 2012). Therefore, these strategies were discussed in depth with participants as they could also be beneficial when parenting a child with ASD. A handout that teaches parents skills on setting limits and consequences to get children to cooperate and listen to their parents’ requests was provided (APPENDIX H-2). Participants had the opportunity to role-play and practice more skills from the handout such as using I-messages, giving “closed-choices”, using “when-then” statements, and saying “yes” to positively guide their child’s behavior. Parents of children with ASD could benefit from learning to implement these strategies as most of them are similar to ABA strategies but are not always taught to parents. During role-play opportunities, one of the participants pointed out that the “closed-choices” and “when-then” strategies were similar to the ABA strategies of “providing choices” and the “Premack principle”, which she had previously used with her daughter. Therefore, this participant was able to demonstrate through role-playing with the facilitator how she gives “closed-choices” to her daughter during lunch/dinner time as well as when she wants her to complete homework assignments. Another participant stated that she uses I-messages with her students at a childcare program, so she was able to model to the other
participants how she uses this strategy. All of the participants practiced constructing I-messages as well as setting limits and consequences based on real situations and behaviors they had experienced with their child before.

This session concluded with an enrichment activity where participants learned how to teach their child to make musical instruments using paper plates, beans, and any other household materials (APPENDIX H-3). Children can learn the concepts of taking turns using the materials, use their imagination to decorate the paper plates, and listen to the sounds the beans make. Participants could use their acquired skills when teaching this activity by redirecting their child’s behavior when needed, using “when-then” statements, and using I-messages.

Session 4

The outline and PowerPoint for Session 4 are in APPENDIX I. The purpose of this session was to enhance parents’ knowledge of child development, learn how to build strong parent-child relationships, and learn how to engage in enrichment activities with their child.

First, developmental milestones were discussed because research shows that many parents lack accurate knowledge about the development of children and often overestimate their child’s abilities (“Zero to Three”, 1999). Understanding developmental milestones of children at different ages can give parents an idea of what to expect as their child grows up. For parents of children with ASD, knowing the developmental milestones can assist in identifying early signs of developmental delays which can lead to early identification and the start
of early intervention ("Child Development Basics", n.d; Smith, 2002). Therefore, handouts from the CDC website on developmental milestones ages 2 months to 5 years old (APPENDIX I-1) were provided to all participants. Because many parents may either overestimate or underestimate their child’s abilities, a list of age-appropriate chores (APPENDIX I-2) for children ages five and up was also provided so that participants could get an idea of the age-appropriate chores their child could be doing. Participants thought the list of chores was a great idea to get their children to help out around the house/daycare which would allow for them to be more independent as well.

Next, building strong parent-child relationships was discussed since this is critically important for children’s social and emotional development. Many children with ASD often have emotion-processing deficits that can make it difficult for parents to connect with their child and develop a close parent-child relationship (Sivaratnam et al., 2015). A lack of reciprocal interactions between the parent and the child can also be due to children with ASD being less securely attached to their parents compared to typically-developing children (Sivaratnam et al., 2015). To build strong parent-child relationships, parents need to meet their children’s basic psychological needs by being responsive, emotionally available, sensitively-attuned, supportive, and provide their children with a sense of closeness, autonomy, and overall secure attachment (Davies, 2011; Kamptner, 2018; O’Connor et al., 2016). Therefore, parents of children with ASD will benefit from learning about secure attachment as the parental behaviors
associated with this attachment style are said to meet children’s basic needs, promote self-regulation, social and emotional competence, resiliency and empathy, and result in fewer behavior problems (Mullin, 2012; Sroufe, 2015). A handout on what children’s basic needs are and why it is important to meet these needs was given to parents (APPENDIX I-3). The DIR/Floortime approach was discussed next as this approach can help parents of children with ASD connect and interact with their child.

The DIR/Floortime approach is a method of treatment for children with ASD that has been found to improve children’s social and emotional intelligence as they learn to relate to others through warm, intimate, and meaningful interactions (Greenspan & Wieder, 2009). The ultimate goal of Floortime is that caregivers spend uninterrupted time interacting with their child and following their child’s lead in activities that interest the child (Greenspan & Wieder, 2009; Mercer, 2017). Therefore, participants will benefit from learning about the DIR/Floortime approach as it helps children feel connected and close to their parents. The Circles of Communication game is another great way for parents to create opportunities to connect with their child through back-and-forth interactions (Greenspan & Wieder, 2009). A 7-minute video that models the Circles of Communication game during a Floortime therapy session was presented to the participants (CaminhosdoAutismo, 2010). Participants noticed how the child in the video was having a hard time communicating his needs, and
how Dr. Greenspan and the parent used toys that the child liked to get him to verbally ask for what he wanted using at least one-word sentences.

Lastly, interventions for children with ASD were discussed. These interventions are typically behaviorally-based and show minimal gains in children’s social-emotional, cognitive, and language development (Greenspan & Wieder, 2009). Taking a more developmentally-appropriate approach through spontaneous interactions and developmentally appropriate activities can help to create meaningful learning opportunities that support children’s interactive and thinking skills (Greenspan & Wieder, 2009). The Powerful Interactions framework was then discussed in this session as it encourages parents to create opportunities to interact with their children during everyday activities such as bath-time and playtime (Steward-Henry & Friesen, 2018). A list of enrichment activities that parents can try at home with their child was provided to participants (APPENDIX I-4). When children see their parents taking an interest and becoming engaged with them in their activities instead of forcing them to do as they want, children are more likely to acknowledge their parent’s presence, value their relationship, and have a natural desire to interact with them and share their world (Greenspan & Wieder, 2009; Siegel & Bryson, 2012). Thus, parents learned how to connect, interact, and extend their child’s learning during enrichment activities. Because some of the easiest and most important activities which parents can do to support children’s language development are to talk, read, and sing to their children (Suskind, 2015), parents were taught the lyrics
and body movements for a children's song. This is an easy interactive activity that even busy parents can engage in with their child. A copy of the lyrics can be found in APPENDIX I-5.

At the end of this session, participants completed the post-training self-assessment and the class evaluation.
CHAPTER THREE

RESULTS

Pre- and Post- Training Assessments

The results for the pre- and post- training assessments are based on the responses of Participants 1, 2, and 3 who attended all of the workshop sessions.

Pre-and Post-Self-Assessments

Results for the pre- and post-training assessments are shown in Table 3 below and support the goals of this project. Participants’ overall knowledge and confidence in understanding and managing challenging behaviors of children with ASD increased across all fourteen items.
Table 3. Pre- and Post-Means for the Training Self-Assessment Scale

<table>
<thead>
<tr>
<th>Items</th>
<th>TOTAL GROUP Pre-test (N=3)</th>
<th>TOTAL GROUP Post-test (N=3)</th>
<th>PARENTS Pre-test (N=2)</th>
<th>PARENTS Post-test (N=2)</th>
<th>TEACHER Pre-test (N=1)</th>
<th>TEACHER Post-test (N=1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Knowledge about identifying the underlying causes of their child's challenging ASD behaviors</td>
<td>4</td>
<td>5.3</td>
<td>4</td>
<td>5.5</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Knowledge about using ABA strategies</td>
<td>3.3</td>
<td>5.7</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>3. Confidence in using ABA strategies to manage their child's challenging behaviors</td>
<td>3</td>
<td>5.3</td>
<td>3.5</td>
<td>6</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>4. Knowledge about what the “ABCs” of behavior are</td>
<td>2.7</td>
<td>6</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>5. Confidence in identifying the “ABCs” of their child’s behavior</td>
<td>2.7</td>
<td>6</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>6. Knowledge about “positive child guidance” strategies</td>
<td>1.7</td>
<td>4.3</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>7. Confidence in using “positive child guidance” strategies to manage their child’s challenging behaviors</td>
<td>1.7</td>
<td>6.3</td>
<td>1</td>
<td>4.5</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>8. Knowledge about children’s developmental milestones</td>
<td>4</td>
<td>4.7</td>
<td>3</td>
<td>4</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>9. Confidence in identifying their child’s developmental milestones</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>10. Knowledge about how to build strong</td>
<td>3.3</td>
<td>5.7</td>
<td>2.5</td>
<td>5.5</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
First, it was expected that participants would better understand the underlying factors related to the challenging behaviors of children with ASD. Results from Item 1 indicate that participants felt slightly more knowledgeable after the workshop compared to the first session.

Second, it was expected that parents would better understand how to combine ABA and positive child guidance strategies to manage their child’s ASD behaviors. As Items 2-7 indicate, participants’ knowledge and confidence of using ABA strategies, knowledge and confidence of identifying the “ABCs” of behavior, and knowledge and confidence in using “positive child guidance” strategies increased substantially. A notable increase was particularly observed
in participants’ confidence in using “positive child guidance” strategies to manage their child’s ASD behaviors (Item 7).

Third, it was expected that participants would enhance their knowledge of child development, ways to build strong parent-child relationships, and methods to engage with their child in enrichment activities to support their overall development. Results for items 8-13 demonstrate that participants’ overall knowledge was enhanced. Results for item 8 indicate a slight increase in participants’ knowledge of developmental milestones as these participants had some prior knowledge on this topic. Lastly, results for Item 12 demonstrate a notable increase in participant’s knowledge about how to create and engage in enrichment activities with their child at home.

In addition, Item 14 examined participant’s confidence in parenting their child with ASD. Results indicate that participant’s confidence increased at the end of the workshop. Item 15 examined how stressed participants felt on a daily basis. Results demonstrate a slight decrease in the stress level of participants after the workshop.

In general, all three goals of this project were met with data demonstrating an increase in participants understanding of challenging ASD behaviors and their underlying factors, being able to manage their child’s challenging ASD behaviors using a combination of ABA and positive child guidance strategies, and gaining greater knowledge on child development, ways to build strong parent-child
relationships, and methods to engage in enrichment activities with their child to support their overall development.

**Post-Class Evaluation**

All 3 participants completed the class evaluation following the last workshop session. The post-class evaluation indicated that participants found the workshop sessions to be beneficial.

The first question asked participants if they felt that the workshop was beneficial for them and their family. Overall, participants indicated the information they learned was informative and beneficial (Table 4).

Table 4. Did You Find this Workshop Beneficial for You and Your Family? Why or Why Not?

<table>
<thead>
<tr>
<th>P1</th>
<th>“Yes, I had very little knowledge on ABA strategies and I plan on using them with the young child I work with.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>P2</td>
<td>“I did. You presented information that I had no idea about like the positive child guidance strategies.”</td>
</tr>
<tr>
<td>P3</td>
<td>“Yes, this workshop helped me learn more about the ABA strategies that are used in my daughters’ therapy and strategies that can help connect more with my daughter.”</td>
</tr>
</tbody>
</table>

The second question asked participants what information was the most useful for them. Participant 1 shared that learning about the underlying causes of children’s ASD-related behaviors was very helpful as it helped her identify what strategies would be helpful to manage those behaviors. Participant 2 mentioned that learning about the different sensory sensitivities and what could
help was useful since her child has a number of the sensitivities reviewed. Participant 3 mentioned that learning about positive child guidance strategies was useful since it addressed her child’s challenging behaviors in a more positive way which helped her to be more understanding of her child’s feelings (Table 5).

Table 5. What Information that was Presented was the Most Useful for You?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>“I liked learning about what causes certain ASD-related behaviors and what strategies are helpful to address those behaviors.”</td>
</tr>
<tr>
<td>P2</td>
<td>“The sensory sensitivities and what can help because my son has a couple of them.”</td>
</tr>
<tr>
<td>P3</td>
<td>“The positive child guidance strategies have been useful to learn about because they are a more positive way to deal with behaviors.”</td>
</tr>
</tbody>
</table>

The third question asked participants what information that was presented was the least useful for them. Participants 1 and 3 mentioned that children’s developmental milestones were the least useful information for them since Participant 1 had knowledge on this matter and Participant 3 stated that her child was older now and this would have been useful when her child was first diagnosed with ASD. Participant 2 responded that all the information was really useful since her child has or has had most of the challenging behaviors that were reviewed throughout the sessions (Table 6).

Table 6. What Information that was Presented was the Least Useful for You?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>“I think just children’s developmental milestones since it was something that I learned as an undergrad and that I continue using working with young children.”</td>
</tr>
</tbody>
</table>
The fourth question asked participants what other important information they felt should be included in order to improve this workshop. Participant 1 recommended expanding the resource list provided and include more websites that can provide parents and teachers with in-depth information about the topics reviewed as well as websites that provide engaging and age-appropriate activities to do with children during quarantine. Participant 2 stated that she would like more information on the causes for some sensory sensitivities and things that can be done at home to help children with ASD with poor social skills. Participant 3 stated that the handouts provided on positive child guidance strategies were useful and informational, but she recommended including videos for a visual representation of how these are implemented (Table 7).

Table 7. What Information do You Believe Should be Included in Order to Improve this Workshop?

<table>
<thead>
<tr>
<th>Participant</th>
<th>Suggested Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>“Include more resources like websites that we can use for fun activities to do with the kids during quarantine and if we want to learn more information in depth”</td>
</tr>
<tr>
<td>P2</td>
<td>“I think including more information on the reason why some children have some sensitivities and why children with ASD have them more. Maybe talk about what parents can do at home to help their kids with their social skills like having conversations and playing with other kids.”</td>
</tr>
<tr>
<td>P3</td>
<td>“I liked learning about the positive strategies and the handouts were helpful but I think it would be good to include some videos of other parents using those strategies so we can visually see how they do it.”</td>
</tr>
</tbody>
</table>
The last question asked participants if they would continue to implement the information that was learned in this workshop in their daily life, and why or why not. All of the participants stated that they would continue using the information learned throughout the workshop sessions. Participant 3 mentioned that because some ABA and positive child guidance strategies are so similar and lead to the same behavior outcomes, it made it easier for her to remember these strategies and use them with her child. Participant 1 mentioned that she will continue to use the “ABC’s” and functions of behavior because it will help her to better determine why the child she works with engages in specific challenging behaviors and what strategies will be helpful to use. Participant 2 mentioned that on top of wanting to continue to use the ABA and positive child guidance strategies, she was excited to try out a variety of enrichment activities with her child which could help her build a stronger parent-child relationship (Table 8).

Table 8. Will You Continue to Implement the Information that was Learned in this Workshop in Your Daily Life? Why or Why Not?

<p>| | |</p>
<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>“Yes, using the ABC’s and four functions of behavior will help me to better understand why the child I work with engages in specific behaviors. I can then determine what strategy will help me best to manage those behavior.”</td>
</tr>
<tr>
<td>P2</td>
<td>“Yes, I want to make time to try out different enrichment activities with my child I think it will help me connect with him more and have a stronger relationship with him.”</td>
</tr>
<tr>
<td>P3</td>
<td>“I will continue practicing the ABA and positive child guidance strategies since they are both very similar and sometimes I am using those strategies with my daughter without even noticing.”</td>
</tr>
</tbody>
</table>
Additional Findings

The demographic questionnaire included a question that asked participants what their biggest challenge was right now in parenting their child with autism. Each of the participants’ major parenting concerns are noted below (Table 9). These concerns were addressed during discussion with participants throughout sessions 1-3.

Table 9. Biggest Challenge in Parenting a Child with Autism

<table>
<thead>
<tr>
<th>Participant</th>
<th>Challenge</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>“Right now it is the aggressive behaviors in the classroom when he gets frustrated because he cannot communicate his needs. He has had many incidents in which he has broken skin by biting, hitting, and scratching.”</td>
</tr>
<tr>
<td>P2</td>
<td>“My biggest challenge is him not being able to wipe himself and needing me for things he can do on his own. He doesn’t like grooming activities.”</td>
</tr>
<tr>
<td>P3</td>
<td>“Sometimes I struggle with her crying when myself or her sibling aren’t able to play with her or when she needs to transition to another activity and needs to stop playing.”</td>
</tr>
</tbody>
</table>

Below is a textual summary of each participant’s experience in the workshop.

Participant 1 is a 25-year old graduate student and daycare teacher. She works with approximately 12 students each day and has a 4-year old student with ASD in her classroom. Her student has level 3 ASD severity and has been receiving ABA services for only a month. Participant 1 has some background knowledge on child development and positive child guidance practices but has
no experience with ABA. She stated that her biggest challenge at the moment was not knowing how to manage her student’s aggressive behaviors (i.e., scratching, hitting, & biting) when he gets frustrated. The most useful information for her was learning about what causes certain ASD-related behaviors and what strategies are helpful to address these behaviors. During session 2, Participant 1 stated, “I now understand that my student tends to engage in aggressive behaviors when he wants access to something but is unable to communicate due to his speech deficits”. She stated that she can use the strategy of physically blocking and redirecting aggressive behaviors and help her student communicate through the use of pictures and progressively teach him functional communication skills. Participant 1 stated that she will continue to use the “ABCs” and four functions of behavior to determine what strategies can best help her manage her student’s behaviors.

Participant 2 is a 39-year old stay at home mother with an 8-year old boy with level 2 ASD severity. Her son has been receiving ABA services for approximately 5 years; however, Participant 2 stated that she has not received any formal parent training on ABA strategies. She stated that her biggest challenge at the moment with parenting her child with ASD was her son not liking grooming activities and not being able to wipe himself after using the restroom. Participant 2 stated that this was most likely due to her son having tactile sensory sensitivities. The most useful information from this workshop for her was learning about the different sensory sensitivities and what interventions can help.
However, Participant 2 was still curious about the reasons why children with ASD seem to have more sensitivities compared to typically-developing children and she wanted more information to be included on the workshop. Participant 2 also stated that learning how to create and engage in enrichment activities motivated her to do this more often with her son as a way to strengthen her relationship with him.

Participant 3 is a 42-year-old stay at home mother with an 8-year old girl with level 1 ASD severity. Her daughter has been receiving ABA services for 4 years. Although Participant 3 stated that her daughter’s therapist has taught her how to implement some of the goals in place, she has not received any formal parent training on ABA strategies. Participant 3 stated that her biggest challenge at the moment with parenting her child with ASD was her daughter crying when it is time to stop playing and transition to another activity or when someone is not available to play with her. During role-playing opportunities, Participant 3 learned how to prime her daughter by stating how many minutes she had left before having to clean up and transition to the next activity. She also stated that creating a visual schedule with her daughter’s daily routine could be helpful for her daughter to know of upcoming activities. The most useful information from this workshop for Participant 3 was learning about positive child guidance strategies as she stated that “these are a more positive way to deal with behaviors”. Participant 3 stated that she will continue practicing ABA and positive child
guidance strategies as they are both very similar and are helpful to manage behaviors.
CHAPTER FOUR

DISCUSSION

The focus of this project was to create a parenting workshop that supports parents and caregivers of young children with ASD. Goals included the following:

1) help parents understand the underlying factors related to the challenging behaviors of children with ASD;
2) teach parents to combine ABA with positive child guidance strategies to assist them in managing their child’s ASD behaviors;
and 3) enhance parents’ knowledge of child development, ways to build strong parent-child relationships, and methods to engage with their child in enrichment activities that will support their child’s overall development.

The key motivation for this project was the lack of parent training provided in many ABA agencies, often leaving parents of children with ASD feeling unprepared and unable to manage their child’s challenging behaviors (Raulston, Hieneman, Caraway, Pennefather, & Bhana, 2018). Although ABA has been one of the primary interventions used for children with ASD, research studies indicate that parents demonstrate poor adherence to treatment as well as poor understanding of recommended strategies to implement with their children (Moore & Symons, 2011; Raulston et al., 2018). In addition, because positive child guidance strategies have been found to promote positive child outcomes (“Child Development Basics”, n.d.; Rikhy, Tough, Trute, Benzies, Kehler & Johnston, 2010), these strategies, along with how to build strong parent-child relationships and create and engage in enrichment activities, were important
goals of this project to help participants better manage their child’s ASD difficult behaviors and support their overall development.

Overall, findings indicated that participants’ knowledge and confidence on how to use ABA and positive child guidance strategies, to build strong parent-child relationships, and to create and engage in enrichment activities increased as a result of the four-session workshop. Therefore, the three goals of this project were met.

Pre-Post-Class Assessments

The scores for the pre-and post-assessments indicated that participants benefitted from the four-session workshop. Further, the assessments also indicated that participants’ confidence in parenting a child with ASD increased while their daily stress decreased slightly by the end of the last workshop session.

