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Pepperdine University
Graduate School of Education and Psychology

SOCIAL SKILLS TRAINING: A PARENT EDUCATION PROGRAM FOR CULTURALLY DIVERSE PARENTS
OF CHILDREN WITH AUTISM SPECTRUM DISORDERS

A dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Nicole Brown, M.A.

October, 2010

Shelly Harrell, Ph.D. - Dissertation Chairperson

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DEDICATION

“We are simultaneously like all others, many others, a few others, and no others”
- *unknown author*

To the parents of children with Autism Spectrum Disorders who love that their child is like no other, yet appreciate the moments when they see how they are like many others.

ACKNOWLEDGMENTS

It is with sincere gratitude that I wish to thank my understanding and patient husband and daughter, who have supported my never-ending quest for knowledge. I am extremely grateful to my parents who instilled in me, the need for academic excellence. Thank you to my in-laws whose support throughout the years has afforded me the opportunity to attain my academic goals. Thank you to my committee for their encouragement, support, and guidance through this process and throughout my career.

Thank you to my family, friends, and colleagues whose support throughout my life and career has made all the difference. You are each a wonderful blessing in my life and without you, this dissertation would not have been possible.

I would like to extend a special thank you to all of the children with Autism and their families whose experiences have inspired my research and ignited my desire to develop this program.

VITA

Nicole E. Brown

EDUCATION

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|---------------------------------|--------------------|----------------------|
| Florida Institute of Technology | Melbourne, Florida | March 2010 - Present |
|---------------------------------|--------------------|----------------------|
- BACB (Behavior Analyst Certification Board) approved distance learning coursework in Behavior Analysis
 - Independent Supervised Fieldwork under the supervision of Nikol Manes, M.S., B.C.B.A.
-
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| Pepperdine University | Los Angeles, California | Sept. 2005 – Oct. 2010 |
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- Doctor of Clinical Psychology (Psy.D.), APA (American Psychological Association) Accredited Program
 - One-year specialization track: *Cognitive-Behavioral Therapy*
 - One-year specialization track: *Cultural-Ecological and Community-Clinical Interventions*
 - Activities: Multicultural Research and Training Lab (MRTL), Student Government Association Student Representative
-
- | | | |
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| Pepperdine University | Encino, California | Aug. 2003 - May 2005 |
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- Master of Arts in Psychology
 - Activities: Psi Chi Honor Society (President)
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| Pepperdine University | Malibu, California | Aug. 1997 - April 2001 |
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- Bachelor of Arts in Psychology
 - Minor in Spanish
 - Activities: Industrial Organizational Psychology Club (Internship Coordinator); Ambassadors Council (Historian); Panhellenic Association (President, Judicial Board Member); Interfraternity Council (Judicial Board Member); Delta Gamma Sorority (Vice-President Panhellenic, Vice-President Social Standards, Director of Rituals); Riptide Student Spirit Club; Black Student Union
-
- | | | |
|---------------------------------|-------------------|-----------------------|
| University of California, Davis | Davis, California | Jan. 1999 - July 1999 |
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- Psychology Core Courses/Ethnic Studies
-
- | | | |
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| University of Belgrano | Buenos Aires, Argentina | April 1998 - July 1998 |
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- Studied Spanish language and culture
 - Traveled extensively throughout South America including Argentina, Brazil, Uruguay and Chile

CLINICAL EXPERIENCE

- | | | |
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| Learning Dynamics | Woodland Hills, CA | May 2009 – Present |
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- Chairman of the Board and Executive Director*
- Founder of nonprofit community resource organization that provides parent education, adaptive skills training, psychological therapeutic services, educational therapy, and community education to English and Spanish speaking families

Kaiser Permanente Medical Center Los Angeles, CA Aug. 2009 – Aug. 2010
Psychology Intern, Department of Psychiatry

- Completion of APA Accredited Predoctoral Internship in Clinical Psychology
- Provided individual, couple, and family therapy
- Served as co-facilitator for weekly therapy groups including panic, phobia, and OCD; junior high school coping; coping for latency aged children with ADHD; and multifamily limit setting
- Conducted psychodiagnostic assessments for outpatient psychiatry department, Attention Deficit Disorder psychoeducational assessments for pediatric department, and neuropsychological evaluations for pediatric oncology department
- Completed four-month rotation in work stress clinic. Assisted in delivery of eight-session psychoeducation course on identification, reduction, and management of work-related stress
- Served on multidisciplinary team with occupational therapy, speech and language therapy, neurology, pediatrics, and psychiatry to assist in the diagnosing of children with Autism Spectrum Disorders
- Responsibilities included medical chart review; clinical interviewing; test administration, scoring, interpretation; DSM IV-TR diagnostic formulation; treatment planning, report writing; and feedback to family and referring clinician
- Attendance at weekly didactic training seminars with topics in psychological assessment, diversity, neuropsychology, behavior medicine, couple therapy, and professional ethical/legal issues

LAC+USC Medical Center Los Angeles, CA Sept. 2008 – July 2009
Los Angeles County + University of Southern California Medical Center
Psychology Clerk, Department of Psychiatry and the Rand Schrader Clinic

- Conducted psychodiagnostic and neuropsychological assessments for outpatient psychiatry clinic and general hospital patients via Consultation and Liaison
- Conducted English and Spanish neuropsychological assessments of individuals with HIV/AIDS at Rand Schrader Clinic
- Responsibilities included medical chart review; clinical interviewing; test administration, scoring, interpretation; DSM IV-TR diagnostic formulation; report writing; and feedback to referring clinician
- Attendance at weekly didactic training seminar with topics including psychological assessment, cross-cultural assessment across the life span, psychopharmacology, and ethical/legal issues
- Management of Assaultive Behavior Training

Yellen and Associates Northridge, CA Feb. 2007 – May 2009
Psychological Assistant, Supervisor: Andrew Yellen, Ph.D.

- Development, implementation, and facilitation of six weekly social skills groups for children ages 4 -15 years old with various diagnoses including Autism, Asperger, Attention Deficit, and Bipolar disorders
- Provided individual, couple, and family therapy; conducted psychological and psychoeducational testing and assessment, including assessments with individuals ages 15-35 living in a dual-diagnosis residential facility
- Served as a peer supervisor to one post-doctorate psychological assistant and one predoctoral student

Pepperdine Community Counseling Center Encino, California Sept.–Dec. 2005;
Therapist, Doctoral Student, Supervisor: Anat Cohen, Ph.D. Sept. 2006 – Jan. 2008

- Worked with children, families, individuals, and couples to develop social and emotional skills
- Facilitated healing process during and after difficult situations and served as an active listener

RESEARCH EXPERIENCE

Pepperdine University Los Angeles, California June 2008 – Aug. 2008
Independent Research, under the direction of Caroline Keatinge, Ph.D.

- Independent research on the development of current projective tests including their scoring system and standardization, with emphasis on the use of projective tests with ethnically diverse populations
- Preparation for conceptualizing a rationale for development of a projective test that is culturally sensitive

Pepperdine University Malibu, California Sept. 2004 – Dec. 2004
Research Assistant, Tomas Martinez, Ph.D.

- Examined the impact of the LA Bridges Program in providing at-risk junior high students with an alternate lifestyle. Emphasis on family impact, academics, self-esteem and leadership
- Experience in administration of Wide Range Achievement Test (WRAT 3), Coopersmith Self-Esteem Inventory (CSI), and California Healthy Kids Survey (CHKS) assessment measurements

Pepperdine University Encino, California Sept. 2004 – Dec. 2004
Research Assistant, Tamar Bourian, Psy.D. Candidate

- Located, compiled, and indexed articles on bullying with emphasis on the effects of bullying on the victim and skills victims need to manage their experience

Pepperdine University Malibu, California Jan. 2000 – April 2001
Independent Research, under the direction of Tomas Martinez, Ph.D.

- Independent research on the development of non-profit organizations, with emphasis on group homes. Creation of a group home model based on a combination of psychological and sociological methods, current set-up of group homes, and skills and techniques needed to function as a citizen in today's society

Pepperdine University Malibu, California May 2000 – Aug. 2000
Summer Undergraduate Research Program (SURP), with Khanh Bui, Ph.D.

- Development of a computer program that examines individuals' implicit racial stereotypes towards violence

Pepperdine University Malibu, California Jan. 2000 – April 2000
Research Assistant, Annette Ermshar, Ph.D.

- Located, compiled, and indexed current articles on Velo-cardio-facial Syndrome (VCFS) with emphasis on developmental factors associated with this disorder. Assisted in the recruitment of participants for research on the developmental factors associated with VCFS

STUDENT AFFAIRS & UNIVERSITY EXPERIENCE

Pepperdine University Malibu, California June 2006 – Jan. 2007
Member, University Diversity Council

- Contributed to the collaborative effort of creating a strategic plans and goals for the alignment of diversity with the Christian mission and vision of the university
- Served as Seaver Undergraduate College Staff Representative

Pepperdine University Malibu, California Nov. 2002 – Jan. 2007
Manager, Washington D.C. Internship Program

- Provided career and academic advising to undergraduate students
- Facilitation of program information sessions, professional skills, and time management workshops
- Development and implementation of marketing strategies resulting in a over 200% increase in participants and expansion of program from two terms to year-round
- Set and managed program budget of over \$700,000 in expenses and over \$1,000,000 in revenue
- Development and implementation of program assessments and production of quarterly and annual reports
- Hired, trained, supervised, evaluated and coordinated schedules and team meetings for student staff

Pepperdine University Malibu, California Nov. 2002 – Mar. 2003
Manager, On-Campus Interview Program

- Development and implementation of marketing strategies resulting in an increase from 22 to 224 student participants in three months
- Created and executed one day recruitment interview fair and coordinated school district/private school recruitment fair
- Facilitated and hosted on-campus interviews and supervised student staff

Pepperdine University Malibu, California Oct. 2000 – Nov. 2002
Student Organizations Coordinator

- Advised 60 student organizations on-campus, including fraternities, sororities, and clubs
- Supervised, planned, and executed student related special events including Homecoming, New Student Orientation Sessions, and Greek Recruitment
- Developed and maintained student organization related policies and university policies related to on-campus advertising and coordinated and approved student organization calendar of events
- Developed and implemented program assessments and produced monthly and annual evaluative reports
- Developed and maintained filing system for confidential records
- Hired, trained, supervised, evaluated and coordinated work schedules and team meetings for 9 student staff members
- *Student Affairs Staff Member of the Month, June 2002*

ABSTRACT

Current information pertaining to families with a child diagnosed with Autism Spectrum Disorders indicates a need for parent interventions that target social skills training, culturally responsive treatments for ethnic minorities, and stress and coping. In response to these needs, a culturally responsive program was designed to teach parents of children ages 6-12 with autism spectrum disorders (ASD), to facilitate social skills development in their children and reduce the parental stress associated with having a child diagnosed with an autism spectrum disorder. The program is intended to be a resource for clinicians that want to provide culturally responsive social skills training for parents of children with ASD, by serving as an adjunct to traditional forms of social skills training. This study consisted of three phases. The first phase consisted of a comprehensive review of existing literature. The second stage consisted of the integration of data in preparation for the development of the program. The final stage consisted of having the program evaluated for accuracy, effectiveness, and relevance of content by an expert panel.

Chapter One: Introduction

Autism spectrum disorders (ASD) are complex developmental disabilities that are characterized by a significant range of impairments in social interaction and communication, and the presence of restrictive or repetitive patterns of interest and behavior (American Psychological Association [APA], 2000). ASD include diagnoses of autistic disorder, pervasive developmental disorder – not otherwise specified (PDD-NOS), and asperger syndrome. These three conditions share some of the same diagnostic symptoms; however symptom onset and severity vary. Pervasive developmental disorders include these three developmental disabilities, as well as rett syndrome and childhood disintegrative disorder.

The Center for Disease Control's (CDC) Autism and Developmental Disabilities Monitoring (ADDM) Network released data in 2009 regarding an 11 site study based on data from surveillance year 2006 in order to determine the prevalence of ASD in the United States. The results indicated that approximately one percent of all children ages 3-17 and 1.3% of all children ages 6-8 in the United States had an ASD. These results show an increase in prevalence from the data related by the CDC and ADDM in 2007 indicating that approximately 1 in 150 eight year-old children in multiple areas of the United States had an ASD. Prevalence of ASD was 4.5 times higher among boys than girls. The prevalence of ASD among ethnic minorities varied, therefore it cannot be concluded that there are clinically significant differences in ASD across ethnic groups (CDC, 2009).

In response to this large rate of occurrence, the Combating Autism Act (CAA) was passed in 2006 authorizing \$920 million dollars in federal funding to support Autism. In 2009, President Barack Obama included \$211 million dollars for autism in his Fiscal Year 2010 budget. This is the first year since the CAA was passed that funding for autism has been included in a President's budget proposal. The Department of Health and Human Services (2009) reported:

The President is committed to providing an additional \$1 billion over the next eight years to expand support for children, families, and communities affected by ASD. The FY 2010 Budget includes \$211 million dollars across Health and Human Services programs for ASD research, treatment, screening, surveillance, public awareness and supportive services. (p.3)

Even with these efforts, parents of children with ASD have one of the highest reported levels of stress when compared to other parent groups (Baker-Ericzen, Brookman-Fraze, & Aubyn, 2005; Gupta, 2007). Additionally, culturally diverse children with ASD may have an increased risk of low developmental achievement because cultural barriers prevent their families from accessing information about available services (Rodriguez, 2009). Furthermore, the majority of evidenced-based interventions have not included many ethnically diverse participants in their studies (Munoz & Mendelson, 2005; Zions, Zions, Harrison, & Bellinger, 2003), giving evidence that there is a need for interventions that are culturally responsive (Dyches, Wilder, Sudweeks, Obiakor, & Algozzine, 2004).

This dissertation seeks to serve as a support for primary caregivers of children with ASD. The goal of the proposed study is to develop a culturally responsive parent education program that assists parents in positively reinforcing social skill development in children with ASD. Parents will learn how to assist their children in generalizing adaptive skills into their everyday lives. This program is intended to assist parents in managing stresses associated with a child's diagnosis of an ASD.

Overview of Autism

Autism is a complex neurobehavioral disorder in which, “specific cognitive deficits play a key role, and for which genetic factors predominate in aetiology” (Bailey, Phillips, & Rutter, 1996, p. 117). Autism is characterized by impairment in reciprocal social interaction, impairment in communication, and the presence of repetitive and stereotyped patterns of behaviors, interests, and activities.

Individuals with autism experience abnormalities in verbal and nonverbal communication. Verbal communication can be delayed or absent. If verbal communication is delayed, marked impairments observed may include lack of reciprocal conversation and use of idiosyncratic or stereotyped and repetitive language. Nonverbal communication impairments may include limited use of imaginative play, delayed language comprehension (e.g., questions, directions, humor), and difficulty joining words with gestures (APA, 2000).

According to the American Psychiatric Association (2000), abnormalities in social interaction may be observed through impairment in a person’s ability to effectively use nonverbal behaviors to regulate social interaction, inability to establish and maintain developmentally appropriate peer relationships, and lack of social reciprocity or awareness of others. The presence of repetitive and stereotyped patterns of behaviors, interests, and activities may be observed in a variety of ways. Examples of ways these characteristics may manifest themselves include restricted interests, preoccupation with parts of objects or movement, inflexible or nonfunctional routines, and stereotyped body posture or movements.

According to the American Academy of Pediatrics (2007), early signs of autism may be present before a child is 18 months. There is no cure for autism. However, “manifestations of the disorder [autism] vary greatly depending on the developmental level and chronological age of the individual” (APA, 2000, p. 70). Treatments that target the symptoms most central to autism (e.g. impairment in social interaction, communication, presence of restrictive or

repetitive patterns of interest and behavior) are often effective in facilitating significant improvement. Prognoses for symptom reduction are often better for children when the interventions are implemented at an early age (Howlin, 1997; Stahmer & Aarons, 2009).

Cultural Diversity and Autism

Many individuals with psychological and educational problems do not obtain services that are helpful in managing their difficulties. Oftentimes this is because these services are unknown or unavailable to them. In 2000, the Surgeon General released a report entitled *Mental Health: Culture, Race, and Ethnicity*. In regards to mental health services, the report indicates that ethnic minorities have less access and are less likely to receive services, often receive a poorer quality of treatment, and are underrepresented in mental health research (U.S. Department of Health and Human Services, 2001).

