8-Week Training Course on Autism Spectrum Disorder

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Master of Science in Education

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MASTER'S DEGREE FINAL EVALUATION REPORT

Completion Term: Spring 2026

Type of exit requirement: Professional Project

The supervisory committee met with the candidate for a final evaluation in which all aspects of the candidate's program were reviewed. The committee's assessment and recommendations are:

Recommendations:

- ✓ Degree should be awarded

Recommendations:

- ✓ Exit Requirement has been approved

Abstract

The purpose of my professional project is to create an understanding and knowledge of autism Spectrum Disorder (ASD) for parents and professionals who support children with ASD in the child's home or school setting. The objective is to understand the definition of autism and recognize the characteristics before learning about strategies that support communication, social relationships, emotional regulation, sensory processing, and the importance of child/family involvement.

I am creating an 8-week course to support anyone who wants to gain knowledge on ASD, specifically families and professionals that interact with children with ASD. This 8-week course is offered online for a minimal fee. It is a self-paced course with a new module being introduced each week. Each Module includes a learning objective, required readings/media and a discussion question to allow participants an opportunity to apply what they learned and how they will implement it.

This course is also designed to give families and professionals that work with children with ASD a chance to collaborate and learn from one another's experiences. The course is ideal for daycare employees, preschool teachers, early intervention educators, and families who struggle to engage in everyday activities with their child diagnosed with ASD. Parents and professionals receive a certificate upon the completion of the course.

Chapter 1

Project Introduction

Growing up in school, I never heard the term "Autism" (ASD). It wasn't something that was talked about amongst peers. If I did encounter anyone with autism, I wouldn't have known. ASD can sometimes be confused with attention deficit hyperactivity disorder (ADHD). They have similarities such as difficulty focusing and hyperactivity.

When I became a mother, my children attended preschool and I still was not familiar with the term autism. We attended a playgroup with other children, and it was there I met a mom with a child with autism. Her son was 6 years old at the time and was non-verbal. She was so patient with him as she tried to understand his needs. I remember watching him play on his own often. He would not interact with peers. Other children would initiate play with him, only to be ignored. Thinking back, I wonder if he felt lonely. I didn't understand what autism was, but I also didn't ask.

Job Experience

I started a job in 2016 at The Family Nurturing Center (FNC), a relief nursery serving children ages 0-5 years old. I was hired as an administrative assistant, spending time each day in the classroom assisting staff. The classroom consisted of eight students and two to three adults. The students were between 2-4 years old and were considered high risk to their emotional safety and well-being, including children with ASD. During my time in the classroom, I observed children with ASD refuse to drink from a certain color cup or sit in a different chair. They did not like change; they thrived on everything being the same. I observed them playing on their own and not joining circle time with the other students. The teacher was patient and always accommodated their needs. I did not have many one-on-one interactions with them since the

teacher was trained to handle their specific needs. My role was to assist the other children, which allowed the teacher to focus more attention on the children with ASD who required closer observation.

After working at FNC for two years, I decided to switch roles to a home visitor with Healthy Families of America (HFA). HFA is a national evidence-based home visiting program focused on early childhood relational health. My role was focused on supporting families with their child's development and milestones, and on helping strengthen parent-child relationships. The children were 0-3 years old. I would visit families weekly, bi-weekly or monthly depending on their needs or risk factors. I worked at HFA for eight years. During this time, I became an expert in child development. During my 8 years as a home visitor, I supported hundreds of families. I can remember only two to three that were referred for ASD by their pediatrician. I regularly made referrals to early intervention services if the child showed a delay in speech. This happened about a dozen times as a home visitor. We had many training sessions while I was employed with HFA, and none of them were on ASD.

College Experience

During my fourth year as a home visitor, I decided to enroll in college to earn my bachelor's degree in Early Childhood Studies with an emphasis on Early Intervention, Early Childhood Special Education (EI/ECSE). My goal was to become an Early Intervention (EI) specialist, which is now known as an Early Intervention Educator. As a student, I took many courses in child development, but not specifically for ASD.

Early Intervention Educator

In 2024, I completed my bachelor's degree in Early Childhood Studies and began my career as an Early Intervention Educator (EIE). My role includes developing, planning and

implementing Individual Family Service Plans (IFSP) using a primary service provider approach for children with developmental delays. Services are provided in the child's natural environment, which is in the home or daycare/preschool. The most common developmental delay that I provide services for is communication, and about half of my caseload consists of children with ASD. I have referred six children for ASD evaluations. At first, I felt quite intimidated, as I doubted my knowledge and understanding of ASD. Most of my current knowledge comes from hands-on experience with children who show ASD indicators. I have not received formal training in this area.

However, we are provided with a skills trainer (ST) who specializes in ASD. The skills trainer joins the visit with us and brings cause-and-effect toys to build engagement. She uses strategies to gain back-and-forth play. Once the child is diagnosed with ASD, the ST can be added to the service plan, and we conduct joint visits. During these visits, I am observing the child's response to the ST and coaching the parents on strategies used by the ST.

The most challenging home visits for me are those involving children with ASD. The reason for that is because there is no joint attention from the children. They avoid interaction and often do not respond to my presence. Parents often report their child prefers to play on their own, so they find themselves not engaging as much. Parents also tell me they feel guilty for not spending enough time with their child but when they do try to engage their child, they don't respond. Without having much knowledge about ASD, I don't feel confident walking into these home visits. It's challenging for the parents and me. Parents are often overwhelmed with appointments for special services such as occupational therapy (OT), speech therapy (SLP), and other therapies, including educational and behavioral therapy.

I also visit the child's preschool or daycare as part of my services. I am currently meeting a child twice a month at his daycare for speech delays. He is not diagnosed with ASD but has some strong indicators, including not responding to his name, no eye contact, non-verbal, and no joint attention. I will need to have a conversation with mom about my observations and discuss if she has any concerns about ASD and if she wants to move forward with an ASD evaluation. I feel okay having the conversation, but there is room for growth. Based on my experiences, I felt a strong need to develop a training program that addresses this need.

Rationale

The primary purpose of this training program is to equip professionals and families with evidence-based strategies for effectively engaging children with autism, while also fostering a deeper understanding of ASD and its impact on development. The program is designed to support participants in identifying meaningful ways to promote positive outcomes and long-term success for children with ASD.

An additional objective of the program is to create a supportive network for families who share common experiences in raising a child with ASD. This collaborative environment allows families to exchange effective strategies, reflect on approaches that were less successful, and build collective knowledge through shared experiences. The training program also serves early childhood professionals, including daycare providers and preschool staff, by enhancing their ability to recognize characteristics of ASD and implement developmentally appropriate strategies to support social communication.

The overarching goal of the program is to empower families to move beyond feelings of shame and guilt and toward confidence and advocacy, enabling them to positively influence their child's development through intentional and responsive parent–child interactions.

Eight weeks is a short time to cover everything there is to know about ASD. My goal is that parents would continue learning from each other once the course is complete. Parents will have access to everyone's contact information with the intent of building community. In the last module *Impact on Family,* participants research a variety of community-based resources, such as playgroups, support groups, and family organizations, with the goal of encouraging families to access, join, and actively participate in these supportive services. Participants will also have access to resources to download. I understand that children with ASD should not be excluded from typically developed children. There are many opportunities for children with ASD to participate in inclusive environments, which teaches children to build relationships with all peers along with a range of other benefits. I think it is just as important to have a space where children with ASD can gather with their parents and share a common interest.

Learning Outcomes

My project effectively shows learning outcomes required for early childhood education, M.S. Ed. Program at Western Oregon University. It also displays my knowledge and education as a student of early childhood and my career as a service provider for families with children ages 0-3 years old that have developmental disabilities. The learning outcomes include:

- Effectively apply the professional content expertise, knowledge, skills, and dispositions of their education profession.
- Use research and evidence to develop environments that support and assess learning and their own professional practice.
- Show commitment to and develop professional education leadership attributes.

I utilize my experience working with families to prioritize their needs while showing respect and confidentiality. I want parents to feel like they are the expert when it comes to their

child's development. I also use my knowledge of child development to expand my learning skills around ASD so that other professionals can utilize the learning materials as tools in their toolbox.

For the second learning outcome I thoroughly investigate other ASD programs and learn from their objectives and goals. I also research their reviews from members that completed the program for the purpose of learning what was effective or non-effective. I research evidence-based practices for interventions that are proven to be safe and effective through science research.

My commitment is to build a community that empowers parents and embraces supportive connections. There are many personal development trainings on disabilities with ASD but it's usually short and condensed. My goal is to develop a training program with practical skills that parents use every day in the home and professionals practice in their work environment.

Finally, by completing my goal and creating an 8-week training guide, I demonstrate my professional growth, dispositions, and leadership through the careful steps I took to successfully finish my project. I dedicated many hours researching information from articles, videos, websites, and expert podcasts, drawing on both professional experiences supporting autistic children and personal lived experiences. It also required leadership and a friendly disposition to engage with families and identify which skills or resources would be most effective in supporting both their role as parents and their child's development. Upon completion of this project, I am confident in my performance that I have successfully implemented all the learning outcomes required for Early Childhood Education, M.S. Ed. Program at Western Oregon University.

In addition to my project meeting the learning objectives for Early Childhood Education, M.S. Ed. Program. My project also meets the Course Accreditation Framework for Continuing Professional Development (CPD). I listed the framework below.

Course Accreditation Framework for Continuing Professional Development (CPD)

- Accessibility- The course is accessible to all learners.
- Content- The information in the course is factually correct, relevant, and up to date. Resources and content are provided by a trusted source.
- Creative- The course is organized to include videos, group discussion and handouts.
- Relevant- Training materials are relevant to the subject. Handouts will reflect the content given throughout the module. The material is relevant and flows throughout the sessions.
- Eligibility- No prerequisites are required for the course. The course is targeted towards parents with children diagnosed with ASD and professionals working with children diagnosed with ASD, however anyone is welcome to take the course that is interested in learning about ASD.
- Details- Ensures the course is entirely accurate, easy to understand and adheres to professional writing standards. Spelling and grammar are correct, and references are reliable.
- Intellectual Property- The content has been truthfully and legitimately produced, looking out for clear indications of plagiarized content. Sources will be cited as necessary.
- Tested- An effective course will contain some form of assessment that enables the learner to solidify the knowledge they have gained and validate their progress.
- Expertise- The course possesses the relevant knowledge and experience.
- Duration- CPD credits are assigned to the course. CPD credits are worked out as 1 hour of study = 1 CPD credit.

The CPD Framework meets most of the standards. Tested and Duration is not applied to this course. There is no testing required to earn the certificate at the end of the course. The

requirement is that all assignments are completed to receive their certification at the end of the eight weeks. The discussion questions in each module are designed to apply their knowledge of the material learned. The course does not offer CPD credits, it offers a certificate upon completion.

Course Structure and Accessibility

The course is available and accessible to all participants. This includes those with visual and hearing impairments. Participants will need a computer or phone to access the modules along with internet access. Content is available from trusted sources to ensure everyone has a meaningful learning experience. The modules are user friendly to ensure easy accessibility for everyone, even those with less technology experience. The handouts reflect the content delivered throughout the session. Participants receive the content of the course that is advertised online. There are no prerequisites to participate in the course.

Anyone interested in learning about Autism Spectrum Disorder (ASD) is welcome to attend. The training program is eight weeks long. Participants must begin in Week 1; otherwise, they will need to wait until the next course cycle begins, which will start eight weeks later. All references are up to date, easy to understand, and follow professional writing standards. Materials in the course are not plagiarized. I adhere to professional writing standards by including references when I have used other people's work and have been granted access to do so. The course contains relevant content based on my knowledge and experience in creating the activity effectively.

Module Design

The first thing I did to design my 8-week course was narrow down the main topics I wanted to include. I chose learning objectives that enhance parents' daily interactions with their

child and help professionals build confidence by knowing exactly what to say, do, and adapt in the moment when working with children diagnosed with ASD. Since one of the main indicators of ASD is challenges with social communication and interaction skill, I wanted to create a training course for parents and professionals to enhance play, turn taking and interacting with a child diagnosed with autism.

Participants will enroll online by creating an account and password. They will use their login and password to access the course. The 8-week training course is divided into 8 modules. Participants will have access to one module at a time. They will have one week to complete the module before moving on to the next module. New content for each module is available on Sundays. Assignments and discussion posts are due on Saturdays. The modules consist of videos, resources, reading and discussion questions to reflect on the content learned and shared experiences. Each module takes approximately 1-2 hours to complete. Participants have lifetime access to the course for future references. They also earn a certificate to show their professional learning.

Content of the Eight Modules

I debated whether to start module 1 with the definition and characteristics of autism since it's easy to assume participants taking the course already know the definition and characteristics of autism. However, I think it's appropriate to introduce the course with the basics of the course. Parents and professionals may also learn new terms or research compared to what they already know or build further knowledge of ASD.

The first module begins with an introduction. Participants are going to introduce themselves in a discussion post and answer some questions to get to know each other. The module gives a definition of autism along with videos and articles defining autism. It also

includes causes of autism, characteristics, and treatment options for autism. Learning materials include video clips and research-based articles.

The second module explains different types of autism. The different types include Kenner's Syndrome, Childhood Disintegrative Disorder (CDD), Rett's Syndrome, Asperger's Syndrome, and Pervasive Development Disorder. Each one is discussed in detail using reading material and video clips. The module explains how autism is diagnosed and what type of assessment is used to qualify a child for autism. There is a discussion post that includes a case study with questions to expand the participants' learning experience.

In the third module, parents and professionals learn strategies that support learning for children with autism. Reading materials include the use of applied behavior analysis (ABA). The module introduces task analysis steps, life skills, and joint attention strategies. In addition to the learning material, there is a discussion post to deepen the learners' understanding of strategies that support learning for children with autism.

The next module is about communication. This is an important module since most children with autism are non-verbal. The module explains the development of communication and strategies for promoting language development in children that are nonverbal. It also introduces assistive devices and understanding body language, gestures, and facial expressions. Information is given on how to introduce visuals. There are articles and video clips included along with a discussion post.

The fifth module is about social relationships. Participants gain a toolbox of what they can do to enhance play, turn taking and interaction. It is difficult for children with autism to share interest or emotions. They don't understand what others are thinking or feeling. Participants learn through videos and reading material along with a discussion post.

The sixth module is about challenging behaviors. This can be challenging for nonverbal children with autism. Participants explore types of interventions, ABC model, and how to support your child's emotions. Strategies are demonstrated using video clips along with reading material. A discussion post is also part of the module.

The seventh module is about sensory processing. Participants learn the 8 sensory systems and practical ways to support sensory regulation. The module covers sensory systems and sensory seeking behaviors. The module follows the same format as the previous six above. It includes reading material, video clips and discussion posts.

The last module dives deep into the impact autism has on the family and the importance of family-child engagement. Participants research resources, playgroups and support groups in their community and share them in their discussion post. There is also an opportunity for anyone to volunteer by starting a support group. The module also includes reading material and video clips.

At the end of the course, participants receive a certificate and lifetime access to all the learning material used in the course. Participants are required to complete a survey at the end of the course to receive their certificate. I will assess my success by the feedback in the survey. This will help me determine what changes I need to make to the course and how effective the learning material is based on participants' feedback.

Chapter 2

Literature Review

Introduction

Autism spectrum disorder (ASD) is a complex neurodevelopmental condition characterized by challenges in social communication, restricted interests, and repetitive behaviors. Because characteristics vary widely in severity, children with ASD require individualized supports that address their developmental, behavioral, and communication needs. Early intervention has been consistently identified as one of the most effective ways to improve outcomes, yet families often face barriers in accessing high-quality services, understanding early signs, and navigating the diagnostic process (Zawacki, et al., 2025).

In recent years, attention has shifted toward intervention models that actively involve parents, educators, and other caregivers in supporting the child's development. Parent training programs, school-based interventions, and teacher-focused professional development have demonstrated promising results, especially when delivered with fidelity and tailored to the child's strengths and needs (Zawacki, et al., 2025). However, the literature also reveals gaps in resources, variability in professional training, and differences in parents' readiness to engage in treatment, all of which impact the effectiveness and sustainability of intervention efforts.

This literature review examines key findings across studies focused on parent-implemented interventions, educator training, and barriers to early and effective ASD support. It highlights the importance of early engagement, professional competence, and family-centered approaches, while underscoring system-level challenges that continue to affect families and practitioners. Together, these studies provide insight into effective strategies, persistent limitations, and the broader implications for practice, policy, and future research.

Question #1 Why is it important for educators to be trained in ASD?

A study was conducted to determine teachers' knowledge of ASD, including teachers from any stage and specialization. The research was conducted from four databases (Web of Science, Scopus, PsycInfo and Google Scholar) between 2015-2020. The results concluded that teachers had poor knowledge of ASD. Teachers' knowledge about ASD is necessary as many of them can act as knowledge broadcasters of social change towards an inclusive education (Mari, et al., 2021). It's important that educators are aware of the benefits of adopting inclusive approaches to support children with ASD and their families. This awareness depends on intensive training, continuing professional development and improving their knowledge (Mari, et al., 2021).

Research on Educators Knowledge

Educators that work directly with children with ASD should have knowledge about assessments, treatments, social interactions, and strategies for early inclusion in conventional environments. It is also important that educators understand the characteristics of ASD so the child can be assessed and diagnosed as soon as possible. An interview was conducted of 25 teachers using interviews and questionnaires. The goal was to build a consistent framework around educators' knowledge of ASD. The results were disappointing. We can also draw some positive conclusions from this review. It appears that, if specific efforts are made in teacher training, this has an effective impact on the improvement of teacher's knowledge (Mari, et al., 2021). The results suggest that teachers should not only learn the theory of ASD but more practical training on how to engage with the child day to day in the classroom or in their home.

Another study, conducted in 2019, strove to address barriers to educator implementation of a classroom-based intervention for preschoolers with ASD (Wilson et al., 2019). The biggest

barrier is staff's lack of knowledge of ASD. Using a grounded-theory framework, the analysis revealed several factors that make it difficult for schools to effectively support students with ASD. These included gaps in teacher preparation, challenges with staff collaboration and consistency, the demanding nature of ASD instruction, limited time and resources, and inconsistent support from administrators. Teachers and administrators often viewed these issues differently, highlighting a disconnect in how each group understands the barriers. The study also outlines creative approaches for improving the transfer of effective practices to real classrooms and considers how these findings can inform teacher training programs and future policy decisions.

Intervention Models

Several intervention models have shown strong results when delivered in clinical or home environments, particularly when they are carried out by research personnel who have been extensively trained to use the procedures with high implantation fidelity. The literature provides some insight into barriers to implantation of evidence-based interventions in public school classrooms. One major barrier pertains to lack of adequate training to prepare educators to effectively instruct children with ASD (Wilson et al., 2019).

Given the rising number of students with ASD, school systems are in dire need of evidence-based, cost-effective, and efficient educational service delivery models that address the intensive, specialized learning needs of children with ASD, as well as practical needs of educators (Wilson, et al., 2019). There are two key areas that must be addressed. The first is making sure that evidence-based interventions are adjusted so they can be used effectively and realistically by community providers. The second is identifying the exact barriers that prevent these interventions from being used in community settings and developing strategies to

overcome those barriers. Both priorities are necessary to support the long-term use and success of evidence-based ASD practices.

Research Training Study

The research focuses on the second priority. They share results obtained during a qualitative examination of the perceived acceptability of the Early Achievements (EA) intervention by teachers, teaching assistants, and special education administrators during the 2-year iterative process of translating the intervention for implantation by teachers (Wilson, et al., 2019). Throughout the project, educators participated in training and received support directly in their classrooms from study team members to ensure strong, accurate use of the intervention.

At several points over the two-year span, educators and administrators were invited to share feedback about challenges they encountered and ways the training program could be improved. The study team then reviewed this feedback, identified the main barriers, and put practical solutions into action to help improve implantation. The goal of the EA intervention was to work with, rather than replace, the classroom practices, curricula, and materials educators already used. It aimed to strengthen teachers' abilities to support preschool children with ASD, especially in the core areas of social and communication skills.

The workshops included both instruction and hands-on practice. For seven months, educators also received weekly job-embedded coaching from the study team. Between coaching sessions, teachers used self-monitoring forms to track how well they were implementing each part of the EA program. The coaching sessions involved observing classroom practice, giving real-time support, and then meeting afterward for reflection. During these conversations, the coach provided feedback related to fidelity and worked with the educator to create an action

plan. Together, they identified the specific strategies to improve and outlined steps the teacher would focus on before the next coaching visit.

Educator Preparedness

The six identified overarching barrier categories were classified as Educator Preparedness, Educator Engagement, and Educational Team Cohesion, difficulties inherent in Instructing Students with ASD, factors associated with limitations in educational time and resources, and Administrative-Related Decisions and Support (Wilson, et al., 2019). The category with the most barrier types was Educator Preparedness. The challenges identified in this category were largely the result of educators not receiving enough training—either during their preparation programs or through ongoing professional development—to use evidence-based instructional approaches confidently and accurately with students with ASD. The team took action to address the barriers. At study launch, the compensation for gaps in educator training was addressed by designing a thorough professional development program involving six workshops and job-embedded coaching (Wilson, et al., 2019). According to the educators, the EA instructional strategies were unfamiliar, which made them seem removed from their usual teaching practices.

Educators explained that their training had not prepared them to focus on developmental learning goals—especially those involving language development, cognitive growth, or social interaction skills. Although the study has limitations, the findings still add valuable insight to the literature. They shed light on the challenges educators and administrators see when trying to use an evidence-based intervention with young students with ASD. The study also highlights realistic solutions and outlines meaningful implications for teacher education and policy.

Question #2 How do parents get support for their child with ASD?

Autism spectrum disorder requires an enduring commitment from families given the pervasive nature of the condition (Reddy, et al., 2019). Children with ASD often experience behavioral and sensory challenges, along with difficulties in communication and self-care, which can have profound effects on daily family life. Parents frequently adjust routines and manage social stigma, and in some cases may even put their careers on hold to care for their child. Cultural beliefs can further exacerbate stress, as some communities mistakenly attribute ASD to poor parenting or ineffective discipline. Because the disability is often not visible, these misconceptions are reinforced, leaving parents feeling frustrated and exasperated.

Barriers to Services and Educational Supports

In response, parents strive to improve their child's quality of life by seeking various interventions. Families with more resources are often able to access a broader range of services, while under-resourced parents are limited to minimal support through government programs, highlighting inequities in access to care and support. One mom shared a major challenge is the lack of specialized facilities for children with autism; there is no local center equivalent to the school in or nearby her city. In addition, the skills and knowledge of some educators were sometimes insufficient.

In some educational settings, teachers lack empathy and find it challenging to manage behaviors with limited support for the child's development. This can cause emotional stress for families. The findings highlight the critical need for professionals to deepen their understanding of ASD and strengthen their ASD-specific skills, particularly given the vulnerability of this population. Training programs for health professionals should include more focused, up-to-date

content to ensure that practitioners develop the competencies necessary to support autistic children and their families effectively.

Importance of Awareness, Advocacy, and Professional Training

Awareness will promote understanding and reduce negative perceptions, thereby moderating stress for families and increasing opportunities for support (Reddy, et al., 2019). To provide meaningful care, professionals must recognize and respond to the unique needs of each family, offering interventions that are appropriately tailored and delivered at the family level. The scarcity of resources and limited access to services also underscores the need for strong advocacy on behalf of these families. Broader systemic changes are needed to expand supports such as specialized schooling, healthcare, and therapeutic services, and these changes must be driven at governmental levels. Advancing this goal will require continued awareness efforts, updated research, and collaboration with advocacy organizations. Additionally, teacher education programs should include training in ASD identification and classroom management to better prepare educators to meet the needs of autistic learners.

Parent Training as an Evidence-Based Intervention

Parent training is an empirically supported intervention for children with disruptive behaviors uncomplicated by ASD (Bearss, et al., 2015). Parent training teaches caregivers specific strategies to address challenging behaviors in their children. Although interest in parent training for children with ASD has increased and early studies show promising results, it has not yet been tested in large, randomized trials. Because it is a short-term intervention that can be used in different settings such as clinics and schools, establishing its effectiveness could have meaningful public health benefits.

Evidence from Randomized Clinical Trials

A notable contribution to the evidence on interventions for autism is the randomized clinical trial described in Effect of Parent Training vs Parent Education on Behavioral Problems in Children with ASD (Bearss et al., 2015). In this study, researchers conducted a 24-week randomized clinical trial involving 180 children aged 3 to 7 years old who had ASD and exhibited moderate or greater behavioral difficulties. The trial directly compared a structured parent-training program—designed to teach parents specific, practical behavior-management strategies—to a more general parent-education condition that provided information about ASD without skills-based coaching. This design allowed investigators to determine whether targeted parent-training delivered measurable benefits beyond standard educational support for families.

The results of such large-scale, rigorously controlled studies are critical, given the growing interest in parent-mediated interventions and their potential to be implemented effectively in everyday settings such as schools, clinics, and community programs. The study was designed to evaluate whether parent training would be superior to parent education for reducing behavioral problems such as tantrums, noncompliance, aggression, and self-injury in children with ASD (Bearss, at al., 2015).

Parent training was delivered individually to caregivers through 11 core 60–90-minute sessions, with up to two optional sessions, 1 home visit, and up to six parent–child coaching sessions over 16 weeks. An additional home visit and two booster phone calls were provided between weeks 16 and 24. Spreading sessions over time allowed families flexibility while still receiving the full intervention.

Parent education involved 12 informational sessions and one home visit over 24 weeks, covering ASD evaluation, development, schooling, advocacy, and treatments. It served as a

comparison to see if information alone could reduce behavior problems, with manuals providing scripts and handouts for consistency. This study compared parent training to parent education in 180 children with ASD and significant behavioral problems. Both groups improved, but parent training produced greater reductions in disruptive and noncompliant behaviors and showed better overall improvement, as rated by a blinded clinician.