There were three main results expected from the workshop. First, it was expected that participants would better understand the underlying factors related to the challenging behaviors of children with ASD. Deficits in social communication, restrictive and repetitive behaviors, sensory sensitivities, and maladaptive behaviors often cause increased levels of parental stress (Boyd, McDonough, & Bodfish, 2011; Leekam et al., 2006). Therefore, sessions 1 and 2 included a PowerPoint that focused on discussing some of the challenging behaviors of children with ASD and what can help. Results from the assessments demonstrated that participants’ knowledge on the underlying factors related to
the challenging behaviors of children with ASD slightly increased. Although information on what parents can do to help with the challenging behaviors was discussed, the underlying factors were only briefly mentioned by the facilitator and were not included in the PowerPoint slides. One of the participants suggested including more information explaining what causes sensory sensitivities and why they seem to be more prevalent in individuals with ASD. Overall, these results were valuable as much of the stress surrounding parenting a child with ASD has been linked to the severity of the child’s impairments and challenging behaviors (Benson, 2006; Pozo, Sarria, & Brioso, 2013). Therefore, it can be implied that parents of children with ASD may experience less stress when they understand the reasons behind their child’s challenging behaviors.

Second, it was expected that parents would better understand how to combine ABA and positive child guidance strategies to manage their child’s ASD behaviors. Results indicated that participants’ knowledge and confidence in using ABA strategies, knowledge and confidence in identifying the “ABCs” of behavior, and knowledge and confidence in using “positive child guidance” strategies increased. Session 3 included a PowerPoint that provided a brief introduction to ABA and positive child guidance, and various strategies for guiding behavior were defined and explained. Handouts explaining the various ABA and positive child guidance practice were provided to participants. Because research studies indicate that parents demonstrate poor adherence to treatment as well as poor understanding of recommended strategies to implement with their children
(Moore & Symons, 2011; Raulston et al., 2018), the facilitator and participants engaged in role playing about how to effectively use antecedent and consequence strategies to manage challenging behaviors. Role-playing has been found to be an effective training strategy in accelerating acquisition of knowledge and skills due to the active participation of trainees and the immediate feedback provided by the trainer (Sogunro, 2004). Results from items 4 and 5 of the pre-and post-assessments indicated an increase in participant’s knowledge about the “ABCs” of behavior and their confidence in identifying the “ABCs” of behavior. Reviewing different scenarios of behaviors and having participants fill out an ABC data sheet during Session 2 seemed to be an effective strategy in helping participants understand what triggers a behavior, what a behavior looks like, and how they should respond to a behavior. This information was important to include in the workshop because knowing the “ABCs” of behavior along with the function of the behavior can assist parents in teaching their child replacement behaviors, such as functional communication skills, in which children learn to appropriately communicate their needs instead of engaging in problematic behaviors (Hagopian & Graham, 2009).

Additionally, participant’s knowledge about positive child guidance strategies saw a notable increase in their confidence in using these strategies to manage challenging behaviors. Based on their pre-assessment scores, participants started the workshop with very little knowledge and confidence in using positive child guidance strategies. These strategies were taught, as they
have been associated with positive child outcomes and have been found to be effective in guiding and redirecting behaviors of typically developing children (Marion, 2015; Miller, 2016; Siegel & Bryson 2012). Some of the key components that may have contributed to the increase in participants’ confidence in using positive child guidance strategies were defining and explaining the strategies within the PowerPoints and handouts provided to the participants and giving opportunities for the participants to practice implementing the strategies taught via role play. This likely helped parents feel better prepared and confident in using the ABA and positive child guidance strategies at home or in daycare with their child with ASD.

Third, it was expected that participants would enhance their knowledge of child development, ways to build strong parent-child relationships, and methods to engage with their child in enrichment activities to support their child’s overall development. Developmental milestones were discussed in the last session because research studies show that many parents lack accurate knowledge about the development of children and often overestimate their child’s abilities (“Zero to Three”, 1999). Pre-assessment scores indicated that participants had prior knowledge on developmental milestones and felt somewhat confident in identifying their child’s developmental milestones. Although there was a slight increase in participant’s post-assessment scores, this information didn’t seem to be as useful for them as participants reported that they had prior knowledge on developmental milestones due to their undergraduate courses in child
development or because their child was older and the information would have been more useful if their child was of a younger age. Therefore, this information may be more beneficial for parents of young children with ASD with a recent diagnosis.

Participants’ knowledge and confidence in building strong parent-child relationships also increased from the pre- to post-assessment scores. Because many children with ASD often have emotion-processing deficits that can make it difficult for parents to connect with their child and develop a close parent-child relationship (Sivaratnam et al., 2015), it was important to teach parents how to build strong parent-child relationships with their children as well as its significance for their child’s social and emotional development. The fourth session focused on teaching participants how to meet their child’s basic psychological needs, the key parental behaviors associated with having a secure attachment, the goal of the DIR/Floortime approach, and how parents can create meaningful interactions with their child at home. Although participants reported some confidence on how to build strong parent-child relationships prior to the workshop, two of the participants shared that they were not aware of what it meant for their children to be securely attached, the importance of following their child’s lead during play, and how following their child’s lead and interests can help their child feel more connected and close to their parents. These statements help support that participants increased their knowledge about how to build
strong parent-child relationships and how important parent-child relationships are to their child’s social and emotional development.

A notable increase in participants’ knowledge about how to create and engage in enrichment activities with their child at home was observed at the end of the workshop. Participants had very little knowledge or confidence on how to create and engage in enrichment activities prior to the start of the workshop. Research studies indicate that spontaneous interactions and developmentally-appropriate activities can help to create meaningful learning opportunities that support children’s interactive and thinking skills (Greenspan & Wieder, 2009). Therefore, the facilitator demonstrated how to create and engage in different enrichment activities at the end of each workshop so participants could practice with their child at home. A list of various enrichment activities was provided to participants with instructions and key points on how to connect, interact, and extend their child’s learning during these activities. Participants shared their appreciation of the facilitator demonstrating how to effectively engage in enrichment activities with their child, as Participants 2 and 3 stated that they did not know how to interact or expand their child’s learning during fun activities. Participant 1 stated that she was able to incorporate the book and fish decorating activity into her curriculum and her student with ASD was able to engage and complete this activity without any aggressive behaviors. She stated that her student with ASD needed reminders to wait his turn when the materials he needed were being used but that overall everyone had fun with decorating the
fish print-out activity. Participant 3 mentioned that she modeled to her daughter how to create a texture balloon and allowed her to make three different balloons using flour, hair gel, and rice. Participant 2 stated that she enjoyed spending time with her son and connecting with him during the enrichment activities since he often spends times alone playing on his iPad. Ultimately, the pre-and post-assessment scores suggest that participants had great interest in learning about fun and creative activities to engage in with their child. This was valuable because when children see their parents taking an interest and becoming engaged with them in their activities instead of forcing them to do what the parents want, children are more likely to acknowledge their parent’s presence, value their relationship, and have a natural desire to interact with them and share their world (Greenspan & Wieder, 2009; Siegel & Bryson, 2012).

Overall, the pre-post-self-assessment scores increased across all items indicating that participants gained knowledge and confidence from the information taught at each workshop session. Participants engaged in discussion and participated during role play which may have fostered greater understanding in the three primary goals of this project. Participants’ increased understanding and confidence in using ABA and positive child guidance strategies along with their increased understanding about child development, how to build strong parent-child relationships, and how to engage in enrichment activities was significant as this project aimed to rectify the shortcoming of existing interventions that are mainly behaviorally-based or rarely available for parents.
Increased scores on the post-training assessment suggest that interventions like this one would be beneficial for parents and caregivers of children with ASD as integrating and teaching ABA strategies and developmentally-appropriate practices can help with better understanding children’s behaviors and how to manage these behaviors in a more positive and effective way that will bring about the best developmental outcomes for their children.

Lastly, the feedback from the participants’ class evaluation suggested that the information that was taught in the four-session workshop can benefit parents and individuals who work with children with ASD. The participant who was a daycare teacher shared that this program was beneficial as she had little knowledge about ABA strategies and about what causes certain ASD-related behaviors. This suggests that this program would be helpful for teachers and anyone working or taking care of children with ASD who wants to learn how to manage challenging behaviors. All three participants commented that they would continue practicing the information they learned in the workshop as this would help them not only understand and manage challenging behaviors but also engage in activities that will help them connect and develop a close relationship with their child.

Limitations and Future Trainings

While this workshop was overall a success, there were some limitations of the current project. First, the current project was originally designed to be presented in an in-person format. However, due to the current Covid-19
pandemic, the parenting workshop was moved to an online format and presented via Zoom. The use of this online application presented connectivity issues for some of the participants and the facilitator had to wait to continue presenting until participants were able to rejoin the meeting.

The second limitation to the current project was the small number of participants. Moving the parent workshop from in-person to an online format made it difficult to recruit participants in a short amount of time with only three participants being available to join all four sessions. If the current project is implemented again, it may be beneficial to include more participants and making it more widely available for teachers or other individuals who work with children with ASD.

Third, having the workshop online prevented the participants from receiving hands-on practice in creating and engaging in the enrichment activities that the facilitator modeled at the end of each session. Although all the participants reported to have engaged in these activities with their child at home or at daycare, a hands-on approach or role playing in-person among participants would give participants more confidence in how to effectively engage in these activities at home.

Fourth, one participant suggested including more information on the reason why some children have certain sensitivities and why children with ASD, compared to typically-developing children, have them more. In the future, this project can include more information and resources explaining sensory
sensitivities. It may also be beneficial to have participants share their experiences with interventions or strategies that they’ve tried at home to manage sensory related behaviors.

Lastly, since the facilitator has been an ABA therapist for the child of Participant 2 and 3, post-training assessment scores may contain some bias in favor of the facilitator. Participant 1 was an acquaintance of the facilitator and her responses may have also contained some bias.

Summary and Conclusions

The purpose of this project was to create a parenting workshop for parents and caregivers of young children with autism in order to help them better understand the underlying factors related to the challenging behaviors of children with ASD and how to combine ABA with positive child guidance strategies to help them manage their child’s ASD behaviors. A third goal was to enhance parents’ knowledge of child development, how to build strong parent-child relationships, and how to engage with their child in enrichment activities that will support their child’s overall development.

Overall, the results from the pre- and post-class assessment indicate that participants had a positive experience and benefitted from the information and the activities that were provided. The assessments also indicated that participants’ confidence in parenting a child with ASD increased, while their overall parenting stress decreased slightly. This project speaks to the need for more interventions that integrate positive child guidance strategies and
developmentally-appropriate practices within ABA interventions, as a combination of these strategies can help parents to effectively manage ASD-related behaviors (Sivaratnam, Newman, Tonge, & Rinehard, 2015; “Zero to Three”, 1999). Children with ASD will also benefit from this type of intervention as a combination of ABA and positive child guidance strategies can help children feel safe and secure, learn to take responsibility for their actions, learn to regulate their behaviors, get their basic psychological needs met, and have more meaningful interactions with their parents (Marion, 2015; Mullin, 2012; Siegel & Bryson, 2012; Sroufe, 2015).

This project differs from other current interventions in that it included general information on ASD with a focus on the challenges of raising a child with ASD. Multiple challenging behaviors were discussed during some of the sessions along with research-based information on effective ABA strategies and positive child guidance strategies that can help parents manage these behaviors. Participants also learned about the importance of engaging in enrichment activities and how to effectively create and engage in these activities with their child at home, something that lacks in current interventions.

In sum, having this class available to parents, caregivers, and professionals who work with children with ASD may empower them with the skills needed to effectively manage challenging behaviors and at the same time support children’s overall development.
APPENDIX A

PRE-TRAINING SELF-ASSESSMENT
**Pre-Training Self-Assessment**

Instructions: Circle the number that best reflects how you feel **NOW**:

1. **How knowledgeable** do you feel about identifying the underlying causes of your child’s challenging ASD behaviors?
   - Not at all knowledgeable
   - Very knowledgeable
   - 1 2 3 4 5 6 7

2. **How knowledgeable** do you feel about using “Applied Behavior Analysis” (ABA) strategies?
   - Not at all knowledgeable
   - Very knowledgeable
   - 1 2 3 4 5 6 7

3. **How knowledgeable** do you feel about identifying the “ABC’s” (Antecedent, Behavior, Consequence) of behavior?
   - Not at all knowledgeable
   - Very knowledgeable
   - 1 2 3 4 5 6 7

4. **How confident** do you feel about using “Applied Behavior Analysis” (ABA) strategies to help manage your child’s challenging behaviors?
   - Not at all confident
   - Very confident
   - 1 2 3 4 5 6 7

5. **How knowledgeable** do you feel about “positive child guidance” strategies?
   - Not at all knowledgeable
   - Very knowledgeable
   - 1 2 3 4 5 6 7

6. **How confident** do you feel about using positive child guidance strategies to help manage your child’s challenging behaviors?
   - Not at all confident
   - Very confident
   - 1 2 3 4 5 6 7

7. **How knowledgeable** do you feel about children’s developmental milestones?
   - Not at all knowledgeable
   - Very knowledgeable
   - 1 2 3 4 5 6 7

8. **How knowledgeable** do you feel about how to build strong parent-child relationships?
   - Not at all knowledgeable
   - Very knowledgeable
   - 1 2 3 4 5 6 7
9. How **knowledgeable** do you feel about how to create and engage in enrichment activities with your child at home?

| Not at all knowledgeable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Very knowledgeable |

10. How **confident** do you feel in parenting your child with ASD?

| Not at all confident | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Very confident |

Developed by Vanessa Huizar
APPENDIX B

POST-TRAINING SELF-ASSESSMENT
Post-Training Self-Assessment
Instructions: Circle the number that best reflects how you feel NOW:
1. How knowledgeable do you feel about identifying the underlying causes of your child’s challenging ASD behaviors?
   Not at all knowledgeable 1 Very knowledgeable 7
   2 3 4 5

2. How knowledgeable do you feel about using “Applied Behavior Analysis” (ABA) strategies?
   Not at all knowledgeable 1 Very knowledgeable 7
   2 3 4 5

3. How knowledgeable do you feel about identifying the “ABC’s” (Antecedent, Behavior, Consequence) of behavior?
   Not at all knowledgeable 1 Very knowledgeable 7
   2 3 4 5

4. How confident do you feel about using “Applied Behavior Analysis” (ABA) strategies to help manage your child’s challenging behaviors?
   Not at all confident 1 Very confident 7
   2 3 4 5

5. How knowledgeable do you feel about “positive child guidance” strategies?
   Not at all knowledgeable 1 Very knowledgeable 7
   2 3 4 5

6. How confident do you feel about using positive child guidance strategies to help manage your child’s challenging behaviors?
   Not at all confident 1 Very confident 7
   2 3 4 5

7. How knowledgeable do you feel about children’s developmental milestones?
   Not at all knowledgeable 1 Very knowledgeable 7
   2 3 4 5

8. How knowledgeable do you feel about how to build strong parent-child relationships?
   Not at all knowledgeable 1 Very knowledgeable 7
   2 3 4 5
9. How **knowledgeable** do you feel about how to create and engage in enrichment activities with your child at home?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Very knowledgeable</th>
</tr>
</thead>
</table>

10. How **confident** do you feel in parenting your child with ASD?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Very confident</th>
</tr>
</thead>
</table>
APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE
Demographic Questionnaire
Please fill out the following:

1. Your age: ______

2. Your gender (circle one): male female

3. Your relationship to the child(ren) with autism:

4. Your current marital status (check one):
   ___single
   ___married
   ___separated/divorced
   ___widowed
   ___other
   (____________________)

5. What is your ethnic background? (check one):
   ___Asian
   ___African American
   ___Caucasian
   ___Hispanic
   ___Native American
   ___Middle Eastern
   ___Biracial
   ___Other (____________________)

6. What is the highest level of education you have completed? (check one):
   ___Did not complete high school
   ___High school graduate
   ___Some college/trade school
   ___Graduated with Bachelor’s degree
   ___Some graduate school

7. Number of children in your household diagnosed with autism? ____________
   a. Age(s) _________________________
   b. Gender _________________________

8. What is the level of severity of your child’s autism? (Level 1 Mild: requiring support,
   Level 2 Moderate: requiring substantial support, Level 3 Severe: requiring very
   substantial support)

  ________________________________________________________________________
9. Please specify if your child(ren) is receiving services for his/her autism (ABA, Occupational Therapy, Speech, etc.)

__________________________________________

_____
a. number of children receiving services? ________________

10. What is your biggest challenge right now in parenting a child with autism?

__________________________________________

__________________________________________

__________________________________________

________________________
APPENDIX D

WORKSHOP EVALUATION
Workshop Evaluation

1. Did you find this workshop beneficial for you and your family? Why or why not?

2. What information that was presented was the most useful for you?

3. What information that was presented was the least useful for you?

4. What important information do you believe should be included in order to improve this workshop?

5. Will you continue to implement the information that was learned in this workshop in your daily life? Why or why not?
A FOUR-SESSION WORKSHOP FOR PARENTS OF CHILDREN WITH AUTISM

**Beginning June 1st**

Workshop designed for parents of children ages 4-10

**Monday** and **Wednesday** mornings

10:00am-12:00pm

June 1st
June 3rd
June 8th
June 10th

**Topics Include:**

- Understanding children’s challenging behaviors
- How to combine ABA with positive child guidance strategies to manage challenging behaviors
- Enhance parents’ knowledge on child development,
- Teach parents’ ways to build strong parent-child relationships
- Teach parents’ ways to engage with their child in enrichment activities

**Location:** Zoom invitation will be sent the morning of each session.

For more information please contact Vanessa Huizar
Email: huizarv1@coyote.csusb.edu
Phone: (951) 230-4905

Developed by Vanessa Huizar
APPENDIX F

SESSION 1 POWERPOINT
UNDERSTANDING & MANAGING CHALLENGING BEHAVIORS WHILE SUPPORTING THE DEVELOPMENT OF CHILDREN WITH AUTISM: A PARENTING WORKSHOP

Presented By: Vanessa Hulicar

WELCOME!

- Introductions
- Purpose of this project
- Assessments
- Overview of sessions
Who am I?

Vanessa Huizar

Purpose of this project

- There is a lack of parent training provided by many ABA agencies making parents feel unprepared to manage their child’s behaviors on their own.

- This workshop is intended to support parents of young children with ASD to understand some of the underlying factors related to their child’s challenging behaviors and the options that are available to manage these behaviors.

- A combination of ABA and positive child guidance strategies will be taught to support parents in raising a child with ASD and effectively manage challenging behaviors.

- In addition, this project is intended to enhance parents’ knowledge of child development, ways to build strong parent-child relationships, and methods to engage with their child in enrichment activities that will support their overall development.
Overview of workshop

Session 1
- Overview of Autism
- Challenges of Raising a Child with Autism
  - Lack of Parent Preparedness
  - Challenging Behaviors and What Can Help
    - Lack of Social Communication
    - Restrictive and Repetitive behaviors
  - Enrichment Activity

Session 2
- Challenges of Raising a Child with Autism (continued)
  - Sensory Sensitivities
  - Maladaptive Behaviors
- Parent Discussion
- List of Resources
- Enrichment Activity

Session 3
- Effective Ways to Guide Children’s Challenging Behaviors
  - Introduction to ABA & Positive Child Guidance
  - Applied Behavior Analysis: Where Challenging Behaviors Come from and How to Respond
  - Explanation of Strategies for Guiding Behavior
  - Enrichment Activity

Session 4
- Supporting Your Child’s Development
  - Developmental Milestones
  - Building Strong Parent-Child Relationships
  - Engaging in Enrichment Activities
  - Enrichment Activity

Please complete the following:

1. Self-Assessment
2. Demographic Questionnaire
OVERVIEW OF AUTISM

Data and Statistics of Autism

- About 1 in every 59 children has been diagnosed with ASD
- Boys are 4x more likely to get diagnosed compared to girls
- ASD affects children of all races and socioeconomic background
- A clear cause for ASD has not been determined. However, risk factors for developing ASD include a combination of genetic and environmental factors
Some signs of autism

○ Child has difficulty in dealing with changes in routine
○ Has poor speech or a lack of speech
○ Has a strange attachment to objects
○ Engages in inappropriate play with toys
○ Is oversensitive or under sensitive to sounds

The Three Functional Levels of Autism

ASD Level 1
Requiring Support

difficulty initiating social interactions
organization and planning problems can hamper independence

ASD Level 2
Requiring Substantial Support

social interactions limited to narrow special interests
frequent restricted/repetitive behaviors

ASD Level 3
Requiring Very Substantial Support

severe deficits in verbal and nonverbal social communication skills
great distress/difficulty changing actions or focus
**Topic: Challenges of Raising a Child with Autism**

**Challenges of Raising a Child with ASD**

- Parents of children with ASD have higher levels of stress compared to parents of typically-developing children.