The majority of evidenced-based treatments for children have been developed using homogeneous Caucasian participant groups (Burns, Hoagwood, & Mrazek, 1999; Lau, 2006; Wilder, Dyches, Obiakor, & Algozzine, 2004). However, in the United States ethnic minority groups comprise the majority of people serviced in community mental health settings (United States Department of Health and Human Services, 2007). This is especially true in states with populations that are more ethnically diverse. For example, according to the State of California Department of Finance (2007) Caucasians comprised 44% of the total population in California in 2005 with the remaining 56% of the population consisting of Latinos, Asian-Americans, African-Americans, Pacific Islanders, American Indians and multiethnic individuals.

“Educating children from all cultures requires working effectively with their parents” (Manning, & Lee, 2001, p. 163). However, when it comes to individuals with disabilities, it is important to recognize that interpretations of disabilities vary across cultures. Culture

influences parents' beliefs about the etiology, symptoms, prognosis, and appropriate treatment interventions for their child (Mandell, & Novak, 2005). Skinner and Weisner (2007) state:

Interventions, no matter how well-designed and well intended they may be, will not work if they cannot be taken up by service providers and families and find a place in the cultural models and daily routines and practices of service organizations and families. (p. 310)

When clinical interventions are culturally responsive the likelihood of positive outcomes increases (Munoz & Mendelson, 2005). Therefore, to better meet the needs of these families it is important to equip parents and children with interventions that are culturally congruent.

Social Skills Deficits & Training

Social deficits are a defining characteristic of ASD (Rogers, 2000). Individuals with ASD need assistance in developing social skills and generalizing those skills to their environment (Mesibov, 1984). Many agencies and mental health professionals offer social skills training opportunities for individuals with ASD. These trainings often consist of weekly meetings for 1 hour and are conducted in small groups.

Adaptive behaviors are culturally influenced (Olmeda & Kauffman, 2003), and social skills training can be helpful in developing adaptive skills and socially appropriate peer interactions (Carter & Hughes, 2005). Therefore, it is unfortunate that, "...little of the research on SST [Social Skills Training] focus on their relevance or effectiveness for non-White populations" (Banks, Hogue, Timberlake, & Liddle, 1996, p. 415). When interventions are culturally congruent and parents are empowered, the probability of parents integrating learned information into their family context increases (Kalyanpur & Shridevi, 1991). This is important because, if the environment the individual is exposed to during the remainder of the week does not positively reinforce the skills being taught, it is difficult to for the skills to become generalized outside of the social skills group setting (Sheridan, Kratochwill, & Elliott, 1990).

Purpose of the Proposed Project

Current information pertaining to families with a child diagnosed with ASD indicates a need for parent interventions that target stress and coping, social skills training for autistic children, and culturally responsive treatments for ethnic minorities (Coard, Wallace, Stevenson, & Brotman, 2004; Lau, 2006; Southam-Gerow, Weisz, & Kendall, 2003). In response to these needs, the purpose of this project is to design a culturally responsive program that teaches parents of school-aged children with ASD to facilitate social skills development in their children and reduce the parental stress associated with having a child diagnosed with an ASD.

The program will serve as a resource for clinicians that want to provide culturally responsive social skills training for parents of children with ASD. The program is intended to serve as an adjunct to traditional forms of social skills training. A central goal of the program is to facilitate the empowerment of the clinician in implementing culturally responsive social skills interventions. In addition to providing clinicians with a resource for integration of culturally congruent techniques, clinicians will be provided with resources that will enable them to empower their parent-clients, and indirectly children with ASD.

The specific objectives of this project include: a) a review of the literature on ASD, social skills training, multicultural approaches to interventions with individuals with ASD, and the benefits of parent education; b) development of a culturally responsive social skills training program for parents of children with ASD; and c) a critique of the program by an expert panel to evaluate its accuracy and relevance towards the intended population.

Definition of Key Terms

Culturally responsive: the process of developing appropriate and effective tools that work in the cultural context of the client by utilizing cultural knowledge, experiences, skill, and

desire to create an environment that cultivates a belief in which alliances across cultures is enriching, rather than threatening, to shared goals (adapted from Campinha-Bacote, 2002).

Multicultural: any language, culture, ethnicity, national origin, or socioeconomic status differing from the dominant middle- or upper-class European American, English-speaking culture (Wilder et al., 2004, p. 105).

Autism Spectrum Disorders (ASD): complex developmental disabilities that are characterized by a significant range of impairments in social interaction and communication, and the presence of restrictive or repetitive patterns of interest and behavior (APA, 2000).

Summary

Recent autism statistics suggest that prevalence rates are increasing in general and among ethnic minorities (CDC, 2007). This suggests that there is a need for interventions designed to target associated social skills, communication, and behavioral difficulties in order to assist in the development of adaptive skills and reduce associated stressors. In response to the need of these families, this project is focused on the development of a program specifically designed for parents of children with autism. The goals of this program are to: (a) provide parents with information on ways to increase their child's engagement in adaptive social skills, (b) to assist parents in identifying ways to decrease their subjective distress and increase effective ways of coping with the stress of parenting a child with autism, and to (c) provide families with a program that is culturally congruent.

Chapter Two: Literature Review

ASD affect social interaction, language and communication, as well as the expression of restrictive or repetitive behaviors and interests. This chapter reviews deficits in ASD, parenting, and social skills training to assist in the development of an effective social skills training program for parents of children with ASD. There is no known single cause for ASD, but it is generally accepted that its origin is neurological and caused by abnormal brain structure or functioning. Turk et al. (2009) states that:

Autism is not just one condition, but a wide range of social and communicatory disturbances that are influenced in their clinical presentations by etiology, level of intellectual functioning, presence or absence of epilepsy and a range of other factors that affect socialization and language development. (p. 680)

The symptoms of ASD range for each individual. “There is no single behavior that is always typical of autism and no behavior that would automatically exclude an individual child from a diagnosis of autism, even though there are strong and consistent commonalities, especially in social deficits” (National Research Council, 2001, p. 11). In order to gain a comprehensive understanding of the current literature in ASD, this chapter reviews the literature examining deficits in functioning associated ASD, parenting children with ASD, social skills training, and parent education and collaboration.

Social Skills Deficits

Impairment in social skills is considered to be a primary characteristic of ASD. “Social deficits are some of the most difficult to ameliorate in children with ASD and are considered a hallmark feature of the disorder” (Baker-Ericzen et al., 2005, p. 201). This element has remained consistent since the disorder was first identified (Kanner, 1943). Social skills are comprised of six domains including interpersonal behaviors, self-related behaviors, academic-related skills, assertion, peer acceptance, and communication skills (Gresham & Elliott, 1987). It is believed

that the origin of social deficits in children with ASD range from neurological impairment to limited social interaction opportunities to attain skills. "...Efforts to understand the nature of the social difficulties in autism, and to find effective treatments, have driven research and clinical and educational practice for the past 40 years" (National Research Council, 2001, p. 66).

Social skills impairments in children with ASD are seen in a variety of contexts. These children often fail to develop age-appropriate peer relationships (Welsh, Park, Widaman, & O'Neil, 2001), appear to have a lack of interest or enjoyment in social interactions (Leaf, Dotson, Oppeneheim, Sheldon, & Sherman, 2010), have deficits in social and emotional reciprocity (Le Sourn-Bissaoui, Caillies, Gierski, & Motte, 2009), and have communication deficits including difficulty with pragmatic language and understanding nonverbal behaviors (Loukusa & Moilanen, 2009).

Impairment in social functioning makes it difficult for children to establish and maintain meaningful and fulfilling interpersonal relationships. "Interaction with peers is another dimension of children's social development that becomes increasingly important for children beginning at the age of 3" (National Research Council, 2001, p. 73). Children with ASD are generally interested in interacting with others, although they experience difficulty understanding how to do so. The combination of social functioning deficits that children with ASD have often results in difficulty identifying, understanding, and following social expectations. In a study of high-functioning children with autism, Bauminger and Kasari (2000) found that children with autism had a desire for social involvement with others, yet experienced greater amounts of loneliness and less satisfaction with their social relationships than typically developing children.

Children with autism have difficulty adapting meaning to their experiences, and making connections between ideas and events. "Their world consists of a series of unrelated

experiences and demands, while the underlying themes, concepts, reasons, connections, or principles are typically unclear to them” (Mesibov, Shea, & Schopler, 2004, p. 21). Typically developing peers often perceive children with ASD as self-centered and socially awkward, making it difficult for them to establish and maintain friendships.

Sociocultural context also influences social behaviors. The relationship between culture and social functioning is reciprocal. Behaviors of which members of a particular culture engage contribute to appropriate social functioning. Behaviors may be consistent in multiple cultures; however, the meaning that is given may vary greatly. Additionally, the socially acceptable behaviors in a given culture are determined by whether engagement in these behaviors is reinforced by members of the culture or result in negative consequences. An understanding of culturally influenced behavior facilitates a more accurate distinction between cultural differences in social skills and deficits in this area of functioning (Delgado Rivera & Rogers-Adkinson, 1997; Olmeda & Kauffman, 2003). Deficits in social skills that are not addressed may result in future difficulties for children. The effects may include negative peer interactions and rejection (Rodriguez, Smith-Canter, & Voytecki, 2007), poor academic performance (Welsh et al., 2001), and depression (Stewart, Barnard, Pearson, Hasan, & O’Brien, 2006).

Behavior Deficits

Children with ASD often “...demonstrate restrictive, repetitive, and stereotyped patterns of behavior, most often characterized by preoccupation with narrow, rigid and inflexible interests or ways of thinking or behaviors” (Cotugno, 2009, p. 1268). Restricted Repetitive Behaviors (RRBs) are a diagnostic component of ASD. Similar to other characteristics of ASD, behavior deficits vary among children. “These can include behavioral (e.g., stereotypes), communicative (e.g., echolalia), and cognitive (e.g., obsessions, insistence on sameness)

components along with occurrences of self-injurious behaviors or unusual sensitivity to sensory experiences” (Chowdhury, Benson, & Hillier, 2010, p. 210).

Restrictive behaviors may include a limited range of interests, preoccupation with parts instead of whole objects, and insistence on adhering to a set pattern of behavior that may appear resistant to change (APA, 2000). Repetitive behaviors may serve a self-soothing function. Examples of these behaviors include hand flapping, rocking the body back and forth, spinning, and walking on tippy toes. Children with ASD often display little creativity, imagination, or symbolic representation in their play (Rutherford, Young, Hepburn, & Rogers, 2007). Changes in routine can frighten children with ASD, and may result in tantrums or aggression. Aggression may be directed towards others, or inwards, resulting in self-injurious behaviors.

Children with ASD may have an aversion to certain sounds, touching certain textures, or human contact (Chen, Rodgers, & McConachie, 2009). These children tend to avoid or become overly stimulated in social situations, resulting in significant impairment in social interactions. Their behavior may not be easily understood by others. This often further contributes to difficulty in social acceptance (Swaim & Morgan, 2001). Murphy et al. (2005) state, “... one of the most important factors in determining quality of life is the presence of challenging behavior” (p. 405). Identifying behavior deficits in children with ASD can contribute to developing a comprehensive and effective treatment plan.

Cognitive Functioning

Human cognition involves the perception, processing, acquisition, retrieval, transformation, use and exchange of knowledge. A person’s cognitive ability directly impacts how a person learns and functions. When a person has impairment in their ability to input and process visual and verbal stimuli, this effects their ability to understand and function. All people

vary in their cognitive abilities, and children with autism are no different. The relative strengths and weaknesses of children with ASD are reflected in the child's cognitive, emotional, and social abilities. Therefore understanding a child's cognitive ability impacts their social functioning.

Social skills deficits are a hallmark of ASD and are present, regardless of the child's cognitive abilities. Research suggests that Intelligence Quotient (IQ) and social skills ability are not interdependent in children with ASD (Kenworthy, Case, Harms, Martin, & Wallace, 2010). Rather, deficits in social skills are more severe than deficits in intelligence in children with ASD. Liss et al. (2001) investigated the relationship between IQ, adaptive behavior, autistic symptoms, and other cognitive skills in children with ASD. The results indicated that adaptive functioning does not increase with higher levels of cognitive functioning. Therefore, it is beneficial to provide social skills training as part of a treatment plan for children with autism, regardless of their cognitive functioning abilities.

Communication Deficits

Communication is the primary tool of social interaction and problems in this area have significant implications for the development of relationships. Verbal and nonverbal communications are considered a core deficit in the diagnostic criteria for ASD. "Communication problems exacerbate all the other issues, and delay the possibility of addressing social difficulties and the restrictive, repetitive interests and behaviors" (Sanders, 2008, p. 76). Understanding an individual's communication abilities is important in developing a treatment plan to assist them socially. There is significant variability in the verbal skills ability of individuals with ASD. Although some individuals with ASD have language skills in the normal range, the majority of children with ASD experience deficits in this area (Kjelgaard & Tager-Flusberg, 2001). Language deficits in individuals with ASD range from an absence of functional speech to functional speech with the presence of idiosyncratic verbal communication. Cuccaro

et al. (2007) conducted research with individuals with autism ages 3-21 years (146 African-American, 298 Caucasian). The results of their study indicated that there was no significant difference among participants in social and repetitive domains. However, African-American participants acquired first words and speech significantly later than the Caucasian participants and “the presence of functional language was very different in our groups as was the age at acquisition suggesting the possibility of a more severe language phenotype in our African American participants” (p. 1024).

In addition to expressive language, individuals with ASD experience difficulties with language comprehension (Mesibov et al., 2004). “Overall, for people with autism, the auditory channel is less efficient and comfortable than the visual channel, so that hearing and processing language are relatively difficult tasks” (Mesibov et al., 2004, p. 62). They encounter great difficulty with pragmatics, or the role that context plays in understanding the meaning of a communicated message. Pragmatics can be defined as the “critical feature of human interaction that represents the intrinsic blending of social, emotional, cognitive, and linguistic factors in the sending and receiving of messages” (Twachtman-Cullen, 1998, p. 205-206). Individuals with ASD have difficulty with pragmatics which leads to consistent misperceptions of communicated messages. Therefore, “strategies to repair these misunderstandings become critical intervention targets to enable children to influence others in intended ways” (Meadan, Halle, Ostrosky, & DeStefano, 2008, p. 37).

Individuals with ASD can experience difficulty generating and comprehending nonverbal behavior appropriately in communication interactions. According to Mehrabian (1972), nonverbal communication (e.g. tone and body language) accounts for over 90% of meaningful communication. His more recent publication indicates that although nonverbal communication comprises the majority of meaningful communication, the exact percentage of nonverbal

communication is difficult to indicate (Mehrabian, 2009). Nonverbal communication is culturally influenced (Mehrabian, 2009). For example, proximity and the amount of physical contact that is socially appropriate (Delgado Rivera & Rogers-Adkinson, 1997) vary among cultures.

“Teachers who ignore the cultural implications of a particular communication style will probably be less effective, particularly for students with high-functioning autism, than those who recognize both culture and disability related approaches” (Wilder et al., 2004, p. 109). By developing a program that is culturally congruent with varying communication styles, there will be an increase in potential effectiveness. There will be a greater likelihood that the information and interventions will be understood and integrated into the participant’s life.

Parents of Children with Autism Spectrum Disorders

From the time a child is born, the demands of parenting can be challenging and overwhelming. Parents are responsible for providing support and resources to cultivate the physical, psychological, and educational development of their child. Throughout a child’s developmental lifespan, from infancy through adulthood, parents experience stress in relation to their parenting responsibilities (Crnic & Acevedo, 1995). In the United States, there tends to be a current culture of pressure to ensure that children are heavily involved in activities, sports, lessons, challenging academic work, and play dates. This pressure can leave many parents anxious, stressed, and exhausted (Mazur, 2006).

However, for parents of children with ASD, these pressures are coupled with the challenge to provide services, support, and care to their children with special needs (Phetrasuwan & Shandor Miles, 2009). Children with ASD often experience difficulty expressing their needs and wants which can leave parents feeling frustrated with their communication with their child. These children have difficulty understanding social norms and engaging in socially appropriate behavior. As a result, people in the community may stare or make comments about

the child's behavior. Consequently, parents of children with ASD may feel as though others can not relate to them. They often do not feel competent at parenting their child (Allen & Mendelson, 2000). This can result in an increase in stress and a sense of isolation from others. Whether going to a friend's home, a restaurant, or a store, parents of children with ASD can feel uncomfortable taking their child into community settings due to their child's deficits in adaptive behavior (Osborne & Reed, 2009; Phetrasuwan & Shandor Miles, 2009). Baker-Ericzen et al. (2005) found that child-related stress in mothers of children with autism was predicted by their child's social interaction skills. The authors' findings highlight the importance of "a focus on social deficits in this population, in order to increase child functioning and family functioning" (p. 201).