Collaboration Between Parents and Educators

When parents and educators work together, children with ASD are assured the best possible outcomes (Ruble, et al., 2010). Research now shows that children with ASD benefit from specialized interventions, including environmental supports and adaptations, as well as parent and teacher training programs that help build social and communication skills. More targeted interventions focus on environmental support and on developing engagement, communication, social, and self-direction skills.

Parental Awareness, Adjustment, and Emotional Responses

Most parents start out naïve about the possibility that their child is on the autism spectrum- excepting parents who have encountered autism in a previous child (Gentles, et al., 2019). A key factor influencing the pace of adjustment is how strongly parents are attached to their earlier expectations for the future. Another factor affecting parents' readiness to adjust their expectations is their initial understanding of autism and their emotional attitude toward it. Most parents began to recognize their child's autism by first noticing what initially appeared to be minor signs. A parent may begin to question their child's behaviors when subtle actions raise a vague suspicion that further investigation is needed. Eventually, parents interpret that the signs they have observed in their child indicate a problem sufficiently concerning to warrant urgent attention and action (Gentles, et al., 2019).

Parents identified denial as the most visible emotional barrier to accepting the possibility of autism. It often delayed their readiness to act and slowed involvement in desired care. Research highlights the importance of being sensitive to parents' varying levels of awareness and understanding of their child's autism when engaging them early in the clinical process. Some parents, particularly at the time of diagnosis, may already have foundational knowledge and be highly motivated to collaborate with professionals.

Question #3 What are the Treatments for ASD?

The term autism spectrum disorder (ASD) refers to a class of pervasive developmental disorders characterized by impairments in social interaction, deficits in speech/language and communication development, and restricted, repetitive, and stereotyped behaviors (Verschuur et al., 2014). 43 studies were summarized in terms of participant characteristics, dependent variables, intervention procedures, intervention outcomes and certainty of evidence (Verschuur et al., 2014). Most of the reviewed studies (56.4%) had serious methodical limitations. However, the reviewed studies that provided conclusive or preponderant evidence (43.6%) indicated that pivotal response treatment (PRT) results in increases in self-initiations and collateral improvements in communication and language, play skills, affects and reductions in maladaptive behavior for several children (Verschuur et al., 2014).

Pivotal Response Treatment as an Evidence-Based Intervention

Caregivers and staff members are taught to implement PRT techniques effectively using an individualized training approach that combines several well-used instructional strategies (Verschuur et al., 2014). This is important because the child will get the proper interventions in their natural environment. It also improves communication and language, play skills, affect, and reductions in maladaptive behavior (Verschuur et al., 2014). It's important for the child to learn

to function in a classroom with their peers. This involves communication and problem solving. If a child with ASD does not learn these skills, it can be difficult for them to feel included with their peers. They often feel isolated and play alone, although they prefer to play alone, it is critical for them to learn social skills to prepare them for the world.

PRT is described as a comprehensive naturalistic intervention model based on applied behavior analysis (ABA). PRT aims to reach pivotal behaviors to children with ASD to achieve generalized improvements in their functioning (Vershuur et al., 2014). This is an evidence-based practice and an established intervention. Research concluded that PRT effectively improved social and emotional behaviors of young children with ASD (Vershuur et al., 2014). PRT is based on four pivotal areas: motivation, initiation, response to multiple cues, and self-management. PRT is conducted by teachers, parents, and therapists. The training uses strategies to give the child motivation by using play-based interactions and rewarding positive behavior.

Strengths and Limitations of Pivotal Response Treatment

This systematic review found evidence to support the use of PRT for increasing self-initiations (Vershuur et al., 2014). Some caregivers and staff members within some studies did not meet the criterion for fidelity of PRT implementation or did not maintain the use of PRT techniques (Vershuur et al., 2014). Six studies (15.4%) were classified as providing a conclusive level of certainty. All six studies reported mixed intervention outcomes for children (Vershuur et al., 2014). The effectiveness rating for this treatment fails to demonstrate effect making it a 4 on the rating scale. This evidence is based on a systematic review.

PRT is only effective if the caregivers and staff are consistent and use PRT effectively. More research needs to be collected to track the gaps and evaluate staff and caregivers. This would require staff to be observed to make sure they are doing it correctly but even then, how

can they be sure they are using it consistently with the child when they have many demands on them with other students. PRT showed good results in children with ASD increasing their self-initiation skills.

Prevalence of Autism and Importance of Early Treatment

ASD is now recognized as a set of common developmental disorders, with an estimated prevalence of about 1 in every 31 children aged 8 years have been identified with ASD. ASD continues to occur in all racial, ethnic, and socioeconomic groups, and is more than three times more common in boys than girls (CDC, 2025). Why is treatment for the disorder important? A few studies have suggested that a small proportion of children identified early with mild symptoms of autism no longer have the disorder several years later (Lord et al., 2024). ASD is a lifelong disorder that may become milder as children grow older, but does not usually resolve completely (Lord et al., 2014). Treatment is important to improve the child's symptoms using a positive approach to improve cognitive abilities.

Early Start Denver Model

Early Start Denver Model (ESDM) did a study for children with ASD under 30 months of age (Lord et al., 2014). They conducted an early comprehensive treatment which is like ABA. The goal of the treatment was to improve the cognitive abilities of the participants (Lord et al., 2014). The ESDM strategies included reinforcing child attempts, using positive effects during everyday interactions for at least 5 hours a week (Lord et al., 2014). ESDM is a developmentally grounded treatment model that addresses multiple domains. There is an emphasis on interpersonal exchange and shared affect, and a focus on verbal and nonverbal communication (Lord et al., 2014). Children in the treatment group received 15 hours a week of in-home intervention by B.A. level therapists, supervised by graduate level, experienced therapists, and a

team of specialists. Parents were asked to use the ESDM strategies during their everyday interactions for at least 5 hours a week (Lord et al., 2014).

Children in the treatment showed increases in IQ of 17 points compared to changes of 7 points on average in the community treatment group (Lord et al., 2014). The treatment was proven to be effective. This was a randomized controlled trial with promising research evidence with a rating of 2 on the rating scale.

I appreciated that parents were actively involved in the treatment while also receiving professional support, which made the intervention more effective. They received a lot of treatment hours. This is very similar to applied behavior analysis (ABA) treatment which is also very effective. It may sound simple to reinforce a child's attempt to use positive affect, but this can be challenging when the child is quiet, independent, and prefers solitary play. Parents must be aware and observant, remaining actively and following the child's lead. I also like how the intervention supports parents in developing these skills so they can better engage their child. The treatment was delivered in the home. Because ASD can range from mild to severe, early intervention is especially important. This approach tends to be most effective when started early in a child's development and is generally more successful for children with mild to moderate symptoms.

ASD is a group of neurodevelopmental disorders defined by impairments in social communication and patterns of restricted, repetitive behaviors or interests (Politte et al., 2015). The estimated prevalence of ASD has increased dramatically in the past several years, rising from 1 in 150 children in 2002 to 1 in 68 in 2012. The specific goals of treatment will change depending on the cognitive level and functional abilities of the individual with ASD, though interventions should always aim to enhance quality of life, relationships, and degree of

independence (Politte et al., 2015). ASD are lifelong disorders, and treatment in adulthood includes ensuring opportunities for social, leisure, and vocational activities, maintaining physical health through diet and exercise, and support for transitions in caregiving as parents age (Politte et al., 2015).

Pharmacological Interventions in ASD

Antidepressants and anxiolytic medications have been studied for the treatment of irritability, repetitive behaviors, and compulsions in ASD with missed results (Politte et al., 2015). While Selective Serotonin Reuptake Inhibitors (SSRI's) and other antidepressants are rarely helpful in alleviating repetitive behaviors, they may be helpful for treatment of depression and anxiety, which are particularly common in higher-functioning individuals with ASD. Evidence regarding the treatment of depression and anxiety in ASD is lacking (Politte et al., 2015). Medication is not meant to be a temporary solution. It's a lifelong decision. Medication is effective for behavior in children with ASD. Medication also reduces commonly associated symptoms, including inattention, impulsivity, hyperactivity, compulsions, anxiety, sleep, disturbance, and irritability but there is no medication approved for treatment of core symptoms of ASD, including social communication deficits and restricted, repetitive behaviors and interest (Politte et al., 2015).

A 2022 systematic review concludes that although some pharmacological agents show effects on associated symptoms, there is still no pharmacological cure or approved medication for core ASD symptoms (Karrim et al., 2022). Pharmacologic interventions in ASD are primarily aimed at reducing commonly associated symptoms, including inattention, impulsivity, hyperactivity, compulsions, anxiety, sleep disturbance, and irritability- namely severe tantrums,

self-injury, and aggression (Karrim et al., 2022). This is a concerning practice that is not effective for specific symptoms of ASD making it a five on the rating scale.

There are different types of medications available to manage some symptoms of ASD, but they are not specific to ASD. They also come with side effects such as nausea, insomnia, and diarrhea. This treatment can be risky, it's not effective long term but could be helpful to manage some symptoms of depression and anxiety that can be characteristics of ASD. The child must have the proper dosage to be effective. This can take many adjustments to get the right dose. Overall, I think it's risky and I would not recommend this treatment.

Conclusion

Across the studies reviewed, early, structured, and family-centered interventions play a critical role in supporting children with autism spectrum disorder (ASD). Research consistently shows that parents benefit from training that equips them with practical strategies to manage challenging behaviors and promote social, communication, and engagement skills. When parents are active partners in intervention—supported by professionals through coaching, education, and individualized guidance—outcomes tend to improve for both the child and the family.

The literature also highlights significant barriers, including limited resources, insufficient professional training, and variability in parents' readiness to recognize or accept early signs of ASD. These factors influence access to services and the effectiveness of intervention efforts. Addressing these barriers requires enhanced professional preparation, increased awareness, and system-level changes that expand access to high-quality, evidence-based supports.

Overall, the research underscores the need for collaborative, accessible, and adaptable intervention models that empower families, strengthen professional practice, and promote early developmental gains. Continued efforts to refine training, increase awareness, and advocate for

expanded services will be essential in improving long-term outcomes for children with ASD and their families.

This literature review confirms there is a lack of education for families and professionals to identify characteristics of ASD and implement strategies to support social communication and improve engagement. Participants will gain knowledge through the 8- week course that they can apply to their daily lives at work or home.

Chapter 3

The Project Design

Context

This project is designed to support families and educators who are seeking tools and resources when parenting or supporting children with ASD. There is lots of information available which can feel overwhelming for parents. Professionals like myself are not properly trained to support children with ASD with confidence due to lack of knowledge and strategies to engage and interact with children with ASD.

When I first became an early intervention educator nearly two years ago, I was working with nonverbal two-year-olds. At that time, my coworkers asked whether I had observed any indicators of autism spectrum disorder (ASD). Because I had never previously worked with children diagnosed with ASD, I was unfamiliar with the early signs and felt embarrassed to admit that I had not noticed any indicators. Since then, I have become more comfortable and confident working with children with ASD; however, I recognize the importance of continuing to build my knowledge and skills to better support these children and their families. My goal is that this project helps families and professionals better understand what research says about ASD, specifically how to engage and communicate with children with ASD.

Prevalence

Autism spectrum disorder defines a heterogeneous set of complex neurodevelopmental disorders affecting 1 in 54 children in the USA according to current estimation and confers lifelong challenges (Zhang, et al., 2022). ASD is characterized by difficulties with social communication as well as repetitive, restricted repertoire of behaviors and interests (Zhang, et

al., 2022). One of the goals of my projects is to help participants understand what ASD is and how to identify characteristics commonly associated with children with ASD.

Why Children with ASD Need Support

Children with ASD experience a wide range of strengths, challenges, and support needs. They are often observed playing on their own. It is important for them to feel included and connected by giving them opportunities for social interaction and participation without feeling isolated. Families and educators play a critical role in a child's developement. I chose to design this 8-week course for educators and families to empower them with knowledge and skills to recognize characteristics of ASD, create supportive home and learning environments, and promote each child's strengths and well-being.

The 8-week course will be conducted online so everyone can go at their own pace. Participants will have one week to complete the module. Each Module will be posted on Monday and will end on Sunday. That gives participants a week to complete their assignments.

Parenting a child with ASD can feel overwhelming and sometimes lonely. Parent training is an empirically supported intervention for children with disruptive behaviors uncomplicated by ASD. Parent training provides parents with specific techniques to manage behavioral problems in children (Bearss, et al., 2015). This is why families need to gain knowledge and confidence in supporting a child with ASD. This 8-week course identifies their child's unique needs, and develops practical skills to support their child's emotional, social and academic growth.

I am eager to learn these skills alongside the course participants to enhance my ability to support the families I serve as an early intervention educator. I aim to build a community of families and educators who support each other, offer encouragement, and share experiences

without judgement or shame. Finally, the course is designed to equip participants with tools, understanding, and a collaborative network to help every child thrive.

Design Methods discusses the program development process

The first thing I did to develop the 8-week training program for ASD is organize the overall structure of the program. In developing the training modules, I needed to decide the most appropriate sequence in which the topics should be presented. The order was intentionally structured to move from foundational knowledge to more applied skills, ensuring that learners first develop a basic understanding of ASD before progressing to identifying early indicators and implementing effective intervention strategies. This progression was designed to build confidence, reduce uncertainty, and support practical application in early intervention settings.

In addition to organizing the overall structure of the program, I also needed to determine the learning objectives for each module and decide the sequence of instructional components, including readings, videos, discussions, and case studies. Establishing clear objectives and a consistent order of activities helped ensure that each module was focused, cohesive, and aligned with the overall goals of the training program.

The second step I took was to create a separate folder on my desktop for each of the eight modules. Initially, I stored all of my research articles in a single folder; however, as the number of resources grew, this approach became overwhelming and difficult to manage. To improve organization and clarity, I reviewed the research articles and sorted them into the appropriate module folders based on their relevance to each topic. This organizational strategy helped organize the development process and made it easier to locate and apply research when designing each module.

Thirdly, I conducted extensive research to ensure the training program was focused on current, evidence-based practices. I wanted to research how many other training programs were available online. I came across a wide range of ASD training including free introductory courses, professional development, specialized clinical or educator training, short continuing professional development (CPD), continuing education unit (CEU) modules, and paid certificates and professional development programs.

Existing Online training Programs

One particular online course I found helpful was “Many Faces of Autism” (Autism Certification Center, n.d).It's a free course that introduces the characteristics of ASD and dispel common misconceptions through the experiences and perspectives of individuals on the autism spectrum. The course claims whether you are a parent, grandparent, neighbor, co-worker, teacher, bus driver, or librarian, you will find valuable insights and information in this 90 minute course (Autism Certification Center). They offer courses for toddler and preschool age, school age, and transition age. I knew I wanted to model this course with an emphasis on families and educators supporting toddlers and preschool age children with ASD.

I reviewed this course to gather information on organization and topics. I came up with 8 modules similar to the topics found in Many faces of autism. In the Many Faces of Autism course parents shared the shame and guilt they feel about raising a child with ASD. Receiving a diagnosis of autism can be devastating to some parents, but for others it can be a relief to have a label for their child’s symptoms (Autism Research Institute). This was a motivating factor for me, as it reinforced the importance of developing a training program that could help families better understand autism spectrum disorder and contribute to reducing the stigma often associated with it.

I also spent many hours reviewing peer-reviewed journal articles and reputable websites to gather information for inclusion in the modules. In addition, I identified relevant multimedia resources, including video clips, YouTube videos, and TED Talks, that would enhance learning and support participant engagement throughout the training program.

Organizing Each Module

The final step in the development process was creating each module, beginning with Module One. Although this step was made easier by the organizational work completed earlier, it was also the most challenging and time-consuming. Developing the slide presentations required careful planning, and considerable thought was given to writing discussion questions that were meaningful, relevant, and encouraged participants to apply their learning. I was also intentional and thoughtful in selecting content for the slides and choosing research articles, with the goal of providing sufficient depth without overwhelming participants.

Course Format/Google Slides

- Eight structured learning modules
- Canva-based presentations for each module outlining objectives and key concepts
- Short video clips from YouTube and TED Talks to enhance understanding
- Practical strategies and real-life examples
- Guided discussion questions and reflection activities
- Downloadable resources and handouts
- Knowledge checks or simple assessments

Modules Included

1. What Is Autism?
2. Different Types of Autism Spectrum Disorder (ASD)

3. Parenting and Teaching Strategies
4. Communication Skills and Supports
5. Social Relationships and Peer Interaction
6. Emotional Regulation and Coping Skills
7. Sensory Processing and Sensory Needs
8. The Impact of Autism on the Family

List of Material/ Class presentation

- Canva-based slide presentation for each module
- Module objectives listed at the beginning of each presentation
- Research-informed learning content
- Short video clips from YouTube and TED Talks
- Visual examples and case scenarios
- Guided discussion questions
- Reflection activities
- Downloadable handouts and resources

Timeline and Organization

This project was created between mid-January and mid-February 2026, from the first proposal through the completion of all materials. Each module was thoughtfully organized to be easy to navigate and understand. Presentations are simple and clear, using bullet points, helpful headings, and easy-to-read fonts so learners can follow along without feeling overwhelmed.

Summary Description

This 8-week autism spectrum disorder (ASD) training course is designed to help families, caregivers, and support professionals better understand autism and the unique strengths and needs of individuals on the spectrum. Participants will learn about common characteristics of ASD, the importance of neurodiversity, and how autism can look different from person to person. The course focuses on practical, everyday strategies to support communication, sensory needs, behavior, social skills, and emotional regulation at home, school, and in the community. Through easy-to-understand lessons, real-life examples, and helpful activities, learners will gain tools to build positive relationships, create supportive environments, and feel more confident in supporting individuals with ASD and their families.

Data Collection/Evaluation Procedures

Participant learning and course effectiveness will be evaluated primarily through a Google survey completed at the end of the course. The survey will gather feedback on the clarity of content, usefulness of materials, and overall satisfaction with the course. Participant engagement will also be observed through completion of modules, participation in reflection activities, and participation in discussion questions.

Survey results will be used to guide improvements to future versions of the course. The survey will have questions on a rating scale of 1-5 (1= Strongly Disagree, 5= Strongly Agree) in addition to open ended questions. Questions that will be asked in the survey include:

- The course was easy to navigate?
- The presentations were clear and easy to understand?
- The videos supported my learning?
- The course content was relevant to my needs?

- I gained practical strategies I can use?
- I feel more confident supporting an individual with ASD after completing this course?
- Which module (s) did you find most helpful and why?
- Which module (s) did you find least helpful and why?
- What topics would you like to see added or expanded?
- What improvements would you suggest?
- Any additional comments or feedback?

Connection to the research

The instructional and design choices for this course were guided by research that shows people learn best when information is practical, easy to understand, and directly connected to real-life situations. Studies on adult learning emphasize the importance of relevance and immediate application, which is why this course focuses on everyday strategies that families and educators can use at home, school, and in the community. Parent training is an empirically supported intervention for children with disruptive behaviors uncomplicated by ASD (Bearss et al., 2015).

Research on Universal Design for Learning (UDL) supports presenting information in multiple ways so that more learners can access and understand content. In alignment with this approach, each module includes presentations, written explanations, and videos. Presentations were intentionally created with clear headings, bullet points, and easy-to-read fonts to make content feel approachable and not overwhelming.

Multimedia learning research also shows that combining visuals with spoken explanations can improve understanding. For this reason, short video clips from reliable sources

such as TED Talks and YouTube are included to reinforce key ideas and provide real-life examples. The use of discussion questions and reflection activities is based on research suggesting that people learn more deeply when they actively think about and apply what they have learned. Finally, organizing the course into weekly modules supports gradual learning and allows participants to build knowledge step by step. Overall, these design decisions aim to create a supportive, accessible, and practical learning experience for families and educators. When parents and educators work together, children with ASD are assured the best possible outcomes (Ruble, et al., 2010).

Chapter 4

Final Project

Introduction

This chapter is focused on the implementation of this 8-week training course on ASD. Throughout this chapter, I will walk the reader through the content of each of the eight modules. The materials included in this course include case studies, strategy guides, and structured slides that represent both academic research and applied practice. Each module was designed intentionally to demonstrate not only knowledge of ASD but also the ability to translate that knowledge into applicable strategies.

Throughout this course, participants will examine the characteristics of ASD, the diagnostic process, commonly used assessment tools, and the strategies most effective for engagement. This course represents my work by showcasing the integration of research, clinical understanding, and instructional design. It demonstrates the ability to synthesize complex information, align content with professional standards, and present it in a clear, accessible format for all learners.

Each module begins with learning objectives and the agenda so participants understand what is expected of them. I created a google slideshow for the eight modules. These slides fully highlight the content by building a strong conceptual foundation of ASD and translating that knowledge into effective, ethical practices that implement evidence-based interventions to support children with ASD in the home or school settings. I also used Canva to design colorful and engaging slides that promote engagement and reinforce key concepts. The first module includes slides detailing the learning objectives and agenda to establish structure and

expectations. Although each module contains its own objectives and agenda, they will not be repeated in this presentation, as they follow the same standardized format introduced in Module One.

Module 1 Intro to ASD

The first module introduces ASD, including its definition, core characteristics, potential causes, and current treatment options. I start the module with learning objectives and the agenda.

Figure 1

Learning Objectives

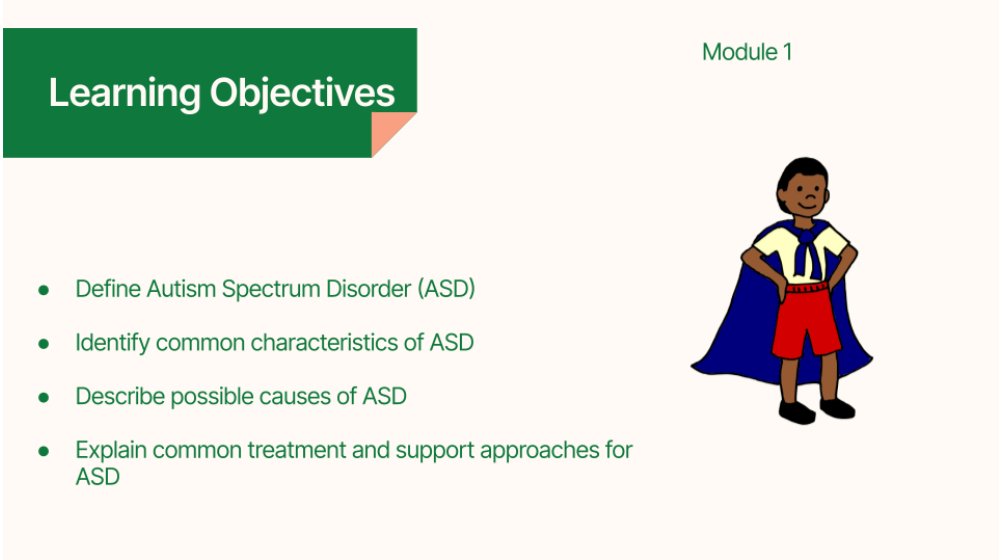
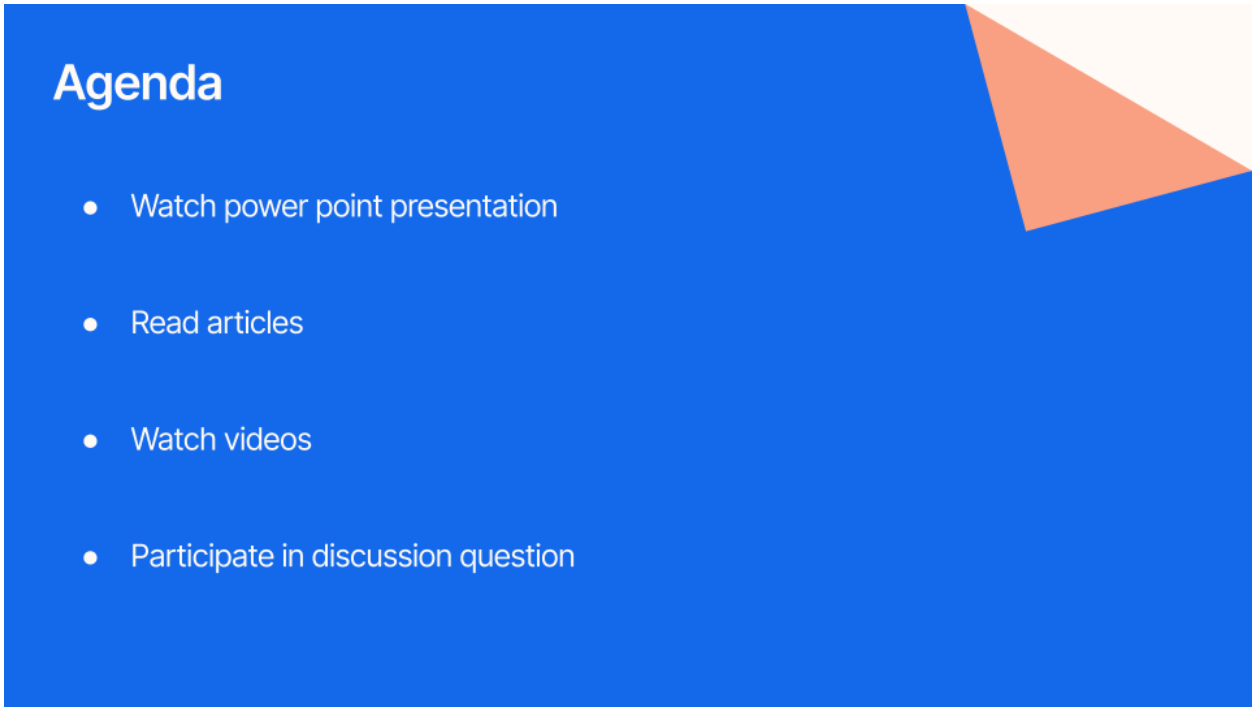


Figure 2

Agenda



Definition of ASD and Prevalence

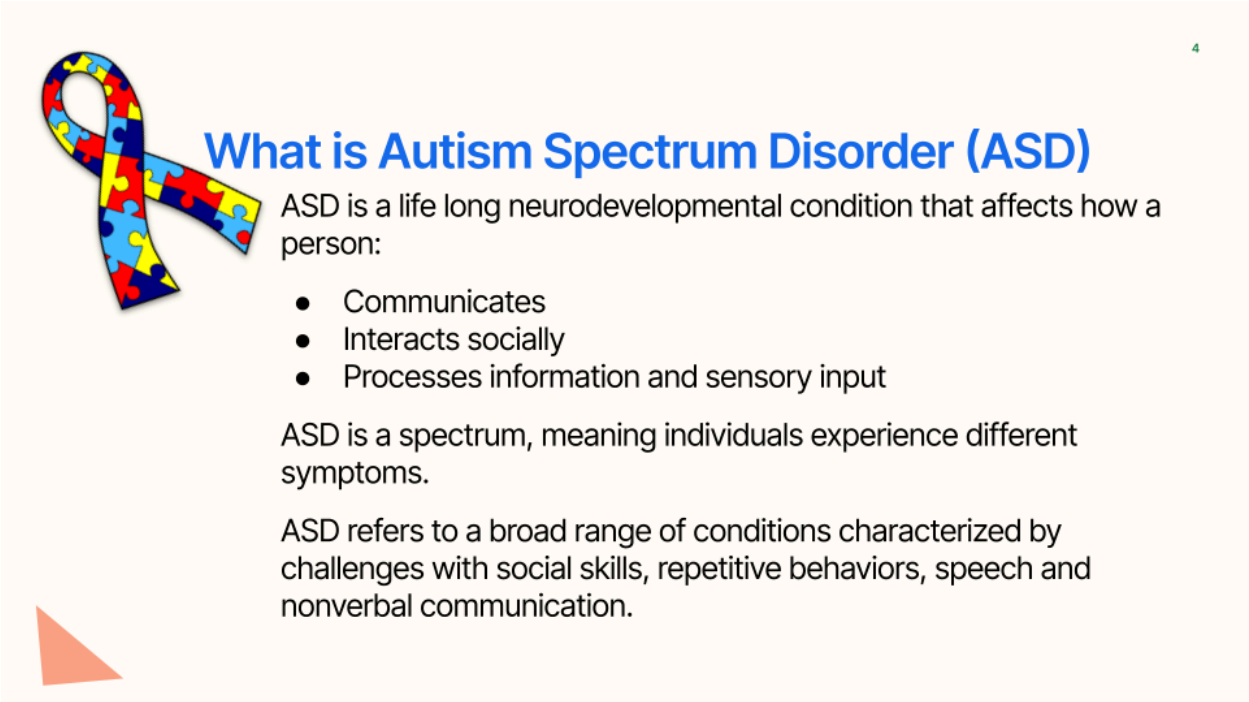
The next thing included is the definition of ASD. ASD refers to a broad range of conditions characterized by challenges with social skills, repetitive behaviors, speech and nonverbal communication (Autism Speaks, n.d.). According to the Centers for Disease Control, ASD affects an estimated 1 in 31 children and 1 in 45 adults in the United States today (Autism Speaks, 2020).On average, autism is diagnosed around age 5 in the United States, with signs appearing by age 2 or 3.