- This stress has been linked to the severity of the child’s impairments and problematic behaviors.

- In addition, parents often feel unprepared to manage these challenging behaviors due to a lack of parent training in ABA services.
Discussion

What are some of the challenges you face in raising your child with ASD?

CHALLENGING BEHAVIORS AND WHAT WE CAN DO TO HELP
Challenging Behaviors of Children with ASD

- Deficits in Social Communication
- Restrictive and Repetitive Patterns
- Sensory Sensitivities
- Maladaptive Behaviors

Deficits in Social Communication

- Individuals with ASD typically have significant deficits in verbal and non-verbal communication.
- About one-third of the ASD population are non-verbal and have a delay in, or total lack of, the development of spoken language.
  - **Echolalia**: repeating the words, phrases, or sentences of what others have said.
  - **Scripting**: repetition of words, phrases, intonation, or sounds of the speech of others, sometimes taken from movies etc.
  - **Scrolling**: is when your child goes through several answers to a question before landing on the correct answer.
Deficits in Social Communication (continued)

- Individuals with autism who have deficits in social communication also have difficulty in initiating and sustaining a conversation with others.

- They often avoid making eye contact with others and may not understand gestures, facial expressions, and body posture.

- As a result, they often fail to develop peer relationships with others.

- Tantrums, protests, hyperactivity, or aggressive behaviors → their form of communication

What can help?
- Doctors often refer children who have speech and language deficits to a speech language pathologist or other specialists
- Alternative Augmentative Communication (AAC)
  - Picture Exchange Communication System (PECS)
  - Sign Language
  - Speech-Generating Devices
Speech & Language Pathology

Examples of the skills that speech therapy may work on include:
- Strengthening the muscles in the mouth, jaw and neck
- Making clearer speech sounds
- Matching emotions with the correct facial expression
- Understanding body language
- Responding to questions
- Matching a picture with its meaning
- Using a speech app on an iPad to produce the correct word
- Modulating tone of voice

Picture Exchange Communication System (PECS)

PHASE I
- start to communicate
- individual work to exchange single pictures for items or actions they really want

PHASE II
- Stimulate and maintain
- individual work to generate two or more pictures to make the best choices. These are placed in a PECS Communication Book and covered with self-adhesive tabs. This allows quick access to the pictures

PHASE III
- using Communication Book
- individual work to generate
- Communication Book

PHASE IV
- Generalize structure
- individual work to use full sentences or a list of steps
- Reinforce step using a token or token protocol followed by signature or the item being requested
Picture Exchange Communication System (PECS)

**Attributes & Language Expansion**
Individuals learn to expand their sentences by adding adjectives, verbs, and prepositions.

**Phase V**
Responding Requesting individuals learn to use PECS to answer questions such as "What do you want?"

**Phase VI**
Overlearning Individuals are taught to combine in response to questions such as "What do you want?" and "What is it?" They learn to make up sentences starting with "I need..." or "I have..." and "It is..." etc.

Speech Generating Devices

- Speech-generating devices play pre-recorded words or phrases when the user flips a switch or presses buttons or keys. Some devices speak words as the words are typed on a keyboard.

- To choose and buy an appropriate speech-generating device for your child, you might need to get some training from a speech pathologist or occupational therapist to use the device with your child.
What can help?

- Social skills training teaches individuals with autism the rules and expectations when we interact with others, how to make and maintain friendships, how to act in different social situations etc.
- Social skills can be taught by parents, teachers, behavioral therapist and other professionals.
- Many ABA companies also have social skills groups that children, teenagers, and adults can join.

Restrictive and Repetitive Behaviors aka Stimming

**“Lower order behaviors”**
- Repetitive motor actions, movements, sensory manipulation of objects, and some self-injurious behaviors
- Ex: Hand flapping, body rocking, biting nails

**“Higher order behaviors”**
- Cognitive behaviors such as specific rituals and routines, insistence on sameness, and restricted interests
- Ex: Lining up objects/toys, wanting to wear same clothes, interested in particular toy/character/game
What can help?

- First, acknowledge your child’s feelings. Many repetitive behaviors may be a sign of anxiety.
- Silly putty & stress balls can help reduce hand flapping and biting nails as it keeps the child’s hands occupied.
- Engaging in physical exercise before activities when behavior tends to occur.
- Exercise can induce fatigue/tiredness and can also provide the individual access to the same reinforcer as the stereotypic behavior.

What can help?

- If behaviors occur due to child being non-verbal and unable to communicate, teach the child to communicate their needs using visuals.
- Using visual schedules can help children who have restrictive interests and have difficulty in transitioning from preferred to non-preferred activities.
What can help?

Vocally or physically block the repetitive behavior
- Response block and redirect self-injurious behaviors such as head banging or hitting.
- Add padding or protective strips to areas where they typically bang, especially sharp corners.
- Check for ear infections, vision problems, and teething as some kids will head bang to distract them from headaches.
- If head banging is intense, your pediatrician may recommend that your child wear a helmet to prevent injury.

Provide sensory alternatives
- Massage head and face with your hands or a vibrator.
- If head banging is due to needing sensory stimulation, let your child push his head into a pillow or beanbag chair or talk to your OT about weighted hats to give your child more sensory input in his head.
- Do headstands (help your child do this safely)

ENRICHMENT ACTIVITY TIME!
Reading book + Arts & Crafts

- **Procedure:** Read the book *The Rainbow Fish* to your child. Then, on the table: place colored glitter or sequins, glue, markers, and the fish worksheet.

- Children will decorate their own “gitterfish” by giving the corresponding glitter color to each number on the scales.

- Discuss the main point of the book: “sharing or giving something you have to someone else who wants it makes others feel good.” Share the different colored glitter available to decorate your rainbow “gitterfish.” You can also discuss how fish don’t have skin like we do; they have “scales” that cover their bodies.

YouTube Link: https://youtu.be/QFORvxhub28

References


References


References

Autism Prevalence

- In 2020, the CDC reported that approximately 1 in 54 children in the U.S. is diagnosed with an autism spectrum disorder (ASD), according to 2016 data.
  - 1 in 34 boys identified with autism
  - 1 in 144 girls identified with autism
- Boys are four times more likely to be diagnosed with autism than girls.
- Most children were still being diagnosed after age 4, though autism can be reliably diagnosed as early as age 2.
- 31% of children with ASD have an intellectual disability (intelligence quotient [IQ] <70), 25% are in the borderline range (IQ 71–85), and 44% have IQ scores in the average to above average range (i.e., IQ >85).
- Autism affects all ethnic and socioeconomic groups.
- Minority groups tend to be diagnosed later and less often.
- Early intervention affords the best opportunity to support healthy development and deliver benefits across the lifespan.
- There is no medical detection for autism.

What causes autism?

- Research indicates that genetics are involved in the vast majority of cases.
- Children born to older parents are at a higher risk for having autism.
- Parents who have a child with ASD have a 2 to 18 percent chance of having a second child who is also affected.
- Studies have shown that among identical twins, if one child has autism, the other will be affected about 36 to 95 percent of the time. In non-identical twins, if one child has autism, then the other is affected about 31 percent of the time.
- Over the last two decades, extensive research has asked whether there is any link between childhood vaccinations and autism. The results of this research are clear: Vaccines do not cause autism.

Intervention and Supports

- Early intervention can improve learning, communication and social skills, as well as underlying brain development.
- Applied behavior analysis (ABA) and therapies based on its principles are the most researched and commonly used behavioral interventions for autism.
Many children affected by autism also benefit from other interventions such as speech and occupational therapy.
Developmental regression, or loss of skills, such as language and social interests, affects around 1 in 5 children who will go on to be diagnosed with autism and typically occurs between ages 1 and 3.

Associated Challenges

- An estimated one-third of people with autism are nonverbal.
- 31% of children with ASD have an intellectual disability (intelligence quotient [IQ] <70) with significant challenges in daily function, 25% are in the borderline range (IQ 71–85).
- Nearly half of those with autism wander or bolt from safety.
- Nearly two-thirds of children with autism between the ages of 6 and 15 have been bullied.
- Nearly 28 percent of 8-year-olds with ASD have self-injurious behaviors. Head banging, arm biting and skin scratching are among the most common.
- Drowning remains a leading cause of death for children with autism and accounts for approximately 90 percent of deaths associated with wandering or bolting by those age 14 and younger.

Associated Medical & Mental Health Conditions

- Autism can affect the whole body.
- Attention Deficient Hyperactivity Disorder (ADHD) affects an estimated 30 to 61 percent of children with autism.
- More than half of children with autism have one or more chronic sleep problems.
- Anxiety disorders affect an estimated 11 to 40 percent of children and teens on the autism spectrum.
- Depression affects an estimated 7% of children and 26% of adults with autism.
- Children with autism are nearly eight times more likely to suffer from one or more chronic gastrointestinal disorders than are other children.
- As many as one-third of people with autism have epilepsy (seizure disorder).
- Studies suggest that schizophrenia affects between 4 and 35 percent of adults with autism. By contrast, schizophrenia affects an estimated 1.1 percent of the general population.
- Autism-associated health problems extend across the life span – from young children to senior citizens. Nearly a third (32 percent) of 2 to 5-
year olds with autism are overweight and 16 percent are obese. By contrast, less than a quarter (23 percent) of 2 to 5-year olds in the general population are overweight and only 10 percent are medically obese.

- Risperidone and aripiprazole, the only FDA-approved medications for autism-associated agitation and irritability.

### Caregivers & Families

- On average, autism costs an estimated $60,000 a year through childhood, with the bulk of the costs in special services and lost wages related to increased demands on one or both parents. Costs increase with the occurrence of intellectual disability.
- Mothers of children with ASD, who tend to serve as the child’s case manager and advocate, are less likely to work outside the home. On average, they work fewer hours per week and earn 56 percent less than mothers of children with no health limitations and 35 percent less than mothers of children with other disabilities or disorders.

### Autism in Adulthood

- Over the next decade, an estimated 707,000 to 1,116,000 teens (70,700 to 111,600 each year) will enter adulthood and age out of school-based autism services.
- Teens with autism receive healthcare transition services half as often as those with other special healthcare needs. Young people whose autism is coupled with associated medical problems are even less likely to receive transition support.
- Many young adults with autism do not receive any healthcare for years after they stop seeing a pediatrician.
- More than half of young adults with autism remain unemployed and unenrolled in higher education in the two years after high school. This is a lower rate than that of young adults in other disability categories, including learning disabilities, intellectual disability or speech-language impairment.
- Of the nearly 18,000 people with autism who used state-funded vocational rehabilitation programs in 2014, only 60 percent left the program with a job. Of these, 80 percent worked part-time at a median weekly rate of $160, putting them well below the poverty level.
- Nearly half of 25-year-olds with autism have never held a paying job.
- Research demonstrates that job activities that encourage independence reduce autism symptoms and increase daily living skills.

### Economic Costs
• The cost of caring for Americans with autism had reached $268 billion in 2015 and would rise to $461 billion by 2025 in the absence of more-effective interventions and support across the life span.
• The majority of autism’s costs in the U.S. are for adult services – an estimated $175 to $196 billion a year, compared to $61 to $66 billion a year for children.
• On average, medical expenditures for children and adolescents with ASD were 4.1 to 6.2 times greater than for those without autism.
• Passage of the 2014 Achieving a Better Life Experience (ABLE) Act allows tax-preferred savings accounts for people with disabilities, including autism, to be established by states.
• Passage of autism insurance legislation in all 50 states is providing access to medical treatment and therapies.

What is autism spectrum disorder?

Autism spectrum disorder (ASD) is a developmental disability that can cause significant social, communication, and behavioral challenges. The term “spectrum” refers to the wide range of symptoms, skills, and levels of impairment that people with ASD can have.

ASD affects people in different ways and can range from mild to severe. People with ASD share some symptoms, such as difficulties with social interaction, but there are differences in when the symptoms start, how severe they are, the number of symptoms, and whether other problems are present. The symptoms and their severity can change over time.

The signs of ASD begin in early childhood, usually in the first 2 years of life, although a small minority of children may show hints of future problems within the first year of life.

Who is affected by ASD?

ASD affects people of every race, ethnic group, and socioeconomic background. It is five times more common among boys than among girls. The Centers for Disease Control and Prevention (CDC) estimates that about 1 in every 68 children in the U.S. has been identified as having ASD.

How does ASD affect communication?

The word “autism” has its origin in the Greek word “autos,” which means “self.” Children with ASD are often self-absorbed and seem to exist in a private world in which they have limited ability to successfully communicate and interact with others. Children with ASD may have difficulty developing language skills and understanding what others say to them. They also often have difficulty communicating nonverbally, such as through hand gestures, eye contact, and facial expressions.

The ability of children with ASD to communicate and use language depends on their intellectual and social development. Some children with ASD may not be able to communicate using speech or language, and some may have very limited speaking skills. Others may have rich vocabularies and be able to talk about specific subjects in great detail. Many have problems with the meaning and rhythm of words and sentences. They also may be unable to understand body language and the meanings of different vocal tones. Taken together, these difficulties affect the ability of children with ASD to interact with others, especially people their own age.

Below are some patterns of language use and behaviors that are often found in children with ASD.

- **Repetitive or rigid language.** Often, children with ASD who can speak will say things that have no meaning or that do not relate to the conversations they are having with others. For example, a child may count from one to five repeatedly amid a conversation that is not related to numbers. Or a child may continuously repeat words he or she has heard—a condition called echolalia. Immediate echolalia occurs when the child repeats words someone has just said. For example,
the child may respond to a question by asking the same question. In delayed echolalia, the child repeats words heard at an earlier time. The child may say “Do you want something to drink?” whenever he or she asks for a drink. Some children with ASD speak in a high-pitched or sing-song voice or use robot-like speech. Other children may use stock phrases to start a conversation. For example, a child may say “My name is Tom,” even when he talks with friends or family. Still others may repeat what they hear on television programs or commercials.

Narrow interests and exceptional abilities. Some children may be able to deliver an in-depth monologue about a topic that holds their interest, even though they may not be able to carry on a two-way conversation about the same topic. Others may have musical talents or an advanced ability to count and do math calculations. Approximately 10 percent of children with ASD show “savant” skills, or extremely high abilities in specific areas, such as memorization, calendar calculation, music, or math.

Uneven language development. Many children with ASD develop some speech and language skills, but not at a normal level of ability, and their progress is usually uneven. For example, they may develop a strong vocabulary in a particular area of interest very quickly. Many children have good memories for information just heard or seen. Some may be able to read words before age five, but may not comprehend what they have read. They often do not respond to the speech of others and may not respond to their own names. As a result, these children are sometimes mistakenly thought to have a hearing problem.

Poor nonverbal conversation skills. Children with ASD are often unable to use gestures—such as pointing to an object—to give meaning to their speech. They often avoid eye contact, which can make them seem rude, uninterested, or inattentive. Without meaningful gestures or other nonverbal skills to enhance their oral language skills, many children with ASD become frustrated in their attempts to make their feelings, thoughts, and needs known. They may act out their frustrations through vocal outbursts or other inappropriate behaviors.

How are the speech and language problems of ASD treated?

If a doctor suspects a child has ASD or another developmental disability, he or she usually will refer the child to a variety of specialists, including a speech-language pathologist. This is a health professional trained to treat individuals with voice, speech, and language disorders. The speech-language pathologist will perform a comprehensive evaluation of the child's ability to communicate, and will design an appropriate treatment program. In addition, the speech-language pathologist might make a referral for a hearing test to make sure the child's hearing is normal.

Teaching children with ASD to improve their communication skills is essential for helping them reach their full potential. There are many different approaches, but the best treatment program begins early, during the preschool years, and is tailored to the child's age and interests. It should address both the child's behavior and communication skills and offer regular reinforcement of positive actions. Most children with ASD respond well to highly structured, specialized programs. Parents or primary caregivers, as well as other family members, should be involved in the treatment program so that it becomes part of the child's daily life.

For some younger children with ASD, improving speech and language skills is a realistic goal of treatment. Parents and caregivers can increase a child's chance of reaching this goal by paying attention to his or her language development early on. Just as toddlers learn to crawl before they walk, children first develop pre-language skills before they begin to use words. These skills include using eye contact, gestures, body movements, imitation, and babbling and other vocalizations to help them communicate. Children who lack these skills may be evaluated and treated by a speech-language pathologist to prevent further developmental delays.

For slightly older children with ASD, communication training teaches basic speech and language skills, such as single words and phrases. Advanced training emphasizes the way language can serve a purpose, such as learning to hold a conversation with another person, which includes staying on topic and taking turns speaking.
Some children with ASD may never develop speech and language skills. For these children, the goal may be to learn to communicate using gestures, such as sign language. For others, the goal may be to communicate by means of a symbol system in which pictures are used to convey thoughts. Symbol systems can range from picture boards or cards to sophisticated electronic devices that generate speech through the use of buttons to represent common items or actions.

**What research is being conducted to improve communication in children with ASD?**

The federal government’s Autism CARES Act of 2014 brought attention to the need to expand research and improve coordination among all of the components of the National Institutes of Health (NIH) that fund ASD research. These include the National Institute of Mental Health (NIMH), along with the National Institute on Deafness and Other Communication Disorders (NIDCD), the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), the National Institute of Environmental Health Sciences (NIEHS), the National Institute of Neurological Disorders and Stroke (NINDS), the National Institute of Nursing Research (NINR), and the National Center for Complementary and Integrative Health (NCCIH).

Together, five institutes within the NIH (NIMH, NIDCD, NICHD, NIEHS, and NINDS) support the Autism Centers of Excellence (ACE) [https://www.nichd.nih.gov/research/supportedPages/ace.aspx](https://www.nichd.nih.gov/research/supportedPages/ace.aspx), a program of research centers and networks at universities across the country. Here, scientists study a broad range of topics, from basic science investigations that explore the molecular and genetic components of ASD to translational research studies that test new types of behavioral therapies. Some of these studies involve children with ASD who have limited speech and language skills, and could lead to testing new treatments or therapies. You can visit the NIH Clinical Trials website [https://clinicaltrials.gov](https://clinicaltrials.gov) and enter the search term “autism” for information about current trials, their locations, and who may participate.


NIDCD-funded researchers in universities and organizations across the country are also studying:

- How parents can affect the results of different types of language therapies for children with ASD.
- Enhanced ways to improve communication between children with and without ASD. This could involve a communication board with symbols and pictures, or even a smartphone app.
- Factors that may better predict whether an infant is at risk for developing ASD when an older sibling has the disorder, and when the infant shows problems in early social communication skills.
- Techniques to help researchers better understand how toddlers with ASD perceive words, and the problems they experience with words.
- Cost-effective ways to prevent or reduce the impact of conditions affecting speech, language, and social skills in high-risk children (for example, younger siblings of children with ASD).
- The development of software to help people with ASD who struggle with speech to communicate complex thoughts and interact more effectively in society.

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Where can I find additional information about ASD?

Information from other NIH Institutes and Centers that participate in ASD research is available on the NIH Health Information page (https://www.nidcd.nih.gov/health-information) by searching on the term “autism.”

In addition, the NIDCD maintains a directory of organizations that provide information on the normal and disordered processes of hearing, balance, taste, smell, voice, speech, and language. Visit the NIDCD website at https://www.nidcd.nih.gov/directory to search the directory.

More NIDCD fact sheets on Voice, Speech, and Language:

- Speech and Language Developmental Milestones
- Specific Language Impairment

Visit the NIDCD website at https://www.nidcd.nih.gov to read, print, or download fact sheets.

For more information, contact us at:

NIDCD Information Clearinghouse
1 Communication Avenue
Bethesda, MD 20892-3456
Toll-free voice: (800) 241-1044
Toll-free TTY: (800) 241-1055
Email: nidcdinfo@nidcd.nih.gov

https://www.nidcd.nih.gov

Follow the NIDCD on Twitter at @NIDCD

The NIDCD supports and conducts research and research training on the normal and disordered processes of hearing, balance, taste, smell, voice, speech, and language and provides health information, based upon scientific discovery, to the public.

Autism Spectrum Disorder: Communication Problems in Children
NIH Pub. No. 97-4315
October 2016

Enrichment Activity:
Reading Book + Arts & Crafts

What you will need:

- The Rainbow Fish by Marcus Pfister
- Fish paper template (you can find any template on google and print them)
- Colorful sequins or glitter
- Glue
- Markers

Instructions:

- Read the book The Rainbow Fish aloud with your child
- Have children decorate their own "glitterfish" by gluing the corresponding sequin/glitter color to each number on the scales (young kids can just glue glitter as they wish).
- During the activity discuss the main point of the book: "sharing or giving something you have to someone else who wants it makes others feel good."
- Have children mand (i.e., "can I have...?", "I need...") and share the different colored glitters available to decorate their rainbow "glitterfish".
- You can also discuss how fish don't have skin like we do; they have "scales" that cover their bodies.