The combination of parenting pressures associated with raising a child with ASD often leaves parents struggling with personal, familial, physical, emotional, and financial difficulties. The Taylor, Washington, Artinian, and Lichtenberg (2007) study with urban African-American parents and grandparents identified significant predictors of parental stress including the number of children in the home, the inability to decrease stress (lack of social support), and serving as a caregiver to child with a physical or mental disability.

Without adequate support, parents of children with ASD may experience elevated levels of stress. Stephen Palmer (2003) stated "stress occurs when the perceived pressure exceeds your perceived ability to cope" (p. 134). Parents of children with ASD consistently experience significantly high levels of stress when compared to parents of "typically" developing children (Bouma & Schweitzer, 1990; Brobst, Clopton, & Hendrick, 2009; Tomanik, Harris, & Hawkins, 2004) and parents of children with other disabilities (Abbeduto et al., 2004). Studies on parental stress associated with autism indicate that these parents consistently score high on measures in multiple domains including depression, anxiety, and marital discord (Lee, 2009).

Hoffman, Sweeney, Hodge, Lopez-Wagner, & Looney (2009) conducted a parenting stress study with 104 mothers of children with autism and 342 mothers of typically developing children participated. The ethnic groups of participants in this study varied, with ethnic minorities comprising the majority of participants; Caucasian mothers of children with autism comprising 40%, and Caucasian mothers of typically developing children comprising 38% of the participant pool. The results of this study indicated that mothers of children with autism report significantly higher levels of stress than mothers of typically developing children on all six of the child domains and on six of the seven parent domain scales examined. The greater the level of severity of autistic symptoms, the greater the mother's parent stress score. The more problematic the behaviors of the child reported, the more the mothers of both groups indicated less closeness to their children. Mothers of children with autism and mothers of typically developing children did not report a difference in their child attachment scores. Although mothers of children with autism experience significant levels of parenting stress, they maintain close relationships with their children. The results of this study support "reducing parental stress should contribute to improving the family climate, to parents' ability to manage their children's behavior, and in turn, to improved outcomes for children with autism and their families" (p. 185-186).

According to Thomas, Ellis, McLaurin, Daniels, and Morrissey (2007), when parents' of children with ASD levels of stress are high, their likelihood of utilizing intervention services increases. Even though the number of ethnic minorities and parents of children with autism are on the rise and their experiences include significant levels of stress, there are few programs that are designed to reduce this distress and improve subjective well-being (Coard et al., 2004). Additionally, ethnic minorities have limited access to healthcare (Thomas et al., 2007) and "disparities in service use associated with race, residence and education point to the need to

develop policy, practice and family-level interventions that can address barriers to services for all children with ASD” (Thomas et al., 2007, p. 1908).

Social Skills Training

Among the wide spectrum of deficits that are characteristic of ASD, deficits in social skills are consistently seen in all individuals. Social skills training assists children in learning how to interpret verbal and nonverbal stimuli to improve their functioning associated with everyday social interactions. “Interventions which address the social competency needs and concerns of ASD individuals appear critical in overcoming many of the negative and debilitating effects of these disorders” (Cotugno, 2009, p. 1269). Typically developing children are able to develop social skills through incidental learning, by simply being exposed to social situations. “Social engagement appears to be a pivotal response, a skill that leads directly to increased attainment of other important skills without the need for direct programming” (Rogers, 2000, p. 406). The process of acquiring social skills for children with ASD is more difficult. Children with ASD, often require systematically taught social skills, as early as possible. “Teaching social skills to children with autism is critical if these children are to develop meaningful relationships and enjoy a high quality of life as they grow older” (Leaf et al., 2010, p. 186). Providing social skills training for children can reduce future negative social outcomes (Rodriguez et al., 2007).

Cotugno (2009) examined the effectiveness of a group-based social competence and social skill training intervention program with children ages 7-11 years old with ASD. The program was stage-based, utilized a cognitive-developmental model, and provided systematic intervention and instruction. The results indicated that “...social competency groups that focus on process-oriented variables combined with skill-based instruction can benefit individuals with ASD in specific areas of social interaction” (p. 1275).

Social skills training is most effective when taught in the most natural ways possible (Gresham & Elliott, 1987; Rodriguez et al., 2007). Generalization of learned skills can be improved when trainings include real life settings. Thorn, Pittman, Myers, and Slaughter (2009) conducted a community involvement study at a residential facility. Their study included 418 Caucasian participants and 136 African-American participants, the majority of whom were adults. The results of their study indicated that “increased functional skills enhance relationship opportunities by creating a sense of ability and commonality in social settings” (p. 899). Furthermore, “increased functional skills in areas such as social interaction, safety, dining etiquette, money management, etc. enhance social relationships by highlighting abilities and unifying common interests” (p. 899). Children with autism may have objects or topics that they perseverate on across multiple settings. Examples of these obsessions include toys (e.g. trains, video games) and television programs (e.g. cartoons, movies). The obsession themes of children with autism can often be problematic in regards to adaptive social interactions. However, Baker, Koegel, and Koegel (1998) found that positive social interactions between children with autism and their typically developing peers can be achieved by transforming these obsessions into common games. Participants in their study maintained positive peer interactions when the adult facilitator was absent, and generalized their behavior to other non-obsession themed games. For children with ASD, “the optimal environment for acquiring communication skills is interactive and centered around the individual’s activities and interests” (Ostrosky, Donegan, & Fowler, 1998, p. 438).

Social competence is an important aspect of child development and can be taught utilizing a continuum of interventions (Brown, Odom, & Conroy, 2001). Teaching parents strategies to effectively manage their child’s behavior will assist in the reduction of parental stress (Tomanik et al., 2004). “Having an autistic child may have already profoundly disrupted

the family by heightening marital tension and increasing pressure on siblings.” (Allen & Mendelson, 2000, p. 711). Bristol, Gallagher, and Holt (1993) found that maternal depressive symptoms were able to be reduced indirectly when mothers participated in an intervention program that was designed to facilitate child learning and manage difficult behavior. It can be beneficial for the intervention to be conducted in a group setting. Being part of a support group relieves feelings of isolation so frequently experienced by parents of children with ASD. “Those families who are sometimes isolated with relatively little contact with similar families can see their situations in a shared, comparative context” (Skinner & Weisner, 2007, p. 310). Additionally, cooperative learning is consistent with the cultural values of many African-Americans and Latinos. Cooperative, person-centered learning can enhance people’s self-efficacy as learners, self-esteem, and empathy for others in a culturally responsive manner (Callicott, 2003; Lohrmann-O’Rourke, & Gomez, 2001).

Adaptive behaviors are socially constructed and vary among cultures. Ethnic families often experience difficulty in establishing a balance between the values of their culture and the cultural values of mainstream United States. Subsequently, “appropriate intervention for children and families must be based on maintaining cultural behaviors while assisting in the development of skills to function successfully in the mainstream culture” (Delgado Rivera & Rogers-Adkinson, 1997, p. 79). For example, children with ASD often have poor eye contact and this often becomes a focus in social skills training. In some cultures it is inappropriate for women to make eye contact with men. In other cultures looking downward and not establishing or maintaining eye contact is a sign of respect. Effective interventions are congruent with the cultural models, daily routines, and practices of families (Skinner & Weisner, 2007). Developing a program that utilizes culturally responsive social skills training can increase

parents' probability of applying learned social skills, resulting in increased effectiveness of techniques.

Parent Education and Collaboration

Parent education is beneficial and has been found to consistently provide positive effects to both parents and their children. Research has shown that clinician-parent collaborative treatments are successful in assisting children with learning and generalization of target behaviors (Bristol et al., 1993; Lerman, Sweizy, Perkins-Parks, & Roane, 2000; Sheridan et al., 1990; Sheridan, 1997); reducing parent stress (Koegel, Bimbela, & Schreibman, 1996) and increasing parent confidence (Brookman-Fraze, 2004). Collaboration with a professional can provide parents with an opportunity to successfully learn and refine skills that will be of assistance to their children. In the Lerman et al. (2000) study, all of the parent participants were taught how to provide praise for their children's compliance. All of the parents in this study required feedback in order to increase their delivery of correct praises to a level that resulted in child compliance.

Beliefs regarding the effectiveness and risks associated with treatments can differ between parents, particularly multicultural parents, and that of clinicians. "If parents feel that clinicians do not respect their beliefs and decisions or are unwilling to negotiate around the use of additional treatment strategies, these strategies may become alternative rather than complementary" (Mandell & Novak, 2005, p. 113). Therefore, the inclusion of parents is essential to a child's treatment. The Individuals with Disabilities Education Act (1997) emphasizes parent involvement in all stages of treatment (referral, assessment, determining eligibility, program planning, and accountability on agreed upon treatment) by including parents in the decision-making process. Woods (1996) stated:

If professionals and parents can accept the challenge of taking on new roles and expectations by working creatively and cooperatively with each other and by

establishing an atmosphere of mutual trust and respect, children with diverse needs and capabilities can benefit enormously. (p. 173)

The inclusion of parents in the treatment process can assist in increasing, strengthening and generalizing learned skills to the home environment. Sheridan et al. (1990) found that social initiation behaviors of socially withdrawn children were increased in the school environment when teachers were involved in the treatment. When parents were also included in the treatment, the effects appeared stronger and were generalized to the home setting.

Traditional psychotherapy and classroom settings have been found to be successful in assisting individuals acquire learned skills. However, these settings do not provide a real-life environment to ensure that generalization of learned techniques has been acquired. According to Thorn et al. (2009), “true participation in community integrated activities creates an endless continuum of functional learning opportunities in which an individual can learn and practice new skills, and staff can capitalize on skill reinforcement, generalization and incidental learning opportunities” (p. 896). Collaboration with parents allows the continued facilitation of taught skills to be reinforced and generalization to be observed, outside of the psychoeducational setting. Thorn et al. (2009) stated:

Regardless of the teaching methodology, learning techniques can be further enhanced when learning opportunities occur across multiple contexts, particularly real-life community-integrated contexts. This is a crucial factor for individuals with significant ID [intellectual disability] who need to learn practical functional skills and partake in real-life activities and experiences in order to transition to a more independent life. (p. 892)

Although there is little research available regarding culturally responsive parenting programs (Coard et al., 2004), research indicates that culture influences parenting methods (Delgado Rivera & Rogers-Adkinson, 1997). Collaborating with parents in the treatment of their child allows the parents’ views, voices, and experiences to enrich interventions and increase both the parents’ and the clinician’s understanding of the material as it relates to the family. When professionals share their expertise collaboratively and with empathy it creates an

empowering relationship that facilitates positive changes. “Such empathy involves the acceptance and open acknowledgment of the parents' competence, the willingness to interact with them on equal terms, and the adoption of a nonjudgmental stance” (Kalyanpur & Shridevi, 1991, p. 531). Treatments that are congruent with the culture of the family and integrated into the family's way of life will remain effective after the intervention period with the professional (Albin, Lucyshyn, Horner, & Flannery, 1996; Marshall & Mirenda, 2002).

Need for Culturally Responsive Interventions

In 2007, the population of minorities in the United States surpassed 100 million, making approximately one in three residents a minority. Louis Kincannon, the Director of the U.S. Census Bureau at the time stated, “to put this into perspective, there are more minorities in this country today than there were people in the United States in 1910. In fact, the minority population in the U.S. is larger than the total population of all but 11 countries” (US Census Bureau, 2007, para. 3). Although the minority population has continued to steadily increase, and is projected to comprise the majority of the U.S. population in 2042 (U.S. Census Bureau, 2008), there is still a need for culturally responsive social skills training for parents of children with ASD (Coard et al., 2004; Lau, 2006; Southam-Gerow, et al., 2003).

Research indicates that the prevalence of ASD is not consistently influenced by ethnicity (Cuccaro, Wright, Rownd, Waller, & Fender, 1996; Palmer, Blanchard, Jean, & Mandell, 2005). However, Mandell, Novak, and Zubritsky (2005) found that children received a diagnosis of ASD at a later age when they were poor, living in rural areas, and had four or more primary care physicians prior to diagnosis. Cuccaro et al. (1996) conducted a study examining the impact of ethnicity and socioeconomic status on clinicians' perceptions of children with developmental disabilities. One hundred eighty-five professionals were surveyed. Participants included school-based speech pathologists, school psychologists, and physicians who listed child psychiatry as an

area of practice. The majority of the participants were female (76%) and Caucasian (92%), and all disciplines had at least 10 years of professional experience. The results of this study indicated that the child's ethnicity did not appear to influence clinicians' perceptions of autism or ADHD when specific diagnostic categories for autism were provided.

Begeer, El Bouk, Boussaid, Terwogt, and Koot's (2009) findings were consistent with Cucarro et al. (1996). However, their study additionally indicated that "pediatricians may be inclined to attribute social and communicative problems of children from non-European minority groups to their ethnic origin, while they would possibly attribute the same problems to autistic disorders in children from majority" (p. 146). Furthermore, "this indicates that, based on spontaneous clinical judgments, non-European minority groups do not receive the same access to autism diagnoses and treatments in comparison to majority group" (p. 146).

Disabilities are interpreted differently across cultures (Rogers-Adkinson, Ochoa, & Delgado, 2003). Definitions and meanings of disability, language and communication style, and perceptions about receiving assistance from individuals outside of the family are some of the cultural factors that may cause misunderstandings between parents and service providers. "Once a developmental delay or disability has been identified, families then are faced with making sense of the condition in relation to cultural models of disability" (Mandell et al., 2005, p. 304).

There are many challenges in providing services to minority families. Often these families have a limited amount of services available to them (Thomas et al., 2007). It is important for clinicians to provide realistic resources as well as find a way to meet the needs of the family without compromising the families' beliefs and values. "Services provided to low income minority families are often rendered ineffectual because the families' needs and values are misunderstood or ignored" (Kalyanpur & Shridevi, 1991, p. 531). Kalyanpur and Shridevi

(1991) conducted a qualitative study that involved extensive interviewing and observation of four, low-income, African-American, single mothers interaction with professionals from an outreach agency. The results of their study indicated aspects associated with participants' perceptions of empowering and disempowering relationships with professionals. Disrespect, focusing on deficits, and discounting parenting style differences were associated with disempowering relationships. In contrast, participants perceived professionals as empowering when the participants felt the professionals were: conversational, established rapport, responsive to their needs, provided emotional support, provided specific services, shared personal experiences, and were accepting and understanding.

Parents from diverse cultures may have different beliefs and expectations about teaching, learning, and parenting (Callicott, 2003; Manning & Lee, 2001). Clinicians are able to work with families more holistically and select appropriate and effective interventions when they work collaboratively, and conceptualize families in the families' sociopolitical context. "...Collaboration requires participants to come together around a common goal and to cooperate in ways that consider the perspectives of each of them" (Marshall & Mirenda, 2002, p. 219). The effectiveness of an intervention is a direct result of the extent to which the intervention is congruent with the ecological and familial context in which it is implemented (Snell, 1997).

Chapter Three: Methodology

The goal of the proposed study was to develop a program for use by clinicians providing social skills training to parents of children ages 6 through 12 with ASD in order to increase awareness and provide considerations for working with ethnically diverse clients. This chapter will focus on the methodology that was used guide the development of the program. This study consisted of three phases. The first phase consisted of a comprehensive review of existing literature. The second stage consisted of the integration of data in preparation for the development of the program. The final stage discusses the process of having the program evaluated for accuracy, effectiveness, and relevance of content by an expert panel.

Program Development

Review of the literature and existing resources. Sources of data considered during the review of literature were compiled from academic databases including Psych INFO, Academic Search Elite, Psych ARTICLES, Research Library, Dissertations and Theses, Education Full Text (Wilson), ERIC, EBSCOHOST, books in print, and other internet resources. Information from local and national organizations was also considered including the National Institute of Mental Health (NIMH), the Centers for Disease Control and Prevention, the United States Department of Health and Human Services Office of Minority Health, Mental Health America, the Autism Society of America, and the Organization for Autism Research. The review of literature mainly centered on concepts and topics related to culture, social skills training, and parent education. More specifically, keyword searches included various combinations of the following terms: culture, African-American, Latino, interracial, ethnicity, diversity, autism, autism spectrum disorders, Asperger's, developmental disabilities, parent education, social skills, adaptive skills, social skills training, parents of children with developmental disabilities, assessment, evaluation, intervention, support, and treatment.

It was important to assess the resources that are currently available to parents in order to examine overlap and uniqueness of the proposed program. In order to examine the uniqueness of the proposed program, a review of the academic literature, a comprehensive search of the literature published by autism support organizations, popular media, online resources, and existing print resources for minority families was conducted.