Anyone can be autistic, regardless of sex, age, race or ethnicity, However, research from the CDC says that boys get diagnosed with autism four times more often than girls (Autism

Speaks, 2020). Girls may have more subtle presentation of symptoms, fewer social and communication challenges, and fewer repetitive behaviors. Autism is a lifelong condition, and a child with autism needs, strengths and challenges can change over time. As they transition through life stages, they may need different types of support and accommodations.

Figure 3

What is ASD



Characteristics of ASD

The next slide shows the characteristics of ASD. Autism Spectrum Disorder is characterized by differences in social communication and patterns of behavior. These characteristics vary widely, which is why autism is described as a spectrum. One of the primary

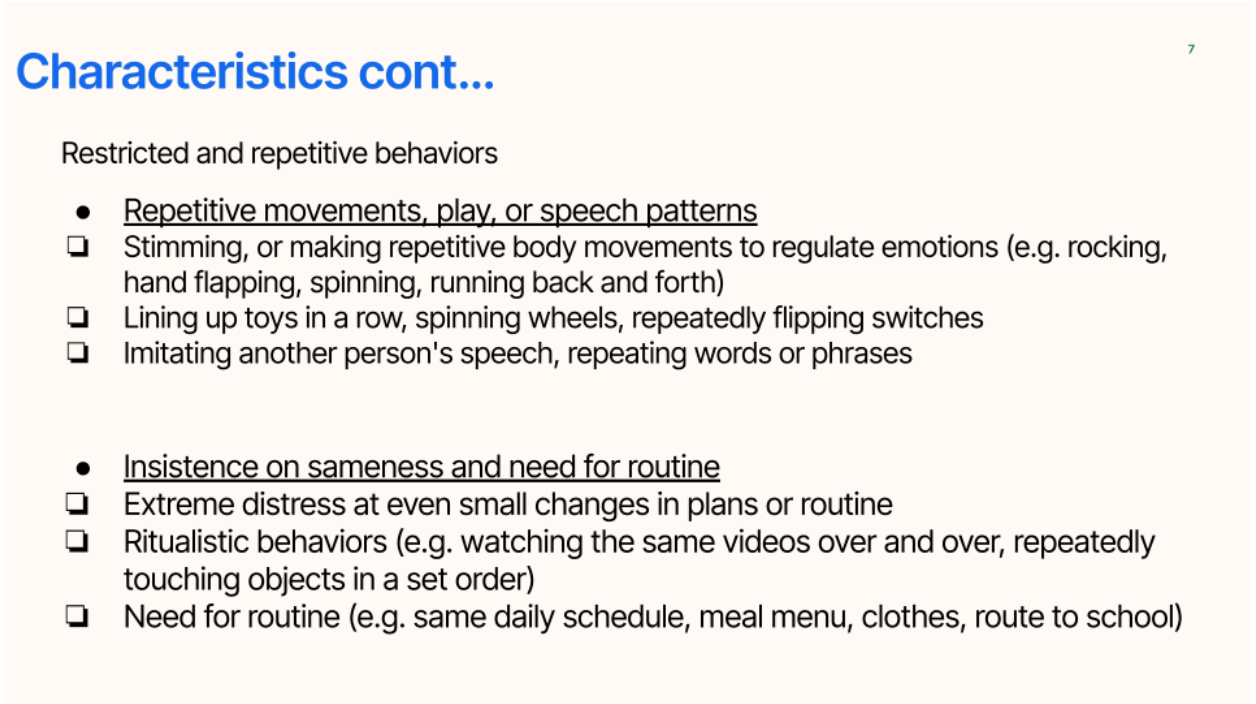
characteristics involves social communication differences. This may include difficulty with back-and-forth conversation, reduced eye contact, challenges understanding social cues, or difficulty developing and maintaining peer relationships. Some individuals may have delayed speech, while others may have strong verbal skills but struggle with pragmatic or social language.

Another core characteristic involves restricted and repetitive behaviors. This can include repetitive movements, strong preferences for routines, intense or highly focused interests, and difficulty with changes or transitions. Many individuals with ASD also experience sensory processing differences. They may be highly sensitive or under-responsive to sounds, lights, textures, smells, or other sensory input.

It is important to emphasize that characteristics can look different from one individual to another. Some individuals may require significant support, while others may function independently but still experience challenges in social or flexible thinking situations. Overall, ASD is defined not by a single behavior, but by patterns across communication, behavior, and sensory processing that impact daily functioning.

Figure 4

Characteristics of ASD



Characteristic cont...

8

- Intense and highly focused interests
  - ❏ Extreme interest or knowledge of specific, narrow topics
  - ❏ Strong attachment to a certain object (e.g. a toy or figurine)

- Under-or over-sensitivity to sensory stimulation
  - ❏ Sensory differences, like unusual sensitivity to light, sound, touch, or texture
  - ❏ Lack of sensitivity to pain or temperature
  - ❏ Sensory-seeking behaviors (e.g. smelling or touching of objects, visual fascination with lights or movement)

Other Characteristics

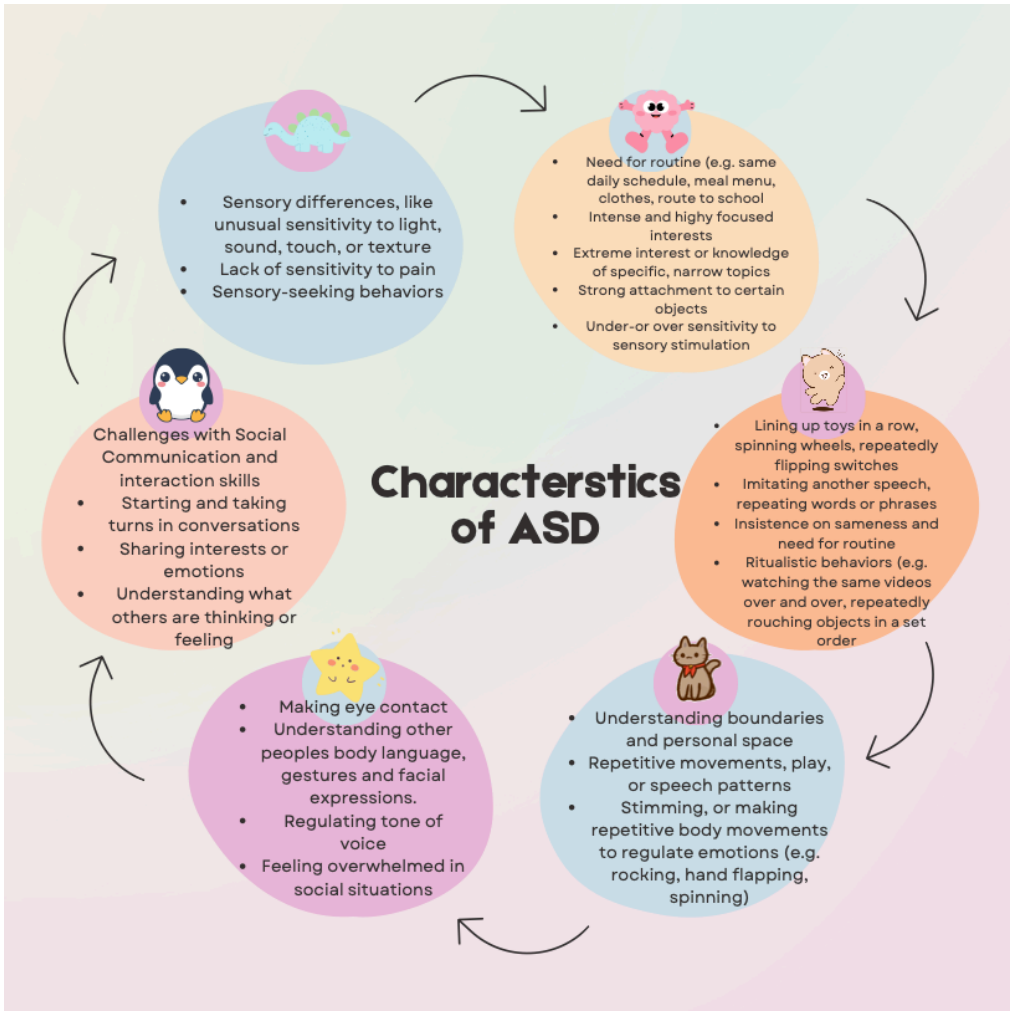
9

- ❏ Using other kinds of communication besides spoken language (e.g. typing on a computer, pointing to pictures on a tablet, or communicating through behavior.
- ❏ Difficulty with executive functioning (e.g. planning how to complete a task, juggling multiple tasks, making decisions)
- ❏ Trouble with fine motor skills and coordination
- ❏ Needing help with daily living skills
- ❏ Difficulty regulating and/or communicating emotions, sometimes resulting in harmful or self-injurious behaviors, sensory overload, meltdowns and shutdowns

Figure 5

Handout for Participants to Print

The purpose of the handout was to create a colorful image of the characteristics of ASD and to organize it on one page rather than three separate slides.



I embedded a video on signs of ASD in children. Although the video is short, it clearly illustrates the early signs of ASD in children. It was intentionally included to promote engagement and deepen participants' comprehension through a visual and real-world example.

Signs of Autism in Children

Causes of ASD

Next, participants learn about causes and treatments of ASD. Research suggests that ASD develops from a combination of genetic influences and environmental influences, including social determinants (autism speaks, n.d.). Autism risk factors include but are not limited to prenatal pesticide exposure, very low birth weight, maternal diabetes, extreme prematurity and oxygen deprivation from birth complications. Autism is often diagnosed around the same time children receive routine vaccinations, which has led to concerns about a connection-but decades of scientific research have confirmed that vaccines do not cause autism (autism speaks, n.d.).

Treatment for ASD

Treatment for ASD includes Pivotal Response Treatment (PRT) and Early Start Denver Model (ESDM). Pivotal Response Treatment, or PRT, is a type of intervention used with individuals who have Autism Spectrum Disorder. It is based on Applied Behavior Analysis (ABA), but it looks very different from traditional structured ABA because it is more natural and play-based. PRT focuses on improving what are called *pivotal skills*. These are important skills like motivation, social initiation, and self-management. The idea is that when these core skills improve, many other areas of development improve as well (Politte, et al., 2015).

During PRT, the child leads the activity. Instead of the therapist choosing what to work on, the child's interests are used to create learning opportunities. For example, if a child is interested in a toy, the therapist uses that interest to encourage communication or social interaction. Another important feature of PRT is natural reinforcement. This means the reward is

directly related to the behavior. If a child asks for a toy, the reward is getting to play with the toy, not a sticker or candy. This helps skills transfer to real-life situations. Overall, PRT is effective because it increases motivation, reduces frustration, and helps children use skills across different settings like home, school, and the community. PRT is only effective if the caregivers and staff are consistent and use PRT effectively.

The Early Start Denver Model, or ESDM, is an early intervention approach designed for young children with Autism Spectrum Disorder, typically between the ages of one and four years old. It is based on principles of ABA, but it also incorporates developmental and relationship-based strategies.ESDM is play-based and focuses heavily on building positive relationships between the child and the adult. Learning takes place during natural routines such as play, meals, and daily interactions rather than in highly structured teaching sessions (Lord et al., 2014).

This approach targets multiple areas of development at the same time, including communication, social interaction, cognitive skills, and motor development. The goal is to support overall development rather than focusing on isolated behaviors. A key component of ESDM is parent and caregiver involvement. Parents are trained to use strategies during everyday interactions, which helps children practice skills consistently across different settings. Overall, ESDM is effective because it starts early, uses natural and engaging interactions, and supports both the child and family in promoting developmental growth.

Medications

It is important to understand that there is no medication that cures or treats Autism Spectrum Disorder itself. Autism is a neurodevelopmental condition, and medication does not

change the underlying neurological differences. However, medications can be helpful in managing certain symptoms that may interfere with daily functioning, learning, or quality of life. These medications are used to support individuals with ASD, not to treat autism directly.

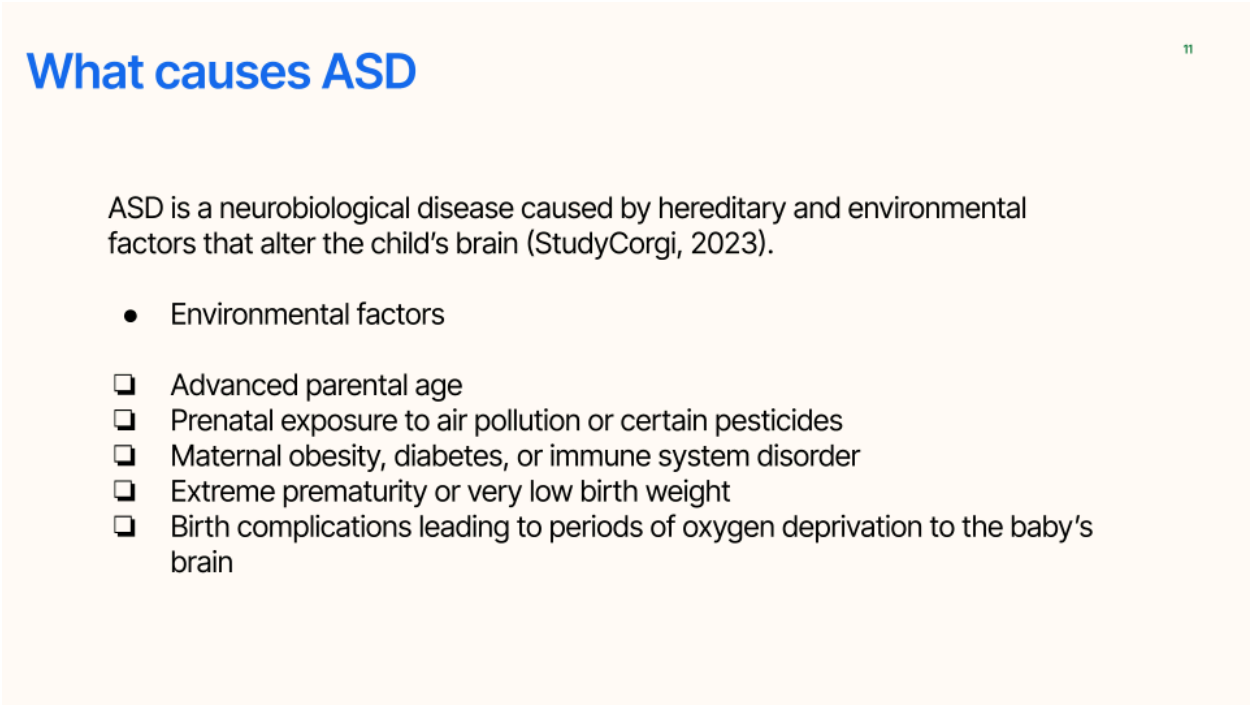
Some medications are used to help with irritability, aggression, or severe behavioral challenges. Risperidone and aripiprazole are two medications that are FDA-approved for treating irritability associated with autism.

Other medications may be prescribed to address anxiety, mood difficulties, attention problems, or hyperactivity. For example, antidepressants like SSRIs may be used for anxiety, while stimulant or non-stimulant medications may help with attention and impulse control.

Sleep difficulties are also common in individuals with ASD, and melatonin is frequently used to support sleep regulation. Medication decisions are highly individualized and are always monitored by a healthcare professional. Not every person with autism needs medication, and medications are most effective when used alongside behavioral, educational, and therapeutic support.

Figure 6

Causes of ASD



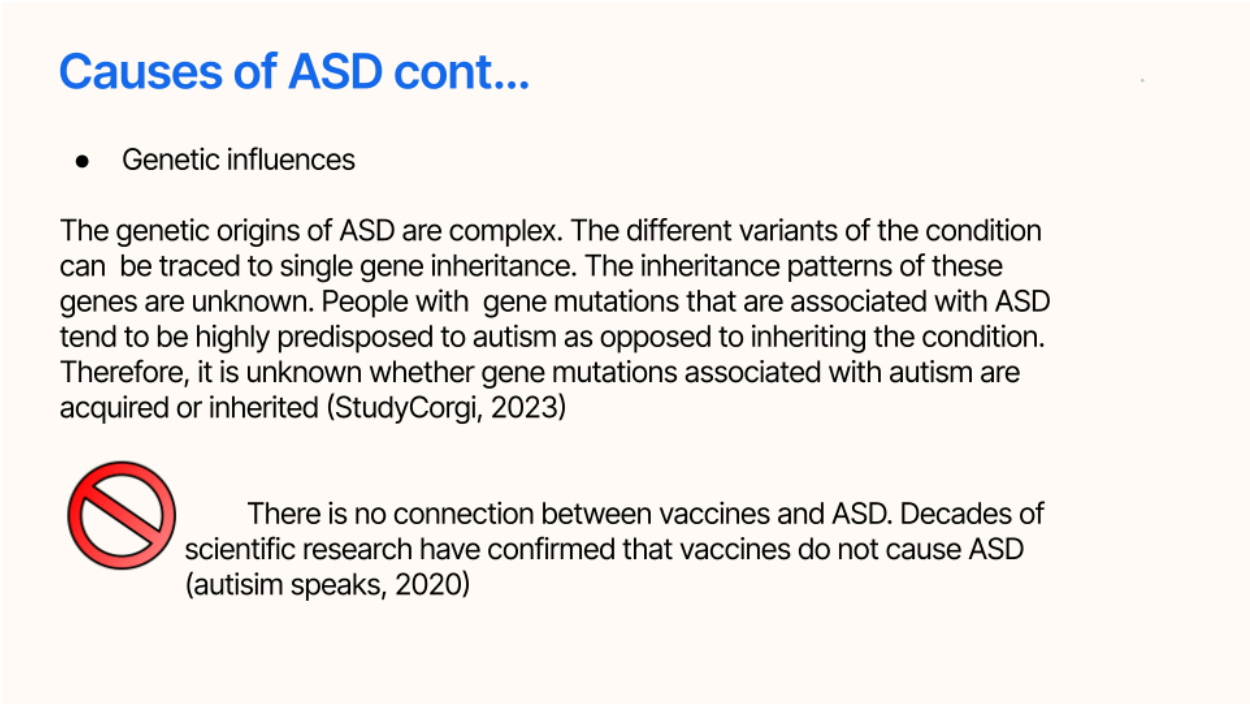
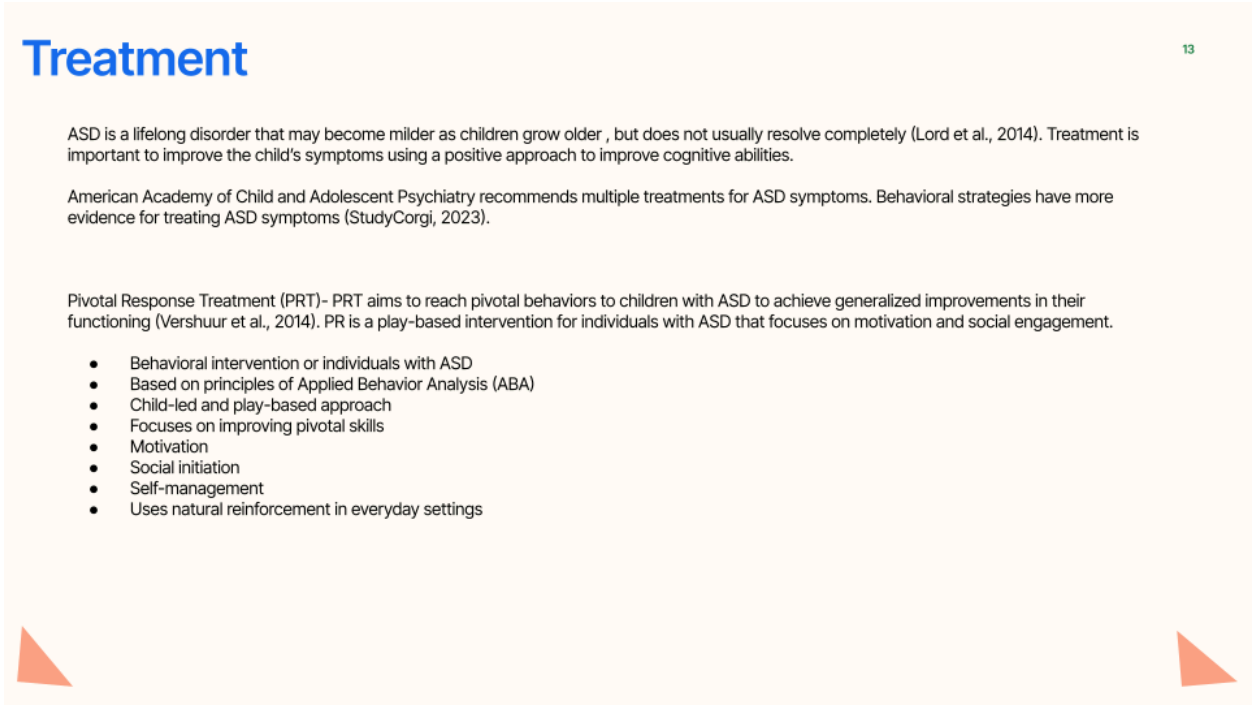