![The Rainbow Fish](image)
1 = RED
2 = BLUE
3 = GREEN
4 = YELLOW
5 = PINK
6 = PURPLE
UNDERSTANDING & MANAGING CHALLENGING BEHAVIORS AND SUPPORTING THE DEVELOPMENT OF CHILDREN WITH AUTISM: A PARENTING WORKSHOP

Presented By: Vanessa Hszar

Topic: Challenges of Raising a Child with Autism (continued)
Overview of workshop

Session 1
- Overview of Autism
  - Challenges of Raising a Child with Autism
- Lack of Parent Preparedness
- Challenging Behaviors and What Can Help
  - 1. Lack of Social Communication
  - 2. Restrictive and Repetitive behavior
- Enrichment Activity

Session 2
- Challenges of Raising a Child with Autism (continued)
  - 3. Sensory Sensitivities
  - 4. Maladaptive Behavior
- Parent Discussion
- List of Resources
- Enrichment Activity

Session 3
- Effective Ways to Guide Children’s Challenging Behavior
  - Introduction to ABA & Positive Child Guidance
  - Applied Behavior Analysis (ABA): Challenging Behavior’s Come from and How to Respond
  - Positive Child Guidance: Definition & Explanation of Strategies for Guiding Behavior
- Enrichment Activity

Session 4
- Supporting Your Child’s Development
  - Developmental Milestones
  - Building Strong Parent-Child Relationships
  - Engaging in Enrichment Activities
- Enrichment Activity

Debrief: Take-Home Enrichment Activity
Challenging Behaviors of Children with ASD

- Deficits in Social Communication
- Restrictive and Repetitive Patterns
- Sensory Sensitivities
- Maladaptive Behaviors
Sensory Sensitivities

- The overall explanation for sensory processing problems is that the brain has trouble receiving and responding to information that comes in through the senses. As a result, children may develop unusual behaviors as their body responds negatively to certain sensitivities.

- Individuals have difficulty understanding what is going on inside and outside of their bodies so they may avoid confusing or unpleasant sensations or may seek more of the sensation.

The following sensory sensitivities will be discussed today:

1. Oral Sensory Sensitivities
2. Auditory Sensory Processing Difficulties
3. Tactile Sensitivities
Oral Sensory Sensitivities

- Oral sensory sensitivity means that children may have extreme sensitivity in and around the mouth.
- Food selectivity is said to be related to oral sensory sensitivity.
  - Children will often avoid tasting or smelling certain foods, will limit themselves to eating only certain textures, and crave only the specific foods they are used to eating.
  - Some children have poor oral health as they have difficulty tolerating the feeling of a toothbrush in their mouth or the taste of toothpaste.

What can help?

- It may be easier for some to try a bit of new food every 2-3 days by having it with a food that is preferred.
  - Eat a bite of the new food and two bites of the preferred food.
- You should SLOWLY expose the child to new food and reinforce approximations when he/she dislikes the texture or smell of new food.
  - Eat: tolerate food on a plate next to him, tolerate smelling the food, tolerate food on his plate, tolerate bringing the food close to his mouth, tolerate licking the food one time, etc., until the child finally tries a bite of the new food.
- Limits are coupled with incentives for child to work with you.
  - Eat: if child is sitting at the table and is reluctant to try new food but is willing to try just a bit, then if he does so he can get up and play with that new toy (reinforcer).
What can help?

- For children that have difficulty with their oral care, parents can experiment with different types of toothbrushes with different bristles and toothpastes flavors to see which one the child prefers.

- Oral massage with a washcloth first so that the child gets used to the sensory experience before using a toothbrush.

- Create a social story with pictures of the dentist’s office, the dentist chair, and what the tools that will be used look like to get the child familiar with what will happen at his appointment.

- Engage in role-play and pretend to be the dentist to get the child familiar with the process and feel less scared.

Auditory Sensory Processing Difficulties

- Children with ASD who have auditory sensory processing difficulties may be hypersensitive or oversensitive to sounds.
  - Hypersensitive- Individuals pick up on sounds most people can’t hear, have difficulty filtering out irrelevant sounds
  - Oversensitive- Individuals become miserable with sounds at a much quieter volume/not loud
- Others individuals underreact to sound and may need a lot of sound to “wake up” their ears. These individuals often do not respond when their name is being called.

- Some children may often find themselves in unsafe situations by running away, hiding, or hurling themselves as a way to escape the triggering sounds.
What can help?

Avoid noisy places whenever you can.

Let your child use noise-blocking headphones, earmuffs, or earplugs but make sure these are not worn all the time—only when they really need them.

Some kids can better tolerate the sounds if they are the ones in charge of it—have them flush the toilet or vacuum. Cheerios or Goldfish crackers to tolerate the sounds.

Counting down until they turn on loud/noisy items can help them tolerate the noise better since they can brace themselves for the sound.

If your child does not respond to his/her name...

1. Look for an opportunity to approach him closely while he is mildly occupied with another activity. (It’s probably best to avoid a situation where he’s deeply engrossed in something like a favorite video.)

2. Say his name. After saying the child’s name, immediately tap his shoulder and, if needed, gently guide his face to look at you. Do not require direct eye contact, as it can be uncomfortable for some people affected by autism.

3. As soon as he looks towards you (even inadvertently), provide the rewarding activity or item along with immediate praise such as “nice responding to your name.”

Tactile Sensitivities

- This can include individuals with ASD who dislike certain feelings and textures – remove their clothes, scratch skin that has been touched, dislike being hugged/touched, and do not like any grooming activities.
- And/or who have a need for touching people, objects, or surfaces – like to touch other’s hair, rough/soft surfaces.
- Other individuals may also have a high tolerance for pain.
- Some of these behaviors can be common stim/self-stimulatory behaviors which serve practical purposes for the child – touching/rubbing/scratching objects, others, or own body with hands or putting body parts or objects in their mouth.

What can help?

- It is important for parents to first seek professional help to identify the specific sensory issues of the individual.

- Occupational therapy (OT) is often recommended as many therapist are trained in sensory integration.
- The goal of OT is to foster appropriate responses to sensation in an active, meaningful, and fun way so the child is able to behave in a more functional manner.
What can help?

- Sensory boards, slime, fidget toys, etc., can be used as replacement behaviors/activities for stimming or for those who like to touch different objects, surfaces, textures.
- Clothing that accommodates personal sensitivities—lightweight clothing with no tags.
- Asking for permission before touching.

Maladaptive Behaviors

- Some maladaptive behaviors include: tantrums, aggression towards self or others, destructive behaviors, and self-stimulatory behaviors that interfere with the child’s daily routine.
What Influences Maladaptive Behaviors?

**Biological Factors**
- Deficits in communication
- Sensory sensitivities
- Sleep problems
- Having other disorders (anxiety, ADHD, Intellectual disability)

**Environmental Factors**
- Denied access to preferred items/activities
- Placing demands
- Unable to communicate their needs or preferences

What can help?

- **FIRST**, be able to identify the function of the behavior to use replacement behaviors that are socially appropriate.

- Facilitated Communication (FC) and Picture Exchange Communication System (PECS) to aid non-verbal children to communicate their wants and needs through typing on a keyboard or exchanging pictures.

- **Physical containment** to immediately stop children from engaging in self-injurious or aggressive behavior.

- How to manage these maladaptive behaviors will be further explained in the next session.
The Four Functions of Behavior

1. Attention
2. Access to tangibles or activities
3. Escape or avoidance
4. Self-Stimulatory Behavior (SSB)

The ABC’s

- To help us identify the function of the child’s behavior we first need to identify the following:
  - **A** = Antecedent
    - What occurs before the behavior
    - What triggers the behavior
  - **B** = Behavior
    - The response in measurable terms (what did the behavior look like?)
    - Frequency, duration, intensity
  - **C** = Consequence
    - What happens after the behavior. The consequence can increase or decrease the likelihood of the behavior happening again in the future
    - How are we responding to the behavior after it happens?
Let’s Practice!

Case #1
Jerry does not have verbal communication. When Jerry’s mom is on the phone, Jerry looks at his mother and begins to throw his food on the floor. Jerry’s mother quickly hangs up the phone, runs to Jerry, and says “Stop throwing your food on the floor!” and cleans the mess.

<table>
<thead>
<tr>
<th>Antecedent</th>
<th>Behavior</th>
<th>Consequence</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jerry's mother is on the phone</td>
<td>Jerry throws food on the floor</td>
<td>Mother hangs up the phone and says, “Stop throwing your food on the floor!”</td>
<td>Attention</td>
</tr>
</tbody>
</table>
Let’s Practice!

Case #2
When Carol walks by the toy section at Target, she quickly points to her favorite toy and says “Mommy, can you buy me this toy?” Carol’s mother responds, “No, you have too many at home.” Carol begins to scream and cry. Carol’s mother buys her the toy to avoid further embarrassment.

<table>
<thead>
<tr>
<th>Antecedent</th>
<th>Behavior</th>
<th>Consequence</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>“No, you have too many at home”</td>
<td>Scream &amp; Cry</td>
<td>Mother buys toy</td>
<td>Asceea</td>
</tr>
</tbody>
</table>
Let's Practice!

Case #3

Think of a behavior your child recently engaged in, identify the **antecedent, behavior, & consequence** and what the **function** of the behavior was.

Helpful Resources

**BOOKS**
- Engaging In Autism: Using the Floortime Approach to Help Children Relate, Communicate, and Think by Stanley I. Greenspan and Serena Wieder
- Raising A Sensory Smart Child by Lindsey Diet and Nancy Reske

**WEBSITES**
- Autism Speaks - [autism Speaks.org](http://autism Speaks.org)
- Interactive Autism Network - [ianscommunity.org/cs/articles/prob_behave](http://ianscommunity.org/cs/articles/prob_behave)
- Sensory Smart Parent - [sensorysmartparent.com](http://sensorysmartparent.com)
SENSORY ENRICHMENT ACTIVITY TIME!

Texture Balloons
1. Choose 2-3 balloons
2. Blow the balloons to stretch them out then release the air
3. Use a funnel if needed to fill the balloons with any filler of your choice
4. Tie the balloons once filled
5. Have your child experience and describe the different textured...
References


References

References

APPENDIX G 1-3
SESSION 2 HANDOUTS
### Sensory Checklist

From *Raising a Sensory Smart Child*, © Biel & Peske, 2005, 2009

#### TOUCH

<table>
<thead>
<tr>
<th>Item</th>
<th>AVOIDS</th>
<th>SEeks</th>
<th>MIXED</th>
<th>NEUTRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being touched on some body parts, hugs and cuddles</td>
<td></td>
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<tr>
<td>Certain clothing fabrics, seams, tags, waistbands, cuffs, etc.</td>
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<tr>
<td>Clothing, shoes, or accessories that are very tight or very loose</td>
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<tr>
<td>Getting hands, face, or other body parts “messy” with paint, glue, sand, food, lotion, etc.</td>
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<tr>
<td>Grooming activities such as face and hair washing, brushing, cutting, and nail trimming</td>
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<tr>
<td>Taking a bath, shower, or swimming</td>
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<tr>
<td>Getting towel-ed dry</td>
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<tr>
<td>Trying new foods</td>
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<tr>
<td>Feeling particular food textures and temperatures inside the mouth—mushy, smooth, etc.</td>
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<tr>
<td>Standing close to other people</td>
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<tr>
<td>Walking barefoot</td>
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</tbody>
</table>

#### PROPRIOCEPTION (BODY SENSE)

<table>
<thead>
<tr>
<th>Item</th>
<th>AVOIDS</th>
<th>SEeks</th>
<th>MIXED</th>
<th>NEUTRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities such as roughhousing, jumping, banging, pushing, bouncing, climbing, hanging, and other active play</td>
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<tr>
<td>High-risk play (jumps from extreme heights, climbs very high trees, rides bicycle over gravel)</td>
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<tr>
<td>Fine motor tasks such as writing, drawing, closing buttons and snaps, attaching pop beads and snap-together building toys</td>
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<tr>
<td>Activities requiring physical strength and force</td>
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<tr>
<td>Eating crunchy foods (pretzels, dry cereal, etc.) or chewy foods</td>
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<tr>
<td>(e.g., meat, caramels)</td>
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<tr>
<td>Smooth, creamy foods (yogurt, cream cheese, pudding)</td>
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<td></td>
<td></td>
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<tr>
<td>Having eyes closed or covered</td>
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</tbody>
</table>
### VESTIBULAR (MOVEMENT SENSE)

<table>
<thead>
<tr>
<th>Activity</th>
<th>AVOIDS</th>
<th>SEeks</th>
<th>MIXED</th>
<th>NEUTRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being moved passively by another person (rocked or twirling by an adult, pushed in a wagon)</td>
<td>✔️</td>
<td>❌</td>
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<tr>
<td>Riding equipment that moves through space (swings, teeter-totter, escalators and elevators)</td>
<td>✔️</td>
<td>❌</td>
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<td>❌</td>
</tr>
<tr>
<td>Spinning activities (carousels, spinning toys, spinning around in circles)</td>
<td>✔️</td>
<td>❌</td>
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<tr>
<td>Activities that require changes in head position (such as bending over sink) or having head upside down (such as somersaults, hanging from feet)</td>
<td>✔️</td>
<td>❌</td>
<td>❌</td>
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</tr>
<tr>
<td>Challenges to balance such as skating, bicycle riding, skiing, and balance beams</td>
<td>✔️</td>
<td>❌</td>
<td>❌</td>
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<tr>
<td>Climbing and descending stairs, slides, and ladders</td>
<td>✔️</td>
<td>❌</td>
<td>❌</td>
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<tr>
<td>Being up high, such as at the top of a slide or mountain overlook</td>
<td>✔️</td>
<td>❌</td>
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<tr>
<td>Less stable ground surfaces such as deep pile carpet, grass, sand, and snow</td>
<td>✔️</td>
<td>❌</td>
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<tr>
<td>Riding in a car or other form of transportation</td>
<td>✔️</td>
<td>❌</td>
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</tbody>
</table>

### AUDITORY/LISTENING

<table>
<thead>
<tr>
<th>Activity</th>
<th>AVOIDS</th>
<th>SEeks</th>
<th>MIXED</th>
<th>NEUTRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing loud sounds—car horns, sirens, loud music or TV</td>
<td>✔️</td>
<td>❌</td>
<td>❌</td>
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<tr>
<td>Being in noisy settings such as a crowded restaurant, party, or busy store</td>
<td>✔️</td>
<td>❌</td>
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<tr>
<td>Watching TV or listening to music at very high or very low volume</td>
<td>✔️</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Speaking or being spoken to amid other sounds or voices</td>
<td>✔️</td>
<td>❌</td>
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</tr>
<tr>
<td>Background noise when concentrating on a task (music, dishwasher, fan, etc.)</td>
<td>✔️</td>
<td>❌</td>
<td>❌</td>
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<tr>
<td>Games with rapid verbal instructions such as Simon Says or Hokey Pokey</td>
<td>✔️</td>
<td>❌</td>
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<tr>
<td>Back-and-forth, interactive conversations</td>
<td>✔️</td>
<td>❌</td>
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<tr>
<td>Unfamiliar sounds, silly voices, foreign language</td>
<td>✔️</td>
<td>❌</td>
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<tr>
<td>Singing alone or with others</td>
<td>✔️</td>
<td>❌</td>
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</table>
### VISION

<table>
<thead>
<tr>
<th>Activity</th>
<th>AVOIDS</th>
<th>SEeks</th>
<th>MIXED</th>
<th>NEUTRAL</th>
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</thead>
<tbody>
<tr>
<td>Learning to read or reading for more than a few minutes</td>
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<tr>
<td>Looking at shiny, spinning, or moving objects</td>
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<tr>
<td>Activities that require eye-hand coordination such as baseball,</td>
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<tr>
<td>catch, stringing beads, writing, and tracing</td>
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<tr>
<td>Tasks requiring visual analysis like puzzles, mazes, and hidden pictures</td>
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<tr>
<td>Activities that require discriminating between colors, shapes, and sizes</td>
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<tr>
<td>Visually &quot;busy&quot; places such as stores and crowded playgrounds</td>
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<tr>
<td>Finding objects such as socks in a drawer or a particular book on a shelf</td>
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<tr>
<td>Very bright light or sunshine, or being photographed with a flash</td>
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<tr>
<td>Dim lighting, shade, or the dark</td>
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<tr>
<td>Action-packed, colorful television, movies or computer/video games</td>
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<tr>
<td>New visual experiences such as looking through a kaleidoscope or colored glass</td>
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</table>

### TASTE AND SMELL

<table>
<thead>
<tr>
<th>Activity</th>
<th>AVOIDS</th>
<th>SEeks</th>
<th>MIXED</th>
<th>NEUTRAL</th>
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<tbody>
<tr>
<td>Smelling unfamiliar scents</td>
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<tr>
<td>Strong odors such as perfume, gasoline, cleaning products</td>
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<tr>
<td>Smelling objects that aren’t food such as flowers, plastic items,</td>
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<tr>
<td>playdough, and garbage</td>
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<tr>
<td>Eating new foods</td>
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<tr>
<td>Eating familiar foods</td>
<td></td>
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<tr>
<td>Eating strongly flavored foods (very spicy, salty, bitter, sour, or sweet)</td>
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</tbody>
</table>
## ABC Data Sheet

<table>
<thead>
<tr>
<th>Antecedent</th>
<th>Behavior</th>
<th>Consequence</th>
<th>Duration/Frequency</th>
</tr>
</thead>
<tbody>
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</table>

Developed by Vanessa Huizar
Enrichment Activity:
Sensory Texture Balloons

What you will need:
- 2-3 balloons
- Funnel (optional)
- Filler of your choice (rice, flour, sand, hair gel etc)

Instructions:
- Blow the balloon first to stretch it out and then let the air out
- Have your child fill the balloon with the filler of their choice. (Using a funnel can make it easier to pour the fillers inside the balloons).
- If you do not have a funnel, you can help your child to stretch out the opening of the balloon while they pour the fillers inside. This can get a little messy, but that's OK!
- Tie the balloons once filled
- Have your child experience and describe the different textures!
APPENDIX H

SESSION 3 POWERPOINT
UNDERSTANDING & MANAGING CHALLENGING BEHAVIORS AND SUPPORTING THE DEVELOPMENT OF CHILDREN WITH AUTISM: A PARENTING WORKSHOP

Presented By: Vanessa Hulzar

Topic: Effective Ways To Guide Children's Challenging Behaviors
Overview of workshop

Session 1
- Overview of Autism
- Challenges of Raising a Child with Autism
- Lack of Parent Preparedness
- Challenging Behaviors and What Can Help
  - 1. Lack of Social Communication
  - 2. Restrictive and Repetitive behaviors
- Enrichment Activity

Session 2
- Challenges of Raising a Child with Autism (continued)
  - 3. Sensory Sensitivities
  - 4. Maladaptive Behavior
- Parent Discussion
- List of Resources
- Enrichment Activity

Session 3
- Effective Ways to Guide Children’s Challenging Behavior
- Introduction to ABA & Positive Child Guidance
- Applied Behavior Analysis: Where Challenging Behavior Came From and How to Respond
- Positive Child Guidance: Definition & Explanation of Strategies for Guiding Behavior
- Enrichment Activity

Session 4
- Supporting Your Child’s Development
  - Developmental Milestones
  - Building Strong Parent-Child Relationships
- Engaging in Enrichment Activities
- Enrichment Activity

Debrief: Take-Home Enrichment Activity
Introduction to Applied Behavior Analysis and Positive Child Guidance

- **Applied Behavior Analysis** focuses on reducing problematic behaviors and teaching skill deficits.
- To understand problem behavior, ABA emphasizes the importance of knowing what happened before the behavior occurred (antecedent) and what happened immediately after the behavior was exhibited (consequence).
- ABA-based interventions reinforce and provide access to preferred items or activities when the child engages in a more appropriate alternative behavior instead of the maladaptive behavior.
- **Positive child guidance** helps to meet the developmental needs of children through effective problem solving, honest communication, and assertiveness.
- Supports children’s development and life skills without the use of punishment strategies.
- Promotes positive child outcomes which may also be effective with children with ASD.