Integration of data and development of program. Information from the comprehensive literature review was integrated to develop the parent social skills training program. The structure of the program includes five classes that provide information on three primary topics: (a) communication and behavior, (b) emotional awareness, and (c) parent self-care.

Communication and behavior. The program assists parents in learning how to help their child to develop socially appropriate informal and formal speech usage. The content focus includes verbal and non-verbal communication skills. Verbal skills include initiation of conversation, reciprocal conversation (including relevant topic discussion), voice volume and tone. Non-verbal communication skills include eye contact, gestures, and listening strategies.

Emotional awareness. The program assists parents in strengthening their ability to identify, label, and express feelings in order to assist them in developing these abilities in their children. Parents learn how to help their child gain an understanding of others' feelings, others' perception of them, and of situation-based emotions.

Parent self-care. The program assists parents in developing an awareness of their range of intellectual, spiritual, emotional/social, and physical needs in order to pinpoint ways to provide self-renewal. Caregivers learn about the differences between self-care and selfishness and learn techniques to help them balance the demands of work and family, and maintain performance at peak levels in both environments.

Evaluation of the Program

The final stage of this research study consisted of an evaluation of the program by a panel of expert clinicians who work with children with autism and their families. The scope of the evaluation was limited to the program design, content, and clinical applicability. The data collected from the evaluation phase provided strengths and limitations of the program that will be included in the discussion section of this dissertation.

Evaluator participation. For purposes of this study, the panel of evaluators consisted of five experienced professionals in the field of autism who were recruited from agencies in the Los Angeles area that provide services to children with autism and their families. Evaluator eligibility criteria included: (a) a master's or doctorate degree in psychology or related field; (b) have at least 7 years of experience providing direct intervention services to children with autism and their families with at least 5 of those years serving predominantly African American, Latino, and/or Asian clients; (c) academic training or continuing education training in multicultural therapeutic considerations; and (d) residence in Southern California.

Recruitment strategies and procedures. Requests for study evaluators were made via phone call and in writing through a participant recruitment email (Appendix A). Requests were sent to previously identified agencies in the Los Angeles area that provide services to children with autism and their families. The Autism Society of America, The AutSpot, Special Needs Network, Talk About Curing Autism (TACA), and the National Autism Association were contacted. These organizations were identified because of their commitment to Autism. The agencies were provided with information regarding the purpose of the proposed project, eligibility criteria, and the procedures involved in participation. The agency was asked to provide a list of references of professionals that are experts in autism and reside in the Southern California area. The agencies were informed that they were under no obligation to assist with the study and were free to withdraw at anytime without prejudice.

The investigator then randomly contacted the potential evaluators via email or phone to formally request their participation in the study (Appendix B) and verify eligibility (Appendix C) until five evaluators were confirmed. Clinicians who agreed to participate in the evaluation process were mailed an evaluation packet (Appendix D-F) via the United States Postal Service mail containing: (a) two informed consent forms [one for the participant to keep] that described the purpose of the study, safeguards for privacy and confidentiality, and potential risks and benefits of participating in the evaluation (Appendix E); (b) a summary of the project that explains that evaluators are under no obligation to assist with the study and are free to withdraw at anytime without prejudice (Appendix D); (c) a program evaluation form (Appendix F); (d) a copy of the program materials; and (e) a postage-paid pre-addressed return envelope.

Upon receiving the evaluation packet, evaluators were required to read all enclosed materials and complete the evaluation questionnaire. The content of the evaluation questionnaire included demographic questions (e.g. work setting and title) and free response and rating questions pertaining to the content, accuracy, usefulness, strengths and weakness of the program. After completing the questionnaire, evaluators returned all materials to the investigator using the enclosed postage-paid pre-addressed envelope. Voluntary participation was strongly emphasized throughout the process, and participants were informed that they were allowed to withdraw from the study at any time without prejudice.

Analysis of Evaluation

After the evaluation forms were completed by the participants, the responses were reviewed by the researcher and integrated into considerations for future revision of the program. Responses were compiled together by question, key themes were identified for each question, and observations were made regarding the frequency of the themes across

evaluators. Based on the responses received by evaluators, strengths and limitations of the content and format of the program are presented in the discussion section of the dissertation.

Chapter Four: Results

This chapter will provide a summary of the process of developing, creating, and evaluating the parent education program. First, a brief overview of the data collection phase will be presented, which included the review of past and current literature sources. Next, the contents of the program will be reviewed and summarized. Finally, feedback obtained from evaluators who provided critical reviews of the program for its usefulness, accuracy, and relevance will be presented.

Brief Overview of Data Collected from Literature Review

The initial phase of the study included an extensive review of literature to better understand autism, social skills deficits, social skills training and the presence of culture in these areas. Various sources of data were collected from academic databases, local and national organizations, online resources and existing print resources targeting parents of children with ASD. Based on information obtained from the literature, it was determined that social skills deficits are a defining feature of ASD (Rogers, 2000), with individuals needing assistance developing and generalizing these skills to their environment (Mesibov, 1984). The number of ethnic minorities and children diagnosed with ASD are on the rise (CDC, 2009). Research indicates that parents of children with ASD have significant levels of stress and discomfort related to their child's deficits in adaptive functioning (Osborne & Reed, 2009), and few culturally responsive programs designed to reduce this stress and improve subjective well-being (Coard et al., 2004).

Despite the elevated levels of stress associated with their children's social skills deficits, few culturally responsive programs are available to assist parents in developing adaptive functioning abilities in their children. Because of the lack of cultural responsiveness, the efficacies of many programs are negatively impacted (Kalyanpur & Shridevi, 1991). The

effectiveness of an intervention is a direct result of the extent to which the intervention is congruent with the ecological and familial context in which it is implemented (Snell, 1997). In order to increase the efficacy of treatment interventions, the literature recommends that treatments are congruent with individual's ecological and familial context. A comprehensive culturally responsive parent-focused intervention, such as a parent education program, is needed to supplement child-focused treatment and assist in the generalization of adaptive target behaviors. Research indicates that clinician-parent collaborative treatments are effective in assisting children with learning and generalization of target behaviors (Bristol et al., 1993; Lerman et al., 2000; Sheridan, 1997; Sheridan et al., 1990) and reducing caregiver stress (Koegel et al., 1996).

The data purport that, despite the high levels of reported stress in parents of children with ASD, caregiver child-related stress was predicted by the child's social interaction skills (Baker-Ericzen et al., 2005). Implications for such findings are significant and include the development of interventions designed to enhance children's adaptive functioning. Specific interventions as outlined in the literature should consist of communication and behavior, emotional awareness, and parent-self care. Therefore, the goal of this study was to develop a program specifically for parents of children with autism that targets the development of adaptive skills in their children, and reduces the associated parenting stressors. The goals of this program are to: (a) provide parents with information on ways to increase their child's engagement in adaptive social skills, (b) to assist parents in identifying ways to decrease their subjective distress and increase effective ways of coping with the stress of parenting a child with autism, and to (c) provide families with a program that is culturally congruent.

Integration of Data

Data collected from the literature was compiled to inform the content of the manual. When recurrent themes emerged, they were identified for inclusion in the program design (e.g. verbal communication, nonverbal communication, behavior modification, and stress management).

Additional sources of data utilized for treatment interventions presented in the program were adapted from printed and electronic resources related to social skills training, parent-clinician collaboration, coping, and psychological functioning and well-being. The content focus of the program include two targeted domains: 1) the identification of relative social skills deficits in participant's child(ren) with ASD, 2) the presentation of culturally congruent coping behaviors and strategies designed to increase adaptive functioning in children and manage associated parenting stress.

Resource Manual

The program outline, *Social Skills Training: A Parent Education Program for Culturally Diverse Parents of Children with Autism Spectrum Disorders* is 16-pages in length and presents in black and blue ink. The program outline contains general program notes and content for each session. The general program notes outline educational requirements for program facilitators; recommended group size restrictions; and age, cognitive aptitude, and verbal ability requirements for participants' children with ASD. The program outline details the structure and content for each of the five sessions including introductions, homework review, training focus area with suggested wording of information, breaks, small and large group activities, resources, homework assignments, and closing ritual.

Design and Content of the Program

General program notes. The first section of the program outline highlights the requirements for course facilitators (e.g. education and cultural competency) and children with ASD (e.g. cognitive and verbal abilities) whose parents are participating in the course. Disparities in the quality of mental health services for ethnically diverse populations have been documented (Munoz & Mendelson, 2005). Research indicates that there is a paucity of culturally responsive programs available (Dyches et al., 2004), and cultural barriers may prevent culturally diverse children with ASD from accessing available services (Rodriguez, 2009). While it can be difficult to define and assess cultural competency (Sue, 2003), the U.S. Surgeon General implored that clinical practice guidelines for cultural competence be established (United States Department of Health and Human Services, 1999). Furthermore, the ethical principles of the APA (2010) assert that psychologists should ensure the competence of their services. While there are no formal requirements for practitioners gaining competency in social skills training and culturally responsive interventions, this parent education program requires that facilitators have completed at least four graduate level training courses (or equivalent) in providing culturally responsive therapeutic interventions.

Program structure. The structure of the program provides the opportunity to teach concepts in an easy to understand manner using everyday language. At times, psychological and behavioral terms are utilized. It is explained during the initial session that this allows the class to further serve as a resource. For ecological congruence, the program uses everyday language. However, it is explained to participants that many of the service providers they encounter may utilize language that is consistent with their professional training. As such, our program will utilize and explain terms in order to assist them in improving their access to future services.

A reciprocal relationship exists between culture and socially adaptive behaviors. Culture contextualizes adaptive social behaviors. Additionally, while behaviors may be present in multiple cultures, the significance that is given may greatly differ. It is important to understand how behaviors are bound within a family's culture, in order to distinguish between deficits in adaptive social functioning and culture (Olmeda & Kauffman, 2003). In response to this, this program is designed with the understanding that participants are the experts on their respective cultures. Throughout each session material is presented in a manner that gives families an opportunity to discuss ways that information can be examined and adapted to contextually fit within their everyday lives.

The program facilitator may have an expertise in a particular intervention or topic, but the parents are the experts on the child. The program joins these two areas of expertise in a collaboration to enhance positive treatment effects (Lerman et al., 2000; Sheridan et al., 1990). The concept of collaboration is introduced during the initial session and emphasized throughout the program. Throughout each session there is discussion on how treatment approaches can be adapted to fit the unique child and family.

The group format can further cultivate the peer-learning experience, by providing structured ways to practice social skills (Barry et al., 2003; Epp, 2008). When training includes real life settings, generalization of acquired skills can be improved (Rodriguez et al., 2007). In response, two fieldtrips are scheduled during the duration of the program. This allows parents to practice learned skills in the presence of group facilitators, who are able to provide guidance and feedback.

The program fosters acquisition of information through structured sessions; each containing opportunities for active engagement in experiential learning (Epp, 2008). Additionally, social interaction in individuals with ASD is enhanced when groups combine skill-

based instruction with process-oriented variables (Cotugno, 2009). In addition to small group discussions, a closing ritual was selected to provide a process-oriented variable that would be consistent throughout the duration of the program. The closing ritual was selected based on the prevalence of ritual both in ethnically diverse communities and often in psychological groups. The specific procedure used was selected to provide an opportunity for reflection and to strengthen participants' sense of community.

Multiple effective interventions were found to be used in social skills training of children with ASD. These treatment methods included behavior charts (White, Keonig, & Scahill, 2007); social stories (Delano & Snell, 2006); social scripts (Theimann & Goldstein, 2001); and visual strategies (Bryan & Gast, 2000; Ganz & Flores, 2008). The prevalence of these interventions in the literature warranted their integration in the current program.

Class structure. The program outline includes an overview of content for each of the five psychoeducational sessions. The overview includes specific areas of focus to address during the session, group activities designed to further reinforce learning through experiential methods, and additional resources to provide sources to gain additional information that may be helpful to the participating families. Each of the sessions are identical in structure and vary in the content reviewed. The content focus areas for the five psychoeducational sessions includes introduction to autism and behavior, verbal communication, nonverbal communication, emotional awareness, and parent self-care.

The content focus of the first session is on providing an introduction to autism and behavior modification. Parent participants have been coping with this disorder for differing amount of times and have a varying amount of knowledge about the disorder. In order to avoid making assumptions on participants knowledge of ASD, information is provided on features of

the disorder (e.g. defining characteristics and variation of abilities). This provides the group and the facilitators with a common understanding to build upon.

Based on the information derived from the literature review, behavior modification has a vast body of empirical research supporting its usefulness in ASD symptom reduction. This theory asserts that the antecedents, function, and consequences of a behavior can be modified through environmental interventions (Cooper, Heron, & Heward, 2007). Behavior modification treatments vary in structure and intensity, yet share common principles that have been proven effective. As a result, behavior modification concepts are introduced during the first session and built upon throughout the program.

Impairments in communication have significant implications for the process by which individuals establish and maintain relationships. Difficulties in communication can intensify other symptoms of ASD, delaying the ability to address social skills impairment (Sanders, 2008). The majority of children with ASD have language deficits (Kjelgaard & Tager-Flusberg, 2001), with abilities ranging from absence of speech to functional speech with idiosyncratic verbal communication (Cuccaro et al., 2007). Additionally, individuals with ASD experience difficulties with nonverbal communication including language comprehension and understanding the meaning of a communicated message (Mesibov et al., 2004). The literature expresses the importance of interventions addressing these deficits in order for children with ASD to develop more accurate perceptions of communicated messages (Meaden et al., 2008).

It is vital to understand that socially appropriate communication varies among cultures (Delgado Rivera & Rogers-Adkinson, 1997), and education that does not take into account the implications of culture on communication style will likely be ineffective. Therefore, the emphasis of sessions two and three is to provide parents an opportunity to evaluate their child's

verbal and nonverbal communication abilities, and select appropriate interventions within the context of their child's unique abilities.

Session four continues to build on the social skills training information presented in previous sessions by introducing a focus on emotional awareness. The identification of emotions in others is an essential component of many social processes (Ekman, 1984; Greenspan, 2001). Understanding social emotions and linking emotions (Baron-Cohen, Jolliffe, Mortimore, & Robertson, 1997) and beliefs are difficulties that children with ASD experience (Baron-Cohen, Wheelwright, Hill, Raste, & Plumb, 2001). The difficulty that children with ASD experience in understanding the thoughts and feelings of others impacts their ability to relate socially and communicate effectively with others (Bauminger, 2004). This session provides parents with education on the relationship between emotional awareness, effective communication, and social skills. During this session parents are taught strategies to assist them in cultivating their child's ability to identify and express emotions in themselves and others.

There are few programs for culturally diverse families that are designed to improve subjective well being and reduce distress (Coard et al., 2004). To address this need, the focal point of the fifth program session is parent self-care. Research indicates that having a child with a developmental disability exponentially increases stress, with parents of children with ASD reporting higher levels of stress compared to parents of typically developing children (Brobst et al., 2009). Comparison of data obtained from the literature revealed multiple domains of parent stress including depression, anxiety, and marital discord (Lee, 2009). Positive coping is a theme that is carried throughout the course, and this session will serve as an opportunity to recap this information. During this session participants learn how to identify stressors and potential positive coping strategies. Small groups are utilized to identify positive coping strategies that contextually fit within the unique context of the participant. The same event may not be an

equal stressor among individuals. Therefore, activities during this session are facilitated to assist participants in identifying their subjective stressors and advance their ability to engage in positive coping responses. By providing parents with tools needed to aid in self-care, their subjective well-being and ability to care for themselves, and their child increases.

Overview of Evaluators' Feedback

After the manual was completed it was evaluated by five professionals with expertise in working with children with ASD and their families in Southern California. The evaluators included one licensed clinical social worker, one licensed clinical psychologist, one credentialed special education teacher, and one board certified behavior analyst. All evaluators indicated they had experience providing social skills training, parent education, and behavior modification to ethnically diverse children with ASD and their families in a variety of public and private settings.

Evaluator 1 was a clinical social worker who serves as a Developmental Case Manager in an outpatient medical center. She has over 5 years of experience providing psychotherapy and interventions to children with ASD and their families. Evaluator 2 was a licensed clinical psychologist in an outpatient medical center. She has 10 years of experience providing psychotherapy, psychodiagnostic assessments, and interventions to children with ASD and their families. Evaluator 3 is a credentialed special education teacher. She has over 25 years of experience providing interventions to children with ASD and their families in an educational environment. Evaluator 4 is a board certified behavior analyst. She has over 5 years of experience providing interventions to children with ASD and their families in educational and home environments. Evaluator 5 is a behavior intervention therapist, working in this capacity for the past four years. Prior to this, she served as a credentialed special education teacher for over 20 years in an inner-city educational environment. She has over 25 years of experience

providing interventions to children with ASD and their families in educational and home environments. Table 1 presents the characteristics of the participants of the evaluation phase of the study.