Figure 7

Treatments of ASD



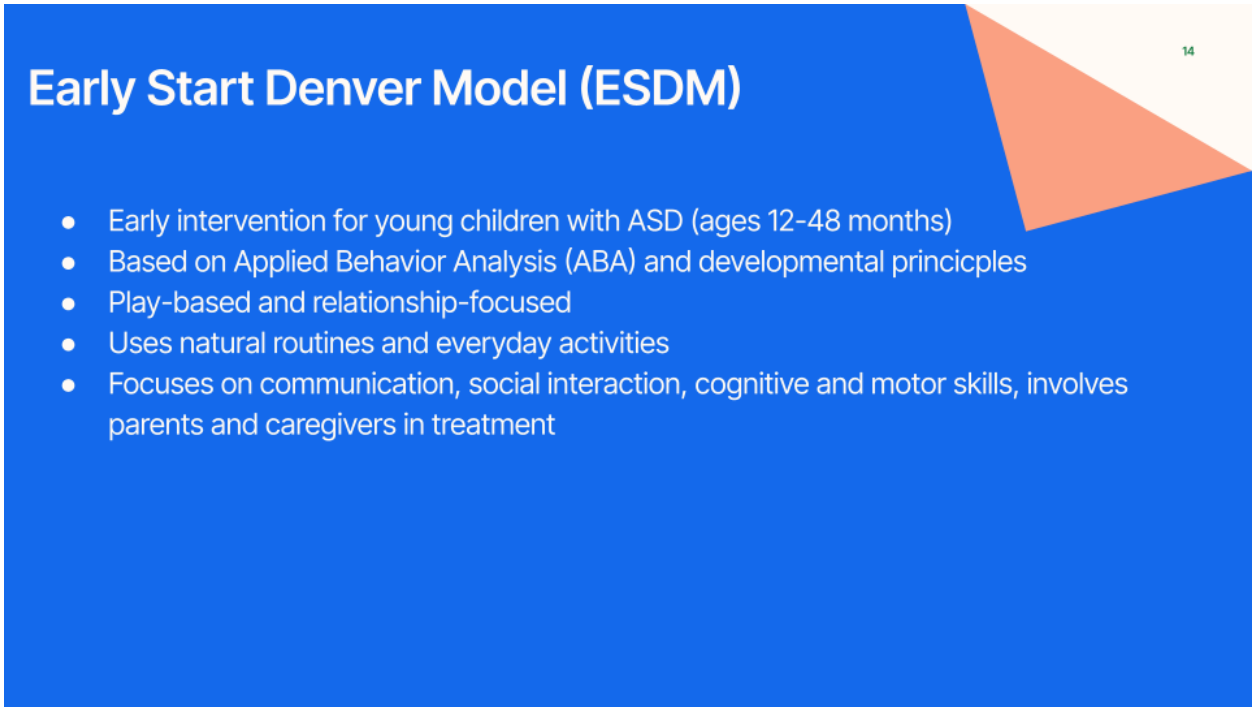


Figure 8

Medications

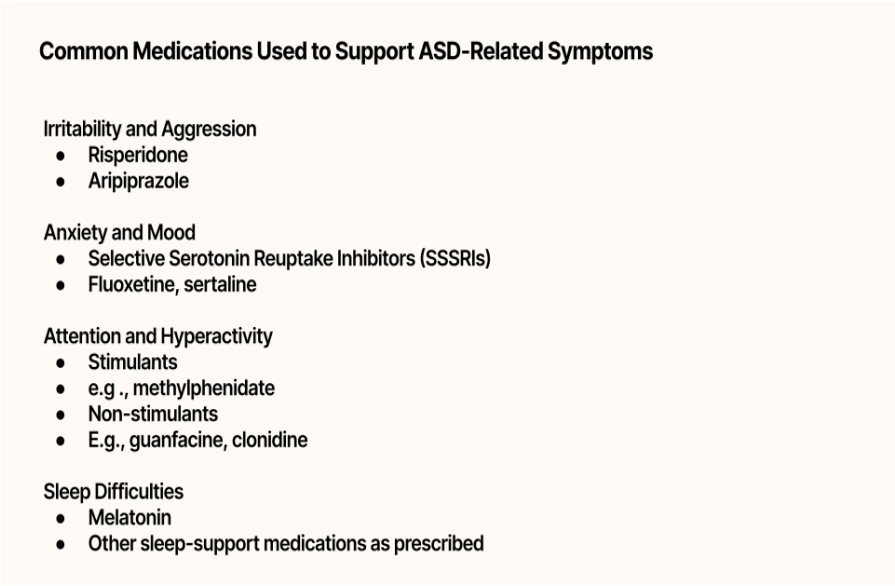
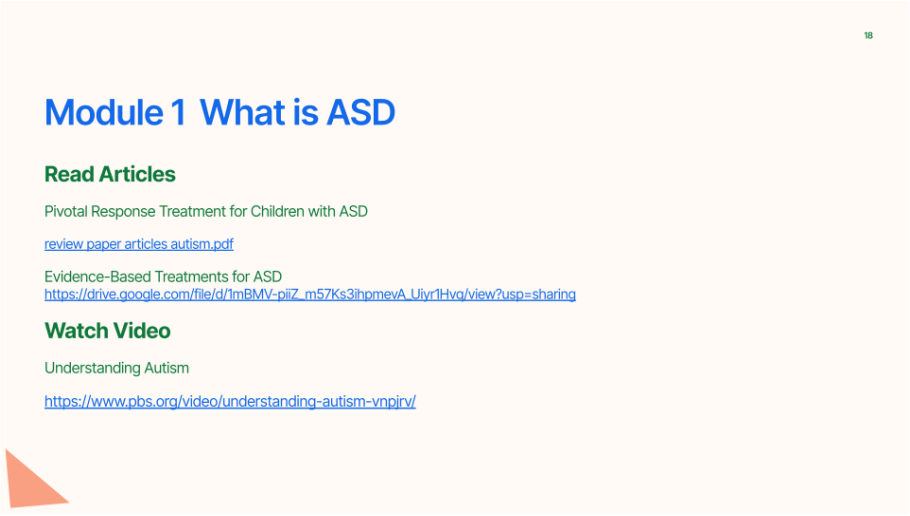


Figure 9

Assignments



Finally, the assigned readings and video were intentionally selected to reinforce key concepts and provide both research-based and practical perspectives. The discussion questions are designed to get to know each other and encourage application and reflection. Participants are expected to respond to their peers to support collaborative learning and to share their experiences.

I included two discussion questions to encourage both community building and content engagement. The first question asks participants to introduce themselves, share what motivated them to take the course, and explain what they hope to gain from it. This helps establish a sense of connection and allows participants to reflect on their personal and professional goals.

The second question asks participants to identify one takeaway from one of the assigned articles and one takeaway from the video. This ensures that participants actively engage with the materials and begin analyzing key concepts rather than passively reviewing the content. Together, these questions are designed to promote reflection, accountability, and meaningful discussion among participants. Participants are then expected to respond to three peers.

Module 2 Types of ASD

This module begins with learning objectives and the agenda. The learning objectives include the following:

- Describe the ASD diagnostic process and professionals involved.
- Identify commonly used screenings and assessment tools for ASD.
- Describe the criteria used to diagnose ASD according to the DSM-5-TR.
- Describe characteristics commonly associated with different types of ASD.

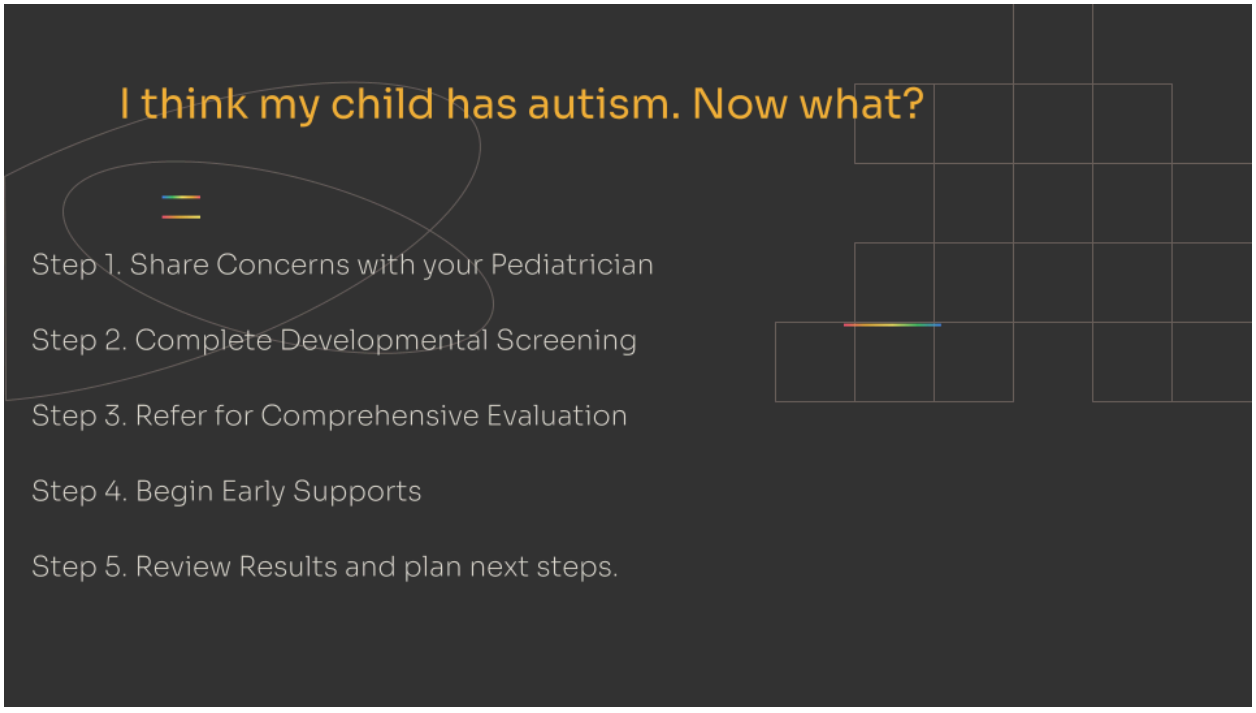
The Agenda includes:

- Watch module 2 presentation.
- Watch assigned videos.
- Read articles.
- Read case study and submit questions in discussion posts.

I start by sharing what to do if you think your child has autism.

Figure 10

What to Do If Your Child Has autism.



Step 1: Share Concerns with a Pediatrician

- Discuss developmental and behavioral concerns

- Request an autism-specific developmental screening
- Ask for referrals to specialists if concerns persist

Step 2: Complete Developmental Screening

- Use standardized screening tools (e.g., M-CHAT)
- Identify risk indicators that warrant further evaluation
- Screening does **not** equal diagnosis

Step 3: Refer for Comprehensive Evaluation

- Conducted by qualified professionals (developmental pediatrician, psychologist, or multidisciplinary team)
- Includes developmental history, caregiver interview, and direct observation
- Diagnosis is based on DSM-5-TR criteria

Step 4: Begin Early Supports

- Access Early Intervention services (birth–3) or school-based services (3+)
- Services may begin before a formal diagnosis
- Common supports include speech, occupational, and behavioral therapies

Step 5: Review Results & Plan Next Steps

- Discuss findings with the evaluation team
- Develop an individualized support plan (IFSP or IEP)
- Adjust interventions as the child develops

Evaluation vs Assessment

I share slides explaining the difference between evaluation vs assessment. An assessment focuses on specific skills or behaviors (language, cognition, social skills). The assessment is the tools and data. Evaluation combines multiple assessments including developmental history, review of records and professional judgement. Evaluation is the full process and conclusions.

Examples of evaluation include:

- A detailed interview
- Play-based and structured activities
- Multiple professionals involved
- Standardized assessment tools
- A written report
- Clear next steps

Examples of an assessment include:

1. Referral or Concern Identified

- Concerns raised by parents, caregivers, teachers, or healthcare providers
- Referral made for developmental or autism-specific assessment

2. Information Gathering

- Parent/caregiver questionnaires
- Teacher or daycare reports (if applicable)
- Review of developmental, medical, and educational records

3. Direct Observation

- Clinician observes the child during play and structured activities
- Focus on communication, social interaction, behavior, and play skills

4. Standardized Assessment Tools

- Autism-specific tools (e.g., observational and interview-based measures)
- Developmental, language, cognitive, or adaptive functioning assessments
- Tools selected based on child's age and needs

5. Additional Domain Assessments (as needed)

- Speech and language assessment
- Occupational therapy (sensory/motor skills)
- Cognitive or developmental testing

6. Scoring & Interpretation

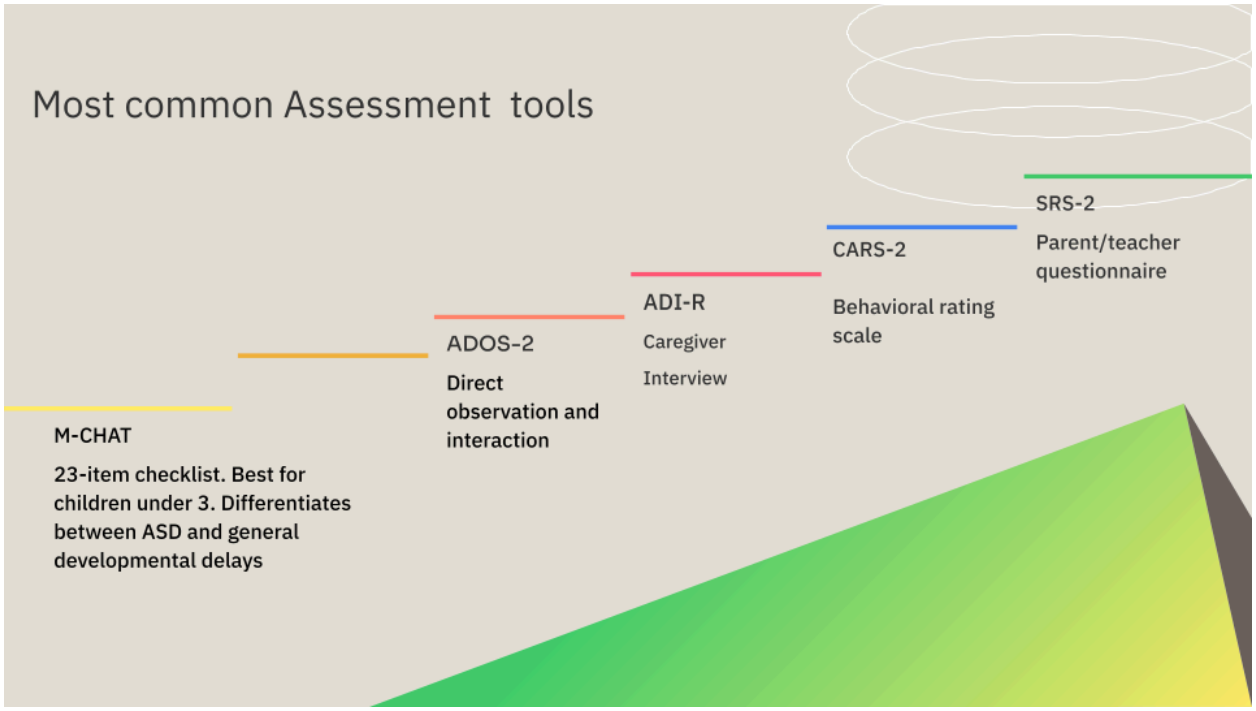
- Clinicians score assessments using standardized criteria
- Results are interpreted within developmental and cultural context

7. Summary of Findings

- Strengths and areas of need identified
- Results shared with the evaluation team for integration

Figure 11

Most Common Assessment Tools



Screening tools like the M-CHAT-R/F and ASQ-3 are often the first step. These tools help identify risk for developmental concerns, especially in young children. They do not provide a diagnosis, but they help determine whether further assessment is needed.

Autism-specific assessment tools are the core of the assessment process.

- The ADOS-2 involves structured, play-based interactions to observe social communication and behavior.
- The ADI-R is a detailed caregiver interview that focuses on developmental history.
- Tools like the CARS-2 and SRS-2 use rating scales and questionnaires to measure autism-related behaviors across settings.

DSM-5-TR

The DSM-5-TR is the official diagnostic manual used by mental health professionals in the United States. It provides standardized criteria for diagnosing conditions, including Autism Spectrum Disorder (autism speaks, n.d.). For autism, the DSM-5-TR uses a single diagnosis called ASD, reflecting that autism exists on a spectrum of strengths and support needs. Diagnosis is based on observed behaviors and developmental patterns, not medical tests. The “Text Revision” indicates updated language released in 2022 to improve clarity while maintaining the same core diagnostic criteria.Clinicians use the DSM-5-TR to interpret assessment results and make consistent, evidence-based diagnostic decisions.

Levels of support in ASD

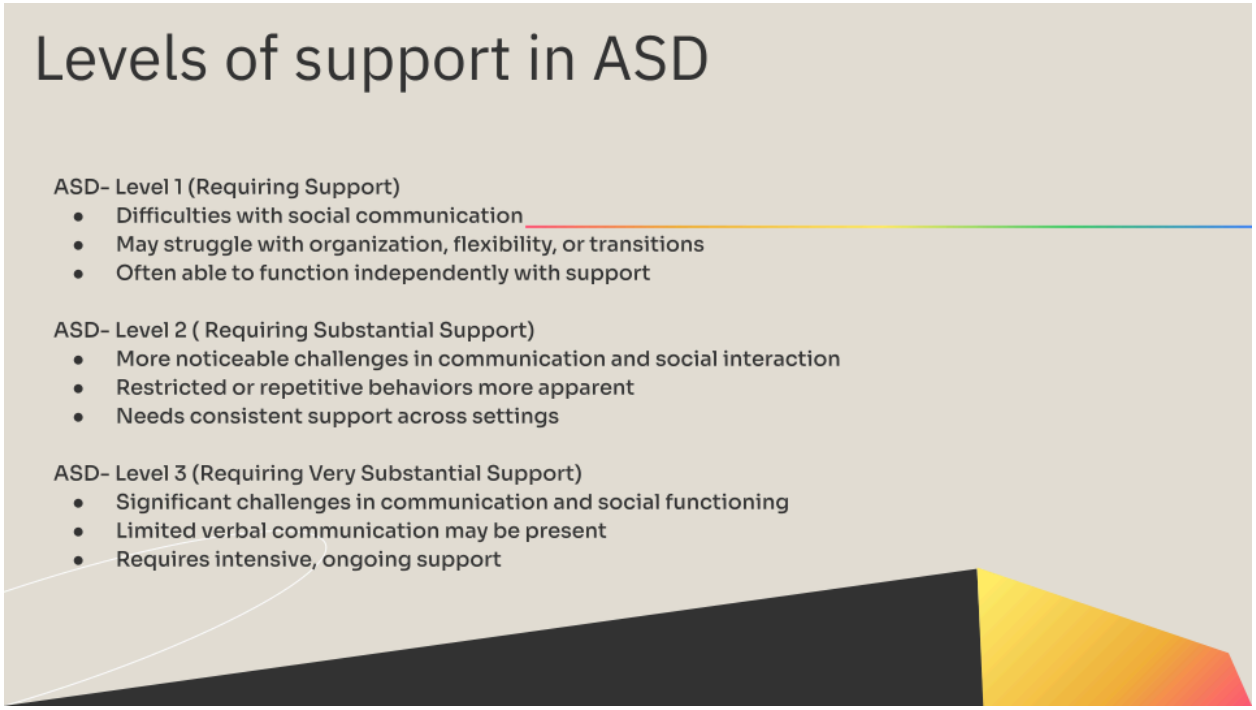
Today, autism is diagnosed as a single condition called Autism Spectrum Disorder, rather than separate types. This reflects the understanding that autism exists on a spectrum, with a wide range of strengths and support needs. The DSM-5-TR describes autism using levels of support rather than distinct categories. Level 1 indicates individuals who require support, Level 2 reflects those who need substantial support, and Level 3 describes individuals who require very substantial support across settings (National Autistic Society, n.d.).

These levels do not measure intelligence or potential. Instead, they describe how much support a person may need to navigate social communication, behavior, and daily life. You may still see older terms like Asperger’s syndrome or PDD-NOS in past records, but these are now included under the single ASD diagnosis. Overall, the spectrum model

helps professionals focus on individualized support rather than labels.

Figure 12

Levels of Support in ASD



I embedded two video clips explaining early diagnosis of ASD and what families can expect during the assessment process. The videos clearly outline how evaluations are conducted and why early intervention is important. They are intended to engage participants and provide practical context to support understanding of the assessment process.

Video clips

Autism assessment: what to expect

Why Early Diagnosis Matters For Children With Autism

Figure 13

Video Clips Slide

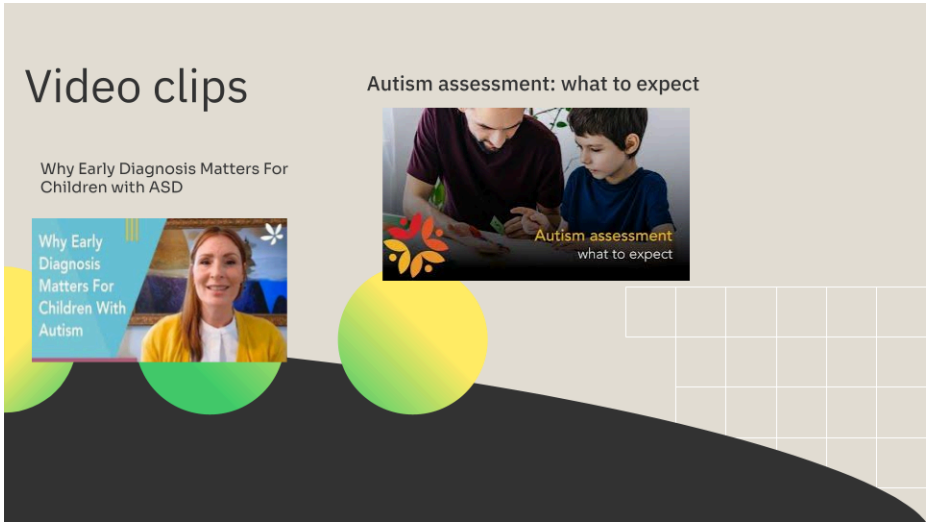


Figure 14

Reading Materials

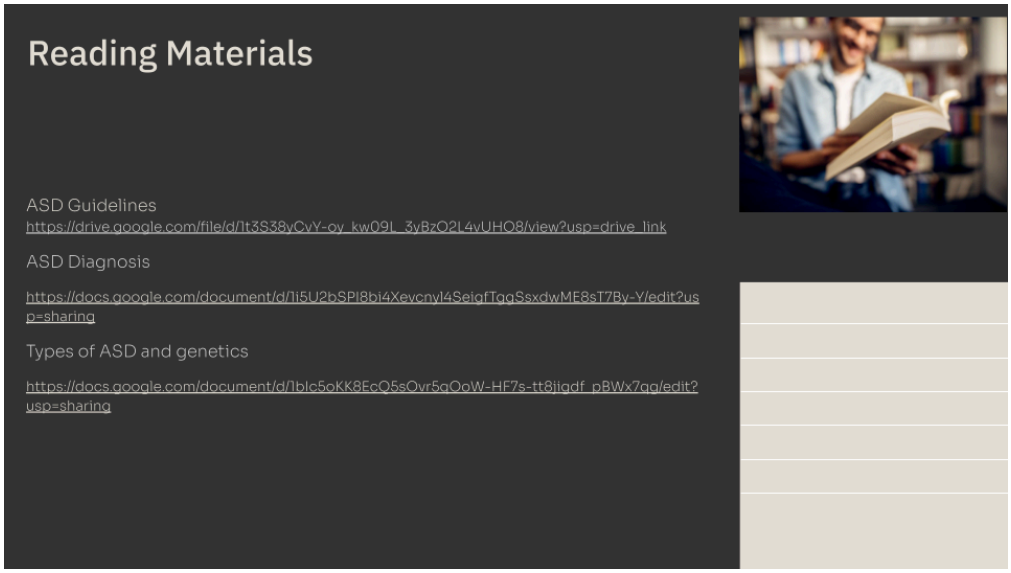
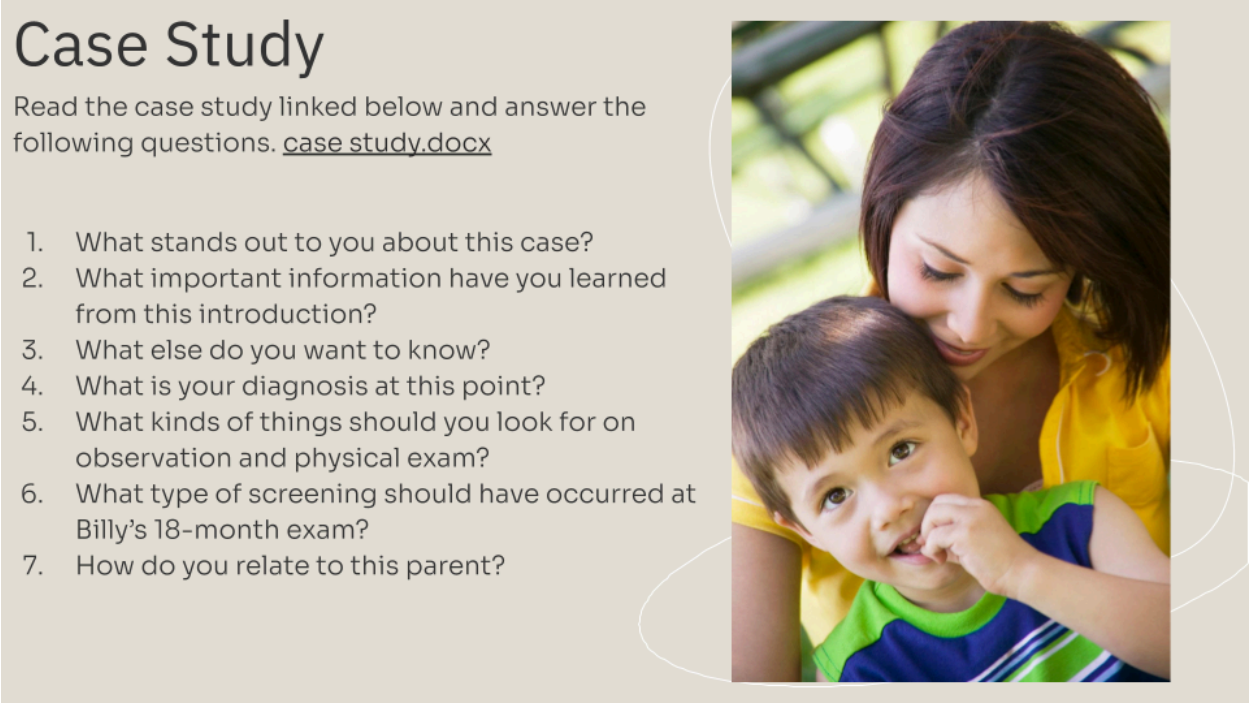


Figure 15

Case Study

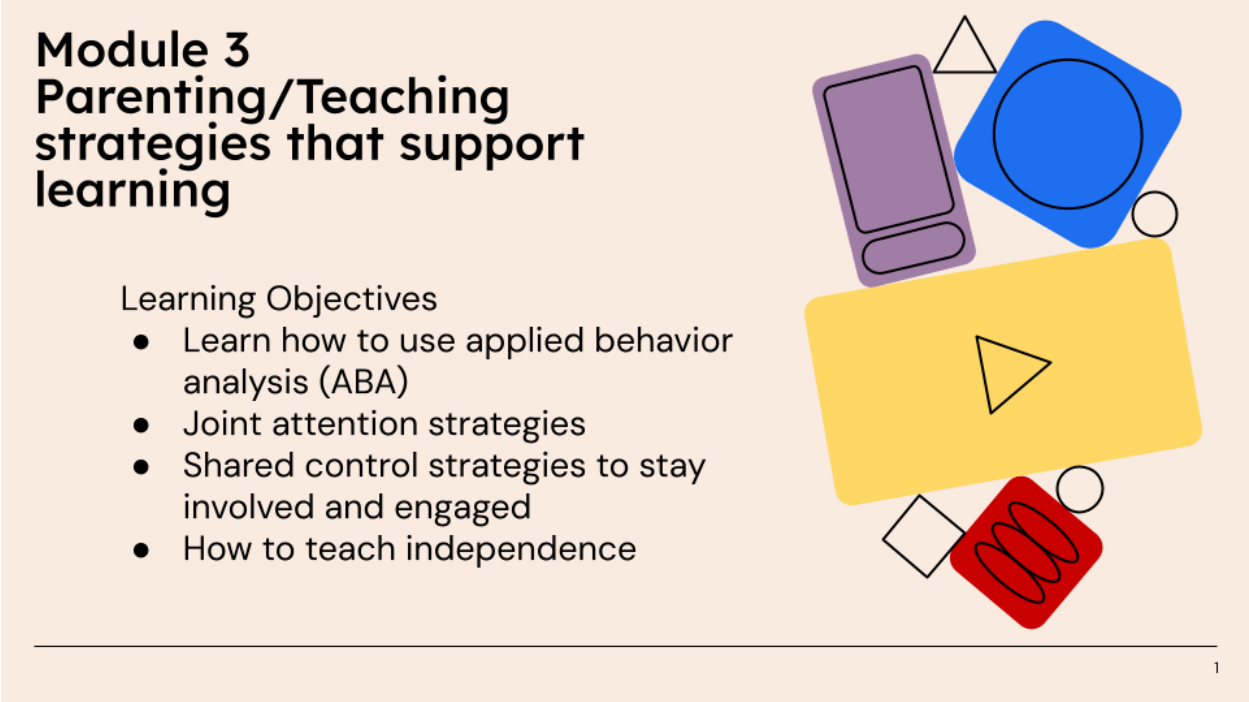


Module 3 Parenting/Teaching Strategies

This module begins with a slide outlining the learning objectives and agenda. The agenda is the same as the previous modules- read articles, watch video clips and participate in discussion posts by answering questions.