Applied Behavior Analysis

- Many parents of children with ASD who receive ABA services report a lack of understanding of when and how to implement intervention strategies.
- We will be reviewing antecedent and consequence strategies which are significant in changing behaviors.
Behavior Change Strategies

- **Antecedent Strategies** are used to **prevent** the behavior from happening (used before behaviors occur).

- **Consequence Strategies** are used to manage behavior and reduce the likelihood of **future occurrences** of the behavior (used after behaviors have occurred).
  - Consequence means how we respond after the behavior has occurred not necessarily that we are giving the child a negative consequence for their behavior.

Antecedent Strategies

- Strategies to **prevent** the behavior from happening:
  - Priming
  - Provide choices
  - First/Then Agreements (Premack Principle)
  - Visual Aids
  - Environmental Arrangements
  - Non Contingent Reinforcement (NCR)
Priming

- Priming is a strategy that consists of using verbal and/or visual cues to prepare a child for a transition.
- If the child usually tantrums when told to turn off TV and go to bed, you can prepare the child for the transition doing the following:
  - Parent sets the timer for 15 minutes and says:
    - "In 5 minutes you have to turn off TV and go to bed."
    - "In 10 minutes you have to turn off TV and go to bed."
    - "You have 5 minutes remaining before going to bed."
  - (alarm rings)
  - Parent/child turns off television "It's bed time"

Provide choices

- Give choices whenever possible. This will make the child feel that they/his is in control when in reality you are in control.
- Example:
  - Which homework do you want to start with, math or reading?
  - Do you want to wear your blue shoes or your red shoes?
  - Which vegetable do you want, broccoli or carrots?
- Not-Example:
  - "If you don't put your shoes on, then you are not going to the park."
First/Then Agreements

- A low compliance activity is followed by an activity of preference for the child
  - Example:
    - First make your bed, then you can play video games
    - First finish your dinner, then you can have ice cream
    - First finish your homework, then I can give you the Pod
  - Non-Example:
    - "You can either make your bed or I'm taking away your video game"

Visual Aids

- Any form of visual stimuli to strengthen and facilitate the accomplishment of tasks
  - Examples: Daily schedules, visual task analysis, timers, 5 minute warnings
  - Visual schedules allow the individual to see the tasks/activities he/she must complete and in which order.
Environmental Arrangements

- You reduce the effort to accomplish a task, and then build up effort as compliance is reached
- Example:
  - Putting the toy box next to the toys on the floor
- Non-Example:
  - Putting the toy box in another room, requiring the child to carry toys a long distance when cleaning up
- Environmental Arrangements can also be used as preventative measures
- Example:
  - If child likes to skip/run away during homework time/session time, then we would position him where he is sitting next to a wall and are on the other side of him. This will block the access of running away.

Non-Contingent Reinforcement

- "CATCH THEM BEING GOOD"
- Reinforce ALL behaviors you want to continue
- Example:
  - Eating, sitting, requesting, playing, looking when name is called etc.
- Non-Example:
  - "He’s supposed to be do that, why should I praise him"
Consequence Strategies

- The following strategies are implemented to decrease the probability of the behavior occurring again in the future:
  - Differential Reinforcement (DRA, DRI, DRO)
  - Extinction
  - Redirection
  - Task reduction
  - Response Blocking
  - Token Economy

Differential Reinforcement

- Differentially reinforcing a particular behavior (desired behavior) while withholding reinforcement for another behavior (problem behavior).

  - DRA – Differential Reinforcement of Alternative behavior:
    - Choose an alternate and desirable behavior
    - Example: Reinforce saying “Excuse me,” while not reinforcing repeatedly poking adult in the side to get attention

  - DRI – Differential Reinforcement of Incompatible behavior:
    - Choose an incompatible behavior (cannot occur while problem behavior occurs)
    - Example: Reinforce saying “Excuse me,” while not reinforcing screaming “Mom, Mom, Mom!”

  - DRO – Differential Reinforcement of Other behavior:
    - Reinforce any behavior other than the problem behavior
    - Example: Reinforce any verbal request while not reinforcing screaming
Extinction

- Extinction: Withholding reinforcement for previously reinforced behavior.
- When implementing this procedure, behavior will initially increase (in intensity, duration, frequency etc.) before decreasing.
- In other words, behavior will get worse before it gets better. This is called the "EXTINCTION BURST"
- This means that the strategies in place are working and the child is no longer being reinforced for maladaptive behaviors.

What would extinction look like?

<table>
<thead>
<tr>
<th>Antecedent</th>
<th>Behavior</th>
<th>Consequence</th>
<th>Extinction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mom says “no candy”</td>
<td>Child screams</td>
<td>Mom gives candy</td>
<td>Mom no longer gives candy when child screams</td>
</tr>
<tr>
<td>Mom is on the phone</td>
<td>Child screams</td>
<td>Mom turns and says, “What?”</td>
<td></td>
</tr>
<tr>
<td>Dad says “Tie your shoes”</td>
<td>Child screams and cries</td>
<td></td>
<td>Dad ties shoe for the child</td>
</tr>
<tr>
<td>Mom says “clean your room”</td>
<td>Child ignores parent</td>
<td></td>
<td>Mom cleans room for child</td>
</tr>
</tbody>
</table>
Redirection

- Physically and/or verbally guiding the child to a desired or approximation to the target behavior.
  - For example: If you asked the child to clean his room and child continues to watch TV (ignoring your instruction) give the instruction once again and physically and/or verbally redirect child to complete the task.
- It can also mean to divert the attention of the child to an alternative event/activity.
  - For example: Taking a dangerous object away from a child and substituting it with a safer one.

Task Reduction

- Reduce task when necessary.
  - For example:
    - If doing 20 math problems is too difficult, have the child complete 10 math problems and give him a break. Once break is over, child must return to initial task.
    - If you told child to clean her room and child engages in tantrum behavior, have the child clean only half of the mess and you can help him/her with the other half.
Response Blocking

- Physically/verbally intervening as soon as the person begins to emit the problem behavior to prevent or “block” the completion of the response.
- Example:
  - Block any attempt of physical injury towards you or others.
  - When Ana lifts her arm to hit with a fist, her sister blocks the response by holding her hand.
  - Block repetitive behaviors that are self-stimulatory.
  - When Donald repeats the same phrase from his favorite movie, his mother blocks the behavior by asking questions related to something different.

Token Economy

- Child receives tokens (points, checkmarks, stickers etc.) depending on a variety of target behaviors. Child accumulates the tokens and exchanges them at specific times for their choice of reinforcers (candy, toy, etc.)
- Ex: Giving child a token or sticker anytime they go sit on toilet when being potty trained. After 5 tokens/stickers they get a big prize.
Positive Child Guidance

- Positive child guidance practices such as setting limits and consequences, using reasons and explanations, and modeling appropriate behaviors have been found to be effective in guiding and redirecting children’s behaviors.

- Skills to help parents set limits and get children to listen and cooperate will be reviewed and practiced (please see handout H-2).
Setting Limits and Consequences

- These strategies are more work than just telling your child “stop it” or “go on time out” but, they are beneficial for your child’s development and the relationship you have with your child.
- We will review and practice the following:
  - Using I-messages
  - Giving “closed-choices”
  - Using “when-then” statements
  - Saying YES!
  - Limit-setting with a consequence

Using I-messages

- I-messages are more effective because they tell your child WHY they can’t engage in certain behaviors.
- I-messages let the child know WHY their behavior is unacceptable and how it makes their parents feel.
- Therefore, children are more likely to change their behavior when there is a reason.

How to construct an I-message

Step 1: State what the child’s unacceptable behavior is
Step 2: State your feelings about it
Step 3: State what effect this behavior has on you
Step 4: Move on to “problem-solving”
  - brainstorm possible solutions with your child, choose a solution and try it out!
Let's Practice

Using “when-then” statements

- This is another way to state the sequence of how things need to be done in a positive way (same as ABA strategy “First/then agreements”)

- Ex: If child wants a new toy when you are in the store, how can you use a “when-then” statement?
Say YES!

- When your child asks you for something say YES, instead of the usual NO.
- This may help reduce behaviors as saying NO to a child usually triggers a negative response.

Example:
- Child: Mom can I have some ice cream?
- Mom: Yes, as soon as you finish your lunch.
- Child: Mom can you buy me this toy?
- Mom: Yes, next time we come back.

Let’s Practice
Limit setting with a consequence

- If the child does not comply with the limits being set, give a consequence (see handout)

- Three-step limit-setting
  - Step 1: Explain rule as need arises
  - Step 2: If limit is disregarded, state consequence for continued disregard by the child of the limit
  - Step 3: If the limit is still disregarded, follow through w/consequence (discuss why it is not ok to engage in behavior, stay with the child to redirect them to another activity)

Limit setting with a consequence

Six-step limit-setting

- Step 1: Explain rule as need arises
- Step 2: If limit is disregarded, state consequence for continued disregard by the child of the limit
- Step 3: If the limit is still disregarded, follow through w/consequence: remove child from area/activity, keep them close to you, and discuss feelings and rules
- Step 4: Have the child take responsibility for deciding for himself when he can control himself and return
- Step 5: Go with the child and help him be successful when he does go back so he has the experience of substituting acceptable for unacceptable behaviors
- Step 6: Follow through with suspending the privilege if child repeats the behavior
ENRICHMENT ACTIVITY TIME!

Musical Instruments

Materials:
- paper plates
- markers
- crayons
- beans, rice, popcorn kernels etc.
- stapler/staples
- tape

Procedure: Have the children decorate the outside of their paper plate. When they are finished decorating, fold plate in half, fill walking plate with beans, and have children staple the paper plate halves together to “close” it with the beans inside. Cover staples with tape. Be sure to write child’s name on their project. (Make sure children do not put beans in their mouths)
References

APPENDIX H 1-3
SESSION 3 HANDOUTS
ABA Strategies for Behavior Change

**Antecedent Strategies**- are used to prevent the behavior from happening (used before behaviors occur).

1. **Priming**- a strategy that consists of using verbal and/or visual cues to prepare a child for a transition:
   - Ex: Using a timer to let the child know when he will be transitioning to another activity

2. **Providing Choices**- Give choices whenever possible. This will make the child feel that he/she is in control when in reality, you are in control
   - Ex: Do you want to wear your blue shoes or red shoes before going outside?

3. **First/Then agreements** (premack principle)- A low compliance activity is followed by an activity of preference for the child
   - Ex: First finish your homework then you can play on your Ipad

4. **Visual Aids**- Any form of visual stimuli to strengthen and facilitate the accomplishment of tasks. Visual schedules allow the individual to see the tasks/activities he/she must complete and in which order
   - Ex: timers, visual routine schedules, task analysis

5. **Environmental Arrangements**- You reduce the effort to accomplish a task, and then build up effort as compliance is reached. Environmental arrangements can also be used as preventative measures
   - Ex: Putting the toy box next to the toys on the floor
   - Ex: Blocking access to door to prevent child from running away if he is one to elope

6. **Non-contingent reinforcement**- Reinforcing ALL behaviors you want to continue. “CATCH EM BEING GOOD!”
   - Ex: eating, sitting, requesting appropriately etc.

**Consequence Strategies**- strategies that are implemented to decrease the probability of the behavior occurring again in the future (used if the behavior already occurred)

1. **Differential Reinforcement (DRA, DRI, DRO)**- reinforcing a particular behavior (desired behavior) while withholding reinforcement for another behavior (problem behavior).
• **DRA – Differential Reinforcement of Alternative behavior**: Choose an alternative and desirable behavior
  
  Ex: Reinforce saying “Excuse me,” while not reinforcing repeatedly poking adult in the side to get attention

• **DRI – Differential Reinforcement of Incompatible behavior**: Choose an incompatible behavior (cannot occur while problem behavior occurs)
  
  Ex: Reinforce saying “Excuse me,” while not reinforcing screaming “Mom, Mom, Mom!!”

• **DRO – Differential Reinforcement of Other behavior**: Reinforce any behavior other than the problem behavior
  
  Ex: Reinforce any verbal request while not reinforcing screaming

2. **Extinction**: Withholding reinforcement for previously reinforced behavior. When implementing this procedure, behavior will initially increase (in intensity, duration, frequency etc) before decreasing. In other words, behavior will get worse before it gets better. This is called the “EXTINCTION BURST

3. **Redirection**: Physically and/or verbally guiding the child to a desired or approximation to the target behavior. It can also mean to divert the attention of the child to an alternative event/activity.
  
  Ex: If you asked the child to do his homework and the child runs to his room, physically and/or verbally redirect the child to the task
  
  Ex: Taking a dangerous object away from a child and substituting it with a safer one

4. **Task reduction**: reduce task when necessary
  
  Ex: If doing 20 math problems is too difficult, have the child complete 10 math problems and give him a break. Once break is over, child must return to initial task

5. **Response Blocking**: Physically/verbally intervening as soon as the person begins to emit the problem behavior to prevent or “block” the completion of
the response. You can also block repetitive behaviors that are self-stimulatory

Ex: When Ana lifts her arm to hit with a fist, her brother blocks the response by holding her hand

Ex: When Donald repeats the same phrase from his favorite movie, his mother blocks the behavior by asking questions related to something different

6. Token Economy - Child receives tokens (points, checkmarks, stickers etc.) depending on a variety of target behaviors. Child accumulates the tokens and exchanges them at specific times for their choice of reinforcers (candy, toy, etc.)

Ex: Give one token to child every time they go sit on the toilet to use the restroom when being potty trained. After 5 tokens earned, they can redeem them for a big prize.
How to Set Limits & Get Children to Cooperate
Setting limits for children and getting children to cooperate with a parent’s request is a challenge that all parents face. Below are 12 terrific skills to help parents set limits and provide structure for their children in a positive manner.

Is learning these strategies more work than just telling a child “Stop it” or “You’re getting a time out”? Yes. But there are important rewards and benefits of using these strategies not only for your child’s development but also for the relationship you have with your child.

FIRST THINGS FIRST:
Below are some important points to consider before we look at specific strategies to set limits/gain children’s cooperation:

- Always intervene immediately if child is in danger of hurting herself, others, or materials/equipment. Sometimes it’s hard to know exactly when to step in and set a limit. This is a helpful guideline.

- What we say and how we say it to children matters a lot. The specific words we use when talking to children affects their development (especially their social skills), their sense of self-worth, overall mental health, and their compliance/cooperation.

- Always provide reasons and explanations for setting limits & asking children to do something.
Not only does this increase children's compliance, but it supports their brain, cognitive, social, language, and emotional development.

- **Meeting child's basic (psychological) needs decreases the number of behavior problems you will have with your child.**
  The more warm, sensitively-attuned, and responsive parents are to their child, and the more time and attention parents give their child, the fewer child behavior problems there will be. Children will also be more compliant.

- **Plan ahead to prevent problems!**
  Some problems can be taken care of by planning again, changing routines, or changing the environment. For example, instead of spending a great deal of time telling your young child “no” and “don't touch that”, childproof your home. If you have mornings that are too hectic and rushed, get everyone’s clothes out and lunches made the night before. Or, before going into a store with a young child, discuss whether it is a “looking day” or a “buying” day.

1. **Use “I-messages”** (see handouts)

2. **Use “positive rephrasing’s”**: tell your child what she CAN do instead of what not to do. Children are more cooperative when we say things in a positive, not negative way:  
   “*Jill, the water needs to stay IN the bathtub—I'm afraid that it will ruin the floor*” (vs. “Don’t splash water all over the floor”).
3. **Redirect the behavior**: “redirects” what a child is doing to a more appropriate place:

   “Michael, I see you are wanting to run. Let’s go outside so you won’t slip on a rug or hurt yourself on a piece of furniture”.

   Or: child is playing with the water in the sink & splashing it all over the floor. “Maria, I see you are having fun playing with that water! Let’s set up a tub of water for you on the patio!”

4. **Distraction**: this is especially useful with young children (up to about age 3); it redirects the child’s attention away from something that could lead to problems:

   For example, while steering your shopping cart down the cereal/toy aisle of the grocery store, keep the child’s attention focused on the cereals so they don’t zero-in on the toys.

5. **Negotiate when you can**: negotiate whenever you can with a child (but when you can’t, don’t)! When you negotiate with children, you are teaching them a very important life skill that will help them get along with others. In addition, children are more cooperative when they have a role in deciding how or when something gets done:

   Parent: “Peter, it’s time for a bath.”
   Child: “Aw, can I play just a little longer?”
   Parent: “Ok, in a few more minutes I’ll remind you.”
6. **Give “closed-choices”**: this is a statement made by a parent to a child that gives the child a limited choice while also accomplishing what the parent needs the child to do. Again, a child is more likely to cooperate when they have a role in the process:

   “Do you want spinach or broccoli for dinner?” (i.e., the child needs to eat a vegetable but has a say in what vegetable will be served)

   “Do you want to take a bath now or in a few minutes?”

   “Do you want to pick up the blue blocks or the red blocks?”

   “Do you want to get down from the countertop yourself or would you like me to help you?”

7. **Use “when-thens”**: this is another way to state in a positive manner the sequence of how things need to be done:

   (For example, a child heads right for the ice cream before he eats lunch): “WHEN you finish your lunch, THEN you can have ice cream”

   Or, a child doesn’t want to get dressed but is about to run outside to play: “WHEN you get your clothes on, THEN we can go outside and play”.

8. **Give “transitional warnings”**: this gives children a “heads up” of an upcoming change; it helps prepare them psychologically, is respectful, and you’ll get better cooperation than if you just pull them away from what they are doing:
“In a few minutes we’ll need to get in the car to go to the grocery store”

9. **Say “Yes!!”**: when a child asks you for something, say “yes” instead of the usual “no”:
   - child: “Dad, can you read this book to me?”
   - Dad: “YES! Just as soon as I am finished with what I’m working on here!”
   - child: “Can I have some ice cream?”
   - Dad: “Yes! Just as soon as you finish your dinner!”

10. **Other helpful phrases**: additional ways to phrase statements in order to set limits or gain cooperation:

    “I need you to... because....”
    “I can’t let you do that because...”
    “That’s not okay because....”

11. **Have a family meeting**: a family meeting is a time when all family members meet to make plans, resolve problems, and/or discuss issues of concern.

    Family meetings:
    - are wonderful opportunities for children to observe and participate in joint problem-solving, brainstorm sessions, and using I-messages/active listening
    - provide children with opportunities to take another’s perspective
    - support the development of their social skills, language development, cognitive development, and emotional development
12. **Limit-setting with a consequence:** the two strategies outlined below are useful when the above techniques aren’t enough to get children to change their behavior. The two strategies below have consequences if children don’t comply with the limits being set by the parent:

**Three-step limit-setting:**
Step 1: Explain rule as need arises: “Jan, trikes aren’t for crashing— it can hurt you and the trike. You **CAN** ride the trike”.
Step 2: If limit is disregarded, state consequences for continued disregard by the child of the limit: “Jan, trikes aren’t for crashing. If you crash again, you’ll need to find something else to do”.

Step 3: If limit is still disregarded, follow through w/consequence (discuss why it isn’t ok to crash; stay with child to redirect them to another activity).

**Six-step limit-setting**
Step 1: Explain rule as need arises: “Jan, sand isn’t for throwing— it can hurt you and another child. You **CAN** pour/ build/etc. with the sand”.

Step 2: If limit is disregarded, state consequences for continued disregard: “Jan, sand isn’t for throwing. If you throw it again, you’ll need to find something else to do”.

Step 3: If limit is still disregarded, follow through with the consequence: Remove the child from the play area (**You can come**
with me or I will help you"); keep her with you; discuss feelings and rules
Step 4: Have child take responsibility for deciding for herself when she can control herself and return
Step 5: Go with her and help her be successful when she does go back so she has the experience of substituting acceptable for unacceptable behaviors

Step 6: Follow through with suspending the privilege if child repeats behavior

“**I-MESSAGES**
An “I-message” is a terrific way to set limits. It is a statement from the parent to the child that tells the child how her behavior (which is unacceptable to the parent) is making the parent feel -- and how it is affecting others/etc. An example is “When you leave the gate open, I am afraid that the dog will run out” (vs. “Stop leaving the gate open!”)

I-messages are more effective than simply telling a child to stop what they are doing because they tell the child why a certain behavior isn’t okay. Kids are more likely to change their behavior when there is a reason. In addition, kids learn how their behavior affects the parent, which also makes them more compliant.
Other benefits for the child when parents use I-messages include:

- child learns problem-solving skills; supports child’s language and cognitive development
- child learns good communication, social, and relationship skills
- child isn’t belittled/ shamed/criticized
- promotes close relationship between parent and child
• enhances the child's ability to take the perspective of another
  (Ginott, 2003; Gordon, 2000; Marion, 2003)

How to Construct an I-message:
(Situation: You wake up to find that you 4-year old is throwing her soccer ball around in your living room...)