Table 1

Evaluators' Characteristics

Evaluator	Ethnicity	Profession	Years of Experience
1	Asian-American	Licensed Clinical Social Worker	9
2	Caucasian	Licensed Clinical Psychologist	10
3	African-American	Special Education Teacher	25
4	Caucasian	Board Certified Behavior Analyst	8
5	Biracial	Behavior Intervention Therapist	25

Evaluators were provided a copy of the program outline, an evaluation form, and an informed consent form. Each evaluator read and completed the written evaluation form in approximately two weeks. At the completion of the evaluation, completed materials were returned to the researcher.

Feedback and results. Tables 2-16 present the evaluators' feedback to questions as listed on the evaluation form.

Table 2

Evaluators' Feedback Question #1

How useful do you foresee this program being for parent social skills training?
 (1) Not Useful (2) Somewhat Useful (3) Neutral (4) Somewhat Useful (5) Very Useful

Evaluator	Rating	Comments
1) Licensed Clinical Social Worker	5	No comment
2) Licensed Clinical Psychologist	5	No comment
3) Special Education Teacher	5	No comment
4) Board Certified Behavior Analyst	4	No comment
5) Behavior Intervention Therapist	5	No comment

Based on feedback scores, the evaluators seemed to agree that they foresee the program meeting the objective of parent social skills training.

Table 3

Evaluators' Feedback Question #2

How useful do you foresee this program being for working with culturally diverse parents?
 (1) Not Useful (2) Somewhat Useful (3) Neutral (4) Somewhat Useful (5) Very Useful

Evaluator	Rating	Comments
1) Licensed Clinical Social Worker	5	"Depending on the level of acculturation and education level."
2) Licensed Clinical Psychologist	5	No comment
3) Special Education Teacher	5	No comment
4) Board Certified Behavior Analyst	4	No comment
5) Behavior Intervention Therapist	5	No comment

Table 4

Evaluators' Feedback Question #3

What did you find particularly useful about this program as it pertains to social skills training for culturally diverse parents of children with autism spectrum disorders?

Evaluator	Comments
1) Licensed Clinical Social Worker	"Several things. 1. Teaching terminology and in depth psycho-education on the subject of understanding the nature of Autism and behaviors related to it. 2. role playing activities and giving homework assignments to apply the information given as well as giving resources parents can access on their own 3. respect for different cultures (I love that!)"
2) Licensed Clinical Psychologist	"I like the opening ritual because it is important for families to connect with others who are having similar experiences. Also, the talking circle is a very thoughtful way of incorporating culture into the program. It is essential to allow space for discussing feelings of anger, shame, guilt, despair, etc."

(continued)

Evaluator	Comments
3) Special Education Teacher	“I really appreciated session theme “Intro to Autism and Behavior.” It is vital to have step by step explanations with class understanding of the impact social skills will play in today’s society.”
4) Board Certified Behavior Analyst	“Aside from the first meeting, I’m not seeing a stress on anything culturally diverse. Are you planning on mentioning that somewhere else in the outline? I understand the eye-contact context, however, are you stressing that or mentioning it elsewhere or placing more stress on other areas of social skills such as emotional balance, stress, etc.?”
5) Behavior Intervention Therapist	The challenges of Autism cross culture lines giving all a common ground. Many of these families are so stressed they cannot think straight. I think that this program sets the tone for people of all backgrounds to learn in a relaxed environment. Providing time for group discussion and sharing of ideas, feelings, etc. sets the tone for parents of all backgrounds to begin to set objectives that will help them meet individual family goals for themselves and their children. This program does a good job providing information in a manner that is culturally responsive both overtly (e.g. discussion about weighing culture) and more subtly (e.g. music, quotes, small group discussion, talking circle).

The evaluators foresaw the program as meeting the objective of being useful for working with culturally diverse parents, with four of the five evaluators indicating they found the program to be “very useful.” One of the five evaluators indicated that she did not see “a stress on anything culturally diverse” outside of the first session. In contrast, another evaluator highlighted aspects that are present in each of the program’s sessions that she felt “overtly and more subtly” enhanced cultural responsiveness. Additionally, the detailed psychoeducation on ASD, discussion opportunities, and talking circle ritual were each mentioned twice throughout the responses to the usefulness of the program as it pertains to social skills training for culturally diverse parents.

Table 5

Evaluators' Feedback Question #4

How useful do you foresee this program being for educating parents on verbal communication?
 (1) Not Useful (2) Somewhat Useful (3) Neutral (4) Somewhat Useful (5) Very Useful

Evaluator	Rating	Comments
1) Licensed Clinical Social Worker	4.5	"Again, I believe this will depend on the parent/caregiver's ability to utilize this information and apply it at home. Some parents with children with ASD have ASD like personalities as well (whether diagnosed or not) which I have found makes working and applying new approaches difficult."
2) Licensed Clinical Psychologist	5	No comment
3) Special Education Teacher	5	No comment
4) Board Certified Behavior Analyst	4	No comment
5) Behavior Intervention Therapist	5	No comment

Table 6

Evaluators' Feedback Question #5

How useful do you foresee this program being for educating parents on behavior?
 (1) Not Useful (2) Somewhat Useful (3) Neutral (4) Somewhat Useful (5) Very Useful

Evaluator	Rating	Comments
1) Licensed Clinical Social Worker	4.5	No comment
2) Licensed Clinical Psychologist	5	No comment
3) Special Education Teacher	5	No comment
4) Board Certified Behavior Analyst	5	No comment
5) Behavior Intervention Therapist	5	No comment

Table 7

Evaluators' Feedback Question #6

How useful do you foresee this program being for educating parents on emotional awareness?
 (1) Not Useful (2) Somewhat Useful (3) Neutral (4) Somewhat Useful (5) Very Useful

Evaluator	Rating	Comments
1) Licensed Clinical Social Worker	4.5	"This would depend on their own cultural background also and their own openness to this type of work. Even though you have focused on culturally sensitive ways to integrate and respect other cultures, some of the activities are very much western/American in how a group is run which may be helpful or not."
2) Licensed Clinical Psychologist	5	No comment
3) Special Education Teacher	5	No comment
4) Board Certified Behavior Analyst	3	No comment
5) Behavior Intervention Therapist	5	"I think that all of the experiential activities enrich the learning opportunities for this aspect of the program."

Table 8

Evaluators' Feedback Question #7

How useful do you foresee this program being for educating parents on self-care and relaxation?
 (1) Not Useful (2) Somewhat Useful (3) Neutral (4) Somewhat Useful (5) Very Useful

Evaluator	Rating	Comments
1) Licensed Clinical Social Worker	4	"This is the hardest part to apply to parents, especially for parents with special needs. Some may even be single parents with more than one child with special needs. Many may say there is never time."
2) Licensed Clinical Psychologist	5	No comment
3) Special Education Teacher	4	No comment
4) Board Certified Behavior Analyst	5	No comment
5) Behavior Intervention Therapist	5	"This is an area that often goes unaddressed in parent training, or is done more informally. This program does a good job of thoughtfully outlining strategies to both emphasize the importance and teach techniques in a practical way."

Feedback from the evaluators suggest that they assess the program as being effective in educating parents in the programs primary content areas including communication, behavior, emotional awareness, and self-care and relaxation. At least three of the five evaluators found the program to be “very useful” in each of these domains. Parent education on behavior was the highest ranked content area, receiving five “very useful” and one “very useful/somewhat useful” scores.

Table 9

Evaluators’ Feedback Question #8

What aspects of this program did you find not particularly relevant for its intended purposes?

Evaluator	Comments
1) Licensed Clinical Social Worker	“None that come to mind. I do feel that a screening process should happen for parents to identify parents that would benefit from this program (i.e., level of acculturation, education/cognitive ability of the parent to grasp the information).”
2) Licensed Clinical Psychologist	“I found every aspect of the manual to be relevant.”
3) Special Education Teacher	No comment
4) Board Certified Behavior Analyst	“I think more stress should be placed on the behavior aspect and less on the emotional aspect. You’re working with kids who have a developmental disability and their expression will mostly be expressed in maladaptive behaviors as you started in the outline. Self-esteem is just as important and stress on the parent is important as well, but going beyond that to reach a deep emotional level will take more than 4 sessions. Working with social skills is more of a behavior skill than a psychological one.”
5) Behavior Intervention Therapist	“I could not find any. I found all of the information provided relevant.”

One of the evaluators, who works as a behavior analyst, stated that “social skills is more of a behavior skill than a psychological one,” and therefore, suggested the program include more of an emphasis on behavior and less on emotional awareness. This may possibly be

related to evaluator’s limited exposure training on psychological aspects of social skills training. While the other four evaluators found the aspects of the program relevant for their intended purposes, one of the evaluators suggested that the program include a screening process for parent participation.

Table 10

Evaluators’ Feedback Question #9

What do you consider to be the strengths of the program?

Evaluator	Comments
1) Licensed Clinical Social Worker	“The education and interaction/engagement of participants with each other and applying the information in activities.”
2) Licensed Clinical Psychologist	“I like the topics selected for each session, they are relevant and appropriate for this population.”
3) Special Education Teacher	“Empowering parents with information to become better advocates for their children; forming partnerships among parents and professionals; allowing parents to express themselves especially uninterrupted; language use, excellent.”
4) Board Certified Behavior Analyst	“Relaxation techniques and the diversity of the program are great. You reached on different aspects and developed a variety of different ideas and activities. Very impressive.”
5) Behavior Intervention Therapist	“Hands-on parent-child activities. Providing of resources. The group activities will facilitate peer learning (insight and problem solving) among members. These parents often feel isolated and alone. This program cultivates an opportunity for them to cope better knowing they are not alone.”

Table 11

Evaluators' Feedback Question #10

What do you consider to be the weaknesses of the program?

Evaluator	Comments
1) Licensed Clinical Social Worker	<p>“Again, my only concern would be the screening process and the effectiveness of this program for parents with limited education (i.e., parents that may have only finished high school or some) and people that come from cultures where they don’t talk about feelings as much (i.e., middle eastern, or Asian) and tend to somatize issues etc and would prefer less “talk” about themselves.</p> <p>I am unsure if you will have enough time to finish the agenda in the amount of time you allotted for given and with a total number of 12 participants. Depending on nature of what is shared and the comfort level of each parent/caregiver to share.”</p>
2) Licensed Clinical Psychologist	<p>“I don't see any significant weaknesses. I do wonder if 2 hour sessions are a little long for busy parents.”</p>
3) Special Education Teacher	<p>No comment</p>
4) Board Certified Behavior Analyst	<p>“See # 8.” [“I think more stress should be placed on the behavior aspect and less on the emotional aspect. You’re working with kids who have a developmental disability and their expression will mostly be expressed in maladaptive behaviors as you started in the outline. Self-esteem is just as important and stress on the parent is important as well, but going beyond that to reach a deep emotional level will take more that 4 sessions. Working with social skills is more of a behavior skill than a psychological one.”]</p>
5) Behavior Intervention Therapist	<p>“I cannot think of any weaknesses. I initially thought that this would not be a good program for parents of children with moderate to severe ASD. I then saw where the criteria outlines that it is for parents of higher functioning children. It will be important to outline a screening process to ensure that this is the population of parents that are recruited.”</p>

The evaluators’ comments varied to some degree, indicating multiple strengths of the program. Based on the on the frequency of the responses, the most useful aspects of the program as described by the evaluators related to the effective use of activities to facilitate

learning and parent collaboration. While two of the evaluators did not indicate weakness of the program, 2 of the evaluators indicated that a screening process for participation is needed. One evaluator emphasized the importance of screening parents' abilities, and the other indicated the child's abilities. As pointed out by one of the evaluators, the program in its present form may contain too much content during each session to complete in the two-hours allotted.

Table 12

Evaluators' Feedback Question #11

What could have been added to the program to make it more useful for culturally diverse parents of children with Autism Spectrum Disorders?

Evaluator	Comments
1) Licensed Clinical Social Worker	“Handouts may be useful in addition to what is taught in class, especially for parents/caregivers that may have thoughts later, want to review the info given. I think the outline is very respectful of different cultures and it would be nice to get each participant to share before and after what they want from the group and what they would like more of afterwards.”
2) Licensed Clinical Psychologist	“Facilitating a discussion on how ASD is viewed in different cultures and how that impacts the specific families attending the program.”
3) Special Education Teacher	“In my opinion, understanding cultural diversity is vital, but it is also important that parents understand that the goal is to help their child to work to his or her potential (socially) without compromising their own culture.
4) Board Certified Behavior Analyst	“If you’re going to discuss cultural diversity, you need to talk about it more and incorporate it more in the sessions- not just the first session. Incorporate how cultural diversity plays a role in all the various social aspects of our lives- point it out in the movies you suggest or the various cultural ritual that each different family has in their home and how that affects not just children, but children with ASD and do they know that not all families do these things? How do they know, etc.”

(continued)

Evaluator	Comments
5) Behavior Intervention Therapist	"I find this program to be culturally responsive and its' design should be received well by people from a variety of cultures. I cannot think of anything specific that could be added to make it more useful for culturally diverse parents.

Table 13

Evaluators' Feedback Question #12

Are there any parts of the program that you would omit, change, or revise?

Evaluator	Comments
1) Licensed Clinical Social Worker	"Add handouts that give the information in easy to read format for parents (assuming they speak/read English). You may want to consider time constraints and ability to complete each activity planned for as you facilitate each session. Give parents opportunity to pass (on sharing Circle) if they don't feel comfortable."
2) Licensed Clinical Psychologist	"No, it is a very good program."
3) Special Education Teacher	No comment
4) Board Certified Behavior Analyst	"See above remarks."
5) Behavior Intervention Therapist	"This is difficult to assess without having implemented the program. I thought about each session, although coming from a teaching background, it is often easier to make recommendations on revisions once you have implemented the material. As it is written, I do not see any changes or revisions in the content. However, I am concerned that there may be too much content outlined than time will permit to be covered. Since the content as presented is relevant, I am unsure what specifically may need to be omitted to work within the time frame. This will likely be something that can be worked out through the implementation process."

Table 14

Evaluators' Feedback Question #13

Additional comments and suggestions

Evaluator	Comments
1) Licensed Clinical Social Worker	"This is awesome Nicole! Hope my comments are helpful? Not sure if they were considerations you already made."
2) Licensed Clinical Psychologist	"At the end of program, parents may want to have the option to connect with each other for continued support. Perhaps this could be facilitated/discussed and encouraged during session five since the topic is self-care and coping with stressors."
3) Special Education Teacher	"Overall, this educational program is excellent. The program is inclusive and informative."
4) Board Certified Behavior Analyst	"Great job. Can tell you thought this out and put forth a lot of effort. Excellent!"
5) Behavior Intervention Therapist	"Very well thought-out program. I was surprised that I gave you all 5s. I wanted to be tougher, but you did a great job covering a lot of material in an easy to understand manner. I think parents that attend this program will be thankful and appreciative for the experience. You have developed a program that appears not only to be informative, but an experience. Well done."

The evaluators' comments varied in response to the question regarding what could have been added to make the program more useful for culturally diverse parents of children with ASD. For instance, one evaluator thought the manual contained a sufficient amount of resources for parents and recommended that no additions be considered. Another evaluator suggested handouts be provided. This evaluator and another both suggested additional discussion points. They felt it would be helpful to provide parents an opportunity to share what they hope to gain from the group experience, as well as participate in a discussion on how ASD is viewed in different cultures. Along these lines, a third evaluator commented that that it will be important to ensure that parents understand the goal is to assist their child socially without compromising

cultural values. Another suggestion came in the form of possibly adding more discussion and suggestions throughout that assist parents in understanding how cultural practices vary across families.

The question regarding what sections of the manual should be omitted, changed, or revised also appeared to be a reiteration of prior question(s) in that three of the five evaluators either left it blank or referred to a response already given. While she found the information relevant and without revisions as currently presented, one evaluator noted that it was difficult to answer this question without having facilitated the program as designed. In addition, similar to prior feedback, the amount of content covered during the sessions was again pointed out as a limitation.

Table 15

Evaluators' Feedback Question #14

In regards to the overall program, please rate the following statement: This program will be beneficial for parents of children with Autism Spectrum Disorders.

(1) Strongly Disagree (2) Somewhat Disagree (3) Neutral (4) Somewhat Agree (5) Strongly Agree

Evaluator	Rating	Comments
1) Licensed Clinical Social Worker	5	No comment
2) Licensed Clinical Psychologist	5	No comment
3) Special Education Teacher	5	No comment
4) Board Certified Behavior Analyst	4	No comment
5) Behavior Intervention Therapist	5	No comment

Table 16.