Figure 16

Learning Objectives

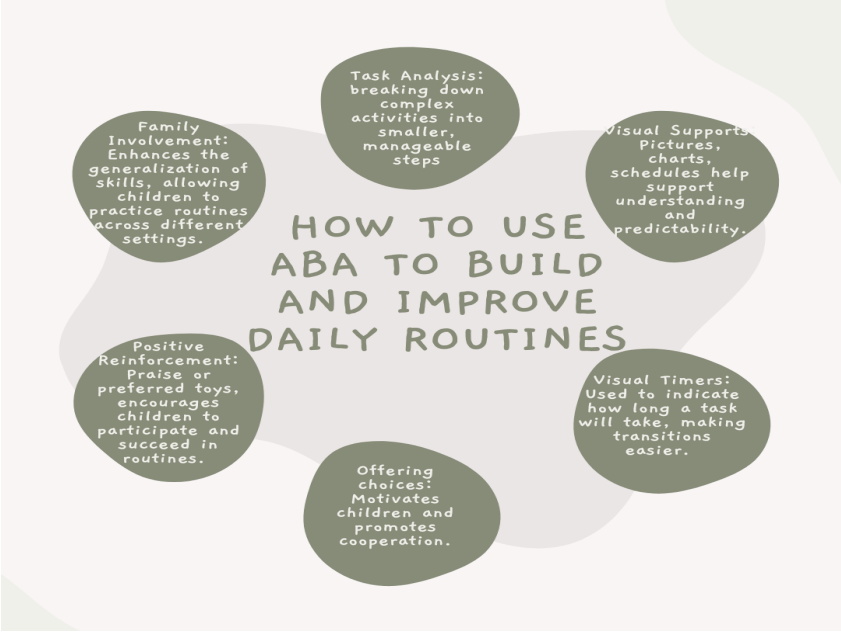


Applied Behavior Analysis (ABA)

We begin by explaining what applied behavior analysis is (ABA). ABA is an evidence-based approach to teaching and behavior support. It focuses on observable behavior. It also examines how the environment influences behavior and uses reinforcement to increase helpful skills. ABA helps educators and families understand behavior, teach replacement skills, reinforce positive behaviors and support meaningful learning and independence.

Figure 17

How to Use ABA to Build and Improve Daily Routines



Applying these methods creates a comprehensive framework for establishing effective, sustainable routines that support developmental progress in children with autism (Heartwise, 2025). Integrating ABA into daily routines offers a range of meaningful benefits for children with autism (Heartwise, 2025). One of the primary advantages is the promotion of essential skills such as communication, social interaction, and self-care. By embedding teaching strategies like task analysis, visual schedules, and reinforcement into everyday routines—such as mealtimes, dressing, or play—children can develop greater independence and confidence in completing daily tasks. ABA principles promote routines that are predictable, supportive, and adaptable. They help children feel secure, reduce behavioral challenges, and foster independence and skill mastery (Heartwise, 2025).

Figure 17

Table of Techniques

Technique	Description	Purpose
Visual Aids	Pictures, icons, charts	Enhances understanding of routines
Task Analysis	Step-by-step breakdown	Simplifies complex activities
Reinforcement	Praise or rewards	Motivates desired behaviors
Natural Environment Teaching	Applying skills in daily settings	Promotes generalization
Parental Involvement	Teaching and reinforcing routines	Ensures consistency across settings

Figure 18

Strategies to Integrate ABA

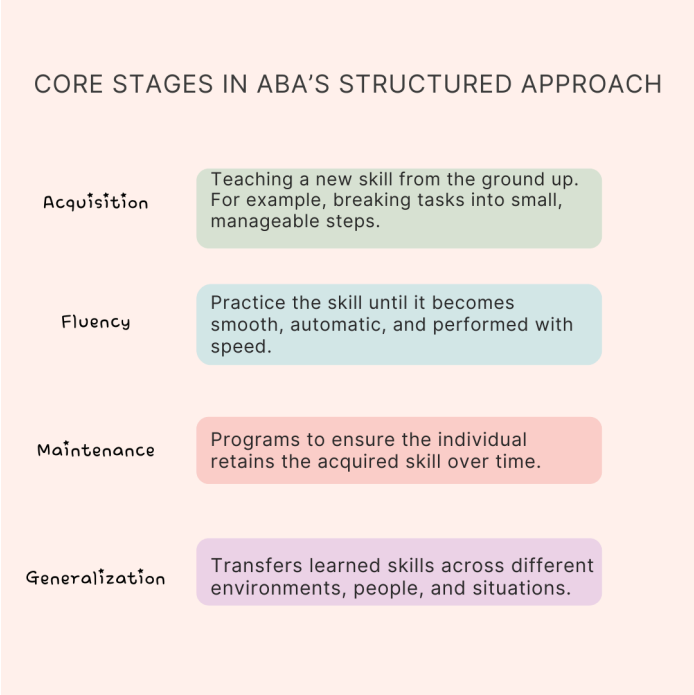
ABA follows a systematic process to help individuals develop new skills and improve behavior. This approach is organized into four main phases: acquisition, fluency, maintenance, and generalization (Heartwise, 2025). The first stage, acquisition, is focused on teaching a new skill from the ground up. During this phase, tasks are broken into small, manageable steps, often using visual aids, prompting, and reinforcement to guide learning. For example, children may learn to brush their teeth or follow simple instructions through repeated, structured practice.

Once the skill has been learned, the process moves into the fluency stage. Here, the goal is to practice the skill until it becomes smooth, automatic, and performed with speed. Techniques such as behavioral momentum and reinforcement are used to increase proficiency, ensuring the individual can perform the skill confidently and efficiently. The third stage is maintenance, which involves programs to ensure the individual retains the acquired skills over time. Regular reinforcement and periodic review are used to prevent skill decay. For instance, maintaining communication skills or self-care routines requires ongoing practice and reinforcement even when the skill is mastered.

Finally, the generalization phase helps transfer learned skills across different environments, people, and situations. This stage ensures that skills are not limited to a specific context but are applicable in real-life situations. Techniques such as varying teaching environments, using natural reinforcers, and involving family members support this broader application. Together, these four stages create a comprehensive pathway that guides individuals with autism through learning, mastering, and applying new skills in everyday life, promoting independence and improved quality of life.

Figure 19

Core Stages in ABA



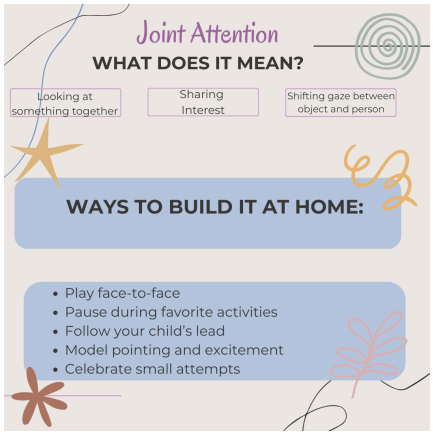
Joint Attention

Joint attention is when a child shares an interaction with an adult or another child. This

interaction does not require spoken language. In fact, joint attention is an important skill that is learned before verbal expression, and it can be exhibited through signs and gestures, eye contact, or other body movements (Huizar, n.d.). It is important for your child to recognize when you are trying to engage with them and to learn how to respond. Many young children who have autism fail to demonstrate these behaviors or the behaviors look noticeably different from what we might expect (Braddock, n.d.). A simple way to begin is by sitting next to your child and copying their actions. This is called parallel play and can naturally transition into joint play over time. When your child notices that you are imitating their actions or sounds, they may begin to imitate you as well. This back-and-forth interaction helps build connection, shared attention, and early social communication skills.

Figure 20

Ways to Build Joint Attention at Home



When building joint attention skills, choose activities that involve turn-taking and naturally draw your child's attention to your face and voice. Repeating the same activities regularly helps your child learn what to expect and feel more comfortable participating. Over

time, with consistent practice, your child may require fewer prompts and may even begin to initiate the activity on their own.

Figure 21

Joint Attention Activities

Dr. Barbara Braddock outlines seven strategies to foster joint attention in an article featured on the Autism Speaks website (Braddock, n.d.).

Seven Strategies for Joint Attention

1. Respond to movements that signal interest: I encourage you to watch the child and respond to movements that indicate interest. Do so even if the child is not deliberately using these movements to communicate with you. For example, you see your child reaching for a toy – perhaps a toy just out of reach. Promptly respond by saying something along the lines of, “I see the toy, too. Would you like to have it?"
    - Does your child sometimes hand you something? Respond to this warmly as a nonverbal sign of communication. For example, “Thank you for showing me this ball. It’s so squishy, isn’t it?”
    - Praise any effort your child makes to show or share something. For example, if your child holds an object up for you to see, respond with appreciation, such as, “Oh, yes, I see the toy car. I like it. Do you?”
    - Similarly, respond with clear interest if your child points at something – whether or not he looks at you. For example, you might mirror his movement by pointing at the same thing, then name it and ask about his interest. As in, “Yes, I see the pretty flower. Do you want to touch it?”
    - In other words, you can share your interest in many ways – through your voice, your eyes, gestures and turning your body to face your child.
2. Encourage your child to respond to gestures and words: A fun strategy we often use in speech therapy is to activate a remote-controlled toy that flashes or makes a sound immediately after pointing to it and giving a verbal prompt such as “Look at the funny toy.” Just take care that the flashing or beeping doesn’t alarm or overwhelm your child.
3. Pair gestures and words: When talking with your child, point, touch and/or show objects

or actions to share with him. For example, you might point to a bird and say, "Look, the bird is eating". You can hold up something in your child's line of vision and comment, "Look, I have a cup of juice."

4. Use gestures in play: It's fun and easy to incorporate gestures in games and routines. A great example is the "so big" gesture with spread arms. ("How big is Aaron? He's sooo big! Can you show me how big you are? Sooo big.") Conversely, you can use your thumb and pointer finger to use the "so little" sign when talking about, say, an insect on the sidewalk. ("Look, the bug is soooo little.")
5. Have fun with facial expressions: Try making silly faces with your child. Imitate his facial expressions in a loving, friendly way. Then see if he will imitate you. This type of interaction – just between two people, no object – can be particularly helpful in developing joint attention.
6. Share focus: Playing with a toy can be a starting point for you and your child to enjoy and share interactions. For example, while you and your child are playing with toy trucks, you can imitate how he pushes a truck back and forth. Then prompt him to imitate you loading it up.
    - You can expand play by making it more creative – such as adding a toy driver or parking the truck in a pretend garage.
7. Share books: Sharing a picture book with your child may be one of the most powerful ways to foster joint attention as well as language. You don't need to read the book word-by- word.
    - Point at pictures and talk about them. Relate them to your child's experiences. For example, "Look, it's a dog! … The dog is eating its dog food. Grandma has a dog, doesn't

she? … What do dogs do?”

Shared Control Strategies to Stay Involved and Engaged

Promoting social interaction for children with Autism Spectrum Disorder (ASD) involves a combination of strategies that focus on natural, motivating activities, supported by structured teaching methods and supportive environments (Mastermind behavior services, n.d.). One effective approach to promoting social engagement in children with ASD is embedding social components into activities that align with the child’s interests. For example, if a child is highly interested in trains, creating playful train-themed scenarios can naturally introduce opportunities for sharing, turn-taking, and conversation. When children participate in activities they find meaningful, their motivation to communicate and interact often increases.

Pivotal Response Treatment benefits

Evidence-based strategies such as Pivotal Response Treatment (PRT) can further support social skill development. PRT focuses on reinforcing positive social behaviors—such as eye contact or initiating communication—within natural play and daily routines. It emphasizes natural reinforcement, modeling appropriate responses, and breaking social skills into smaller, manageable steps to promote success. Visual supports are also essential tools for enhancing social participation. Social stories, visual schedules, and picture cards help children understand expectations and interpret social cues. These supports reduce anxiety and provide structure, making social situations more predictable and accessible.

Peer Involvement

Peer involvement is another important component. Pairing children with peers—whether typically developing peers or other children with ASD—creates opportunities for observation,

imitation, and practice of appropriate social behaviors. Structured peer-mediated interventions, such as social skills groups or guided playdates, encourage interaction within a supportive and intentional setting. Creating supportive environments in natural contexts further strengthens spontaneous social engagement. Small group activities, structured play opportunities, and community outings allow children to explore social roles in familiar settings such as classrooms, parks, or community centers.

Environmental Structuring

Environmental structuring also plays a significant role. Calm, predictable spaces help minimize sensory overload and improve focus during social interactions. Clear routines and visual cues support expectations and reduce uncertainty. Overall, combining interest-based activities, evidence-based teaching strategies, visual supports, peer involvement, and structured environments creates a comprehensive approach. This integrated model enhances motivation, improves understanding, and supports meaningful social engagement for children with ASD.

Figure 22

Strategies For Shared Activities

Independence

Teaching independence skills is crucial for children, especially those with autism. Encouraging independence helps children develop a strong sense of self-belief, fostering confidence, communication skills, curiosity, resilience, and creativity (MagnetABA, 2025). Independence skills play an important role in helping children feel confident and capable. When children learn everyday life skills, they begin to believe in themselves and feel proud of what they can do on their own. Each new skill they master builds their confidence and encourages them to try new things. As their independence grows, they feel more prepared to handle challenges because they know they have the tools and abilities to succeed.

Figure 23 Table

Importance of Independence Skills

Benefits of Teaching Independence Skills	Description
Builds Confidence	Helps children feel secure in their abilities.
Encourages Resilience	Teaches problem-solving and coping with challenges.
Fosters Self-Reliance	Enables them to handle tasks independently.
Promotes Skill Development	Encourages mastery of essential life skills.

Developing Life Skills

Developing life skills is essential in the journey towards independence for children with autism (MagnetABA, 2025). Life skills are the everyday abilities children use to take care of themselves and interact with the world around them. These include things like personal care,

communicating their needs, getting along with others, and making simple choices. As children learn and practice these skills, they grow more confident and begin to feel proud of what they can do on their own.

Parents can support this growth by including their children in everyday routines in fun and meaningful ways. Inviting a child to help with simple household chores, pack their backpack, or plan a family outing gives them real-life practice. These hands-on experiences help children build important skills while also giving them a wonderful sense of accomplishment when they complete a task successfully.

Figure 23 Table

Life Skills

Key Life Skills	Examples
Personal Care	Dressing, grooming, hygiene
Communication	Verbal and non-verbal interactions, active listening
Social Skills	Sharing, taking turns, conflict resolution
Decision-Making	Choosing appropriate responses, evaluating outcomes

Strategies for Teaching Independence

Teaching independence in children with autism requires a variety of effective strategies tailored to their unique learning styles. This section highlights three key approaches: task analysis and chaining, video modeling, and repetition and practice (MagnetABA, 2025).

- Task Analysis and Chaining. are essential methods for breaking down complex skills into smaller, manageable steps (MagnetABA, 2025). Task analysis means breaking a skill

down into small, manageable steps so a child can learn one part at a time. Chaining is teaching those steps in order, helping the child put them together until they can complete

- the whole task independently. These approaches often use visual support and clear, structured guidance, which can be especially helpful for children with autism as they build confidence and independence. Research indicates that breaking tasks into smaller steps can make it easier for children to follow along and learn (Magnet ABA, 2025).
- **Video Modeling** is an effective technique that utilizes video to show desired behaviors or skills. By watching others perform a task, individuals with autism can visualize how to replicate the actions themselves (MagnetABA, 2025). This approach can be especially helpful for children who learn best by seeing things demonstrated. Watching a skill in action makes it easier to understand what to do and helps children feel more confident trying it on their own. Many children with autism respond very positively to video-based instruction, which can make learning new skills smoother, more engaging, and more successful in everyday routines.
- **Repetition and Practice** are crucial for helping children with autism master life skills. Research highlights that these individuals often require explicit instruction, along with additional repetitions, to effectively learn skills (MagnetABA, 2025). Skills like self-care, simple cooking, handling money, shopping, and learning about transportation can be taught step by step over time. As children gradually build these abilities, they gain the tools they need to feel more confident and independent in different settings—at home, at school, and out in the community.

Figure 24 Table

Examples of Strategies to Build Independence

Task Analysis Steps	Example for Making a Sandwich
Identify the task	Making a sandwich
Break it down	1. Gather ingredients 2. Spread mayo 3. Add lettuce 4. Slice tomatoes 5. Add turkey 6. Close sandwich
Teach each step	Provide visuals for each step, demonstrate, and assist as needed

Figure 25 Table

Repetition and Practice

Skills for Independence	Suggested Practice Activities
Self-Care	Brushing teeth, dressing, personal hygiene
Cooking	Making simple meals, following recipes
Money Management	Recognizing bills, making small purchases
Shopping	Creating a shopping list, using a shopping cart

Fostering independence in children with autism is essential, as it allows them to navigate daily life more effectively. Several strategies can support this development, including life skills training, visual aids, and understanding sensory sensitivities (MagnetABA, 2025). Teaching life skills little by little helps children build the tools they need to become more independent. As they grow and practice these skills, they feel more confident managing tasks at home, succeeding at school, and participating in their community.

Articles

Students are expected to read the attached articles as part of their weekly assignments in the agenda. After participants read the articles, they will watch the following video clips and then participate in the discussion for module 3.

- https://www.magnetaba.com/blog/teaching-independence-in-autism?
- https://aimhigheraba.com/self-management-skills-teaching-independence-and-responsibility/
- https://www.heartwisesupport.org/post/using-applied-behavior-analysis-to-build-daily-routines

Video Clips

- PROFESSIONALS— Joint Attention, Play & Engagement Regulation for Kids w/ Autism (PART 8)
- What is autism and how does ABA therapy work?
- Teaching Self Care Skills and Independent Behaviors to Kids with Autism

Discussion Question

Participants will answer questions below based on the following video.

PROFESSIONALS— Joint Attention, Play & Engagement Regulation for Kids w/ Autism (PART 8)

1. How does the video define joint attention, and why is it considered foundational for social development in children with ASD?

2. What strategies presented in the video could be implemented in a classroom or home setting? Provide a specific example.
3. How does following a child's interests increase engagement and social interaction? Why is motivation emphasized in the intervention approach?
4. According to the video, how should adults balance guidance with allowing child-led interaction? What does this suggest about shared control?
5. What was one key takeaway from the video that challenged or reinforced your understanding of joint attention skills?

Participants will post their response to the questions (300 words) and reply to 3 peers (150 words).

Module 4 Communication

Module 4 examines evidence-based strategies for supporting communication in children with ASD. Participants will learn about Augmentative and Alternative Communication (AAC) devices and the picture exchange communication system (PECS), including their purpose, implementation, and role in enhancing language development. In addition, the module highlights the use of speech therapy, visual supports and practical instructional strategies to promote meaningful communication and language growth across settings. Just like the other modules, participants will review the slideshow, read assigned articles, watch video clips, and participate in weekly discussions.

Visual Supports

Children with ASD often experience difficulty processing spoken language. When

listening to others speak, they may struggle to keep up with the pace of conversation. By the time they begin to understand the first sentence, the speaker may have already moved on to several more. Even when a child with ASD appears attentive, they may miss significant portions of the message due to challenges with auditory processing and language comprehension.

In contrast, many children with ASD have strengths in processing information visually and in thinking spatially. In the classroom, communicating visually can make a big difference. (This is not to say that verbal communication should stop—children with ASD still need opportunities to develop their language skills.) Visual supports come in many forms: pictures, objects, gestures, and text (once children can read). Images found online, labels from packaging, pictures in catalogs, or software developed specifically for children with ASD are all possible sources of visual support. Basically, anything informative that children with ASD can see may be considered a visual support (Naeyc, 2019).

Six strategies for using visual supports

1. **Tell a child where to sit or stand.** Placing markers on the floor to show where to stand when lining up or having a marker on the table or chair showing where to sit lets children with ASD know where they are supposed to be. Carpet squares or classroom rugs with defined seating areas serve the same purpose. You can also tape a line in hallways to help direct children.
2. **Show the schedule of classroom activities.** For children with ASD, it may be helpful to have their own individual schedules that they can manipulate. Providing one picture for each activity and lining them up vertically makes it easier for many children with ASD to know what's happening throughout the day.

Some children do better if they carry the picture representing an activity with them to the activity area and check in. Other children prefer to turn the picture over and then make their way to the appropriate area.

3. **Support understanding what you are saying.** Having pictures to accompany your verbal directions can help if a child with ASD appears distressed. Try using a visual guide instead of a verbal one (since hearing even more hard-to-understand words may increase the child's frustration). To support children with ASD in group activities, you may find it helpful to show a large picture of "sit down" or "be quiet," or to have a set of pictures on a lanyard you can show to individual children when necessary.
4. **Help a child develop self-regulation.** To foster children's social and emotional development, parents often share—and have children practice—strategies for calming down, like breathing deeply or going to a cozy nook in the room. For children with ASD, visual explanations and reminders of these strategies can help them self-regulate, especially when they are beginning to become upset. Showing a picture of a person taking a deep breath or squeezing his or her hands together provides a model that is easier to understand than a verbal direction (Naeyc, 2019). Self-regulation skills for positive emotions (like being excited) need to be taught too. For example, a five-point scale for voice level (figure 26) can be represented visually so all the children know when they are using an outside voice or inside one.
5. **Foster independence.** Visually presenting the steps to complete a task encourages children to be independent. For example, you could list the steps for brushing your teeth, washing your hands, and using the bathroom; select a picture to represent each step; and post these guides in the appropriate areas of the bathroom (Figure 27). Functional

routines, like hanging up coats, can also be represented with pictures. Another use of visual support is to put photos of toys and other classroom materials on the shelves where they belong so children can clean up without assistance, enabling children to be independent in this classroom task or home setting. Sometimes, taking the adult who is providing verbal directions out of the situation results in the child with ASD being more willing and able to follow directions.

6. **Expand the use of expressive language.** Children with ASD often experience challenges with expressive language. Providing visual supports, such as single-picture symbols for emerging communicators and language expansion boards for children with more developed skills, can encourage expressive communication with or without spoken language. When a child hands a picture to a communication partner or points to a visual to share information with a teacher/parent or peer, this serves as intentional communication, particularly for children who are nonverbal. These supports enhance mutual understanding between the child and the adult. Additionally, increasing a child's ability to communicate effectively often leads to a reduction in challenging behaviors, as communication provides an appropriate means for expressing needs and wants.