Step 1: State what the child's unacceptable behavior is:
"When you throw that ball in the house..."

Step 2: State your feelings about it:
"...I am afraid..."

Step 3: State what effect this behavior has on you:
"...that it will break that lamp".

Step 4: Then move on to "problem-solving":
  a) brainstorm with child on possible solution (e.g., playing out in the driveway; take child to nearby schoolyard to play)
  b) choose a solution
  c) try it out! (& if it doesn't work, try a different solution you discussed)
Worksheet: Write an I-message for the following situations:

1. Your 3-year old is splashing bath water all over the bathroom floor.

_________________________________________________  

_________________________________________________

2. Your 3-year old has just climbed up on top of your kitchen cabinets.

_________________________________________________

_________________________________________________

3. You are sitting down for dinner, and just realized your 4-year old is secretly feeding her vegetables to the dogs.

_________________________________________________

_________________________________________________

4. Your 5-year old is playing out in the front yard and throwing a ball back and forth to his friend who’s across the street.

_________________________________________________

_________________________________________________
Enrichment Activity:
Musical Instruments

What you will need:
- Paper plates
- Markers/crayons
- Beans/rice/popcorn kernels etc.
- Stapler/staples
- Tape

Instructions:
- Have the children decorate the outside of their paper plate.
- When they are finished decorating, fold plate in half, let children help filling plate with beans
- Have children staple the paper plate halves together to "close" it with the beans inside.
- Cover staples with tape. Be sure to write child's name on their project! (Make sure children do not put beans in their mouths!)
- During the activity discuss the importance of taking turns, "sharing their beans", asking for help when needed, and listening to the different sounds of the beans.
APPENDIX I

SESSION 4 POWERPOINT
UNDERSTANDING & MANAGING CHALLENGING BEHAVIORS WHILE SUPPORTING THE DEVELOPMENT OF CHILDREN WITH AUTISM: A PARENTING WORKSHOP

Presented By: Vanessa Huizar

Topic: Supporting Your Child's Development
Overview of workshop

Session 1
- Overview of Autism
- Challenges of Raising a Child with Autism
- Lack of Parent Preparedness
- Challenging Behaviors and What Can Help
  - 1. Lack of Social Communication
  - 2. Restrictive and Repetitive behavior
  - Enrichment Activity

Session 2
- Challenges of Raising a Child with Autism (continued)
  - 3. Sensory Sensitivities
  - 4. Maladaptive Behaviors
  - Parent Discussion
  - List of Resources
  - Enrichment Activity

Session 3
- Effective Ways to Guide Children’s Challenging Behaviors
  - Introduction to ABA & Positive Child Guidance
  - Applied Behavior Analysis: Where Challenging Behaviors Come From and How to Respond
  - Positive Child Guidance: Definition & Explanation of Strategies for Guiding Behavior
  - Enrichment Activity

Session 4
- Supporting Your Child’s Development
  - Developmental Milestones
  - Building Strong Parent-Child Relationships
  - Engaging in Enrichment Activities
  - Enrichment Activity

Debrief: Take-Home Enrichment Activity
Children’s Developmental Milestones

- Children’s early years are incredibly important for their development.
- Although each child develops at their own pace, the developmental milestones serve as a guide for parents to understand the normal sequence of growth and development of children.
- By understanding the developmental milestones of your child at different stages, you can have age-appropriate expectations of your child’s abilities in different developmental domains.

https://www.cdc.gov/nhsbddd/childdevelopment/childdevelopment_algorithm.html

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Developmental Milestones

- Research shows that many parents lack accurate knowledge about the development of children and often overestimate their child’s ability.

- For parents of children of ASD, the developmental milestones can assist in identifying early signs of developmental delays.

- The developmental milestones checklist also serves as a guide for parents to have age-appropriate expectations of their child’s abilities.
  - Help your child be more independent and begin teaching them age-appropriate skills based on their functioning level.
Developmental Milestones

- Understanding children’s development can also be helpful in understanding children’s behavior.
- For example:
  - It is important for parents of children with ASD to understand that children 3 years old or younger are typically unable to communicate their feelings and are not logical thinkers.
  - Young children have “big emotions” and are unable to cope with them due to brain immaturity.
  - Therefore, children’s difficult behaviors such as tantrums, hitting, crying, hitting, are typical behaviors of children at this age and not necessarily due to the child’s autism.

Building Strong Parent-Child Relationships

- Building strong parent-child relationships is significant for children’s social and emotional development.
- Parents of children with ASD may struggle establishing strong parent-child relationship as many children with ASD have emotion-processing deficits and are usually less securely attached to their parents compared to typically developing children.
- What can help to develop strong parent-child relationships?
  - Understanding and meeting your child’s basic psychological needs
  - DIR/Floortime approach
  - Engaging in enrichment activities
Children’s Basic Needs

- These basic needs are fundamental experiences that are essential for children’s growth and development
- These needs include:
  - A secure attachment
  - Plenty of time and attention from their primary caregiver
  - Feeling understood and valued as a person by their primary caregiver
  - Being treated and viewed as their own individual and not comparing the child or expecting them to be like someone else

What is secure attachment?

- Attachment refers to the strong emotional bond between the caregiver and the child which develops over time and provides the child with a sense of security
- A secure attachment relationship is one where the primary caregiver is warm, sensitively-tuned and responsive
- Warmth is displayed through close bodily contact, gentle care, and soothing the child when the child is in a state of distress
- When caregivers are sensitively-tuned, they are aware of the child’s emotional state and respond to their physical and emotional needs
- A responsive caregiver is one who is attentive, predictable, emotionally available, and responds quickly to the child’s needs
Why is a secure attachment important?

- Children can grow to their fullest potential when their needs are being met.
- Securely-attached children feel safe to explore their environment, express their feelings, and are more open to learning because they are confident that their caregiver will be responsive to their needs.
- When children do not have their basic needs met, developmental and behavioral problems can arise.

The DIR/Floortime approach

- If your child has lack of emotional responsivity or reciprocal interactions DO NOT FEEL DISCOURAGED!
- The Developmental, Individual-difference, Relationship-based approach (DIR) is a model that has been found to improve children’s social and emotional intelligence.
- The Floortime component of the DIR model creates meaningful one-on-one integrations as the caregiver gets down on the floor and spends uninterrupted time interacting with their child during play activities.
  - This can also be done with older kids and teenagers.
  - Ex: going on a drive, ice cream date, etc.
The DIR/Floortime approach

- One of the main goals of Floortime is that caregivers follow the child's lead by engaging in activities that interest the child while also elaborating on their ideas and actions.
- For example, the *circle-of-communication game* can facilitate purposeful emotional interactions between the parent and the child. The purpose of this game is simply for parents to try and get as many back-and-forth interactions with their child based on their responses.
- Overall, this approach makes children feel close and connected to their parents.

https://www.youtube.com/watch?v=0ZpW5dDPbY&t=117s

Developmentally-Appropriate Enrichment Activities

- A child's early interactions and relationship with their caregivers can make a great impact on their brain development and on their learning.
- Enrichment activities are activities that are fun, engaging, and promote problem-solving and critical thinking skills.
- Parents can create spontaneous interactions and meaningful learning opportunities by building on to activities their children already engage in. This can support their child's interactive and thinking skills.
The Powerful Interactions Framework

- This framework encourages parents and educators to create intentional opportunities to interact with children during everyday activities based on the child’s routine, interests, and abilities.

- The meaningful learning opportunity occurs when new information or skills are added to what the child already knows and should be developmentally appropriate, interesting, and understandable to the child.

- For example:
  - When child is painting and can recognize the primary colors (blue, green, yellow), you can add that mixing colors together can make a new color (blue and yellow make green).

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The Powerful Interactions Framework

A meaningful learning opportunity is created by doing the following 3 steps:

Step 1: Be present- put all tasks aside and give your child your full attention

Step 2: Connect- observe what the child is doing (stacking blocks), listen as he talks to you (“I made a tower”), and let him know you are interested (Wow! It’s very tall!)

Step 3: Extend Learning- build on your child’s interest by asking questions, making comments, and doing activities together that show your interests. This will help to expand his thinking and learning (“I wonder how much higher the tower can go?”, “Let’s count the number of blocks in your tower.”)
Don’t give up!!

- Continue to be the amazing parent you are and don’t forget that change comes with time, patience, and lots of practice.
- Take uninterrupted time to engage in activities with your child and don’t forget to be present, listen and observe, and extend their learning through everyday activities.
- Learning opportunities and ways to connect with your child require nothing but your presence and attention. YOU can be your child’s main reinforcer.

“It is never too late to expand the mind of a person on the autism spectrum.”
Dr. Temple Grandin

ENRICHMENT ACTIVITY TIME!
FIVE LITTLE MONKEYS

Singing is an easy activity that parents can do with their children which promotes language development as well as some HUN.

- Five little monkeys swinging in the tree
  teasing Mr. Alligator can’t catch me... can’t catch me along came Mr. Alligator quiet as can be and snapped that monkey right out of that tree
- Four little monkeys swinging in the tree
  teasing Mr. Alligator can’t catch me... can’t catch me along came Mr. Alligator quiet as can be and snapped that monkey right out of that tree
- Three little monkeys...
- Two little monkeys...
- One little monkey...
- No more monkeys swinging in the tree!

References

APPENDIX I 1-5

SESSION 4 HANDOUTS
Your Baby at 2 Months

Milestones matter! How your child plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your child has reached by 2 months. Take this with you and talk with your child's doctor at every well-child visit about the milestones your child has reached and what to expect next.

What Most Babies Do by this Age:

Social/Emotional
- Begins to smile at people
- Can briefly calm himself (may bring hands to mouth and suck on hand)
- Tries to look at parent

Language/Communication
- Coos, makes gurgling sounds
- Turns head toward sounds

Cognitive (learning, thinking, problem-solving)
- Pays attention to faces
- Begins to follow things with eyes and recognize people at a distance
- Begins to act bored (cries, fussy) if activity doesn’t change

Movement/Physical Development
- Can hold head up and begins to push up when lying on tummy
- Makes smoother movements with arms and legs

You Know Your Child Best.

Act early if you have concerns about the way your child plays, learns, speaks, acts, or moves, or if your child:
- Is missing milestones
- Doesn’t respond to loud sounds
- Doesn’t watch things as they move
- Doesn’t smile at people
- Doesn’t bring hands to mouth
- Can’t hold head up when pushing up when on tummy

Tell your child’s doctor or nurse if you notice any of these signs of possible developmental delay and ask for a developmental screening.

If you or the doctor is still concerned
1. Ask for a referral to a specialist and,
2. Call your state or territory’s early intervention program to find out if your child can get services to help. Learn more and find the number at cdc.gov/FindEI.

For more information, go to cdc.gov/Concerned.

DON’T WAIT. Acting early can make a real difference!

www.cdc.gov/ActEarly
1-800-CDC-INFO (1-800-232-4636)

Learn the Signs. Act Early.
Help Your Baby Learn and Grow

You can help your baby learn and grow. Talk, read, sing, and play together every day. Below are some activities to enjoy with your 2-month-old baby today.

What You Can Do for Your 2-Month-Old:

- Cuddle, talk, and play with your baby during feeding, dressing, and bathing.
- Help your baby learn to calm herself. It’s okay for her to suck on her fingers.
- Begin to help your baby get into a routine, such as sleeping at night more than in the day, and have regular schedules.
- Getting in tune with your baby’s likes and dislikes can help you feel more comfortable and confident.
- Act excited and smile when your baby makes sounds.
- Copy your baby’s sounds sometimes, but also use clear language.
- Pay attention to your baby’s different cries so that you learn to know what he wants.
- Talk, read, and sing to your baby.
- Play peek-a-boo. Help your baby play peek-a-boo, too.

- Place a baby-safe mirror in your baby’s crib so she can look at herself.
- Look at pictures with your baby and talk about them.
- Lay your baby on his tummy when he is awake and put toys near him.
- Encourage your baby to lift his head by holding toys at eye level in front of him.
- Hold a toy or rattle above your baby’s head and encourage her to reach for it.
- Hold your baby upright with his feet on the floor. Sing or talk to your baby as he is upright.


This milestone checklist is not a substitute for a standardized, validated developmental screening tool.

www.cdc.gov/ActEarly | 1-800-CDC-INFO (1-800-232-4636)

Learn the Signs. Act Early.
Your Baby at 4 Months

Milestones matter! How your child plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your child has reached by 4 months. Take this with you and talk with your child’s doctor at every well-child visit about the milestones your child has reached and what to expect next.

What Most Babies Do by this Age:

### Social/Emotional
- Smiles spontaneously, especially at people
- Likes to play with people and might cry when playing stops
- Copies some movements and facial expressions, like smiling or frowning

### Language/Communication
- Begins to babble
- Babbles with expression and copies sounds he hears
- Cries in different ways to show hunger, pain, or being tired

### Cognitive (learning, thinking, problem-solving)
- Lets you know if she is happy or sad
- Responds to affection
- Reaches for toy with one hand
- Uses hands and eyes together, such as seeing a toy and reaching for it
- Follows moving things with eyes from side to side
- Watches faces closely
- Recognizes familiar people and things at a distance

### Movement/Physical Development
- Holds head steady, unsupported
- Pushes down on legs when feet are on a hard surface
- May be able to roll over from tummy to back
- Can hold a toy and shake it and swing at dangling toys
- Brings hands to mouth
- When lying on stomach, pushes up to elbows

You Know Your Child Best.

Act early if you have concerns about the way your child plays, learns, speaks, acts, or moves, or if your child:
- Is missing milestones
- Doesn’t watch things as they move
- Doesn’t smile at people
- Can’t hold head steady
- Doesn’t coo or make sounds
- Doesn’t bring things to mouth
- Doesn’t push down with legs when feet are placed on a hard surface
- Has trouble moving one or both eyes in all directions

Tell your child’s doctor or nurse if you notice any of these signs of possible developmental delay and ask for a developmental screening.

If you or the doctor is still concerned:
1. Ask for a referral to a specialist and,
2. Call your state or territory’s early intervention program to find out if your child can get services to help. Learn more and find the number at cdc.gov/FindEI.

For more information, go to cdc.gov/Concerned.

DON’T WAIT.
Acting early can make a real difference!

www.cdc.gov/ActEarly
1-800-CDC-INFO (1-800-232-4636)

Learn the Signs. Act Early.
Your Baby at 6 Months

Milestones matter! How your child plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your child has reached by 6 months. Take this with you and talk with your child’s doctor at every well-child visit about the milestones your child has reached and what to expect next.

What Most Babies Do by this Age:

<table>
<thead>
<tr>
<th>Social/Emotional</th>
<th>Language/Communication</th>
<th>Cognitive (learning, thinking, problem-solving)</th>
<th>Movement/Physical Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knows familiar faces and begins to know if someone is a stranger</td>
<td>Responds to sounds by making sounds</td>
<td>Looks around at things nearby</td>
<td>Rolls over in both directions (front to back, back to front)</td>
</tr>
<tr>
<td>Likes to play with others, especially parents</td>
<td>Strings vowels together when babbling (“ah,” “eh,” “oh”) and likes taking turns with parent while making sounds</td>
<td>Brings things to mouth</td>
<td>Begins to sit without support</td>
</tr>
<tr>
<td>Responds to other people’s emotions and often seems happy</td>
<td>Responds to own name</td>
<td>Shows curiosity about things and tries to get things that are out of reach</td>
<td>When standing, supports weight on legs and might bounce</td>
</tr>
<tr>
<td>Likes to look at self in a mirror</td>
<td>Makes sounds to show joy and displeasure</td>
<td>Begins to say consonant sounds (jabbering with “m,” “b”)</td>
<td>Rocks back and forth, sometimes crawling backward before moving forward</td>
</tr>
</tbody>
</table>

You Know Your Child Best.

Act early if you have concerns about the way your child plays, learns, speaks, acts, or moves, or if your child:

- Is missing milestones
- Doesn’t try to get things that are in reach
- Shows no affection for caregivers
- Doesn’t respond to sounds around him
- Has difficulty getting things to mouth
- Doesn’t make vowel sounds (“ah,” “eh,” “oh”)
- Doesn’t roll over in either direction
- Doesn’t laugh or make squealing sounds
- Seems very stiff, with tight muscles
- Seems very floppy, like a rag doll

Tell your child’s doctor or nurse if you notice any of these signs of possible developmental delay and ask for a developmental screening.

If you or the doctor is still concerned
1. Ask for a referral to a specialist and,
2. Call your state or territory’s early intervention program to find out if your child can get services to help. Learn more and find the number at cdc.gov/FindEI.

For more information, go to cdc.gov/Concerned.

DON’T WAIT. Acting early can make a real difference!
Help Your Baby Learn and Grow

You can help your baby learn and grow. Talk, read, sing, and play together every day. Below are some activities to enjoy with your 4-month-old baby today.

What You Can Do for Your 4-Month-Old:

- Hold and talk to your baby; smile and be cheerful while you do.
- Set steady routines for sleeping and feeding.
- Pay close attention to what your baby likes and doesn’t like; you will know how best to meet his needs and what you can do to make your baby happy.
- Copy your baby’s sounds.
- Act excited and smile when your baby makes sounds.
- Have quiet play times when you read or sing to your baby.
- Give age-appropriate toys to play with, such as rattles or colorful pictures.
- Play games such as peek-a-boo.
- Provide safe opportunities for your baby to reach for toys and explore his surroundings.
- Put toys near your baby so that she can reach for them or kick her feet.
- Put toys or rattles in your baby’s hand and help him to hold them.
- Hold your baby upright with feet on the floor, and sing or talk to your baby as she “stands” with support.


This milestone checklist is not a substitute for a standardized, validated developmental screening tool.

www.cdc.gov/ActEarly  |  1-800-CDC-INFO (1-800-232-4636)

Learn the Signs. Act Early.
Help Your Baby Learn and Grow

You can help your baby learn and grow. Talk, read, sing, and play together every day. Below are some activities to enjoy with your 6-month-old baby today.

What You Can Do for Your 6-Month-Old:

- Play on the floor with your baby every day.
- Learn to read your baby’s moods. If he’s happy, keep doing what you are doing. If he’s upset, take a break and comfort your baby.
- Show your baby how to comfort herself when she’s upset. She may suck on her fingers to self soothe.
- Use “reciprocal” play—when he smiles, you smile; when he makes sounds, you copy them.
- Repeat your child’s sounds and say simple words with those sounds. For example, if your child says “bahr,” say “bottle” or “book.”
- Read books to your child every day. Praise her when she babbles and “reads” too.
- When your baby looks at something, point to it and talk about it.
- When he drops a toy on the floor, pick it up and give it back. This game helps him learn cause and effect.
- Read colorful picture books to your baby.
- Point out new things to your baby and name them.
- Show your baby bright pictures in a magazine and name them.
- Hold your baby up while she sits or support her with pillows. Let her look around and give her toys to look at while she balances.
- Put your baby on his tummy or back and put toys just out of reach. Encourage him to roll over to reach the toys.


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www.cdc.gov/ActEarly | 1-800-CDC-INFO (1-800-232-4636)

Learn the Signs. Act Early.
Your Baby at 9 Months

Milestones matter! How your child plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your child has reached by 9 months. Take this with you and talk with your child’s doctor at every well-child visit about the milestones your child has reached and what to expect next.

What Most Babies Do by this Age:

Social/Emotional
- May be afraid of strangers
- May be clingy with familiar adults
- Has favorite toys

Language/Communication
- Understands “no”
- Makes a lot of different sounds like “mamamama” and “babababa”
- Copies sounds and gestures of others
- Uses fingers to point at things

Cognitive (learning, thinking, problem-solving)
- Watches the path of something as it falls
- Looks for things he sees you hide
- Plays peek-a-boo
- Puts things in her mouth
- Moves things smoothly from one hand to the other
- Picks up things like cereal o’s between thumb and index finger

Movement/Physical Development
- Stands, holding on
- Can get into sitting position
- Sits without support
- Pulls to stand
- Crawls

You Know Your Child Best.

Act early if you have concerns about the way your child plays, learns, speaks, acts, or moves, or if your child:
- Is missing milestones
- Doesn’t bear weight on legs with support
- Doesn’t sit with help
- Doesn’t babble (“mama”, “baba”, “dada”)
- Doesn’t play any games involving back-and-forth play
- Doesn’t respond to own name
- Doesn’t seem to recognize familiar people
- Doesn’t look where you point
- Doesn’t transfer toys from one hand to the other

Tell your child’s doctor or nurse if you notice any of these signs of possible developmental delay and ask for a developmental screening.