Evaluators' Feedback Question #15

In regards to the overall program, please rate the following statement: I would recommend this program to parents of children with Autism Spectrum Disorders.

(1) Strongly Disagree (2) Somewhat Disagree (3) Neutral (4) Somewhat Agree (5) Strongly Agree

Evaluator	Rating	Comments
1) Licensed Clinical Social Worker	5	No comment
2) Licensed Clinical Psychologist	5	No comment
3) Special Education Teacher	5	No comment
4) Board Certified Behavior Analyst	4	"I would recommend this program for people diagnosed with Aspergers disorders. You need to make that dissection. Also, I'm not sure where it emphasized in your outline the cultural awareness of your program of the differences in cultures or how various cultures are different and how that incorporates into social skills groups."
5) Behavior Intervention Therapist	5	No comment

Although the evaluators' comments varied to some degree, there appeared to be a general consensus that the manual serves as a psychoeducational tool to help increase parents' and potentially other clinicians' awareness and understanding of ways to improve social skills functioning. Four of the five evaluators felt that all of the content was relevant. Another evaluator felt that the program should contain more of a focus on behavior modification and less on emotional awareness. In terms of its limitations, two of the five evaluators expressed concern that the outline may contain too much information to cover in the time allotted.

Chapter Five: Discussion

The purpose of this study was to develop a program for use by clinicians providing social skills training to culturally diverse parents of children ages 6 through 12 with ASD. The research tasks included an extensive review of the literature and an evaluation of the manual by experienced professionals. The literature review began with a broad search of scholarly information in the field of psychology related to social skills training. This broad review was narrowed to include aspects of working with culturally diverse clients and parent-professional collaboration. At the conclusion of the data collection phase, theoretical writings, professional organization publications, and research studies were the integrated data sources utilized to support of the development of the program outline. Upon completion of the program outline, an expert panel of five professionals was recruited to evaluate the usefulness and effectiveness of the manual.

Summary of Results

In order to provide clinicians with the tools necessary to facilitate culturally responsive social skills training for parents of children with ASD, this study focused on the development of a program to (a) provide parents with information on ways to increase their child's engagement in adaptive social skills, (b) to assist parents in identifying ways to decrease their subjective distress and increase effective ways of coping with the stress of parenting a child with autism, and to (c) provide families with a program that is culturally congruent. The program, *Social Skills Training: A Parent Education Program for Culturally Diverse Parents of Children with Autism Spectrum Disorders*, incorporates research, strategies, and resources to assist clinicians in understanding and facilitating culturally responsive social skills training using a parent-professional collaborative model.

To better determine the usefulness, accuracy, and relevance of the program, five evaluators provided feedback on its content. Overall, the evaluators agreed that the program is a beneficial resource that provides useful information. They foresaw the program being useful in working with culturally diverse parents of children with ASD and all commented on how the program positively engages participants in the learning process. Three of the evaluators indicated that the session structure established during the initial session cultivates an environment that values cultural diversity. In terms of its limitations, one of the evaluators indicated that it was difficult to thoroughly comment on the program's limitations without having facilitated a pilot program. Additionally, this evaluator, along with a second evaluator, agreed that the program content was lengthy in its presentation given the time allotment of each session.

Strengths of the Manual

A significant strength of the program is the contribution it offers to clinicians that work with culturally diverse parents of children with ASD. As pointed out in the literature, few culturally responsive interventions are available to assist these parents (Lau, 2006). This program attends to the gap between the social skills training needs of culturally diverse parents of children with ASD and the resources available for trained professionals to meet those needs. The program addresses these needs through positive, engaging, and culturally responsive interventions. Available interventions are often ineffective because the families' values are misunderstood or ignored (Kalyanpur & Shridevi, 1991). Providing clinicians with a tool to integrate their expertise in the service of social skills training within a culturally responsive context will supplement and enhance treatments currently available in the ASD community.

The inclusion and equipping of parents in the social skills training process is a strength of this program. Research findings indicate that there is an increase in the likelihood of

generalization and maintenance of treatment effects when caregivers are taught the interventions (Lerman et al., 2000). Inclusion of parents in the educational program also facilitates and opportunity to ascertain “contextual fit” of techniques within the family’s goals and values. Parent-clinician collaboration positively impacts parent-child teaching and often results in an increase in a child’s skill acquisition, an increase in parent confidence, and a decrease in stress (Brookman-Fraze, 2004). Additionally, by providing two opportunities for fieldtrips into the local community with group facilitators, the opportunity to examine skill acquisition and generalization is built into the program. Research indicates that access and engagement in community activities increases community integration success (Thorn et al., 2009).

Another strength of the program is the incorporation of research-based cognitive, behavioral, cultural-ecological, and emotional interventions. These interventions include identification of strength and growth areas, small group discussion, breathing and visualization techniques, semi-structured activities, and problem solving strategies.

The interventions outlined in the program are evidenced-based, and have demonstrated effectiveness in improving skill acquisition abilities and reducing psychological distress within culturally diverse families. Some of the interventions have been adapted to meet the needs of culturally diverse parents of children with ASD. Based on research findings, a hallmark feature of ASD is impairment in social skills functioning (Baker-Ericzen et al., 2005). This contributes to the child’s difficulty establishing age-appropriate peer relationships (Welsh et al., 2001) and the clinically significant levels of stress found in parents of children with ASD (Osborne & Reed, 2009). As a result, parents need to be equipped with psychologically grounded interventions to aid in social skills acquisition, stress management, and the enhancement of positive coping

behaviors and strategies. The design of the program offers empirically valid interventions to promote skill acquisition, manage stress, and increase access to social support systems.

Limitations and Recommendations for Future Steps in Program Development

Although the manual serves as a valuable addition to clinicians working with culturally diverse parents of children with ASD, it also presents with some limitations. One limitation is the lack of parent input into the development and evaluation of program content. While the literature reviewed encompassed studies from parent training development and outcome research, input was not received directly from parents of children with ASD. As the target demographic for receiving the program information, future input and evaluation of the program should include the recruitment of a diverse sample of parents of children with ASD. Although the program identifies a specific target demographic, it does not specify a specific participant selection process. Clarification of a formal parent-child screening process will likely assist in ensuring participants from the intended target demographic.

As pointed out by one of the evaluators, the program can benefit from an increase in specific cultural references. Although the program outlines prerequisite culturally responsive training qualifications for facilitators, the extent to which individuals are versed in subject areas varies. Therefore, the program would benefit from including a section on cultural diversity considerations as part of the outline for each class session.

As pointed out by three of the evaluators, the program has a lengthy presentation. More specifically, there is concern that presentation of the outlined content for each session may require more than the allotted amount of time. Although the program presents with a range of practical tools and strategies assist culturally diverse parents of children with ASD improve their child's social skills functioning, condensing the content covered during each session may facilitate more time to process and develop a greater understanding of the

concepts presented. As pointed out by one of the evaluators, providing handouts for material covered during session will also contribute strengthening the learning of material presented.

In consideration of the limitations of the program, a future step in program development is to refine the content and structure through use of a pilot program with ethnically diverse caregivers of children with ASD. The pilot program could entail execution of the parent education program as outlined. At the end of the program, parents and facilitators would provide feedback as to the utility of the program and comment on which information was beneficial in developing social skills training abilities in a manner that is congruent with the family's cultural values. The pilot program would be of great benefit, in that it would serve as an opportunity to review the program content by integrating direct feedback from individuals within the ASD community.

Future research in the identification and selection of standardized and individualized outcome measures to examine goal attainment may serve as an asset to this program. Facilitators could utilize pre and post-course instruments to evaluate the effectiveness of the program. Selection of both objective and subjective measures may assist in contextualizing the feedback within the cultural context of the participants. This information could then be used to further refine course structure and content.

Conclusions and Implications of the Study

Research shows that the number of children with autism is on the rise, resulting in an increased need for effective and comprehensive treatment programs. Despite the steady increase in the population's ethnic composition, few culturally responsive programs have been developed to address the social skills deficits and associated parent stress from a parent-clinician collaborative model. Existing research findings suggest that stress in parents of children with ASD positively correlates with the adaptive functioning levels of their children. Thus,

increasing support for culturally diverse families of children with ASD is vital considering the prevalence of this disorder in the population.

The development of this parent education program is one of the many resources needed to help culturally diverse children with ASD and their families cope with and manage the impact of social skills deficits. Future interventions and funding sources are needed to further treatment efforts to develop culturally responsive evidenced-based resources within the autism community. Numerous studies have reported on the magnitude of the effect of social skills deficits on children with ASD, pervasive elevations of stress in parents of children with autism, and the scarcity of culturally responsive interventions. Despite the recommendations the studies offered in terms of interventions and strategies, parents of children with ASD continue to report the highest levels of stress in comparison to other parent populations. Until implementation of recommended treatment practices, as outlined in the literature is achieved, culturally diverse parents of children with ASD will remain a population in need of support and assistance.

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APPENDIX A

Agency Contact Scripts and Authorization Form

Telephone Script

Hello is (Director of Agency) available?

If no, leave name, number, and end call.

If yes, continue.

Hello, my name is Nicole Brown, and I am a doctoral student in psychology at Pepperdine University Graduate School. I am calling to inquire if your agency would be willing to assist me with my dissertation research by providing me with a list of mental health professionals in Southern California that you consider to be experts in the area of Autism Spectrum Disorders. I will be asking 3-5 individuals to provide evaluative feedback on a culturally-responsive parent training program I have developed. Do you have a moment for me to very briefly describe the nature and purpose of my study?

If no, thank individual for their time and end call.

If yes, continue.

I am presently conducting my dissertation research under the supervision of Dr. Shelly Harrell, a professor at Pepperdine University. The primary goal of this study will include the development of a culturally responsive program for parents of children with Autism Spectrum Disorders to assist them in learning how to develop social skills abilities in their children.

The initial stage of the project will consist of an extensive review of the literature in search of findings related to social skills training and culture, as it relates to parents of children with Autism Spectrum Disorders. This information will be compiled for inclusion into the development of the parent education program. After the program development is complete, it will be critiqued by an expert panel of clinicians to verify the usefulness, accuracy, and relevance for its intended purposes.

If your agency agrees to assist with the study, I will ask you to provide me with a list of professionals that your agency considers having an expertise in providing social skills and/or parent education to families of children with Autism Spectrum Disorders.

Your agency's participation in this study is completely voluntary. Would you be willing to prepare a list of experts who might be interested in evaluating my program?

If no, thank individual for their time and end call.

If yes, continue.

Thank you for your consent. Your participation is greatly appreciated. In consideration of policies and procedures as outlined by the human subjects review board at Pepperdine University, I will first need your permission in writing authorizing me to reference that I received the

recommended experts' contact information from your agency. May I have your contact information in order to send you an authorizing form?

Thank you. Should you have any additional questions about my research, feel free to contact me, the research investigator, Nicole Brown, M.A., or Shelly Harrell, Ph.D.

Thank you again for your time.

End call.

Email Script

Hello (Director of Agency):

My name is Nicole Brown, and I am a doctoral student in psychology at Pepperdine University Graduate School. I am writing to inquire if your agency would be willing to assist me with my dissertation research by providing me with a list of professionals in Southern California that your agency considers having an expertise in providing social skills and/or parent education to culturally diverse families of children with Autism Spectrum Disorders.

I am presently conducting my dissertation research under the supervision of Dr. Shelly Harrell, a professor at Pepperdine University. The primary goal of this study will include the development of a culturally responsive program for parents of children with Autism Spectrum Disorders to assist them in learning how to develop social skills abilities in their children.

The initial stage of the project will consist of an extensive review of the literature in search of findings related to social skills training and culture, as it relates to parents of children with Autism Spectrum Disorders. This information will be compiled for inclusion into the development of a parent education program. After the program development is complete, it will be critiqued by an expert panel of clinicians to verify the usefulness, accuracy, and relevance for its intended purposes.

If your agency agrees to assist with the study, I will ask you to provide me with a list of professionals that your agency considers having an expertise in providing social skills and/or parent education to families of children with Autism Spectrum Disorders.

Your agency's participation in this study is completely voluntary. If you are willing to participate, please complete and return the attached form authorizing me to reference that I received the recommended experts' contact information from your agency. You may then email or call me with a list of professionals, and their contact information, that you would like to recommend to evaluate my program.

Thank you very much for taking the time to read this email and consider my request. Should you have any additional questions about my research, feel free to contact me, the research investigator, Nicole Brown, M.A., or Shelly Harrell, Ph.D.

Respectfully,

Nicole Brown, M.A.

Email address

Phone number

Agency Authorization Form

Our agency authorizes Nicole Brown, M.A., a doctoral student in clinical psychology at Pepperdine University, Graduate School of Education and Psychology, working under the supervision of Shelly Harrell, Ph.D., to include our agency in the research project entitled "Social Skills Training: Development of a Parent Education Program for Culturally Diverse Parents of Children with Autism Spectrum Disorders." We understand that our agency's participation in this study is strictly voluntary.

Our agency has been asked to participate in this study that will include the development of an education program for parents of children with Autism Spectrum Disorders. We have been asked to volunteer to participate in this study based on our commitment to working with and providing resources to culturally diverse children with Autism Spectrum Disorders and their families. Our participation in this study will consist of providing the researcher with a list of mental health professionals in the Southern California area that we consider being experts in the area of Autism Spectrum Disorders.

Our agency understands that the professionals we refer will be contacted and asked to participate in the research study, by providing evaluative feedback on the culturally-responsive parent training program for parents of children with Autism Spectrum Disorders that Ms. Brown has developed. Furthermore, we understand that our agency's name will be given to the clinician as the referring agency.

Our agency understands that by providing the researcher with a list of professionals to contact, our agency's name may be published or presented to a professional audience as an agency that was contacted to participate in this study. We understand that the names of the clinicians provided will remain confidential and unassociated with our agency, with the exception of the researcher informing the referring clinician of the agency providing their name and contact information, when asking for their participation in the study.

We understand that all information obtained in this study will be kept confidential. This authorization form, along with all other research materials will remain in a locked file cabinet for five years, at which time the data will be destroyed.

We understand that if we have any questions regarding the study procedures, we can contact Nicole Brown, M.A. or Shelly Harrell, Ph.D., Dissertation Chairperson at Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045, to obtain answers to any of our questions. My signature below indicates that I am a representative qualified to sign this authorization form on behalf of the agency. I have read and understand the information in this document and agree to abide by its terms.

_____ Signature	_____ Date	_____ Agency
_____ Name (printed)	_____ Title	

APPENDIX B

Evaluator Telephone Script

Hello, is (name of potential evaluator) available?

If no, leave name, number, and end call.

If yes, continue.

Hello, my name is Nicole Brown, and I am a doctoral student at Pepperdine University Graduate School. I received your contact information from (name of referring agency), as a professional with a specialty in the area of Autism Spectrum Disorders. I am contacting you to see if you would be willing to review and evaluate a social skills training program I am developing for culturally diverse parents of children with Autism Spectrum Disorders. This evaluation study is part of my dissertation research. Do you have a moment for me to describe the nature and purpose of my study?

If no, thank individual for their time and end call.

If yes, continue.

I am presently conducting my dissertation research under the supervision of Dr. Shelly Harrell, a professor at Pepperdine University. The overall purpose of this research project is to develop a social skills training program for culturally diverse parents of children with Autism Spectrum Disorders to improve adaptive functioning in their children. At this particular stage in the project, I have completed the program and am seeking the input of practitioners like you to evaluate the program content. If you decide to participate in this study, you will be asked to read a 10-15 page outline of the program and answer a few questions related to the effectiveness and usefulness of the program. Your input in this project will be strictly confidential and you are under no obligation to complete the study at any time. Is this something that you would be willing to do?

If no, thank individual for their time and end call.

If yes, continue.

Do I have your permission to ask a few background questions, followed by some questions related to your experience with children with Autism Spectrum Disorders and their parents? Please note that you may refuse to answer any question at any time during the interview.

If no, thank individual for their time and end the call.

If yes, continue on and refer to the Evaluator Qualification Form (Appendix C).

After reviewing the Evaluator Qualification Form (Appendix C):

If evaluator does not meet the requirements: *Thank you for your willingness to participate, however you do not meet the qualifications to participate in this study.*

If evaluator does meet the requirements: *May I please have your mailing and email addresses to send you the necessary materials. In addition to the program and evaluation forms, you will receive two consent forms, one for you to keep and the other to be returned with the program documents and completed evaluation form.*

Thank you very much for your time. You should receive your packet within a week. If you should have any questions or concerns regarding the study, please feel free to contact the research investigator or Dr. Shelly Harrell. Thank you again for volunteering to participate. I appreciate your time and assistance.