Figure 26

Five-point scale

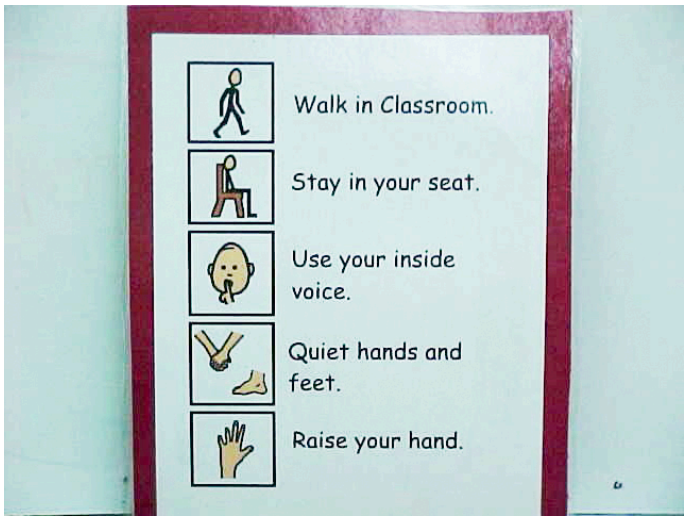


Figure 27

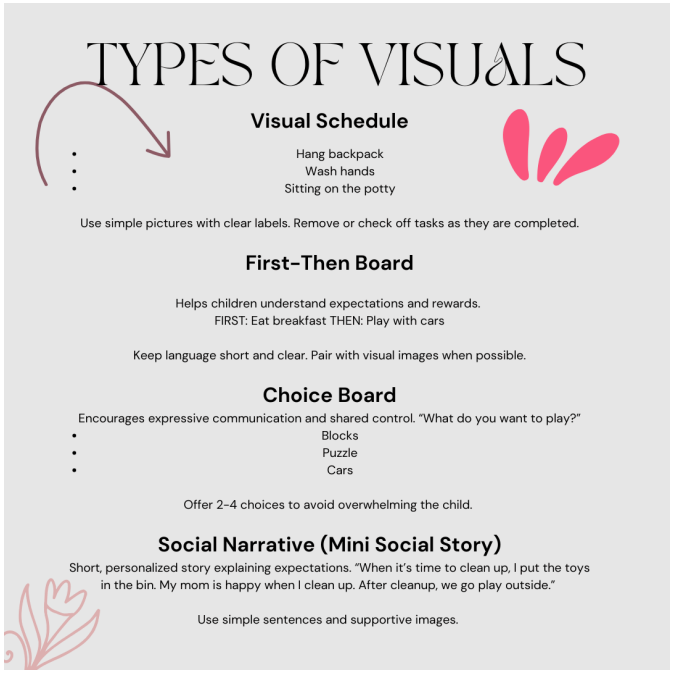
Visual Steps

Figure 28

Visual Supports for Children with ASD

Figure 29

Types of Visuals



Strategies to support language development

Teaching nonverbal autistic children to talk can be challenging. We must remember that children with autism are communicating with gestures, signs, and non-verbal cues. Researchers published the hopeful findings that, even after age 4, many nonverbal children with ASD eventually develop language (autism speaks, n.d.). Autism Speaks offers seven strategies for promoting language development in children and adolescents with nonverbal autism:

1. **Encourage play and social interaction.** Children learn through play, and that includes learning language. Interactive play provides enjoyable opportunities for you and your child to communicate. Try a variety of games to find those your child enjoys. Also try playful activities that promote social interaction. Examples include singing, reciting nursery rhymes and gentle roughhousing. During your interactions, position yourself in front of your child and close to eye level – so it's easier for your child to see and hear you.
2. **Imitate your child.** Mimicking your child's sounds and play behaviors will encourage more vocalizing and interaction. It also encourages your child to copy you and take turns. Make sure you imitate how your child is playing – so long as it's a positive behavior. For example, when your child rolls a car, you roll a car. If he or she crashes the car, you crash yours too. But don't imitate throwing the car!
3. **Focus on nonverbal communication.** Gestures and eye contact can build a foundation for language. Encourage your child by modeling and responding to these behaviors. Exaggerate your gestures. Use both your body and your voice when communicating – for example, by extending your hand to point when you say "look" and nodding your head when you say "yes." Use gestures that are easy for your child to imitate. Examples

include clapping, opening hands, reaching out arms, etc. Respond to your child's gestures: When she looks at or points to a toy, hand it to her or take the cue for you to play with it. Similarly, point to a toy you want before picking it up.

4. **Leave "space" for your child to talk.** It's natural to feel the urge to fill in language when a child doesn't immediately respond. But it's so important to give your child lots of opportunities to communicate, even if he isn't talking. When you ask a question or see that your child wants something, pause for several seconds while looking at him expectantly. Watch for any sound or body movement and respond promptly. The promptness of your response helps your child feel the power of communication.
5. **Simplify your language.** Doing so helps your child follow what you're saying. It also makes it easier for her to imitate your speech. If your child is nonverbal, try speaking mostly in single words. (If she's playing with a ball, you say "ball" or "roll.") If your child is speaking single words, up the ante. Speak in short phrases, such as "roll ball" or "throw ball." Keep following this "one-up" rule: Generally use phrases with one more word than your child is using.
6. **Follow your child's interests.** Rather than interrupting your child's focus, follow along with words. Using the one-up rule, narrate what your child is doing. If he's playing with a shape sorter, you might say the word "in" when he puts a shape in its slot. You might say "shape" when he holds up the shape and "dump shapes" when he dumps them out to start over. By talking about what engages your child, you'll help him learn the associated vocabulary.
7. **Consider assistive devices and visual supports.** Assistive technologies and visual supports can do more than take the place of speech. They can foster its development.

Examples include devices and apps with pictures that your child touches to produce words. On a simpler level, visual supports can include pictures and groups of pictures that your child can use to indicate requests and thoughts.

Augmentative and Alternative Communication (AAC) device/picture exchange communication system (PECS)

An AAC device refers to any system that supports or replaces spoken language (StudyCorgi, 2023). AAC includes picture systems, communication boards, speech-generating devices, iPad communication apps, sign language, and written communication. AAC can be low-tech (paper, pictures, boards) or high-tech (electronic devices with voice output). The purpose of an AAC device is to give children a reliable, functional voice that increases communication, independence and quality of life. It also helps to reduce frustration and challenging behavior. The best person to talk to about AAC is a speech language pathologist (SLP).

PECS is a picture-aided AAC system, which involves certain stages of learning. PECS aids in teaching skills such as using a certain picture to express a request for an item or even making complex messages that serve various communication purposes (StudyCorgi, 2023).PECS is a low-tech AAC system that uses picture exchange to teach requests through exchange. Before using PECS for a student with communication disorders, fundamental assessments have to be done. These assessments are meant to establish specific interventions criteria for each situation (StudyCorgi, 2023).

Speech language Pathologist (SLP)

Speech-language therapy addresses challenges with language and communication. It can help people with autism improve their verbal, nonverbal, and social communication. The overall goal is to help the person communicate in ways that better meet their needs and goals (autism speaks, n.d.).

A speech therapy program typically begins with a comprehensive evaluation conducted by a speech-language pathologist (SLP) to assess the individual's communication strengths and areas of need. Based on the results of this assessment, the SLP develops individualized therapy goals tailored to the person's specific communication profile.

Common goals may include increasing spoken language skills, developing nonverbal communication methods such as gestures or sign language, or implementing alternative communication systems, such as picture-based supports or speech-generating devices. The overall objective is to enhance functional communication and promote greater independence across settings.

Some young children receive speech therapy services through their state's Early Intervention (EI) program. Early Intervention services are available in every state for children under the age of three who are experiencing developmental delays or are not progressing at the expected rate. These services are federally supported and are typically provided at no cost or on a sliding scale based on family income.

Agenda

Participants will now watch the following video clips and read the following articles

below. They will then answer the discussion questions and respond to three peers' posts. The discussion post must be 300 words or more. Peer posts must be 150 words or more.

Video clips

Visual Schedule for Children with Autism Spectrum Disorder

First-Then Boards for Children with Autism Spectrum Disorder

Challenging Behaviors: Charlie and Eileen's Story

Articles

Visual Supports and Autism

https://studycorgi.com/picture-exchange-communication-system-research/

https://www.fortespeech.com/taking-a-look-at-high-tech-aac/

Discussion Question

Watch the following YouTube video and answer the following questions. What is AAC & Does it Stop Children From Talking? | Why Use AAC to Talk

1. What are the key points the video makes about what AAC is and how it supports communication for children with ASD?
2. The video addresses a common concern — “Does AAC stop children from talking?” What was your takeaway from how the video responds to this question?
3. Describe the difference between PECS (Picture Exchange Communication System) and other AAC devices as explained in the video. Why might one be chosen over the other?
4. How might you incorporate AAC strategies into a classroom or home routine to increase communication opportunities for a child with ASD?
5. What did you find most surprising or informative in the video, and how might it challenge your assumptions about communication support?

Module 5 Social Relationships

Module 5 focuses on strategies for promoting social engagement and play in children with ASD. Participants will explore the importance of interactive play, turn-taking, and reciprocal communication in supporting social development. The module also examines how to teach children to share interests, express emotions, and engage in meaningful interactions with peers and adults.

Engagement is defined as "time children spend interacting with the environment in a developmentally and contextually appropriate manner and is widely viewed to be necessary for learning (Nelson et al., 2017). Given the importance of play in skill development and the likelihood of play impairment in children with ASD, intervention to increase play skill development in children appears critical to positive outcomes (Nelson et al., 2017). Children with ASD frequently demonstrate delays in social skills, as well as restricted or repetitive behaviors. In early childhood, these core characteristics are often observed during play activities.

Social Play

Social play includes solitary play, onlooker behavior, parallel play, associative play, and cooperative play. Parallel play was considered to be a bridge between non- social and social play. In 1980, Howes developed an alternative taxonomy of social play that focuses on the complexity of children's social interaction and the degree to which their activities are organized. Definitions of play complexity are numerous, but the scales commonly used include:

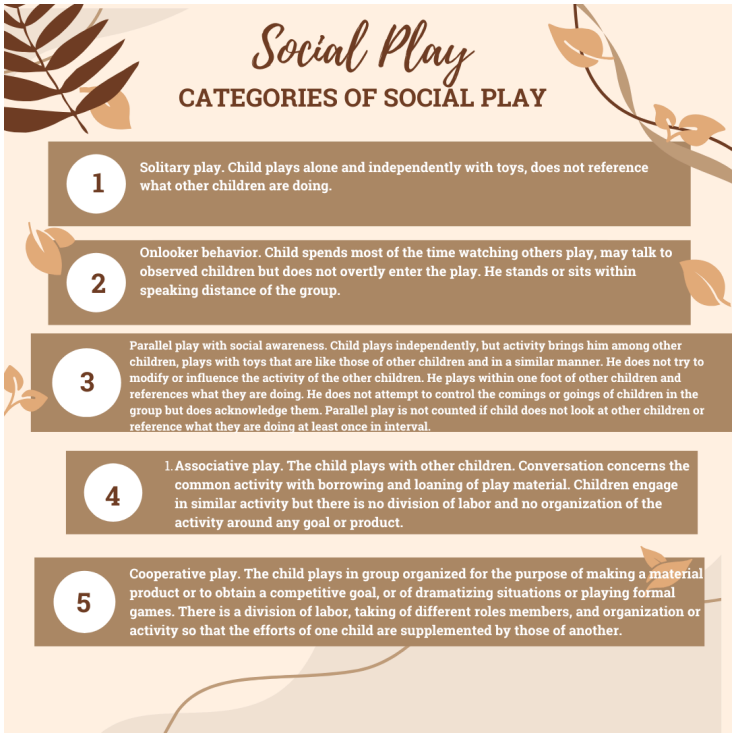
Complexity of Play

1. **Interpersonal play.** Visual and vocal exchanges, imitation of facial expressions and rhythmic body movement. 2.

2. **Exploratory/sensorimotor play.** Mouthing, looking, touching, or repeating an activity in repetitive fashion. A child appears to engage in action because he/she likes the sensations received from this action.
3. **Functional-relational play.** The child uses objects for purposes for which they were intended (using comb for combing hair, rolling a ball). In relational play, a child combines objects that are functionally related such as a car and driver, and bowl and spoon.
4. **Constructive play.** Manipulation of objects for the purpose of constructing or creating something. There appears to be an end goal and objects are transformed into new configurations.
5. **Dramatic play.** A child pretends to do something or be someone. Children may pretend with real objects, substitute objects, or without objects.
6. **Games with rules.** A child plays in an activity with accepted rules, limits, and expectations. It can be a standard or made up game.
7. **Physical activity and rough and tumble play.** Play might be boisterous or physical involving running, jumping, chasing, fleeing, and wrestling. It does not include aggressive behaviors such as closed fisted hits, shoves, and kicks.

Figure 30

Categories of Play



Although levels of social play and play complexity can be seen as hierarchical, all remain important throughout childhood and each serves a role in development of cognitive, motor, communication, and social skills. Therefore, ensuring child utilization of a variety of play levels is important. There are several empirically validated strategies for increasing social play engagement and play quality, including the use of preferred play materials, priming, and modeling (Nelson, 2017).

Preferred Play Materials

Toy preference has been shown to be important in the development of intervention targeting increased play engagement. Children are significantly less likely to engage in play

when presented with nonpreferred materials. However, allowing a child to choose his or her own play materials and making those materials available for play is associated with increased subsequent engagement and decreased inappropriate or unengaged behavior. Additionally, an engagement-based preference assessment that involves both developmentally oriented items and assessment of quality of engagement with stimuli has been shown to be an effective guide for selection of reinforcers for children with autism. Such developmentally oriented materials help prevent child interaction with materials solely for sensory purposes. Therefore, consideration of quality of child engagement with chosen materials, in addition to assessment and incorporation of child choice, is important to promotion of engagement, play, and learning (Nelson et al., 2017).

Priming

Priming is an intervention technique in which modeling and exploration of the desired skill is conducted in a high reinforcement, low-demand condition prior to the context or activity in which the skill is expected to be demonstrated. Through priming, children can be familiarized with educational materials prior to activities. The use of priming in inclusive settings to teach various social skills to children with ASD has support in current research. It has been used to increase initiations with peers and increase toy sharing. However, selecting a context for priming within natural preschool routines may be difficult. (Nelson et al., 2017).

Modeling

When teaching play behaviors to children with ASD, interventions that incorporate modeling have been shown to promote sustained behavior change. Modeling provides clear demonstrations of appropriate play behaviors, allowing children to observe and imitate new

skills. These strategies can also increase a child's motivation to explore a wider range of toys and materials, thereby enhancing the complexity, creativity, and flexibility of their play.

Shared Interest Activities

Teaching social skills to children and adults with ASD can be challenging, but several effective strategies harness shared activities to promote learning and social engagement. These methods include social stories, role-playing, video modeling, and peer-mediated approaches (Mastermind Behavior Services, 2025).

Figure 31

Shared Activities

Complementing these techniques with visual supports—such as picture cards, emotion charts, and social scripts—helps children recognize social cues, understand emotions, and anticipate responses. These visual aids serve as prompts during activities and support independence (Mastermind Behavior Services, 2025).

Structured group activities, like small lunch groups or social skills board games, foster turn-taking, perspective-taking, and emotional regulation. These settings provide opportunities for meaningful social exchanges while often incorporating reinforcement and modeling from facilitators (Mastermind Behavior Services, 2025).

Turn Taking

Turn taking strategies for children with ASD include:

- Using visual cues (e.g., “my turn/ your turn” cards)
- Embedded into play routines. Games with clear turn order (ball rolling, board games)
- Modeling clear turn-taking behaviors. Adult demonstrates waiting and taking turns
- Reinforcing positive participation
- Gradually increasing complexity
- Reinforcement. Praise or a preferred item after each turn

Social Communication

A person with autism may have challenges relating to others. It might seem like they are not interested in others or in making friends. Making eye contact may be uncomfortable for people with autism, and they might be paying attention to someone else even if they don’t look like they are (American Speech-Language-Hearing Association, n.d.).

It may be hard for a person with autism to…

- Share attention with someone else and focus on the same object or event in ways other kids do.
- Join in play with others and share toys.

- Respond when others invite them to play or talk.
- Understand how others feel.
- Take turns in play or in conversation, and
- Make and keep friends.

Figure 32

Social Skills

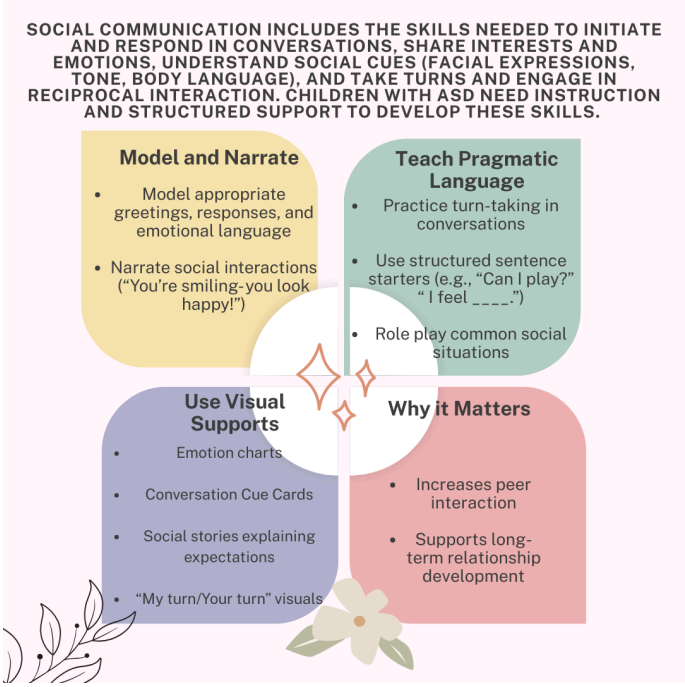


Figure 33

Emotional Expression

Agenda

Participants will follow the same agenda format as the previous modules. Participants will watch the following video clips and read the following articles below. They will then answer the discussion questions and respond to three peers' posts. The discussion post must be 300 words or more. Peer posts must be 150 words or more.

Articles

https://www.autismspeaks.org/social-skills-and-autism

Use of a Creative Dance Intervention Package to Increase Social Engagement and Play Complexity of Young Children with Autism Spectrum Disorder

https://stdidtheautismprojecprod.blob.core.windows.net/theautismproject/documents/how-to-teach-turn-taking.pdf

Videos

Ethan Lisi: What it's really like to have autism | TED Talk

Autism Preschool Classroom: 3 Engagement Strategies That Work!

Discussion Questions

Watch the attached video and answer the following questions.

"Playing with Toys" Real Look Autism Episode 5

1. The video shows a caregiver using imitation to engage a child in play. How does imitating a child's actions support social interaction and joint attention? Why is imitation an effective strategy for children with ASD?
2. How does following the child's interests during play (rather than directing the play) promote engagement and communication? Provide an example from the video or from your own experience.
3. What did you notice about how the caregiver responds to the child's actions? How might this responsiveness influence language development or social communication?
4. Based on the video, what role does *motivation* play in teaching play behaviors to children with ASD? How can educators and caregivers use this idea to plan activities and interactions?
5. After watching the video, what is one strategy you could implement in your practice to support play and interaction with children who have ASD? Why might it be effective?

Module 6 Challenging Behaviors

When challenging behaviors are persistent, they are probably being unintentionally maintained by something in the environment (Coogle et al., 2018). This module addresses

- Strategies to help support your child manage their emotions
- How to respond to challenging behaviors
- How to reinforce positive behaviors

- Types of interventions

ABC Model

The ABC Model helps us understand why a behavior happens. It looks at what happens before, during, and after a behavior. Behavior is communication. When we understand what happens before and after a behavior, we can teach more appropriate ways for children to meet their needs.

- Antecedent (what happens before)- This is often the trigger for the behaviour. This can sometimes be clear-cut such as somebody saying 'no' to a request but in individuals with ASD it can be more difficult to identify because the cause may be related to sensory issues such as loud noises or specific sounds or related to the need for predictable routines. It is therefore important that you record all relevant information including time, environment, what was said, who was present etc….(Neurodivergence Wales, n.d.).
- Behaviour- In this section you will need to record details of the behaviour, without judgement or assumptions. Describe the behaviour rather than jumping to conclusions as many individuals with ASD have difficulties in expressing their feelings in an appropriate way. For example, anxiety may present as worry but could also present in repetitive behaviours or aggression (Neurodivergence Wales, n.d.).
- Consequence (what happens after)- Often the consequence or outcome of the behaviour can provide clues as to what the child is feeling, by showing what the child is trying to achieve. Consequences can sometimes be reinforcing the behaviour. Record exactly what happens including what the child does and what any other children or adults do (Neurodivergence Wales, n.d.).

Figure 34

ABC's of Behavior

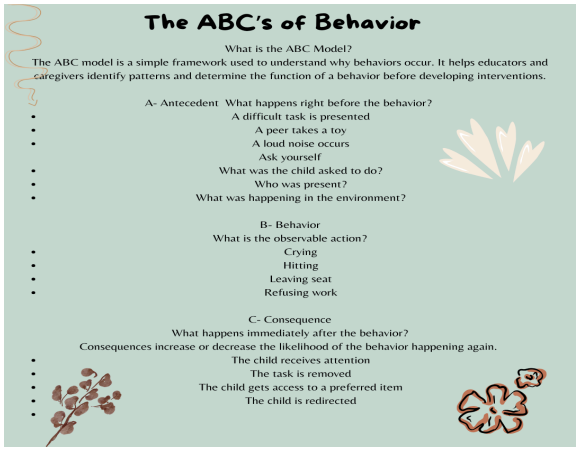
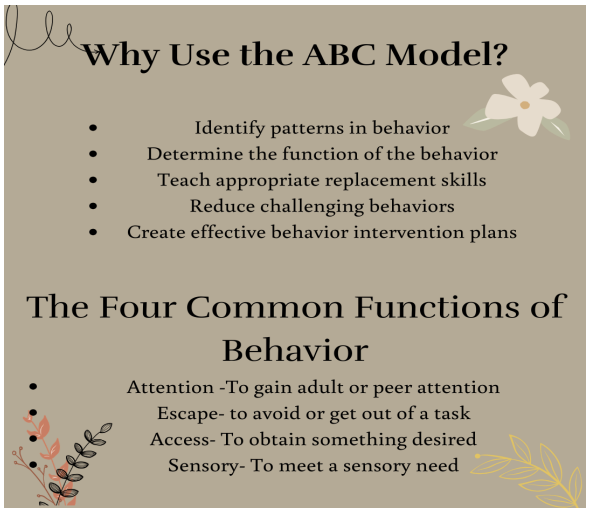


Figure 35

Why ABC?/ Functions of behavior



Example

Antecedent Teacher assigns worksheet

Behavior Child rips paper

Consequence Worksheet removed

Possible Function: Escape from difficult task

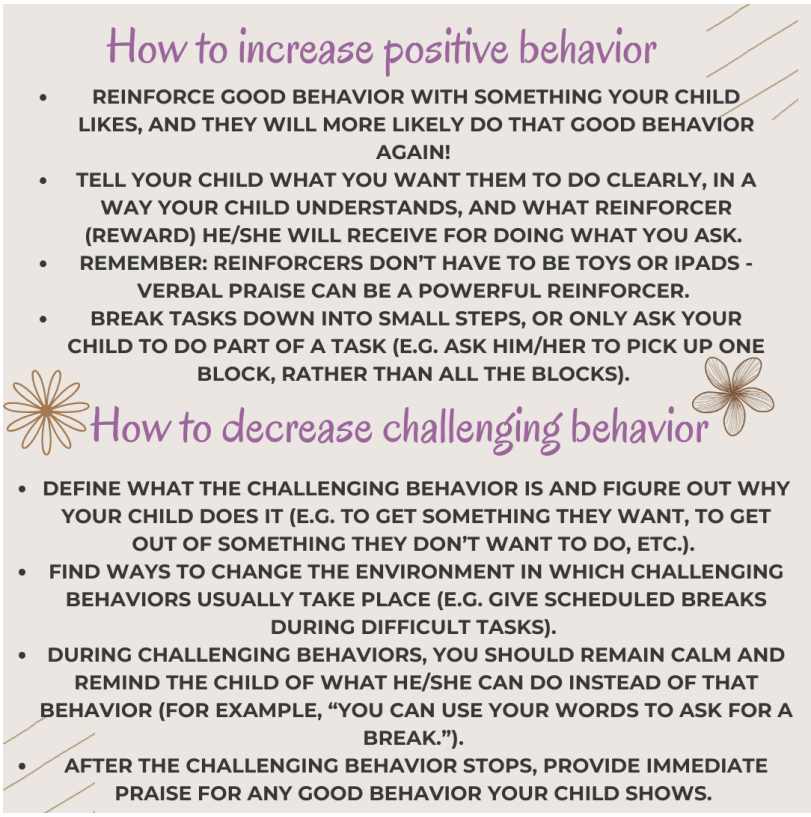
Figure 36

Link to Chart to Identify Behaviors Using ABC Model

Using an ABC Chart to Identify Triggers of Challenging Behaviours in Children with Autism | Neurodivergence Wales

Figure 37

Strategies for Positive and Challenging Behaviors



Dealing with Emotions

Some children act out because they have a hard time regulating their own emotions. This is a common problem for young children who haven't yet developed the ability to cope with big emotions in a constructive way. Some children continue to struggle with self-regulation as they get older. Parents and teachers may notice that they seem particularly sensitive and have outsized

emotional reactions compared to their siblings or peers (Child Mind Institute, n.d.).

Self-Regulation

Self-regulation is the ability to manage your emotions and behave appropriately. This involves resisting emotional reactions, calming yourself down, and having the ability to adjust expectations (Child Mind Institute, n.d.). The good news is that self-regulation is a skill that can be taught and developed over time. Like other skills, it requires modeling, practice, and consistent support. Parents and caregivers play a critical role in helping children learn how to manage their emotions, including intense or overwhelming feelings. With guidance and structured strategies, children can learn to calm themselves and respond more appropriately rather than reacting impulsively or acting out. The following techniques can help support children in developing these self-regulation skills.

Labeling Emotions

Taking time to notice and label emotions helps children become more aware of how they are feeling. This awareness is essential because recognizing emotions is the first step toward learning how to manage them. Simply putting feelings into words can often reduce their intensity. Too often, individuals try to ignore or suppress negative emotions until they become overwhelming. Acknowledging a difficult feeling can make it feel less powerful and create space for constructive problem solving.