If you or the doctor is still concerned
1. Ask for a referral to a specialist and,
2. Call your state or territory’s early intervention program to find out if your child can get services to help. Learn more and find the number at cdc.gov/FindEI.

For more information, go to cdc.gov/Concerned.

Don’t Wait. Acting early can make a real difference!

It’s time for developmental screening! At 9 months, your child is due for general developmental screening, as recommended for all children by the American Academy of Pediatrics. Ask the doctor about your child’s developmental screening.
Help Your Baby Learn and Grow

You can help your baby learn and grow. Talk, read, sing, and play together every day. Below are some activities to enjoy with your 9-month-old baby today.

What You Can Do for Your 9-Month-Old:

- Pay attention to the way he reacts to new situations and people; try to continue to do things that make your baby happy and comfortable.
- As she moves around more, stay close so she knows that you are near.
- Continue with routines; they are especially important now.
- Play games with “my turn, your turn.”
- Say what you think your baby is feeling. For example, say, “You are so sad, let’s see if we can make you feel better.”
- Describe what your baby is looking at; for example, “red, round ball.”
- Talk about what your baby wants when he points at something.
- Copy your baby’s sounds and words.
- Ask for behaviors that you want. For example, instead of saying “don’t stand,” say “time to sit.”

- Teach cause-and-effect by rolling balls back and forth, pushing toy cars and trucks, and putting blocks in and out of a container.
- Play peek-a-boo and hide-and-seek.
- Read and talk to your baby.
- Provide lots of room for your baby to move and explore in a safe area.
- Put your baby close to things that she can pull up on safely.


This milestones checklist is not a substitute for a standardized, validated developmental screening tool.

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Learn the Signs. Act Early.
Milestones matter! How your child plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your child has reached by age 1. Take this with you and talk with your child’s doctor at every well-child visit about the milestones your child has reached and what to expect next.

### What Most Children Do by this Age:

<table>
<thead>
<tr>
<th>Social/Emotional</th>
<th>Movement/Physical Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Is shy or nervous with strangers</td>
<td>☐ Gets to a sitting position without help</td>
</tr>
<tr>
<td>☐ Cries when mom or dad leaves</td>
<td>☐ Pulls up to stand, walks holding on to furniture (“cruising”)</td>
</tr>
<tr>
<td>☐ Has favorite things and people</td>
<td>☐ May take a few steps without holding on</td>
</tr>
<tr>
<td>☐ Shows fear in some situations</td>
<td>☐ May stand alone</td>
</tr>
<tr>
<td>☐ Hands you a book when he wants to hear a story</td>
<td></td>
</tr>
<tr>
<td>☐ Repeats sounds or actions to get attention</td>
<td></td>
</tr>
<tr>
<td>☐ Puts out arm or leg to help with dressing</td>
<td></td>
</tr>
<tr>
<td>☐ Plays games such as “peek-a-boo” and “pat-a-cake”</td>
<td></td>
</tr>
</tbody>
</table>

### Language/Communication

☐ Responds to simple spoken requests
☐ Uses simple gestures, like shaking head “no” or waving “bye-bye”
☐ Makes sounds with changes in tone (sounds more like speech)
☐ Says “mama” and “dada” and exclamations like “uh-oh!”
☐ Tries to say words you say

### Cognitive (learning, thinking, problem-solving)

☐ Explores things in different ways, like shaking, banging, throwing
☐ Finds hidden things easily
☐ Looks at the right picture or thing when it’s named
☐ Copies gestures
☐ Starts to use things correctly; for example, drinks from a cup, brushes hair
☐ Bangs two things together
☐ Puts things in a container, takes things out of a container
☐ Lets things go without help
☐ Pokes with index (pointer) finger
☐ Follows simple directions like “pick up the toy”

### You Know Your Child Best.

Act early if you have concerns about the way your child plays, learns, speaks, acts, or moves, or if your child:

☐ Is missing milestones
☐ Doesn’t crawl
☐ Can’t stand when supported
☐ Doesn’t search for things that she sees you hide.
☐ Doesn’t say single words like “mama” or “dada”
☐ Doesn’t learn gestures like waving or shaking head
☐ Doesn’t point to things
☐ Loses skills he once had

Tell your child’s doctor or nurse if you notice any of these signs of possible developmental delay and ask for a developmental screening.

If you or the doctor is still concerned

1. Ask for a referral to a specialist and,
2. Call your state or territory’s early intervention program to find out if your child can get services to help. Learn more and find the number at cdc.gov/FindEI.

For more information, go to cdc.gov/Concerned.

### DON’T WAIT.
Acting early can make a real difference!

www.cdc.gov/ActEarly
1-800-CDC-INFO (1-800-232-4636)

Learn the Signs. Act Early.
Help Your Child Learn and Grow

You can help your child learn and grow. Talk, read, sing, and play together every day. Below are some activities to enjoy with your 1-year-old child today.

What You Can Do for Your 1-Year-Old:

- Give your child time to get to know a new caregiver. Bring a favorite toy, stuffed animal, or blanket to help comfort your child.
- In response to unwanted behaviors, say "no" firmly. Do not yell, spank, or give long explanations. A time out for 30 seconds to 1 minute might help redirect your child.
- Give your child lots of hugs, kisses, and praise for good behavior.
- Spend a lot more time encouraging wanted behaviors than punishing unwanted behaviors (4 times as much encouragement for wanted behaviors as redirection for unwanted behaviors).
- Talk to your child about what you’re doing. For example, “Mommy is washing your hands with a washcloth.”
- Read with your child every day. Have your child turn the pages. Take turns labeling pictures with your child.
- Build on what your child says or tries to say, or what he points to. If he points to a truck and says “t” or “truck,” say, “Yes, that’s a big, blue truck.”
- Give your child crayons and paper, and let your child draw freely. Show your child how to draw lines up and down and across the page. Praise your child when she tries to copy them.
- Play with blocks, shape sorters, and other toys that encourage your child to use his hands.
- Hide small toys and other things and have your child find them.
- Ask your child to label body parts or things you see while driving in the car.
- Sing songs with actions, like “The Itsy Bitsy Spider” and “Wheels on the Bus.” Help your child do the actions with you.
- Give your child pots and pans or a small musical instrument like a drum or cymbals. Encourage your child to make noise.
- Provide lots of safe places for your toddler to explore. (Toddler-proof your home. Lock away products for cleaning, laundry, lawn care, and car care. Use a safety gate and lock doors to the outside and the basement.)
- Give your child push toys like a wagon or “kiddie push car.”


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Learn the Signs. Act Early.
Your Child at 18 Months (1½ Yrs)

Child's Name

Child's Age

Today's Date

Milestones matter! How your child plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your child has reached by 18 months. Take this with you and talk with your child's doctor at every well-child visit about the milestones your child has reached and what to expect next.

What Most Children Do by this Age:

Social/Emotional
- Likes to hand things to others as play
- May have temper tantrums
- May be afraid of strangers
- Shows affection to familiar people
- Plays simple pretend, such as feeding a doll
- May cling to caregivers in new situations
- Points to show others something interesting
- Explores alone but with parent close by

Language/Communication
- Says several single words
- Says and shakes head “no”
- Points to show someone what he wants

Cognitive (learning, thinking, problem-solving)
- Knows what ordinary things are for; for example, telephone, brush, spoon
- Points to get the attention of others
- Shows interest in a doll or stuffed animal by pretending to feed
- Points to one body part
- Scribbles on his own
- Can follow 1-step verbal commands without any gestures; for example, sits when you say “sit down”

Movement/Physical Development
- Walks alone
- May walk up steps and run
- Pulls toys while walking
- Can help undress herself
- Drinks from a cup
- Eats with a spoon

You Know Your Child Best.

Act early if you have concerns about the way your child plays, learns, speaks, acts, or moves, or if your child:
- Is missing milestones
- Doesn’t point to show things to others
- Can’t talk
- Doesn’t know what familiar things are for
- Doesn’t copy others
- Doesn’t gain new words
- Doesn’t have at least 6 words
- Doesn’t notice or mind when a caregiver leaves or returns
- Loses skills he once had

Tell your child’s doctor or nurse if you notice any of these signs of possible developmental delay and ask for a developmental screening.

If you or the doctor is still concerned
1. Ask for a referral to a specialist and,
2. Call your state or territory’s early intervention program to find out if your child can get services to help. Learn more and find the number at cdc.gov/FindIE.

For more information, go to cdc.gov/Concerned.

DON’T WAIT.
Acting early can make a real difference!

It’s time for developmental screening!
At 18 months, your child is due for general developmental screening and an autism screening, as recommended for all children by the American Academy of Pediatrics. Ask the doctor about your child’s developmental screening.
Help Your Child Learn and Grow

You can help your child learn and grow. Talk, read, sing, and play together every day. Below are some activities to enjoy with your 18-month-old child today.

What You Can Do for Your 18-Month-Old:

- Provide a safe, loving environment. It's important to be consistent and predictable.
- Praise good behaviors more than you punish bad behaviors (use only very brief time outs).
- Describe her emotions. For example, say, "You are happy when we read this book."
- Encourage pretend play.
- Encourage empathy. For example, when he sees a child who is sad, encourage him to hug or pat the other child.
- Read books and talk about the pictures using simple words.
- Say your child's words.
- Use words that describe feelings and emotions.
- Use simple, clear phrases.
- Ask simple questions.
- Hide things under blankets and pillows and encourage him to find them.
- Play with blocks, balls, puzzles, books, and toys that teach cause and effect and problem solving.
- Name pictures in books and body parts.
- Provide toys that encourage pretend play, for example, dolls, play telephones.
- Provide safe areas for your child to walk and move around in.
- Provide toys that she can push or pull safely.
- Provide balls for her to kick, roll, and throw.
- Encourage him to drink from his cup and use a spoon, no matter how messy.
- Blow bubbles and let your child pop them.


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Learn the Signs. Act Early.
Your Child at 2 Years

Milestones matter! How your child plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your child has reached by age 2. Take this with you and talk with your child’s doctor at every well-child visit about the milestones your child has reached and what to expect next.

What Most Children Do by this Age:

Social/Emotional
- Copies others, especially adults and older children
- Gets excited when with other children
- Shows more and more independence
- Shows defiant behavior (doing what he has been told not to)
- Plays mainly beside other children, but is beginning to include other children, such as in chase games

Language/Communication
- Points to things or pictures when they are named
- Knows names of familiar people and body parts
- Says sentences with 2 to 4 words
- Follows simple instructions
- Repeats words he overheard in conversation
- Points to things in a book

Cognitive (learning, thinking, problem-solving)
- Finds things even when hidden under two or three covers
- Begins to sort shapes and colors
- Completes sentences and rhymes in familiar books
- Plays simple make-believe games
- Builds towers of 4 or more blocks
- Might use one hand more than the other
- Follows two-step instructions such as “Pick up your shoes and put them in the closet.”
- Names items in a picture book such as a cat, bird, or dog

Movement/Physical Development
- Stands on tiptoe
- Kicks a ball
- Begins to run
- Climbs onto and down from furniture without help
- Walks up and down stairs holding on

You Know Your Child Best.

Act early if you have concerns about the way your child plays, learns, speaks, acts, or moves, or if your child:
- Is missing milestones
- Doesn’t use 2-word phrases (for example, “drink milk”)
- Doesn’t know what to do with common things, like a brush, phone, fork, spoon
- Doesn’t copy actions and words
- Doesn’t follow simple instructions
- Doesn’t walk steadily
- Loses skills she once had

Tell your child’s doctor or nurse if you notice any of these signs of possible developmental delay and ask for a developmental screening.

If you or the doctor is still concerned
1. Ask for a referral to a specialist and,
2. Call your state or territory’s early intervention program to find out if your child can get services to help. Learn more and find the number at cdc.gov/FindEI.

For more information, go to cdc.gov/Concerned.

DON’T WAIT. Acting early can make a real difference!

It’s time for developmental screening!
At 2 years, your child is due for general developmental screening and an autism screening, as recommended for all children by the American Academy of Pediatrics. Ask the doctor about your child’s developmental screening.

www.cdc.gov/ActEarly
1-800-CDC-INFO (1-800-232-4636)

Learn the Signs. Act Early.
You can help your child learn and grow. Talk, read, sing, and play together every day. Below are some activities to enjoy with your 2-year-old child today.

What You Can Do for Your 2-Year-Old:

☐ Encourage your child to help with simple chores at home, like sweeping and making dinner. Praise your child for being a good helper.

☐ At this age, children still play next to (not with) each other and don’t share well. For play dates, give the children lots of toys to play with. Watch the children closely and step in if they fight or argue.

☐ Give your child attention and praise when he follows instructions. Limit attention for defiant behavior. Spend a lot more time praising good behaviors than punishing bad ones.

☐ Teach your child to identify and say body parts, animals, and other common things.

☐ Do not correct your child when he says words incorrectly. Rather, say it correctly. For example, “That is a ball.”

☐ Encourage your child to say a word instead of pointing. If your child can’t say the whole word (“milk”), give her the first sound (“m”) to help. Over time, you can prompt your child to say the whole sentence — “I want milk.”

☐ Hide your child’s toys around the room and let him find them.

☐ Help your child do puzzles with shapes, colors, or farm animals. Name each piece when your child puts it in place.

☐ Encourage your child to play with blocks. Take turns building towers and knocking them down.

☐ Do art projects with your child using crayons, paint, and paper. Describe what your child makes and hang it on the wall or refrigerator.

☐ Ask your child to help you open doors and drawers and turn pages in a book or magazine.

☐ Once your child walks well, ask her to carry small things for you.

☐ Kick a ball back and forth with your child. When your child is good at that, encourage him to run and kick.

☐ Take your child to the park to run and climb on equipment or walk on nature trails. Watch your child closely.


This milestone checklist is not a substitute for a standardized, validated developmental screening tool.

www.cdc.gov/ActEarly | 1-800-CDC-INFO (1-800-232-4636)

Learn the Signs. Act Early.
Your Child at 3 Years

Milestones matter! How your child plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your child has reached by age 3. Take this with you and talk with your child’s doctor at every well-child visit about the milestones your child has reached and what to expect next.

What Most Children Do by this Age:

Social/Emotional
- Copies adults and friends
- Shows affection for friends without prompting
- Takes turns in games
- Shows concern for a crying friend
- Understands the idea of “mine” and “his” or “hers”
- Shows a wide range of emotions
- Separates easily from mom and dad
- May get upset with major changes in routine
- Dresses and undresses self

Language/Communication
- Follows instructions with 2 or 3 steps
- Can name most familiar things
- Understands words like “in,” “on,” and “under”
- Says first name, age, and sex
- Names a friend
- Says words like “I,” “me,” “we,” and “you” and some plurals (cars, dogs, cats)
- Talks well enough for strangers to understand most of the time
- Carries on a conversation using 2 to 3 sentences

Cognitive (learning, thinking, problem-solving)
- Can work toys with buttons, levers, and moving parts
- Plays make-believe with dolls, animals, and people
- Does puzzles with 3 or 4 pieces
- Understands what “two” means
- Copies a circle with pencil or crayon
- Turns book pages one at a time
- Builds towers of more than 6 blocks
- Screws and unscrews jar lids or turns doorknob

Movement/Physical Development
- Climbs well
- Runs easily
- Pedals a tricycle (3-wheel bike)
- Walks up and down stairs, one foot on each step

You Know Your Child Best.

Act early if you have concerns about the way your child plays, learns, speaks, acts, or moves, or if your child:
- Is missing milestones
- Falls down a lot or has trouble with stairs
- Drools or has very unclear speech
- Can’t work simple toys (such as peg boards, simple puzzles, turning handle)
- Doesn’t speak in sentences
- Doesn’t understand simple instructions
- Doesn’t play pretend or make-believe
- Doesn’t want to play with other children or with toys
- Doesn’t make eye contact
- Loses skills he once had

Tell your child’s doctor or nurse if you notice any of these signs of possible developmental delay and ask for a developmental screening.

If you or the doctor is still concerned
1. Ask for a referral to a specialist and,
2. Call any local public elementary school for a free evaluation to find out if your child can get services to help.

For more information, go to cdc.gov/Concerned.

DON’T WAIT. Acting early can make a real difference!

www.cdc.gov/ActEarly
1-800-CDC-INFO (1-800-232-4636)

Learn the Signs. Act Early.
Help Your Child Learn and Grow

You can help your child learn and grow. Talk, read, sing, and play together every day. Below are some activities to enjoy with your 3-year-old child today.

What You Can Do for Your 3-Year-Old:

- Go to play groups with your child or other places where there are other children, to encourage getting along with others.
- Work with your child to solve the problem when he is upset.
- Talk about your child’s emotions. For example, say, “I can tell you feel mad because you threw the puzzle piece.” Encourage your child to identify feelings in books.
- Set rules and limits for your child, and stick to them. If your child breaks a rule, give him a time out for 30 seconds to 1 minute in a chair or in his room. Praise your child for following the rules.
- Give your child instructions with 2 or 3 steps. For example, “Go to your room and get your shoes and coat.”
- Read to your child every day. Ask your child to point to things in the pictures and repeat words after you.
- Give your child an “activity box” with paper, crayons, and coloring books. Color and draw lines and shapes with your child.
- Play matching games. Ask your child to find objects in books or around the house that are the same.
- Play counting games. Count body parts, stairs, and other things you use or see every day.
- Hold your child’s hand going up and down stairs. When she can go up and down easily, encourage her to use the railing.
- Play outside with your child. Go to the park or hiking trail. Allow your child to play freely and without structured activities.


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Learn the Signs. Act Early.

www.cdc.gov/ActEarly | 1-800-CDC-INFO (1-800-232-4636)
Your Child at 4 Years

Child’s Name          Child’s Age          Today’s Date

Milestones matter! How your child plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your child has reached by age 4. Take this with you and talk with your child’s doctor at every well-child visit about the milestones your child has reached and what to expect next.

What Most Children Do by this Age:

Social/Emotional
☐ Enjoys doing new things
☐ Plays “Mom” and “Dad”
☐ Is more and more creative with make-believe play
☐ Would rather play with other children than by himself
☐ Cooperates with other children
☐ Often can’t tell what’s real and what’s make-believe
☐ Talks about what she likes and what she is interested in

Language/Communication
☐ Knows some basic rules of grammar, such as correctly using “he” and “she”
☐ Sings a song or says a poem from memory such as the “This Little Piggy” or the “Wheel on the Bus”
☐ Tells stories
☐ Can say first and last name

Cognitive (learning, thinking, problem-solving)
☐ Names some colors and some numbers
☐ Understands the idea of counting
☐ Starts to understand time
☐ Remembers parts of a story
☐ Understands the idea of “same” and “different”
☐ Draws a person with 2 to 4 body parts
☐ Uses scissors
☐ Starts to copy some capital letters
☐ Plays board or card games
☐ Tells you what he thinks is going to happen next in a book

Movement/Physical Development
☐ Hops and stands on one foot up to 2 seconds

☐ Catches a bounced ball most of the time
☐ Pours, cuts with supervision, and mashes own food

You Know Your Child Best.

Act early if you have concerns about the way your child plays, learns, speaks, acts, or moves, or if your child:

☐ Is missing milestones
☐ Can’t think of place
☐ Has trouble scribbling
☐ Shows no interest in interactive games or make-believe
☐ Ignores other children or doesn’t respond to people outside the family
☐ Resists dressing, sleeping, and using the toilet
☐ Can’t tell a favorite story
☐ Doesn’t follow 3-part commands
☐ Doesn’t understand “same” and “different”
☐ Doesn’t use “me” and “you” correctly
☐ Speaks unclearly
☐ Loses skills he once had

Tell your child’s doctor or nurse if you notice any of these signs of possible developmental delay and ask for a developmental screening.

If you or the doctor is still concerned
1. Ask for a referral to a specialist and,
2. Call any local public elementary school for a free evaluation to find out if your child can get services to help.

For more information, go to cdc.gov/Concerned.

Don’t Wait.
Acting early can make a real difference!

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Learn the Signs. Act Early.
Help Your Child Learn and Grow

You can help your child learn and grow. Talk, read, sing, and play together every day. Below are some activities to enjoy with your 4-year-old child today.