End call.

APPENDIX C

Evaluator Qualification Form

Participant Number _____

What is the highest degree you have earned? Masters Doctorate

What discipline is your degree in?

Have you received formal education in multicultural therapeutic considerations?

Yes No

Have you received continuing education in multicultural therapeutic considerations?

Yes No

How many years of experience do you have providing direct intervention services to children with Autism Spectrum Disorders (ASD) and their families? _____

How many of these years include providing services to predominantly culturally diverse individuals including African American, Latino, and/or Asian clients? _____

APPENDIX D

Evaluation Packet Cover Letter

Dear (Name of Evaluator),

Thank you for volunteering to serve as an evaluator in my dissertation research study entitled "Social Skills Training: Development of a Parent Education Program for Culturally Diverse Parents of Children with Autism Spectrum Disorders." Enclosed is an outline parent education program, two informed consent forms (one is yours to keep), and a program evaluation form. The evaluation form is provided to facilitate your process in evaluating this program. If it is easier for you to answer questions by placing comments throughout the document, please feel free to do so. It is recommended that the evaluation process be completed at a time that is most convenient to you, taking breaks as needed.

Please remember to review and complete the consent form. Once you have completed your evaluation of the program, please return the signed consent form, completed program evaluation form, and the manual in the postage-paid, pre-addressed envelope provided in this packet.

Although your input is greatly appreciated, please remember that you are under no obligation to complete the study. Should you wish to discontinue participation in this study for any reason, please return all materials in the enclosed postage-paid, pre-addressed envelope.

Thank you very much for your time and contribution to my research project.

Respectfully,

Nicole Brown, M.A.
c/o Pepperdine University
Graduate School of Education and Psychology, PsyD Program
6100 Center Drive
Los Angeles, CA 90045

APPENDIX E

Evaluator Informed Consent Form

I authorize Nicole Brown, M.A., a doctoral student in clinical psychology at Pepperdine University, Graduate School of Education and Psychology, working under the supervision of Shelly Harrell, Ph.D., to include me in the research project entitled "Social Skills Training: Development of a Parent Education Program for Culturally Diverse Parents of Children with Autism Spectrum Disorders." I understand that my participation in this study is strictly voluntary.

I have been asked to participate in this study that will include the development of an education program for parents of children with Autism Spectrum Disorders. I have been asked to volunteer to participate in this study based on my expertise in working with culturally diverse children with Autism Spectrum Disorders and their families in a clinical setting. My participation in this study will consist of approximately 1 ½ hours of my time, in which I will review a program for parents of children with Autism Spectrum Disorders, developed by Nicole Brown, M.A., followed by the completion of an evaluation form related to the usefulness, accuracy, and effectiveness of the program.

I understand that all information obtained in this study will be kept confidential. The Informed Consent Forms will be stored in a file separate from all other study materials. All research materials will remain in a locked file cabinet for five years, at which time the data will be destroyed. I understand that any comments submitted may be published or presented to a professional audience and that no personal identifying information will be released.

I understand that possible risks for participating in the study are minimal but may include mild levels of boredom or fatigue in response to reading the manual and completing the series of rating and open-ended questions on the evaluation form. In consideration of such factors, I understand that I have the option of writing the answers to questions listed on the evaluation form directly in the margins of the program materials, so as to minimize the time. I have also been advised to complete the manual at a time that is most convenient to me, taking breaks as necessary. In addition, I understand that I have the right to not answer any particular question listed on the evaluation form and may withdraw from the study at any time without prejudice.

I understand that if I have any questions regarding the study procedures, I can contact Nicole Brown, M.A. or Shelly Harrell, Ph.D., Dissertation Chairperson at Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045, to obtain answers to any of my questions.

Signature

Date

Name (printed)

APPENDIX F

Program Evaluation Form

Program Evaluation Form

Please note that all information provided on the evaluation form will remain strictly confidential.

DEMOGRAPHICS

What is your age? 25 – 30 31 – 40 41 – 50 51 – 60 61+

What is your gender? Male Female

What is your ethnicity? African-American Asian/Pacific Islander Caucasian
 Latino(a) Native-American Multiethnic
 Other _____

What is your profession? _____

Do you have current licensure/credentialing (if applicable): _____

What is your job title?

What best describes your work setting? Private Practice Hospital
 Community Agency Other: _____

What has been the nature of your work with children with Autism Spectrum Disorders and their families? Social Skills Training Parent Education Behavior Modification
 Other: _____

What are the ages of children with ASD that you have worked with?

0-5 6-9 10-12 13-15 16-18

What are the ethnicities of children with ASD that you have worked with?

African-American Asian/Pacific Islander Caucasian Latino(a)
 Native-American Multiethnic Other _____

PROGRAM EVALUTION

1. How useful do you find this program for parent social skills training? _____
(1) Not Useful (2) Somewhat Useful (3) Neutral (4) Somewhat Useful (5) Very Useful
2. How useful do you find this program for working with culturally diverse parents? _____
(1) Not Useful (2) Somewhat Useful (3) Neutral (4) Somewhat Useful (5) Very Useful

3. What did you find particularly useful about this program as it pertains to social skills training for culturally diverse parents of children with autism spectrum disorders?

4. How useful do you find this program for educating parents on verbal communication? _____
(1) Not Useful (2) Somewhat Useful (3) Neutral (4) Somewhat Useful (5) Very Useful

5. How useful do you find this program for educating parents on behavior? _____
(1) Not Useful (2) Somewhat Useful (3) Neutral (4) Somewhat Useful (5) Very Useful

6. How useful do you find this program for educating parents on emotional awareness? _____
(1) Not Useful (2) Somewhat Useful (3) Neutral (4) Somewhat Useful (5) Very Useful

7. How useful do you find this program for educating parents on self-care and relaxation? _____
(1) Not Useful (2) Somewhat Useful (3) Neutral (4) Somewhat Useful (5) Very Useful

8. What aspects of this program did you find **not** particularly relevant for its intended purposes?

9. What do you consider to be the strengths of the program?

10. What do you consider to be the weaknesses of the program?

11. What could have been added to the program to make it more useful for culturally diverse parents of children with Autism Spectrum Disorders?

12. Are there any parts of the program that you would omit, change, or revise?

13. Additional comments and suggestions:

In regards to the overall program, please rate the following statements using the scale below:
(1) Strongly Disagree (2) Somewhat Disagree (3) Neutral (4) Somewhat Agree (5) Strongly Agree

14. This program is beneficial for parents of children with Autism Spectrum Disorders. _____

15. I would recommend this program to parents of children with Autism Spectrum Disorders.

Thank you for your time!

APPENDIX G
Parent Program Outline

Parent Program Outline

GENERAL PROGRAM NOTES:

- Facilitators should have a master's degree in psychology or related field, at least 2 years experience working with children with ASD and their families, and at least 4 graduate level courses (or equivalent) in providing culturally responsive therapeutic interventions.
- Participants are parents of children ages 6-12 with Autism Spectrum Disorders. Ideally groups are composed of two facilitators and 12 participants, however, no more than 14 participants are strongly recommended.
- Children of participating parents should have low average and above cognitive abilities (e.g. intellectual functioning). Verbal abilities should include at least 4-5 word (unprompted utterances) in response to questions asked.
- You will find some statements in blue that are intended to be examples of how you might want to present the material. Please feel free to put these statements in your own words.

CLASS ONE: INTRODUCTION TO AUTISM & BEHAVIOR

As People Enter:

- a. Have music playing
 - i. Create your own CD based on music preferences of your group
 - ii. *Option:* Have group members rotate providing music each week.
 - iii. Hand out papers for the opening ritual (see agenda item IV).

II. Quote of the Day: On PowerPoint

- a. Each day a quote will be written on the initial slide that is showing as participants arrive. A quote is prewritten on each opening slide for all five sessions. Additional quotes can be found in the notes section of PowerPoint slide if you want to change it. You may also select your own quote to insert.
- b. For example, the preselected quote for this class is "A single arrow is easily broken, but not ten in a bundle." (*Japanese*)

III. Welcome

- a. Welcome everyone to the course and thank them for coming. Introduce yourself as the facilitator and tell them that: **I would like to begin with introductions followed by an opening ritual that we will do every week.**

IV. Introductions

- a. Have everyone go around the room and state their name, what brings them here/ what they hope to gain from course. Start with someone next to you and go around the room, ending with yourself. Use this opportunity to give a more formal introduction of yourself. This introduction should include both your academic and multicultural training and clinical experiences.

V. Opening Ritual: 15 Minutes

- a. The goal of this activity is to help participants develop a sense of community and support one another. Here is one way to introduce this activity/ritual: **A**

major goal of our group over these next few weeks is to provide a safe and comfortable place to talk about and learn about autism. Our time together is precious; it is a time for you to connect with other families who are having similar experiences. Ideally, we would like this to become your community; a place of support, encouragement and information. We're all coming from our busy, crazy lives and in the service of creating our community here in this group we're going to take a few minutes at the beginning of each group to ground ourselves in why we are here and how we can best contribute and best benefit from our time together.

- b. This ritual will be conducted at the beginning of each meeting as a means of centering everyone and allowing them to check in with one another and themselves. During the initial meeting, this ritual will take up more time, because it will need to be introduced and explained. However, during subsequent meetings, this should not take more than 3-5 minutes.
- c. Give everyone a slip of paper and ask them to write 2 or 3 words describing how they are currently feeling, by considering the following questions:
 - i. "Where are you at today?"
 - ii. "How are you feeling?"
 - iii. "What type of space are you in?"
 - iv. "What do you need at this moment?"
- d. Collect the slips of paper in a basket. Remind the participants that: *This exercise is intended to show us all that we share common experiences even though we may not be aware of them.*
- e. Tell participants the following: *When the basket is passed to you, pick one of the pieces of paper out, read it and use it as a way to understand and connect with the energy in the room. If you take your own paper, put it back and choose another before reading.*
- f. Collect the papers back in the basket when the activity has ended.
- g. Tell everyone that: *Now that we better understand where we're at, let's take a few moments to center ourselves and leave the day behind.*
- h. Ask everyone to place both feet flat on the floor. Tell them: *Either place your hands on your knees and relax your back or sit up straight. Close your eyes. Inhale slowly through your nose, and feel the air filling your lungs. Blow out slowly through your mouth (without putting a lot of effort into it). Count to four slowly for an inhale, hold the breath as you center yourself right here and right now in this moment, and now count to six slowly for the exhale. Do this count with them twice to ensure they have it. Feel your muscles relaxing and feel any tension leaving your body.*
- i. In future sessions use the breathing technique as described above or feel free to include visualization or increase the number of breaths depending on your group preference and needs. Visualizations can include images of tension or

stress leaving their body and their body feeling relaxed and tranquil. During future sessions, this part should not take more than two minutes.

- j. Inform everyone that: [What we've done today; sharing where we're at and centering ourselves in our common purpose will be a ritual that is done at the beginning of every session.](#)

VI. Overview and Housekeeping

- a. Course Overview
 - i. This course is facilitated through a cultural-ecological model that emphasizes person-environment fit with selection and implementation of interventions. It is important that this be emphasized throughout the course, but particularly during the first session, as it sets the foundation for the remainder of the sessions.
 - ii. The focus of this course is on providing parents with tools that they can use to work more effectively with their children. The objectives are not to "label" or "pathologize," but rather to view parents as experts on the uniqueness of their child and family system and to provide them with an understanding of how to assess, identify, and implement effective strategies. Again, this should be emphasized throughout, particularly during the first session.
- b. Session Structure
 - i. This program is 12 hours. It is divided into five two-hour sessions, a two hour field-trip.
- c. Language Used
 - i. [In the world of psychology, education, and developmental disabilities there many acronyms and complex/fancy words and phrases. In this course we will use some of these terms in order to assist you in developing your familiarity and understanding of these terms. However, we want all of our language to be understandable. If there is something that you do not understand, please speak up. Chances are someone else in the room may have the same question. If we don't have the answer, we will try to locate it for you.](#)
 - ii. Participants will be shown a cartoon that uses a lot of acronyms to demonstrate the complexity and overwhelming aspects of language specific to children with disabilities. **Cartoon Wording:** John has had an ABA (Applied Behavior Analysis) for his ASD (Autism Spectrum Disorder) - although he may have AS (Asperger's Syndrome) he will need ASL (American Sign Language) probably to include CAMHS (Child and Adolescent Mental Health Services) and possibly a CHAT (Checklist for Autism in Toddlers). The EA (Educational Assistant) know his SLD (Specific Learning Disability) and have recommended SPELL (Structure, Positive approaches and expectations, Empathy, Low arousal, and Links) and TEACCH (Treatment and Education of Autistic and Related

Communication Handicapped Children) alongside PECS (Picture Exchange Communication System). In addition SALT (Speech and Language Therapy) and OT (Occupational Therapy) have been suggested. One last thing- Has he had a DISCO (Diagnostic Interview for Social and Communication disorders) recently?

- iii. Participation: This course interactive in nature and questions and comments are encouraged. We all come to these sessions with a wealth of knowledge. When we share this knowledge with one another we all benefit. This means, we serve as facilitators, and look to everyone here to not only contribute questions, but to contribute comments. Both in agreement and disagreement; discussion is healthy. If we don't know an answer to a question, we will try to locate it and get back to you.
- d. Confidentiality
 - i. Due to the sensitive nature of the material discussed, it is important that confidentiality be addressed at the onset of the course. It is our goal to create a "safe" environment where everyone here feels they can talk freely without fear that "someone will find out what I said." Therefore, it is imperative that information shared during these sessions is not discussed outside of session with anyone. You will want to make sure everyone is in agreement. Make sure that everyone is in agreement and give an opportunity for people to express concerns. Also be sure to give the group the opportunity to decide if this rule applies to discussing sessions with other members of the group outside of session.

VII. Session Theme: Introduction to Autism & Behavior

- a. **What are Autism Spectrum Disorders**
 - i. **Definition of Autism Spectrum Disorders**
 - ii. **Developmental Disabilities Facts and Prevalence**
- b. **What are Social Skills**
- c. **Role of culture in determining appropriate social skills**
- d. **Conceptualization of Autism and impact on social skills**
- e. **How social skills training helps**
- f. **Theories of Learning & Benefits of application to social skills training**
 - i. **Explain what is meant by Behavior**
 - 1. It can be overt or covert, desired or undesired.
 - ii. **Operant Conditioning at a glance**
 - 1. how it is at play in daily interactions with children
 - iii. **Developing Awareness of antecedents**
- g. **Behavioral Consequences**
 - i. Aspects of the behavior influence the consequence
 - ii. Adding vs. removing stimulus

- iii. Increasing vs. Decreasing of behavior
- iv. **Explain Positive Reinforcement, Negative Reinforcement, Positive Punishment, Negative Punishment, and Extinction**
 - 1. **Let's Practice:** Provide parents with situations and have them state the type of consequence. Be sure to provide praise. It is important to remember that parents are sensitive to criticism of their parenting methods. Therefore, again emphasize that our focus is to help parents to gain an understanding of behavior so they can learn to identify both strength and growth areas. **The goal of this class is to help us to develop new helpful and effective skills. In order to best do this, we need to examine what we are currently doing, how effective it is, and if there are some ways we can positively reinforce as well as extinct some of our own behaviors. With that said, I am now going to give you an antecedent. I want us to list some of the behaviors we currently respond with.**
- v. For each situation have the group brainstorm a few examples. Then, for each example, have the group determine which category of consequence it fits in. Next, have the participants determine if that is the category that they would want their behavior to fall in. If not, ask which category they would prefer and have the participants identify a response behavior that they could do in the given situation that would result in the preferred consequence category.
- h. **Q&A**
- i. **Brief Break**
 - i. Tell people 5 minute break, and do not let it go longer than 10 minutes.
 - ii. It is very important that you are especially mindful of the time during the initial session, as it sets the tone for future sessions.
- j. **Resources:** Provide parents with a handout of local and national resources. Briefly explain how they are constantly being exposed to treatment plans, resources, medications, etc. Identify these resources as being a way to gain information on what the research has to say about treatment options. These organizations can also be a source of support. Resource contact information may include the National Institute of Health, American Pediatric Association, The Autism Society of America, Special Needs Network, Talk About Curing Autism (TACA), and the National Autism Association.
- k. **Small Group Activity: Goal Development**
 - i. Small group activities are done towards the end of each session in smaller groups of 2-4 people (depending on the activity). These activities change from week to week, and are typically complementary to the course content that was covered that day.