Parents can support this skill by modeling emotional awareness in their own behavior. For example, if a parent feels frustrated after forgetting something at the grocery store, they might say, “I’m feeling really frustrated right now because I forgot to get milk.” After naming the emotion, the parent can model coping strategies: “I’m going to take some deep breaths to calm down — that usually helps me.” Once calm, the parent can demonstrate problem solving by

asking, “Now what can I do to fix this?” and brainstorming solutions aloud. Another important part of a child learning to consciously label their emotions is that it encourages them to start paying attention to how they feel, which means that they might notice an emotion earlier, before it starts to feel overwhelming (Child Mind Institute, n.d.).

Figure 38

Calm Down Strategies

Parents are often surprised by the intensity of emotions children display during tantrums. However, children do not typically move from calm to overwhelmed instantly — even if it appears that way. Emotions tend to build gradually, much like a wave. When children learn to recognize and label their feelings early, they are better able to manage them before they become overwhelming.

One helpful strategy is teaching children to rate the intensity of their emotions on a scale from 1 to 10, with 1 representing calm and 10 representing extreme anger or frustration. Parents can model this strategy by sharing their own emotional levels. For example, if feeling frustrated after forgetting something at the grocery store, a parent might say, “I’m at about a 4 right now.” While this may feel awkward at first, it encourages children to pause and reflect on their internal state. For children who benefit from visual support, tools such as a “feelings thermometer” can make abstract emotional concepts more concrete and easier to understand.

Figure 39

Feelings Thermometer

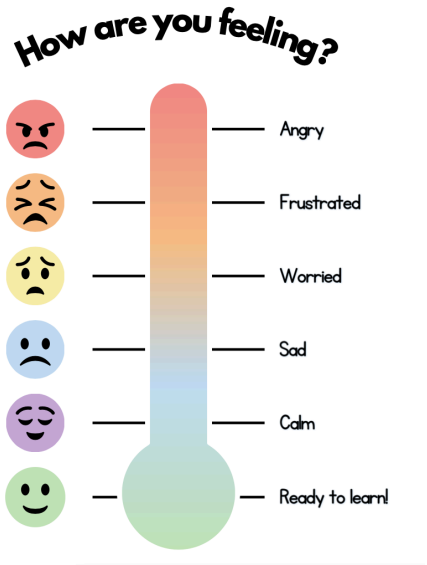


Figure 40

Calming Steps

Teaching Emotions

- Uses emotion words during activities and routines
- Labels child's feelings and expresses empathy and understanding of those feelings
- Matches affect to child's affect during interactions
- Labels their own feelings and models self-regulation actions (e.g., breathing or

counting, this includes taking deep breaths when comforting an infant)

- Poses “dilemmas” and ways to solve them for toddlers during activities and routines
- Uses challenging situations as an opportunity to help toddlers recognize emotions and self- or co-regulate
- Uses skills and strategies to regulate their own emotions

Types of Interventions

There are three types of ABA therapy that is evidence based to support behavior therapy. They are all based on the same simple concept: reinforced behaviors will increase; behaviors that are not reinforced will reduce and eventually disappear (Child Mind Institute, n.d.).

- **Discrete Trial Training,** the original “brand” of ABA designed for young children on the spectrum, remains the most structured form of ABA. It is always done one-on-one. The child sits at a table, and the therapist lays out materials in front of the child. The child is given a task to perform with the material and when he does it right, he is rewarded with what’s called a “primary reinforcer”: an M&M or a Frito, a tickle, a sticker, access to a favorite toy, etc.
- **Pivotal Response Treatment** is more child-driven and less therapist-structured. “Rather than focusing on individual behaviors, PRT looks to target “pivotal”developmental functions. Natural forms of reinforcement related to the behavior are stressed, rather than non-related tangible rewards, such as an M&M. The concept is that if you build these learning modules into a more natural environment, the child is more likely to generalize them.

- **Naturalistic Developmental Behavioral Interventions**: These interventions — for example, Early Start Denver Model (ESDM) or Joint Attention, Symbolic Play, Engagement, and Regulation (JASPER) — incorporate behavioral principles of reinforcement, but are specifically designed to be utilized in natural, social interactions, using natural reinforcers (for example, if the child asks for a red car, he is given a red car), and incorporates multiple teaching objectives within the same activity. For example, one goal might be for the child to learn shapes or letters. But the therapist might also have goals for this child to have the motor coordination to get a piece into a puzzle, and to have the patience to finish something that involves three parts. So, during the course of a puzzle activity the child would be working on cognitive, motor and behavioral goals.
- **Functional Communication Training (FCT)** involves teaching an individual a reliable way of expressing their wants and needs with language, signs or images. It's called "functional" because it doesn't just teach kids to label an item (such as associating the word RED to a picture of an apple) but focuses on using words or signs to get something needed or desired — a food, a toy, an activity, a trip to the bathroom, a break from something. FCT uses positive reinforcement to teach children to communicate effectively with others to get their needs met and reduce problematic behavior.
- **How it works:** Initially the therapist prompts the child to use the word, sign or picture and obtain the reward. This supported communication is repeated, each time resulting in the earned reward, until the child is able to succeed with less and less prompting from the therapist. Once kids are reliably using the functional communication for that item when the item is present, the next step is for them to "generalize," or use it outside the specific situation in which it's been taught, such as communicating with people other than the

therapist.

- **Parent Training for Disruptive Behaviors in Autism Spectrum Disorder** is based on the principles of ABA. It addresses challenging behaviors in youth with ASD, including noncompliance, aggression, temper outbursts and difficulties with transitions.
- How it works: The therapist works closely with the parent to teach techniques (such as prevention strategies, daily schedules, reinforcement, compliance training, functional communication training) to reduce their child's challenging behaviors and to encourage more appropriate behaviors.

Agenda

Participants will follow the same agenda format as the previous modules. Participants will watch the following video clips and read the following articles below. They will then answer the discussion questions and respond to three peers' posts. The discussion post must be 300 words or more. Peer posts must be 150 words or more.

Videos

ATN/AIR-P Video Tool Kit: ABCs of Behavior- Support For Your Child's Success

Addressing Challenging Behaviors (Part 2 of 10) - Autism Speaks Challenging Behaviors Tool Kit

https://www.youtube.com/watch?v=cv9U_VBTWas

Readings

Mom perplexed by toddler stimming | Autism Speaks

Backpack Connection: Teachable Moments: How to Help Your Child Avoid Meltdowns

https://childmind.org/guide/parents-guide-to-problem-behavior/#block_690e32c60a284

Discussion Questions. Watch the video below and answer the following questions.

ATN/AIR-P Video Tool Kit: Positive Reinforcement Strategies For Your Autistic Child

1. What is reinforcement according to the video, and how does it help decrease challenging behaviors in children with ASD?
2. How does reinforcement influence a child's motivation to engage in desired behaviors? Why is motivation important in teaching new skills?
3. Think of a behavior you might encounter in a classroom or home setting. How could you apply reinforcement strategies to increase more functional behavior and reduce problem behavior?
4. What might be the difference between positive and negative reinforcement in the context of supporting children with ASD? How could each be used appropriately?
5. After watching the video, what is one reinforcement strategy you feel confident implementing? What support would you need to implement it effectively?

Module 7 Sensory Processing

This module includes:

- The eight sensory systems
- Sensory processing
- sensory seeking behaviors.
- How the body responds to sensory overload

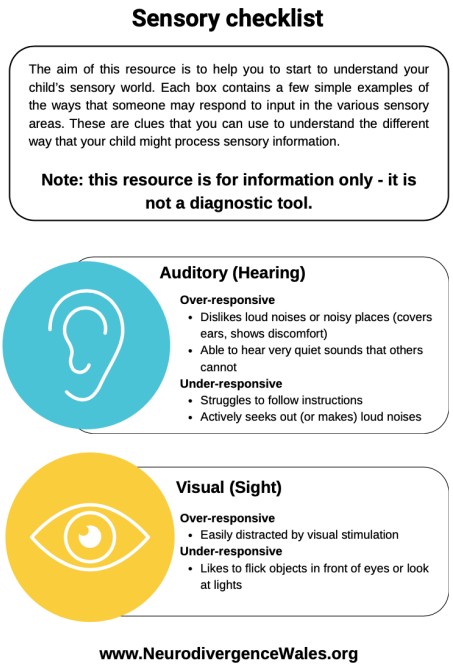
Sensory System

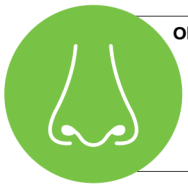
The training program will begin with a Youtube video explaining the eight sensory systems. The video is a great visual in explaining the five senses, smell, touch, taste, vision, hearing, in addition to vestibular, proprioception, and interoception. The 8 senses - InfOT. Each of the eight

sensory systems contributes to our sense of safety, to mastery of our own body, and to the resultant sensory affective combination (Star Institute, n.d.).

Figure 41

Sensory Checklist (1-3)





Olfactory (Smell)

Over-responsive
- Dislikes strong smells or certain smells

Under-responsive
- Sniffs things

Gustatory (Taste)

Over-responsive
- Dislikes strong tastes or certain tastes

Under-responsive
- Prefers strong tastes

Tactile (Touch)

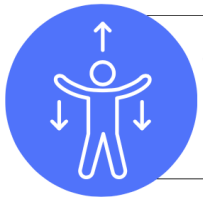
Over-responsive
- Dislikes being touched
- Finds clothing uncomfortable

Under-responsive
- Likes lots of touching and hugging

www.NeurodivergenceWales.org

Vestibular (Balance)

Over-responsive
- Dislikes sudden movements
- Avoids active games
- Has difficulty riding a bike
- **Under-responsive**
- Enjoys rough and tumble
- Rocks body or shakes leg when sitting



Proprioception

(Registering body position and pressure or grading movement.)
- Fidgety, often wants to move
- Likes to squeeze into small tight spaces
- Likes to bang toys and objects
- Enjoys falling off objects

Interoception

(feeling and interpreting what's happening inside our body)
- Often too hot or too cold
- Finds it difficult to tell when they need the toilet
- Finds it difficult to tell when they are hungry or thirsty

Sensory Experiences

Heightened Sensitivity: Some neurodivergent individuals experience heightened sensitivity to sensory input. This can make sounds, sights, smells, being moved or moving, and even internal sensations feel overwhelmingly "big," "loud," or "intense." Experiencing sensation like this is difficult for outside observers to fully grasp.

Lowered Sensitivity: Conversely, some people may have reduced sensitivity to sensory input. The world is experienced as somewhat muted, and sensation is not able to grasp attention in the same way (Star Institute, n.d.).

Sensory Processing

Sensory processing is the neurological process by which the brain receives, organizes, and interprets sensory information from the body and environment so that a person can interact effectively and respond adaptively to stimuli (ScienceDirect Topics, n.d.). Sensory processing issues are often first recognized during the toddler years, when parents notice that a child has an unusual aversion to noise, light, shoes that are deemed too tight and clothes that are irritating. They may also notice clumsiness and trouble climbing stairs, and difficulty with fine motor skills like wielding a pencil and fastening buttons (Child Mind Institute, n.d.).

Sensory Processing Symptoms

Children with sensory processing issues often exhibit extreme behaviors such as:

- Screaming if their faces get wet
- Throwing tantrums when you try to get them dressed

- Having an unusually high or low pain threshold
- Crashing into walls and even people
- Putting inedible things, including rocks and paint, into their mouths

These and other atypical behaviors may reflect sensory processing issues — difficulty integrating information from the senses, which may overwhelm children and result in confusing behavior (Child Mind Institute, n.d.). Sensory processing difficulties are now recognized as a common feature of autism, as the majority of children and adults on the autism spectrum experience significant sensory challenges. However, not all individuals with sensory processing issues are on the autism spectrum. Sensory difficulties are also observed in individuals with attention-deficit/hyperactivity disorder (ADHD), obsessive-compulsive disorder (OCD), other developmental delays, and even in individuals without any additional diagnosis.

Sensory Overload

Sensory overload occurs when an individual's sensory system becomes overwhelmed by too much sensory input. This can happen in various environments and situations, such as crowded places, bright lights, loud noises, or even during times of heightened emotions. For autistic children, who may have sensory sensitivities or differences in processing sensory information, the experience of sensory overload can be more intense and frequent (Ambitious about Autism, 2024).

Figure 42

Signs of Sensory Overload

What does sensory overload look like?

Sensory overload can occur when a student's brain has had so much sensory input that it cannot process any more. This can lead to a meltdown, the child trying to remove themselves from the situation or may result in shut down. Otherwise known as a fight, flight or freeze response. This is the brain's way of coping with the excess information it can't process (GriffinOT, 2020).

- **Meltdown**. Meltdowns can look like tantrums but they are not the same. They typically

occur due to the child not being able to process or maybe move on from a situation. It's a temporary loss of control after a build-up. Behaviours will vary between individual children. Some children are very verbal, some cry and some become more aggressive.

- **Running away (flight)**. Removal, or flight, is also a common response. So, when the individual becomes overloaded they will try to get away from the sensory information that's causing the sensory overload. They may also try to hide away if they can't physically get out of the space.
- **Shutdown (freeze).** Shutdown due to sensory overload usually means the individual goes quiet and just stops processing information. Usually, the individual will become unresponsive. Sometimes they may have movements like rocking or fiddling. Typically, they use these movements in an attempt to try to calm down. It can sometimes be missed in school as the student internalises and is therefore not 'causing disruption' to the class. Unfortunately, they are also not learning either at this time.

Signs of Sensory Overload

- Changes with voice
- Movement change
- Change in skin colour
- Change in focus or attention
- Requesting to leave or to know when something will finish
- Anger, including shouting, lashing out or biting
- Running away or hiding

Helping children avoid sensory overload

- **Be aware of the signs.** Make sure all adults supporting the student are aware of the signs if the individual is starting to overload. These will be different for each person. If you can catch earlier signs it will be easier to help them to regulate.
- **Be aware of the triggers.** Typically, each individual will have certain sensations or environments that trigger an overload. Watch out for these. In some cases the sensation could be removed. In others, make sure the individual is prepared and has a regulation strategy to support them if they have to attend.
- **Provide extra downtime.** Provide additional down time through the individual's day, especially between activities which you know increase their arousal. Activities like assembly and lunch time can be harder for some students. For others it's a particular lesson they find more difficult.
- **Remember sensory inputs are cumulative.** Each sensory input builds on the next, this is what leads to overload. Consider the timetable of the day and also how many sensations you are expecting the individual to process. Don't schedule more overloading activities back to back.
- **Support regulation.** Find activities and strategies that help the individual to regulate and include access to these throughout the day. These will be different for every person. Some general supports include heavy work, yoga, and breathing.
- **Calming breaks.** Consider adding in calming breaks throughout the day. This could include things like movement or breathing exercises, like in the videos below. For some, cycling, running or jumping on the trampoline could help. Others might enjoy yoga.

Figure 43

Strategies to Support Sensory Overload

Sensory Seeking Behaviors

Sensory seeking behaviors are characterized by an increased desire for sensory stimulation and may involve repetitive movements, tactile exploration, or engagement in high-intensity activities to regulate arousal and attention levels. Children who are sensory seeking may:

- Jump, crash into objects , or enjoy rough play (vestibular and proprioceptive input)
- Spin, rock, or swing repeatedly. This can be known as stimming.
- Touch people or objects frequently

- Chew on items (clothes, pencils)
- Make loud noises or seek loud environments
- Prefer bright lights or visually stimulating activities

Figure 44

Self-Regulation Strategies

Stimming

Stimming is what is known as “self-stimulating behaviour”. It is something everyone does to soothe themselves when stressed – some people talk to themselves, sing or bite their nails - but autistic people tend to do it more, partly as they have more to be anxious about. A person’s stim of preference may be unique: some people doodle, others fiddle with a hairband wound around their fingers, use a fidget toy, such as a fidget noodle, or a stress ball, pick their skin, sing, talk non-stop, repeating a favourite script from a TV or movie... the list goes on (Ambitious about autism, 2024).

Stimming used to be seen as something that needed to be stopped. Over time, however,

we have learned that stimming serves an important purpose. It can help a person focus, calm their body, and manage strong feelings — especially in environments that feel overwhelming or overstimulating. For example, a child who is autistic and has ADHD might use a fidget toy to stay focused in the classroom. Rather than being a distraction, the movement can actually help their brain stay engaged. When someone is prevented from stimming, their stress and anxiety can build up, which may even lead to headaches or stomach aches.

Many autistic adults talk about having “public” and “private” stims. Public stims may be smaller or more subtle, while private stims may be bigger and more expressive, like hand flapping. Stimming is not only helpful for calming anxiety — it can also feel good and bring comfort. For young children or non-speaking autistic individuals, stimming can also be a form of communication. It can be one way they express emotions, connect with others, or show excitement. Instead of trying to eliminate stimming, families can focus on understanding what the behavior is communicating and making sure it is safe and supportive.

Interventions

The idea behind Sensory Integration Therapy (SI) is that specific movement activities, resistive body work, and even brushing of the skin can help a child with sensory problems experience an optimal level of arousal and regulation. This, according to some OTs, can actually “rewire” the brain so that kids can appropriately integrate and respond to sensory input, allowing them to both make sense of and feel safer in the world. Such “rewiring,” writes OT can decrease anxiety, making them “more confident, successful and interactive explorers” (Child Mind Institute, n.d.).

Sensory Integration therapy begins with an evaluation by an occupational therapist (OT), who assesses how a child responds to different types of sensory input through testing,

observation, and caregiver interviews. Because each child's sensory needs are unique, therapy is individualized rather than "one-size-fits-all."

Treatment typically takes place in a sensory gym equipped with tools such as swings, crash pads, and weighted items. These activities provide structured sensory input to help the brain process sensations more effectively. For example, both hypersensitive (overresponsive) and hyposensitive (underresponsive) children may use movement activities, but the therapist adjusts the intensity and approach based on the child's needs. The goal of SI therapy is to improve sensory processing so children can better participate in daily activities.

Agenda

Participants will follow the same agenda format as the previous modules. Participants will watch the following video clips and read the following articles below. They will then answer the discussion questions and respond to three peers' posts. The discussion post must be 300 words or more. Peer posts must be 150 words or more.

Videos

12 Mild Autism Stims (last one may need medical attention)

What Are Sensory Processing Issues?

8 Sensory Strategies to Help Your Child Feel Calm and Regulated | Simple Activities That Work

Make it Stop.

Readings

Repetitive behaviours and stimming | Ambitious about Autism

What is sensory overload and how can I support it by Kim Griffin

Sensory overload | What it is and how to support

Discussion Questions

Watch the video and answer the following questions

https:/I n/neurodivergencewales.org/en/parents-carers/sensory-processing/

1. According to the Neurodivergence Wales video, why is it important for caregivers to understand sensory processing differences in neurodivergent children?
2. How does understanding sensory preferences and triggers contribute to a child's emotional regulation and participation in everyday activities?
3. What are some examples of environmental adjustments a caregiver could make at home based on the sensory guidance provided?
4. How can collaboration between families and professionals (e.g., OTs, teachers) enhance support for sensory needs described on the video?
5. Neurodivergence Wales emphasizes a **s**trength-based approach to sensory processing. What does this mean, and how might it differ from a deficit-focused perspective?

Module 8 Family Engagement

The final module focuses on the importance of family engagement in supporting their child's success. Family engagement is essential not only for parents, but also for educators who play a key role in building partnerships and encouraging families to actively participate in their child's growth and development. Autism doesn't just impact the child, it impacts the whole family.

This module explores the impact ASD can have on families, including emotional, social, and logistical challenges. Participants examine why meaningful family engagement improves outcomes for students and identify common barriers that may prevent families from fully participating in collaborative partnerships. The module also emphasizes the importance of

self-care for both families and educators, recognizing that sustainable support requires emotional well-being.

Participants will complete assigned readings and watch selected videos prior to engaging in the discussion forum. In the final discussion forum, participants will research and share local or online support groups, playgroups, and community resources that may benefit families. This collaborative activity encourages participants to build a shared resource network and deepen their understanding of community-based support systems.

Impact of ASD on families

Parents of children with autism often face unique challenges, including high levels of stress and societal misconceptions about their child's capabilities. Building a support network with other parents, family, and support groups can be beneficial in sharing experiences, providing emotional relief, and gaining insights. Additionally, self-care practices are essential to manage stress, allowing parents to replenish their energy and resilience (Magnet ABA therapy, 2025).

In many ways, parents of children with autism have additional responsibilities beyond typical parenting demands. In addition to raising a family, they must learn about autism, navigate complex service systems, advocate for their child’s needs, and manage their own emotions while also supporting other family members. This can feel overwhelming, as there are constant decisions to make, appointments to attend, and long-term considerations to plan for.

Figure 45

10 Parenting Tips

Emotional and Social Effects on Families

Having a child with ASD affects the entire family system. Parents often go through a range of emotions after a diagnosis, including shock, grief, confusion, and sometimes relief as they begin to better understand their child's behaviors. The ongoing responsibilities of therapy appointments, medical care, and educational planning can create stress and emotional fatigue. Siblings may at times feel overlooked or concerned, but they can also develop increased empathy, patience, and understanding as a result of their experiences.

Families may need to adapt routines, modify environments, and advocate actively for their child's rights within schools and communities. The financial cost- potentially around $60,000 annually for therapies, education, and healthcare adds to the burden. Despite these

challenges, many families find their bonds grow stronger through shared experiences and collective resilience (Magnet ABA therapy, 2025).

Understanding the Family Experience

Every stage of the journey can feel hard. All the steps from referral to diagnosis can be full of doubts. You may experience periods of uncertainty and anxiety. And getting an official diagnosis can be extremely hard; learning your child has autism will affect not just them but your entire family and those close to you. Right from the beginning your role as a parent/carer will change and that can lead to a range of emotions and reactions. However you are feeling right now, it can help to remember that getting an early assessment will enable your child to receive early intervention.

To some parents the prospect of autism is a shock. To others it is the confirmation they needed, while still others experience denial. It is important to understand that all of these feelings – including denial – are normal. Parents-to-be often idealise their child from the moment they find out they are having a baby, some even before that. They imagine what they will look like, what characteristics they will inherit, what their likes and dislikes will be, whether they will have friends, learn other languages, or travel the world.

Some parents of autistic children have described feeling as though everything they had hoped for and imagined for their child had been taken away. For some parents, the process might trigger a sense of grief; a feeling that they have lost the child they dreamed of and that another child has been given to them. This sense of grief can come with a range of other feelings.

The journey through autism in the early years can also feel very lonely, especially since parents can have different reactions. A couple raising a child together can have different views and feelings around the diagnosis. Having different perspectives can make you feel isolated from

one another and overwhelmed. Don't deny or ignore your feelings. Anger, sadness and loneliness are all part of the path to acceptance and part of what will make you more resilient (Ambitious about autism, 2024).

Talking to your family and friends about your child's needs

Telling your family and friends that your child may be autistic can be difficult. Some family members might dismiss your concerns, suggesting 'they'll just grow out of it', or that your child's behaviours and actions are something

to do with the way you parent. Some family and friends will be incredibly supportive and will want to know what they can do to help. Reactions can vary widely, but it's important to share. Autism doesn't only affect the child – it affects the entire family and even your close friends (Ambitious About Autism, 2024).

Talking openly with family and friends about a possible autism diagnosis can help them better understand your child's behaviors. Sharing this information provides context for actions that others may have already noticed, such as a strong preference for certain toys, delayed speech, or sensitivities to textures and sensory input. Having these conversations can reduce misunderstandings and encourage greater empathy and support from those around you.

Figure 46

Self-Care Tips

Importance of Self-care

Parenting a child with autism can be incredibly rewarding, but it is also demanding and emotionally intense. Research shows that caregivers of children with autism experience higher levels of stress and anxiety compared to other parents, which can negatively affect their quality of life and overall wellbeing (Edmunds et al., 2025). The ongoing responsibilities of therapy coordination, educational planning, and daily support can create emotional fatigue and increase the risk of burnout.

Self-care is not selfish — it is essential for sustainable caregiving. When parents intentionally take time to care for their own emotional and physical health, they are better equipped to respond calmly, model healthy coping strategies, and maintain consistency in caregiving. Higher levels of parenting stress have been associated with increased anxiety and emotional strain, highlighting the value of stress-management and support strategies for families (Xu et al., 2026).

Studies also show that parents of children with autism face uniquely high emotional burdens, and evidence-based self-care practices — including social support, realistic coping strategies, and access to community resources — can help reduce stress and improve overall wellbeing (Al-Medawi et al., 2025). Experts emphasize that self-care does not have to be elaborate; even small, manageable practices like taking short breaks, connecting with supportive peers, or engaging in brief relaxation activities can help prevent caregiver burnout and promote long-term resilience (Tami, 2026).

Self-care does not have to mean large amounts of time away. It can include:

- Taking short breaks when possible
- Connecting with other parents who understand
- Attending counseling or therapy
- Practicing mindfulness or stress-reduction techniques
- Setting boundaries and asking for help
- Prioritizing sleep and basic health needs

Caring for yourself strengthens your ability to care for your child.