What You Can Do for Your 4-Year-Old:

- Play make-believe with your child. Let her be the leader and copy what she is doing.
- Suggest your child pretend play an upcoming event that might make him nervous, like going to preschool or staying overnight at a grandparent's house.
- Give your child simple choices whenever you can. Let your child choose what to wear, play, or eat for a snack. Limit choices to 2 or 3.
- During play dates, let your child solve her own problems with friends, but be nearby to help out if needed.
- Encourage your child to use words, share toys, and take turns playing games of one another's choice.
- Give your child toys to build imagination, like dress-up clothes, kitchen sets, and blocks.
- Use good grammar when speaking to your child. Instead of "Mommy wants you to come here," say, "I want you to come here."
- Use words like "first," "second," and "finally" when talking about everyday activities. This will help your child learn about sequence of events.
- Take time to answer your child's "why" questions. If you don't know the answer, say "I don't know," or help your child find the answer in a book, on the Internet, or from another adult.
- When you read with your child, ask him to tell you what happened in the story as you go.
- Say colors in books, pictures, and things at home. Count common items, like the number of snack crackers, stairs, or toy trains.
- Teach your child to play outdoor games like tag, follow the leader, and duck, duck, goose.
- Play your child's favorite music and dance with your child. Take turns copying each other's moves.


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www.cdc.gov/ActEarly | 1-800-CDC-INFO (1-800-232-4636)
Your Child at 5 Years

Child’s Name
Child’s Age
Today’s Date

Milestones matter! How your child plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your child has reached by age 5. Take this with you and talk with your child’s doctor at every well-child visit about the milestones your child has reached and what to expect next.

What Most Children Do by this Age:

Social/Emotional
- Wants to please friends
- Wants to be like friends
- More likely to agree with rules
- Likes to sing, dance, and act
- Is aware of gender
- Can tell what’s real and what’s make-believe
- Shows more independence (for example, may visit a next-door neighbor by himself [adult supervision is still needed])
- Is sometimes demanding and sometimes very cooperative

Language/Communication
- Speaks very clearly
- Tells a simple story using full sentences
- Uses future tense; for example, “Grandma will be here.”
- Says name and address

Cognitive (learning, thinking, problem-solving)
- Counts 10 or more things
- Can draw a person with at least 6 body parts
- Can print some letters or numbers
- Copies a triangle and other geometric shapes
- Knows about things used every day, like money and food

Movement/Physical Development
- Stands on one foot for 10 seconds or longer
- Hops; may be able to skip
- Can do a somersault
- Uses a fork and spoon and sometimes a table knife
- Can use the toilet on her own
- Swings and climbs

You Know Your Child Best.

Act early if you have concerns about the way your child plays, learns, speaks, acts, or moves, or if your child:
- Is missing milestones
- Doesn’t show a wide range of emotions
- Shows extreme behavior (unusually fearful, aggressive, shy or sad)
- Unusually withdrawn and not active
- Is easily distracted, has trouble focusing on one activity for more than 5 minutes
- Doesn’t respond to people, or responds only superficially
- Can’t tell what’s real and what’s make-believe
- Doesn’t play a variety of games and activities
- Can’t give first and last name
- Doesn’t use plurals or past tense properly
- Doesn’t talk about daily activities or experiences
- Doesn’t draw pictures
- Can’t brush teeth, wash and dry hands, or get undressed without help
- Loses skills he once had

Tell your child’s doctor or nurse if you notice any of these signs of possible developmental delay and ask for a developmental screening.

If you or the doctor is still concerned:
1. Ask for a referral to a specialist and,
2. Call any local public elementary school for a free evaluation to find out if your child can get services to help.

For more information, go to cdc.gov/Concerned.

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DON’T WAIT.
Acting early can make a real difference!

Learn the Signs. Act Early.
Help Your Child Learn and Grow

You can help your child learn and grow. Talk, read, sing, and play together every day. Below are some activities to enjoy with your 5-year-old child today.

What You Can Do for Your 5-Year-Old:

- Continue to arrange play dates, trips to the park, or play groups. Give your child more freedom to choose activities to play with friends, and let your child work out problems on her own.
- Your child might start to talk back or use profanity (swear words) as a way to feel independent. Do not give a lot of attention to this talk, other than a brief time out. Instead, praise your child when he asks for things nicely and calmly takes "no" for an answer.
- This is a good time to talk to your child about safe touch. No one should touch "private parts" except doctors or nurses during an exam or parents when they are trying to keep the child clean.
- Teach your child her address and phone number.
- When reading to your child, ask him to predict what will happen next in the story.
- Encourage your child to "read" by looking at the pictures and telling the story.
- Teach your child time concepts like morning, afternoon, evening, today, tomorrow, and yesterday. Start teaching the days of the week.
- Explore your child's interests in your community. For example, if your child loves animals, visit the zoo or petting farm. Go to the library or look on the Internet to learn about these topics.
- Keep a handy box of crayons, paper, paint, child scissors, and paste. Encourage your child to draw and make art projects with different supplies.
- Play with toys that encourage your child to put things together.
- Teach your child how to pump her legs back and forth on a swing.
- Help your child climb on the monkey bars.
- Go on walks with your child, do a scavenger hunt in your neighborhood or park, help him ride a bike with training wheels (wearing a helmet).


The milestones checklist is not a substitute for a standardized, validated developmental screening tool.

www.cdc.gov/ActEarly | 1-800-CDC-INFO (1-800-232-4636)

Learn the Signs. Act Early.
**AGE-APPROPRIATE CHORES:**

<table>
<thead>
<tr>
<th>Ages 2 and 3</th>
<th>Personal Chores</th>
<th>Family chores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assist in making their bed</td>
<td>Take their laundry to the laundry basket</td>
</tr>
<tr>
<td></td>
<td>Put toys in toybox</td>
<td>Fill pet’s bowl with water(with supervision)</td>
</tr>
<tr>
<td></td>
<td>Stack books on shelf</td>
<td>Help parent clean up spills and dirt</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dust</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Throw trash away</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ages 4 and 5</th>
<th>Personal Chores</th>
<th>Family Chores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Get dressed with minimal parental help</td>
<td>Wipe spills</td>
</tr>
<tr>
<td></td>
<td>Make their bed with minimal parent help</td>
<td>Set &amp; clear the table with supervision</td>
</tr>
<tr>
<td></td>
<td>Bring their things from the car to the home</td>
<td>Help parent prepare their own meal</td>
</tr>
<tr>
<td></td>
<td>Pick up their toys</td>
<td>Dust with supervision</td>
</tr>
<tr>
<td></td>
<td>Wash their hands</td>
<td>Clean their room with supervision</td>
</tr>
<tr>
<td></td>
<td>Feed pets</td>
<td></td>
</tr>
</tbody>
</table>
### Ages 6 and 7

**Personal Chores**
- Make their bed every day
- Brush their teeth
- Comb their hair
- Choose their outfit and get dressed

**Family Chores**
- Vacuum room
- Dust rooms
- Put the dishes away
- Replace toilet paper roll
- Fold laundry with supervision
- Put their laundry away in drawers/closet
- Empty indoor trash cans

### Ages 8 and 9

**Personal Chores**
- Take care of personal hygiene
- Keep bedroom clean
- Prepare easy meals on their own

**Family Chores**
- Wash laundry
- Put groceries away
- Sweep floor
- Wipe off tables
- Load dishwasher/wash dishes
Basic (Psychological) Needs of Children

What are "basic (psychological) needs of children"?
These are basic, fundamental experiences that have been found through research to be essential to the optimal growth and development of children. Historically, most parenting advice has focused on what adults think children need; we now have research-based information on what children actually need for optimal development.

What are these basic needs?
1. A secure attachment (i.e., relationships with their primary caregivers that are warm, sensitively-attuned, and responsive)
2. Plenty of time and attention from their primary caregivers
3. Feeling understood and valued as a person by their primary caregivers
4. Being treated and viewed as the unique individual they are with their own thoughts, feelings, temperament, and interests (i.e., not comparing them to others or expecting them to be someone they aren’t)

Why is it important for caregivers to meet these needs?
• When these needs are met, children can grow and develop to their fullest potential and will have the best chances to be mentally healthy
• The majority of developmental and behavioral problems or difficulties stem from young children not having these basic needs met

Does meeting children’s needs spoil them?
NO! Instead, it teaches children that they are valued; it helps them to develop trust; it decreases stress and distress in the child; it leads to more optimal development and mental health; and it decreases the likelihood that children will experience developmental or behavioral problems (Brown, 2000; DuM, & Koot, 1997; Greenspan & Brazelton, 2000; Kemper, 2005; Kar, 1994; Kelly, 1996; Siegel, 2006)
Creative Arts: Sun Filters
Secondary Focus: Fine Motor/Cognitive

Suggested adult-child ratio: 1:3 or 1:4

Materials needed:
- 4 small bowls
- water
- yarn/ribbon
- ruffled coffee filters (or paper towels)
- food coloring
- scissors

Procedure: Pour a small amount of water into several small bowls. Tint the water in each bowl with a different color of food coloring. Set out ruffled paper coffee filters. Have each child choose a coffee filter, fold or scrunch it, and dip a corner into the tinted water. Let the children dip their filters into as many bowls of tinted water as they wish. Then have them open the filters to reveal multicolored designs. Create hangers for the sun catchers with yarn or ribbon. Hang the filters to dry. Show the children how they can hang their sun filter in a window at home.

Concepts to emphasize: taking turns; talk about the different colors; discuss what happens when the paper is dipped into the colored waters

Developmental domain/value for child:
Social: taking turns with others in using the materials
**Visual-Perceptual**: seeing the different colors of water; seeing the different designs created

**Fine Motor**: folding and dipping the filters into the tinted water

**Language**: discussing the different designs made by the tinted water on the filters

**Cognitive**: discussing what happens to the filters when they are dipped into the tinted water
Creative Arts: Collage
Secondary Focus: Fine Motor/Sensory-Perceptual

Suggested adult-child ratio: 1:4

Materials needed:
- construction paper
- tacky/craft glue
- popsicle sticks (for glue application)
- crayons

   small containers of different materials:
- colored tissue paper cut into small pieces
- ribbon
- construction paper cut into small pieces/shapes
- yarn
- flowers/small leaves
- beans
- macaroni

Procedure: Provide a number of different things which the children may use to create their collage. Children can glue various collage materials on construction paper.

Concepts to emphasize: Encourage children to select their own materials. Talk with them about what the objects are that they’ve chosen. Encourage children to use their words to express their needs. Also emphasize taking turns.

Developmental domain/value for child:
- Fine-motor: gluing of different materials on paper
- Cognitive: identifying the different materials and objects used on collage
**Language:** using words to express what materials they want, discussing what kinds of materials they have put on their collage

**Social:** taking turns with others
Cooking/Cognitive Activity:  
Cup of Fish  
Secondary Focus: Fine Motor

* This activity must be started near the beginning of class in order for the jello to set.

Suggested adult-child ratio: 1:4

Materials needed:
- book: The Rainbow fish
- blue jello
- water
- gummy fish/ sharks
- large mixing bowl
- large spoon for mixing
- clear plastic cups
- refrigerator
- paper bowls
- ice cubes in cooler
- tray
- plastic spoons
- coffee maker for making hot water

Procedure: Invite children to make pretend fish-in-a-cup. Bring the book, The Rainbow Fish. Then, make blue jello according to the directions on the box. **BE EXTRA CAREFUL CHILDREN DO NOT GET BURNED WITH HOT WATER!** Let the children take turns adding in a little of the jello mix and stirring. Afterwards, a staff member should pour the jello into the clear plastic cups, place the cups on a tray, and put them in the refrigerator. Let them cool in the refrigerator until partially set- about an hour; put lots of ice in cold water (decrease amount of cold water so cold water and ice cubes equal amount of cold water needed for recipe. While jello is in refrigerator, read book about fish: The Rainbow Fish. When jello is partially set, bring the cups out again, and give one to each child. Set out small bowls of various types of gummy fish, so that the children can choose fish and place them in the jello. Then label the children’ cups with their names (write on bottom of cup). Put the jello cups in the refrigerator again until children leave to go home.
**Concepts to emphasize:** naming the different properties of water and jello; what happened when ingredients are mixed; listening to fish book(s)

**Developmental domain/value for child:**

*Cognitive:* naming the different properties of the jello and water (i.e. dry, blue jello mix, hot, boiling, wet water), talk about how the jello mixture becomes harder when it is cooled in the refrigerator), emphasize what happens when you mix the jello mix and the water together (e.g. the water turns blue), naming the colors of the fish

*Social:* taking turns adding jello mix and stir.

*Language:* learning new words, using words to express which fish they want, listening to fish book(s)
Suggested adult-child ratio: 1:3

Materials needed:
- sugar
- milk/half & half
- plastic spoons
- rock salt
- ice cubes
- sandwich-size Ziploc bags
- vanilla
- paper bowls
- gallon-size Ziploc bags

*Write out simple recipe beforehand on big piece of paper

Procedure: 1) Invite children to make ice cream with you. 2) Have ingredients and measuring spoons/cups on table. Discuss with children the names of the different ingredients and the general concept of measuring spoons/cups. 3) Give each child a sandwich-size Ziploc bag. Let the children place the following ingredients into their Ziploc bags: 1 tablespoon sugar, ½ cup milk or half & half, and ¼ teaspoon vanilla. Then zip close the bags (Staff members should help hold the children’s bags while the children are putting in the ingredients and help the children zip their bags). 4) Place all the children’s Ziploc bags into a gallon-size Ziploc bag (make sure all the children’s bags are sealed). 5) Add the following ingredients to the gallon-size Ziploc bag: 2 tablespoons rock salt and enough ice cubes to fill the bag ¾ full. Then seal the bag. 6) Shake and roll the bag over and over again until frozen (about 15-20 min.). Scoop it into bowls and eat!

Concepts to emphasize: the process of following directions for a recipe (e.g. measuring, pouring, shaking, etc.); sensory experience (e.g. colors, textures, temperatures); naming and talking about the ingredients; transformation the
ingredients mix together and freeze to make ice cream; taking turns (using measuring spoons, cups, etc.)

Developmental domain/value for child:

**Cognitive:** the process of making the ice cream (measuring, pouring, shaking), discussing how mixing the ingredients together transforms ingredients into ice cream (salt + ice cubes makes milk, etc., extra cold and turns it into ice cream), naming/labeling ingredients, measuring, following directions in a sequence

**Sensory/perceptual:** discussing the colors, textures and temperature of the ice cream

**Social:** listening to others talk about the process, taking turns measuring, etc.

**Language:** talking to others about what ingredients are being mixed, naming/labeling ingredients
Science/Cognitive Activity:
Flubber
Secondary Focus: Sensory-Perceptual

Suggested adult-child ratio: 1:4

Materials needed: Recipe for 6 children:
- 2 large mixing bowls
- 2 large mixing spoons
- 1 ½ cups & 1 1/3 cups very warm water
- Ziploc baggies & Sharpie marker
- 2 level tsp 20 Mule Team Borax
- white vinegar (for clean-up)
- 2 cups Elmer’s white glue or all purpose washable clear glue
- food coloring (and/or glitter if using clear glue)

Procedure: First remind children not to put any of these ingredients in their mouths. Supervise them very closely! Have children take turns measuring and mixing together the following: Mix 1 ½ cups warm water, 2 cups glue, food coloring/glitter in large mixing bowl (bowl #1). In another large mixing bowl (bowl #2) mix 1 1/3 cups warm water and 2 tsp borax. Mix both mixtures separately and thoroughly. Mix the contents of bowl #2 into bowl #1 (Let the children take turns using their hands to mix on this step.). Lift and turn the mixture until it is fully combined. Discard any left over liquid. Divide the flubber into equal chunks and let the children play with it. Label Ziploc baggies with the children's names, so that they can take their Flubber home.
Note: Will stick to carpet and hair; use white vinegar as a solvent.
**Concepts to emphasize:** Discuss with the children that when you mix together different ingredients, sometimes you get something new. Talk with them about needing to take turns everyone will get to help. Ask the children how flubber feels and what they can do with flubber. Show them some things you can do with flubber: you can stretch it, poke it, roll it in a ball, and bounce it. Describe their play and their discoveries.

**Developmental domain/value for child:**

**Cognitive:** mixing of ingredients/transformations, measuring, what you can do with flubber (properties), following directions

**Sensory/perceptual:** characteristics of various ingredients, how the flubber feels

**Language:** discussing the different things you can do with the flubber, labeling different ingredients

**Social:** talking with others, listening to others, taking turns mixing ingredients

**Emotional:** feelings of accomplishment

**Motor:** mixing ingredients, manipulating the flubber
Science/Cognitive Activity: Playdoh
Secondary Focus: Sensory-Perceptual

Suggested adult-child ratio: 1:3 or 1:4

Materials needed:
- big bowl
- 1 cup of water
- 2 cups of flour
- 1 cup of salt
- 2 tablespoons oil
- measuring cups/spoons
- long wooden spoon
- small plastic baggies
- food coloring or Kool-Aid

Procedure: There are several ways to proceed with this activity:

1. As a group, have the children measure the ingredients and let them take turns putting the ingredients in the bowl (not including the food coloring/Kool-Aid). Let the children each have a turn mixing the ingredients together. Mix until well blended and knead until firm. Put an individually portioned amount into the baggies, and give one to each child. Next, ask each child which color they would like, and either drop a couple drops of food coloring or put a small amount of Kool-Aid in their baggies. Encourage the children to squish their fingers together and mix the color with the playdoh.

2. Same as above (#1), except add the food coloring/Kool-Aid in the big bowl at the same time as when adding the other ingredients.

3. Same as #1, except instead of having the children mix the food coloring/Kool-Aid in baggies, give them each a pile of the playdoh and
have them make a small hole in the middle of the pile to put the food coloring/Kool-Aid in, then they can mix it together with their bare hand. **Caution:** This variation allows for a sensory experience but may be very messy, and it will be harder to clean up the table and the children’s hands!

**Concepts to emphasize:**
1. Transformation of ingredients (i.e. when you add water and oil to the flour and salt, it becomes a different/wet material).
2. Sensory qualities: how the dry ingredients look and feel before water is added to it; how the playdoh feels

**Developmental domain/value for child:**
- **Cognitive:** transformational process; measurement of ingredients
- **Sensory-Perceptual:** how the playdoh feels before water is added to it, how the playdoh feels after all the ingredients have been mixed together
- **Language:** engaging in discussion about names of ingredients, measurement of ingredients, transformational processes, sensory qualities
- **Social:** taking turns measuring and mixing ingredients, participating in a group activity
- **Emotional:** emotional release; soothing/relaxing
Suggested adult-child ratio: any- (though smaller groups are generally more effective)

Materials needed:
- book (children’s picture book)

Procedure: (Be sure to have read the book through before class time). Sit on floor with children. Hold book so all can see pictures clearly. Speak slowly, expressively, and pause for input from children. Run your finger below the words as you read so children understands that you’re reading the words and not the pictures.

Concepts to emphasize: encourage children’s input as you read the book; listening to the story; not talking when others are talking.

Developmental domain/value for child:
- Language: listening to a book; giving input/asking questions
- Social: taking turns talking; sitting/functioning in a group setting
Suggested adult-child ratio: 1:4

Materials needed:
- empty paper towel rolls
- marker
- waxed paper
- rubber bands

Procedure: Have children decorate the outside of the paper towel roll with the markers if they like. Place a piece of waxed paper over one end of the roll and secure it with a rubber band. Poke 2 or 3 small holes into the waxed paper allowing sound to be produced.

Concepts to emphasize: how to make the kazoos; what sound they make; creativity in decorating kazoos; what makes the sound

Developmental domain/value for child:
Cognitive: figuring out what sound the kazoos make and what produces the sound
Social: discussing with others in group about kazoos, taking turns using materials
**Language**: asking to use materials, talking about their kazoos and how sound is produced

**Perceptual**: decorating the kazoos, what the noise sounds like to them
Enrichment Activity: Sing and Dance along

Five little monkeys swinging in the tree (5 fingers up)
teasing Mr. Alligator can't catch me....can't catch me (hands up to face
like moose antlers or one hand in front of nose)
along came Mr. Alligator quiet as can be (finger up to mouth like
SHHH)
and snapped that monkey out that tree(Both hands clap together like
an alligators mouth)

Four little monkeys swinging in the tree
teasing Mr. Alligator can't catch me....can't catch me
along came Mr. Alligator quiet as can be
and snapped that monkey out that tree

Three little monkeys swinging in the tree
teasing Mr. Alligator can't catch me....can't catch me
along came Mr. Alligator quiet as can be
and snapped that monkey out that tree

Two little monkeys swinging in the tree
teasing Mr. Alligator can't catch me....can't catch me
along came Mr. Alligator quiet as can be
and snapped that monkey out that tree

One little monkey swinging in the tree....

No more monkeys swinging in the tree!
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