When parents take care of their own emotional and physical well-being, they are better able to:

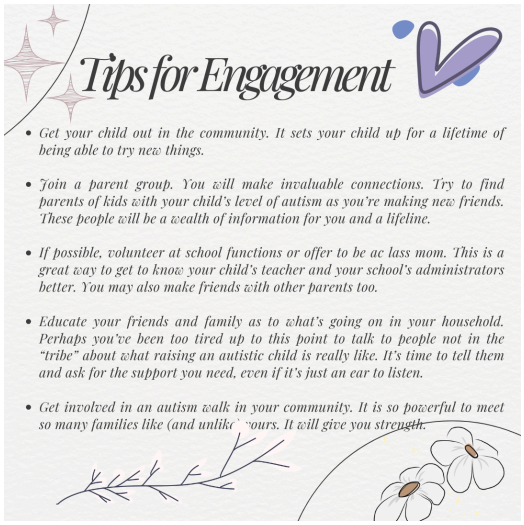
- Respond calmly during challenging moments
- Model emotional regulation for their child
- Maintain patience and consistency
- Strengthen family relationships
- Reduce long-term stress and burnout

Family Engagement

Family engagement is especially critical when supporting children with ASD. Because ASD affects communication, behavior, and social interaction across settings, consistent collaboration between families and professionals is essential. Parents provide invaluable insight into their child's strengths, sensory needs, triggers, and successful regulation strategies. Research indicates that strong family–professional partnerships are associated with improved intervention outcomes, greater skill generalization across home and educational environments, and increased parent confidence in supporting their child (Azad et al., 2021).

Family engagement also promotes consistency in implementing evidence-based practices. When caregivers are actively involved and supported, children with ASD demonstrate stronger gains in communication, adaptive functioning, and social skills (Kuravackel et al., 2022). Meaningful collaboration empowers families to reinforce strategies at home, creating a unified support system. **Figure 47**

Tips for Engagement



Overcoming Barriers

However, families of children with ASD often face unique barriers to engagement. These may include high levels of caregiver stress, time constraints due to therapy demands, financial strain, cultural misunderstandings, and prior negative experiences with service systems (McIntyre & Brown, 2021). Communication gaps between professionals and families can further limit participation and trust. Overcoming these barriers requires culturally responsive communication, flexible scheduling, shared decision-making, and a strengths-based approach that values family expertise.

When educators intentionally build trust and reduce systematic obstacles, family engagement becomes a collaborative partnership rather than an expectation placed solely on parents. This shared responsibility ultimately supports better long-term outcomes for children with ASD.

Agenda

In this final module, participants are expected to complete the assigned readings and watch the accompanying videos before engaging in the discussion.

Discussion Post

After reviewing the materials, participants will contribute to the discussion forum by identifying and sharing the following:

- Two reputable resources for families of children with ASD
- Two support groups (local or online)
- One local playgroup or community-bas
- ed activity that supports children with ASD and their families

Participants should briefly describe each resource and explain how it may benefit families. This

collaborative discussion will help build a shared network of practical support that families can access in their communities. Participants will be asked to complete a google survey before receiving their certificate of completion.

Readings

https://link.assetfile.io/RV3WrfStJsSCH2102dcWD/Parents_Guide_to_Autism.pdf

https://link.springer.com/article/10.1007/s10803-022-05688-8

Resources

CDC's Developmental Milestones | Learn the Signs. Act Early.

Online community for parents and carers | Talk about Autism

Autism Speaks Walk.

The **Autism Speaks Walk** is a great way to connect with families and services in your area. Autism Speaks Walk is the world's largest autism fundraising event dedicated to improving the lives

of people with autism. Powered by the love of parents, grandparents, siblings, friends, relatives, and supporters, the funds raised help ensure people of all abilities have access to the tools needed to lead "their best lives''.

https://act.autismspeaks.org/site/SPageServer?pagename=empower_home

Complete Guide to Autism - Child Mind Institute

Videos

What you should know about raising an autistic child | Patty Manning-Courtney | TEDxAustinCollege

Parents of children with autism share stories to help others

Mom Of Autistic Child Walks Through A Day With Her Son | TODAY

Family with 3 'very different' sons with autism: 'Get educated, be kind'

Google Survey

Please complete the training survey using the link below:

https://docs.google.com/forms/d/e/1FAIpQLSeFpnQjV7Lvq2POs4Fn9Lb7LUA9BjIa7WqskETuyxxLa980Hg/viewform?usp=publish-editor

Chapter 5

Reflection

Reflecting on my original goals outlined in Chapter 1 and my project proposal, I can confidently say that I have made meaningful progress toward developing an 8-week online training course for families and professionals supporting children with autism spectrum disorder (ASD). My primary goals were to deepen my understanding of ASD, strengthen my knowledge of evidence-based practices, and create a structured, practical training program that builds confidence in both families and educators.

Growth in Knowledge and Professional Confidence

One of my primary goals was to strengthen my understanding of ASD, particularly in areas such as joint attention, social communication, emotional regulation, and parent-implemented strategies. In Chapter 1, I shared that I often felt uncertain walking into home visits with children who demonstrated indicators of ASD. I described feeling intimidated due to my lack of formal training and relying primarily on hands-on experience.

Through researching scholarly articles, reviewing evidence-based interventions, and designing each module intentionally, I have significantly expanded my knowledge base. I now have a stronger understanding of:

- Early indicators of ASD
- The importance of joint attention and engagement
- Practical strategies such as following the child's lead, breaking tasks into smaller steps, and supporting sensory regulation

- The role of parent coaching in strengthening outcomes

As a result, I feel more confident entering home visits and guiding families through interaction strategies. While I am still growing professionally, I no longer feel the same level of uncertainty described in Chapter 1. This growth directly aligns with the program learning outcome of effectively applying professional content expertise, knowledge, skills, and dispositions in early childhood education.

Progress in Developing the 8-week Training Course

In my project proposal, I outlined the design of an 8-week self-paced course with structured modules, discussion questions, videos, and readings. I am proud that I successfully developed all eight modules with clear objectives and logical progression—from foundational knowledge of autism to applied strategies that support communication, social relationships, emotional regulation, sensory processing, and family impact.

A major strength of my progress was organizing the modules in a way that balances foundational knowledge with practical application. I debated whether to begin with the definition and characteristics of autism, but ultimately decided that establishing a shared understanding was essential. This decision reflects intentional instructional design rather than assumption.

Perhaps most importantly, I grew personally in how I view family empowerment. One of my goals was to help families move beyond shame or guilt and feel capable of positively influencing their child's development. Through this project, I gained a deeper appreciation for the emotional experiences families face and the importance of presenting information with compassion and clarity.

I also incorporated action research principles by:

- Reviewing successful ASD training programs
- Researching evidence-based practices
- Planning to assess effectiveness through end-of-course survey

This process demonstrates alignment with my proposal goal of grounding the course in research rather than personal opinion.

Challenges and Areas of Struggle

One challenge I experienced was narrowing the scope of the project. ASD is a broad and complex topic, and I initially struggled with wanting to include too much information in each module. Deciding what was essential versus what could overwhelm participants required careful thought and refinement.

Another difficulty was balancing theory with practicality. While research provides valuable insight, translating academic language into strategies that are simple, clear, and actionable took time. I had to continually ask myself: Will families and educators feel more confident after this module? This reflective process improved the quality of my work but required significant revision.

Time management was also a challenge. Designing eight modules, reviewing literature, and organizing content in a structured format required sustained focus and discipline. Ensuring that each module built upon the previous one while maintaining clarity and engagement required careful planning.

One significant area of struggle was the amount of time required to carefully select videos and scholarly articles for each module. I underestimated how long this process would take. In order to ensure the course content was accurate, relevant, and aligned with evidence-based practice, I read each article in full and watched every video before including it in the modules. While this strengthened the quality and credibility of the course, it required far more time than I originally anticipated. I wanted to ensure that the materials were not only research-informed, but also clear, practical, and appropriate for families and professionals. This experience helped me better understand the level of effort required to design high-quality professional development and reinforced the importance of thoughtful content curation.

Overall Growth

Overall, I believe I have made strong progress toward my original goals. I now feel more equipped to recognize early signs of ASD, apply evidence-based strategies, and guide families and professionals with greater confidence. This project strengthened both my professional competence and my personal commitment to inclusive early childhood practices.

While there are still areas for refinement—such as continuing to evaluate participant engagement and improving course delivery—the foundation of the project is solid and aligned with my initial vision. Most importantly, I feel more prepared to support children with ASD in ways that are informed, intentional, and compassionate.

After completing my project and reflecting on the literature review in Chapter 2, I can say that my project both reinforced and confirmed many of the key findings presented in the research, while also challenging me to think more critically about implementation in real-world settings.

Reinforcement

The studies by Bearss et al. (2015) and Lord et al. (2014) emphasized that parent training and parent-implemented interventions significantly improve outcomes for children with ASD. My project strongly reinforced this finding.

As I developed modules focused on communication, joint attention, social interaction, and engagement, I became even more convinced that parents are a powerful influence in their child's development. The literature showed that structured coaching produces better outcomes than education alone. This directly influenced my decision to include discussion posts, applied reflection questions, and practical strategies rather than simply providing information. The research reinforced my belief that empowering parents with skills—not just knowledge—is critical.

Challenges

While the literature supports evidence-based interventions such as Pivotal Response Treatment (PRT) and Early Start Denver Model (ESDM), my project challenged me to recognize how difficult implementation can be outside controlled research settings. Studies often describe interventions delivered with high fidelity, frequent coaching, and structured support systems. However, in my real-world experience:

- Parents are overwhelmed with appointments
- Educators face time and staffing limitations
- Families vary in readiness and emotional acceptance

The literature mentioned barriers such as educator preparedness and limited resources (Wilson et al., 2019), but designing this course made those barriers feel more tangible. I had to consider

whether strategies were realistic for busy families and professionals. This challenged me to simplify content and prioritize practicality.

Confirmation

The research consistently highlighted early intervention as critical for improving developmental outcomes (Lord et al., 2014; CDC, 2025). As an Early Intervention Educator, this strongly aligned with my professional experience. My project confirmed the urgency of equipping both parents and educators with strategies as early as possible. It also reinforced the importance of recognizing early signs and initiating conversations about evaluation—something I previously felt hesitant about but now feel more prepared to address.

Overall Reflection

Overall, my project largely confirmed and reinforced the findings of my literature review. The research supported the need for:

- Increased educator training
- Structured parent training
- Early, evidence-based intervention
- Family-centered, collaborative approaches

At the same time, the project challenged me to consider the complexity of real-world implementation and the time, clarity, and intentional design required to make research-based strategies accessible and sustainable.

Rather than conflicting with the literature, my project deepened my understanding of it. It moved the research from theory into applied practice and strengthened my professional confidence in addressing the gaps identified in the studies.

What I learned about myself

Engaging in this project helped me realize how much I have grown both professionally and personally. When I began this journey, I described feeling uncertain and intimidated in my role as an Early Intervention Educator working with children with ASD. Through researching, designing, and organizing this 8-week training course, I learned that I am capable of deeper expertise, intentional leadership, and meaningful impact.

First, I learned that I am a reflective practitioner. This project required me to examine my own gaps in knowledge and commit to strengthening them. Instead of avoiding areas where I felt less confident, I invested time reading research, watching videos, and carefully selecting evidence-based materials. I realized that being an effective educator does not mean knowing everything—it means being willing to continuously learn and refine practice.

Secondly, I discovered that I value empowerment over simply delivering information. As I created each module, I constantly asked myself whether the content would help families feel more confident and capable. I learned that my leadership style is relational and supportive. I want parents and professionals to leave feeling encouraged, not overwhelmed. This project reinforced that I lead by building trust, clarity, and confidence in others.

I also learned that I hold myself to high professional standards. I did not anticipate how long it would take to read every article and watch every video before including it in the course.

However, I wanted to ensure that everything was accurate, relevant, and practical. This showed me that I am committed to integrity and quality in my work. Additionally, I learned that leadership requires vulnerability. Creating and presenting this course meant stepping into a position of guidance, even while I was still growing in my own understanding of ASD. I realized that leadership does not require perfection; it requires initiative, responsibility, and a willingness to grow alongside others.

Finally, I learned that I am capable of creating meaningful change. Instead of simply recognizing that families and educators need more ASD-specific training, I developed a structured program to address that gap. This project strengthened my confidence and clarified my professional identity. I now see myself not only as a service provider, but as an educator and leader who can contribute to improving support systems for children with ASD and their families.

Overall, this experience reinforced that growth comes through action. By engaging deeply in this project, I became more confident, more research-informed, and more intentional in my practice. Most importantly, I learned that I am capable of leading with compassion, clarity, and purpose.

Reflecting on the INTASC standards

Reflecting on the INTASC standards and the professional standards addressed in Chapter 1, I recognize significant growth in my professional identity, confidence, and application of knowledge. This project strengthened my understanding of learner development, learning differences, evidence-based practice, professional learning, and leadership.

Standard 1: Learner Development

INTASC Standard 1 emphasizes understanding how learners grow and develop across cognitive, linguistic, social, emotional, and physical domains. At the beginning of this project, I had strong foundational knowledge in child development; however, I felt less confident in applying that knowledge specifically to children with ASD.

Through researching ASD characteristics, early signs, and developmental trajectories, I deepened my understanding of how autism affects social communication, emotional regulation, and engagement. I now feel more equipped to recognize developmental patterns associated with ASD and respond with targeted strategies. My understanding has shifted from general developmental knowledge to more specialized, individualized application.

Standard 2: Learning Differences

Standard 2 focuses on using understanding of individual differences to ensure inclusive learning environments. In Chapter 1, I acknowledged feeling uncertain when working with children who avoided interaction or demonstrated limited joint attention.

Through this project, I gained stronger confidence in adapting strategies to meet the unique needs of children with ASD. Designing modules on sensory processing, communication supports, and emotional regulation strengthened my ability to think flexibly and inclusively. I now approach learning differences not as barriers, but as opportunities to individualize support in meaningful ways. I no longer feel intimidated by differences. Instead, I feel better prepared to support them intentionally.

Standard 5: Application of Content

Standard 5 emphasizes connecting content knowledge to real-world application. This standard reflects some of my greatest growth. Before this project, much of my ASD knowledge came from experience rather than research. Through the literature review and module development, I strengthened my ability to connect research-based interventions (such as parent training models and naturalistic developmental strategies) to practical home and classroom settings. I moved from understanding strategies conceptually to intentionally designing instruction that translates research into usable practice. My ability to bridge theory and practice has significantly improved.

Standard 9: Professional Learning and Ethical Practice

Standard 9 focuses on ongoing professional learning and ethical responsibility. At the beginning of this journey, I openly acknowledged gaps in my ASD knowledge. Rather than remaining in that uncertainty, I committed to professional growth. I learned that high-quality professional development requires careful research, thoughtful content selection, and reflection. Reading each article and reviewing every video before including it in the course demonstrated my commitment to ethical practice and accurate representation of information. What has changed most is my confidence in identifying my own areas for growth and proactively addressing them.

Standard 10: Leadership and Collaboration

Standard 10 emphasizes leadership and collaboration with families, colleagues, and community members. This project strengthened my leadership identity in meaningful ways.

Designing and presenting an 8-week course required initiative, organization, and vision. I shifted from viewing myself solely as a service provider to recognizing my role as a leader who can influence practice and build community.

Additionally, my emphasis on collaboration between families and professionals reflects a deeper understanding of shared responsibility in supporting children with ASD. What has changed is my belief in my ability to lead. I now see leadership as creating supportive structures that empower others.

Limitation of this project

While this project successfully developed an 8-week training course to support families and professionals working with children with autism spectrum disorder (ASD), several limitations should be acknowledged. First, the project focused primarily on course design and structure rather than long-term implementation and outcome measurement. Although participants complete discussion posts and a final questionnaire, the project does not include pre- and post-assessments to measure knowledge growth or behavioral change. Without quantitative or longitudinal data, it is difficult to determine the measurable impact of the course on participants' confidence, skills, or child outcomes.

If I were able to change this circumstance, I would incorporate a pre-course and post-course assessment to measure growth in ASD knowledge and confidence levels. Additionally, follow-up surveys several months after course completion could help determine whether participants are applying strategies consistently. These changes would strengthen the validity and credibility of the project and provide clearer evidence of effectiveness.

Depth of Content

Secondly, While the course provides foundational knowledge and practical strategies, it cannot replace formal training programs or intensive coaching models such as those described in the literature (e.g., structured parent training with fidelity monitoring). If given more time and resources, I would expand the course to include optional advanced modules or live coaching sessions. Adding interactive workshops or case-study simulations could deepen application and allow participants to practice strategies with guided feedback. This would likely enhance skill acquisition and confidence beyond informational learning alone.

Live Interviews

Finally, a significant limitation of this project was the absence of direct interviews or formal data collection from families of children with ASD. Although my course design was informed by professional experience and existing literature, I did not conduct structured interviews, focus groups, or surveys with families during the development phase. Because of this, the course content reflects research findings and my professional perspective rather than firsthand qualitative data from participants.

While the literature highlights common barriers families experience—such as emotional stress, limited resources, and difficulty navigating services—interviewing families directly would have provided deeper insight into their lived experiences, priorities, and specific training needs. If I were able to change this circumstance, I would incorporate family interviews or focus groups prior to finalizing the modules. Gathering direct feedback could have shaped the course content more precisely around families' most immediate concerns. It may have influenced which topics received greater emphasis or revealed additional themes not fully addressed in the literature. It

would also increase the credibility of the project by demonstrating that the training was not only research-informed but also community-informed.

Improvements

If I were to improve this project, I would first allow myself more time for development and reflection. While I dedicated significant effort to researching and designing the modules, I underestimated how long it would take to carefully select high-quality articles and videos. Giving myself a longer timeline would have reduced pressure and allowed for deeper refinement of each module.

Additionally, I would enroll in a formal course specifically focused on autism spectrum disorder before finalizing my own training program. Experiencing an ASD course as a participant would allow me to critically evaluate what I found engaging, clear, and practical, as well as what felt overwhelming or ineffective. Observing instructional structure, pacing, interaction styles, and assessment methods from the learner's perspective would strengthen my own course design.

Another improvement would be implementing pre- and post-course assessments to measure growth in knowledge, confidence, and strategy use. Currently, the course includes discussion posts and a final questionnaire, but it does not systematically measure learning outcomes. If circumstances allowed, I would incorporate live virtual workshops, case-study discussions, or short coaching demonstrations. These additions would allow participants to practice strategies in real time, ask questions, and receive feedback. This could significantly enhance skill acquisition and confidence.

One of the most significant improvements would be to include interviews or focus groups with families and early childhood professionals before finalizing the course content. While the modules were informed by research and my professional experience, direct qualitative data would provide deeper insight into families' lived experiences, priorities, and challenges. Incorporating this feedback would make the course more responsive and community-informed. It would also increase the credibility and relevance of the training by ensuring it directly reflects participant needs.

What is next

I would also like to pilot the course with a small group of families or early childhood professionals to gather more structured feedback. Incorporating pre- and post-assessments in future implementations would allow me to measure growth in knowledge and confidence more intentionally. This would strengthen the credibility and impact of the training.

Another next step is exploring opportunities to collaborate with ASD specialists, speech-language pathologists, or occupational therapists to enrich the course content. Partnering with professionals who have specialized expertise would deepen the quality of instruction and provide participants with a broader perspective.

I absolutely see myself continuing to grow in this area. ASD is highly relevant to my current role as an Early Intervention Educator, as approximately half of my caseload consists of children with ASD or developmental indicators. This project has strengthened my interest in becoming more specialized in ASD support.

In the future, I would consider:

- Taking advanced coursework or certification in ASD
- Attending ASD-focused conferences or professional development trainings
- Continuing to refine and possibly expand this training program
- Leading workshops within my district or professional network
- Advocating for stronger ASD preparation in early childhood teacher education programs

This project began as a response to my own uncertainty. It has grown into a commitment to ongoing learning, leadership, and advocacy. Moving forward, I do not see this as a completed assignment, but as the beginning of a deeper professional pathway.

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Appendices

Appendix A

Course Feedback Survey

Participants complete the following survey at the conclusion of the training course to evaluate the effectiveness of the program and identify areas for improvement.

1. On a scale of 1-5, how would you rate the overall quality of this training?

   Poor, 1, 2, 3, 4, 5, Excellent

2. The training increased my understanding of family engagement in supporting children with ASD.

   Strongly Agree

   Agree

   Neutral

   Disagree

   Strongly Disagree

3. The section on the emotional impact of ASD on families was informative and meaningful.

   Strongly disagree

   Disagree

   Neutral

   Agree

   Strongly agree

4. The content on caregiver self-care was relevant and practical.

   Strongly agree

Agree

Neutral

Disagree

Strongly disagree

5. The training helped me better understand barriers to family engagement and how to address them.

   Strongly disagree

   Disagree

   Neutral

   Agree

   Strongly agree

6. I feel more confident applying what I learned to support families of children with ASD.

   Strongly agree

   Agree

   Neutral

   Disagree

   Strongly disagree

   N/A

7. Which topic did you find most valuable?

   Impact of ASD on Families

   Family Engagement Strategies

   Sensory processing (overload)

   Communication

   Emotional regulation

Social relationships

Play strategies

8. Do you feel better prepared to identify the characteristics of autism?

   Yes

   Somewhat

   Not yet

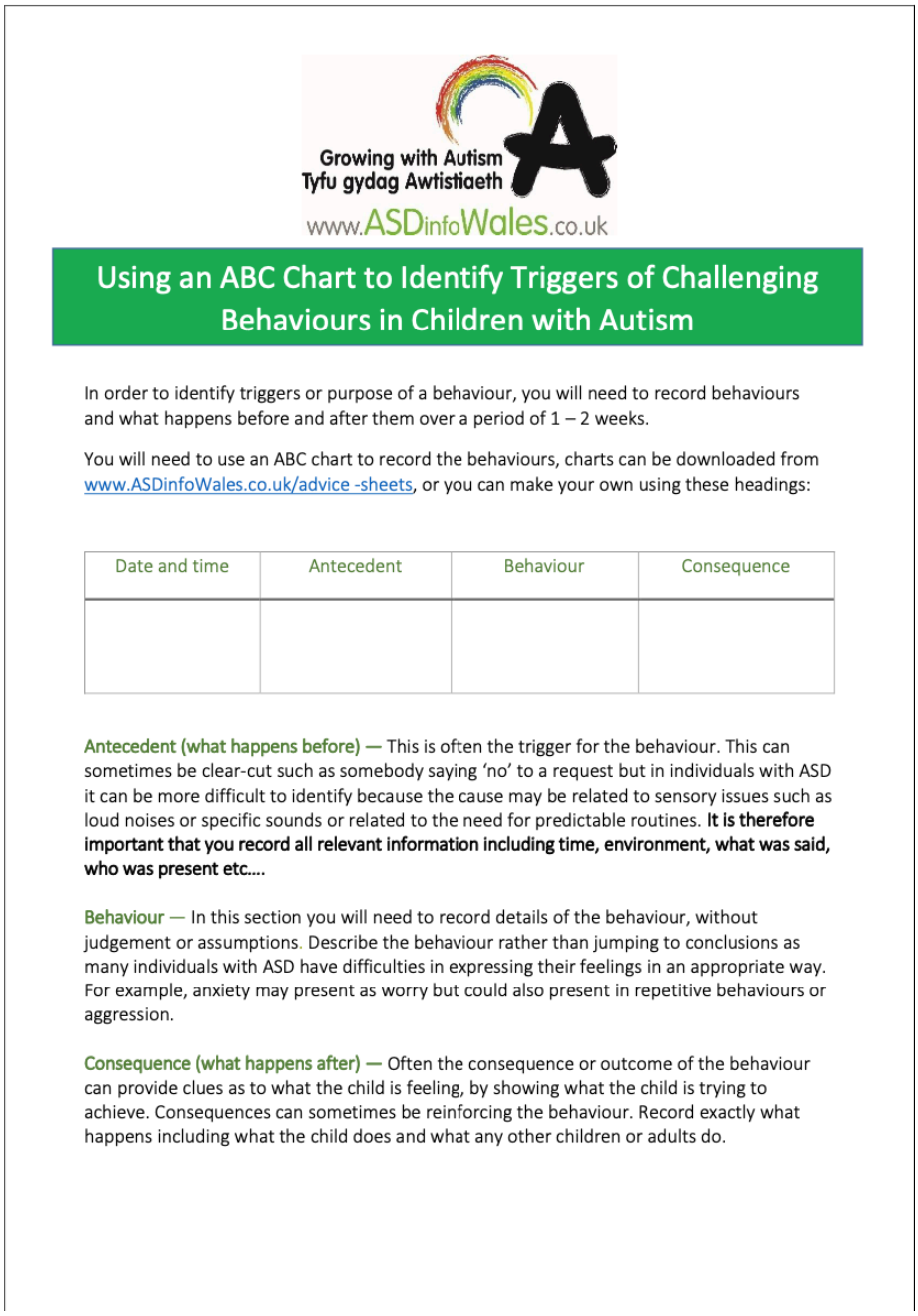
9. What was your biggest take away from this training?

   Your answer

10. What suggestions do you have to improve this training?

Appendix B

ABC Chart to Identify Triggers of Behaviors in Children with Autism



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Using an ABC Chart to Identify Triggers of Challenging Behaviours in Children with Autism

In order to identify triggers or purpose of a behaviour, you will need to record behaviours and what happens before and after them over a period of 1 – 2 weeks.

You will need to use an ABC chart to record the behaviours, charts can be downloaded from www.ASDinfoWales.co.uk/advice -sheets, or you can make your own using these headings:

Date and time	Antecedent	Behaviour	Consequence

Antecedent (what happens before) — This is often the trigger for the behaviour. This can sometimes be clear-cut such as somebody saying 'no' to a request but in individuals with ASD it can be more difficult to identify because the cause may be related to sensory issues such as loud noises or specific sounds or related to the need for predictable routines. **It is therefore important that you record all relevant information including time, environment, what was said, who was present etc....**

Behaviour — In this section you will need to record details of the behaviour, without judgement or assumptions. Describe the behaviour rather than jumping to conclusions as many individuals with ASD have difficulties in expressing their feelings in an appropriate way. For example, anxiety may present as worry but could also present in repetitive behaviours or aggression.

Consequence (what happens after) — Often the consequence or outcome of the behaviour can provide clues as to what the child is feeling, by showing what the child is trying to achieve. Consequences can sometimes be reinforcing the behaviour. Record exactly what happens including what the child does and what any other children or adults do.