- ii. During this activity participants should set at least two goals for themselves. At least one of these goals should be accomplished during the course period. This helps people to distinguish between short and long-term goals. Additionally, towards the end of the course, if time permits, you can reflect with participants on the process of setting and attaining goals. You can discuss the feelings and steps associated with both achieving and not achieving established goals. This reflection process can be helpful in identifying strategies to reinforce achieving goals and avoiding roadblocks.

VIII. Talking Circle: 30 minutes

- a. Each week we will end the group by providing an opportunity to share some of the thoughts you've had today. This activity is based upon a traditional way of communicating or sharing among Native Americans. Sometimes an object is used in the taking circle, for our purposes we've chosen a rock, as a symbol of strength. The idea is to give each person encouragement and space to express feelings, thoughts, and stories. This is a time for giving and receiving within our community. In the Native American tradition, the gift we're giving each other is our full attention and listening with our hearts, our minds and our spirit.
- b. Give each person a small rock.
- c. Pass around a couple of permanent markers and ask participants to write their name on their rock.
- d. Pass around a small pouch and ask participants to place their rock in the pouch. Start the passing of the bag with a person next to you, so that the bag comes back to you last.
- e. Share with the group as the bag is being passed around that: **The purpose of this activity is to provide each person with an opportunity to share their experiences and to really be "heard."**
- f. Explain the significance of the pouch of rocks: **Rocks come in different sizes and shapes. They are similar to each other in composition and sometimes appearance, but also have very unique qualities that differentiate them. In this way they are similar to us and our experiences. Everyone in this room has experienced life and autism in ways that are unique as well as similar. It is likely that we have all experienced joy, happiness, sorrow, despair, anger, fear, love, and courage. At times in our lives we have felt supported, and at other times we have felt isolated and alone. We are similar and different in many ways. To many, rocks are a symbol of strength. This pouch contains the combined strength of all of us in this room. As you hold the bag of rocks and share your experience, embrace the strength of those around you, as it may help you to speak the words that are on your heart and mind. When you doubt that you have the strength to endure what you feel, or speak what is on your mind, know that just as your rock is not alone in the pouch, you are not alone on this journey, you are surrounded by the strength of those of us in this room.**

Whoever has the bag talks, and everyone else listens. You are invited to briefly share what is in your heart. If someone does not want to talk when the bag is given to them, they may pass the bag to the next person without speaking. Each person has about five minutes of uninterrupted time to share.

- g. Be sure to inform the participants that they are free to speak about anything they wish during this time (provided it is not slandering another person). However, for this first session, explain that you would like this to be an opportunity for people to speak briefly about the journey that brought them here. Be sure to mention that this is just a suggestion to be able to get to know a little more about each other, but that people are welcome to talk about whatever they choose. Also, inform everyone that this will be the only time that you offer a suggestion for a topic. That there is no “topic,” but rather it is a space to speak freely. You will want to emphasize “briefly,” in order to be mindful of the time.
- h. After the bag has gone around the circle and everyone has been given a chance to speak, the facilitator should conclude the activity by asking all of the participants to look around at the people in the circle and acknowledge each other in silence. Participants should be encouraged to reflect on what has just been said, what they have learned, what they have accomplished, and what they hope to do.

SESSION TWO: VERBAL COMMUNICATION SKILLS

- I. **As People Enter: Have music playing and a quote for the day.** Sample quote: “It is the province of knowledge to speak and it is the privilege of wisdom to listen.” Oliver Wendell Holmes, US Author and Physician
- II. **Welcome & Ritual**
 - a. Welcome everyone to the course and thank them for coming. Reintroduce yourself as the facilitator and tell them that: [I would like to begin with our opening ritual that we will do every week.](#) (See outline of session 1 for ritual details)
- III. **Review Homework**
 - a. Address any issues that came up in the goal development homework assignment. Ask if anyone able to complete the homework and if anyone would like to share the second goal that they came up with for themselves. Also, ask if anyone started working on their goal already and what progress they have already seen.
- IV. **Session Theme: Verbal Communication Skills & Impact on Social Skills Development**

[Remind everyone that the course is interactive and questions and comments are encouraged.](#)

 - a. **Adaptive vs. Maladaptive Behaviors**
 - i. *Explain the difference between Adaptive and Maladaptive Behaviors*
 - ii. Explain the role of weighing culture and societal aspects (ex. Eye contact with Asian-American families)
 - b. **Selecting Appropriate Interventions**
 - i. Factors to consider (e.g. chronological age and developmental abilities)
 - ii. Bell curve & rainbow to demonstrate ability distribution
 - iii. Impact on self-esteem
 1. Celebrating and strengthening ability vs. not emphasizing disability
 - iv. Use of strong interests as a way to teach skills in a more engaging way
 - c. **Communication Skills**
 - i. Define communication
 - ii. Verbal vs. nonverbal communication
 - d. **Communication Deficits in Children with Autism Spectrum Disorders (ASDs)** (ex. Initiating)
 - e. **Reciprocal Communication**
 - i. Define
 - ii. Role of voice, volume, and tone
 - iii. Requesting
 - iv. Developing these skills through play & modeling
 - f. **Q&A**

V. Brief Break: 5 minutes

VI. Small Group Activity: Go Fish Communication Game

- a. During this activity, participants create a go fish game to play at home with their child and family by creating a list of conversation topics that range in interest level for their child. The ranging of topics based on interest assists the child in learning how to talk about things that are within and outside of their interest areas. It also assists them in practicing reciprocal conversation, taking turns, and shifting of topics.
- b. Brainstorm with parents other ways that they can incorporate practicing verbal communication into their lives.

VII. Closing Ritual: Talking Circle

CLASS THREE: NONVERBAL COMMUNICATION SKILLS

- I. **As People Enter: Have music playing and a quote for the day.** Sample quote: “The real voyage of discovery consists not in seeking new landscapes but in having new eyes.” Marcel Proust, French Novelist

II. Welcome & Ritual

- a. Welcome everyone to the course and thank them for coming. Reintroduce yourself as the facilitator and tell them that: [I would like to begin with our opening ritual that we will do every week.](#) (See outline of session 1 for ritual details)

II. Review Homework

- a. Address any issues that came up in the homework. Check in with participants to see who was able to play the Go Fish game with their family and ask if anyone is willing to share their experience.

III. Session Theme: Nonverbal Communication Skills

There is a lot of information that can be covered in regards to nonverbal communication. Due to the time-limits of this being a two-hour session, you may select the aspects that are most salient to your participants. Two hours is allotted for the fieldtrip, so that you have the option of doing two one-hour fieldtrips or to use one of the hours to cover material that you do not get to from previous sessions.

[Remind everyone that the course is interactive and questions and comments are encouraged.](#)

IV. Nonverbal Communication

- a. **Definition, process of development, greater impact than verbal communication**
- b. **Inclusion of pragmatics (e.g. intonation, rules of communication)**
- c. **Appropriate Nonverbal Communication is a social construct. Discuss relationship between culture, communication, and social skills**
- d. **Deficits (nonverbal) in children with ASD & Impact on Social Skills Development**
- i. Difficulty interpreting and producing nonverbal communication including eye contact and prosody.
 - ii. Prosody includes the intonation, stress, pitch, timing, rhythm of what is being said.
 1. They may speak with a high pitch, show little inflection, or sound monotonous.
 - a. An example of this is, “I will not do that.” See what changes when you emphasize the words I, not, or that.
 2. Literal interpretations are also a common feature of ASD. Due to this, they often struggle to understand sarcasm, exaggerations, understatements, humor, slang, metaphors, and figures of speech.

- a. Example: That’s cool. This is slang for good, not another word for cold.
 - 3. Give examples of sentences said with varied prosody so participants can hear the differences.
 - i. **Pragmatics of Nonverbal Communication**
 - i. **Eye Contact, body posture, facial expressions, and gestures**
 - ii. Discuss ways to reinforce desired amounts (culturally bound) using understanding of behavior modification from session 1.
 - iii. **Rules of communication**
 - 1. Explain that social rules are the unwritten customs, traditions, norms, or standards that are generally accepted by society and are learned through the lifetime by observing others. Examples of social rules that deal with communication include turn taking, avoiding interruption, and staying on the topic of conversation.
 - 2. The rules of communication are also often confusing to children with ASD. Such rules can include the quantity of their speech (no monologues), the relevance of their topics, their ability to describe topics clearly, to transition smoothly between topics, take turns, avoid interruptions, and include appropriate topics or statements.
 - iv. **Literal interpretations & difficulty with sarcasm**
 - j. **Nonverbal Skills for Play**
 - i. **Turn taking and sharing**
 - ii. **Engagement**
 - 1. Explain that engagement is the ability to attend to and be present in a social interaction and it goes along with the concept of reciprocal play.
 - 2. Discuss ways to reinforce engage with children in a culturally congruent manner, using understanding of positive reinforcement from session 1.
 - k. **Communication Strategies**
 - i. **The basics**
 - 1. Get your child’s attention before doing anything.
 - 2. Always stay at your child’s level.
 - a. Give one or two directions at a time to avoid confusing them or slowing down the time it takes them to process the information.
 - b. Have your child repeat the instructions to insure that they understand what you are telling them.
 - 3. Understand your own child’s ability in understanding language and their tendency to interpret literally.

- a. Use direct, explicit, literal questions and directions to help your child understand what you are expressing and avoid miscommunication.
 - b. This is especially helpful in situations where certain behaviors are expected or not expected of them (i.e. not telling her teacher she looks fat).
 - c. Use situations when your child does not understand a social rule or the nonverbal communication of others as opportunities to teach them a new skill.
4. Utilize games to reinforce nonverbal communication, practice informal speech, explore body language and facial expression, and that require turn taking (see resource section for activities).
 5. Use modeling to teach your child appropriate ways of communicating.
 6. Teach your child appropriate ways to ask for help at school and at home when they are stuck so miscommunication and behavioral issues do not ensue.
 - a. Communicate with the teacher what is expected of your child and what accommodations are being made, especially if your child already has an aide with them.
 - i. Ask about any unstructured play time and what activities are available during this time and how transitions are handled.
 - b. Ask adults that work with your child to only use one or two directions at a time (depending on what your child can understand), not to punish errors, and to be explicit on what is expected of him/her (i.e. talking out of turn).
 - c. Give your child a way to ask for help in class.
 - d. If your child is school age, you can talk to them about how they play with the other children at school. It can be helpful to give explicit rules for ways to play with peers. You can come up with this with your child and can include how to handle changes in play, which are often difficult for children to handle. Also, it is important to address any bullying with the teacher.
 - e. Be mindful that although role play may be helpful in many of these aspects, pretend play is difficult for children with ASD, so implementing reinforcement “in-vivo” will be important.

l. Q&A

m. Review of Resources

You can select a few of the items below to review in-session in more detail and you can place the others on a handout for them to take with them.

- i. Review games and activities that expand nonverbal skills (Charades); reciprocal, cooperative play, and increase engagement [board games (Candyland, Chutes and Ladders) and card games (Uno, Go Fish)]
- ii. Social stories
 1. Social stories are tales about different situations, skills, or ideas that help a child with ASD understand the process of the topic. Social stories range in topic from grieving the loss a beloved dog to learning to wash your hands or use the restroom. Let parents know that they can introduce social stories to their child by reading them a story about something that they do very well to reinforce that reading social stories are a positive experience. Then move into an area that the child is currently having or you anticipate them having difficulty with. The benefits of these stories are that they can be customized for any topic, incorporate the needs of everyone involved in the story, and utilize language that is at the child's developmental level. Show the participants an example of a social story.
 2. Let parents know that they can purchase social stories on-line that address specific topics or they can create their own social story for their child. Creating social stories usually takes some practice, so it will be important to provide them with samples of stories and explain the process of developing one.
- iii. Positive reinforcement of appropriate communication
 1. Parents are encouraged to utilize the skills they learned in session one to reinforce their children's appropriate nonverbal communication. Examples include giving a high-five when they make appropriate eye contact or giving them a larger reward at the end of the week if their child was able to successfully complete the behaviors on their contingency grid.
- iv. Behavior contingency grids
 1. Parents can create grids with or for their children that explicitly states a specific reward for completing a series of tasks. The child is then able to place a token/gem/sticker on the grid every time they complete a step to watch their progress towards their goal. Rewards should be chosen with the child's input to ensure the saliency of the goal. An example of this is a grid that gives the child a token each time they are able to complete a game/activity that day that involves taking turns. A contingency grid should be made available to show parents an example during class. It is also important to relate this to concepts from

sessions 1 and 2, to show how you are building upon concepts (e.g. behavior modification, communication)

- v. Watching a foreign film
 - 1. Watch a foreign film with your child and try to understand what the characters are doing or saying. Have your child tell you what the person is doing that helped them understand what was happening. You can also watch a soap opera with the sound off with your child to practice these skills.
- vi. Practice double meanings, slang, clichés, sarcasm, and jokes
 - 1. Parents can practice these forms of informal speech in order to increase their child's ability to understand the accurate meanings when people use them in conversation. Parents can create a list of common clichés and slang and go over them with their children.
 - 2. They can also create a dictionary with their children that includes all the slang, clichés, and double meanings that they learn.
- vii. Games involving facial expression, voice tone, and body language
 - 1. Parents can hold up a partition (a piece of thick 8x11 paper works great) just below their eyes so that it covers the rest of their face. They can then create facial expressions while their child can only see their eyes and have their child guess what emotion they are conveying by only looking at their eyes.
 - 2. Write down phrases and have your child practice emphasizing different parts of the sentence to create different meanings. Parents can also say different phrases to their children and have their child give the meaning of the phrase based on the emphasis, inflection, and pitch the parent presents.
 - a. Examples of phrases are: I didn't do that. She doesn't like me. I won't do that.

IX. Brief Break: 5 minutes

X. Small Group Activity: Understanding Social Rules

- a. The small group activity for today is Understanding Social Rules. During this activity, participants should get into small groups of 3-5 participants and chose one participant to go outside while the others receive special instructions from the group facilitators. After the chosen participants have left the room, hand out a list of social rules to the groups and instruct them to choose 2-3 rules from the list to act out when their other group member reenters. Let them know they should not tell the other member what they are doing, but to have a conversation on the selected topic (listed on the handout) using the rules. After approximately five minutes of conversation, come back together as a whole group and discuss how it felt to those participants that stayed and those that

went outside. Reinforce that children with ASD are often consciously trying to figure out social rules.

XI. Homework

- a. As homework for the next meeting, instruct the participants to try to find the moments when their own child appears to be misinterpreting a social rule and try to understand how their child understands the situation. If they are comfortable, ask them to please share this experience with the group in the next meeting.

XII. Closing Ritual: Talking Circle

CLASS FOUR: EMOTIONAL AWARENESS

III. As People Enter: Have music playing and a quote for the day

IV. Welcome & Ritual

- a. Welcome everyone to the course and thank them for coming. Reintroduce yourself as the facilitator and tell them that: [I would like to begin with our opening ritual that we will do every week.](#) (See outline of session 1 for ritual details)

V. Review Homework

- a. Address any issues that came up in the homework. Check in with participants to see who was able to play the Go Fish game with their family and ask if anyone is willing to share their experience.

VI. Session Theme: Emotional Awareness

- a. **Explain Feelings Model to assist in understanding of relationship between emotional awareness, effective communication, and social skills.**
 - i. Participants should reflect on where they are currently on the feelings model and what cues they have to know this is where they are
- b. **Time Out vs. Avoidance/Withdrawal, and the messages each send in social interactions**
- c. **Identification and expression of emotions: How to increase your self-awareness, modeling abilities, and teach these skills to your child.**
- d. **Self-awareness and emotion regulation: relation to teaching social skills**
- e. **Small Group Activity: Thumbs Up, Thumbs Down (with prompts for feeling & content)**
 - i. In small groups, participants will take turns being the “parent” and “child.” Parents will practice guiding the child through a this emotional awareness exercise.
- f. **Q&A**
- g. **Brief Break: 5 minutes**
- h. **Introduction to relaxation**
- i. **Large Group Activity: Practice**
- j. **Introduction to teaching kids relation**
- k. **Small Group Activity: Practice**
 - i. In small groups, participants will take turns being the “parent” and “child.” Parents will practice guiding the child through a relaxation exercise.
- l. **Homework**
 - i. Set aside time daily to practice relaxation. Goal is to practice twice each day, at least once before bed.
- m. **Closing Ritual: Talking Circle**

CLASS FIVE: PARENT SELF-CARE

- V. As People Enter: Have music playing and a quote for the day.** Sample quote: “The real voyage of discovery consists not in seeking new landscapes but in having new eyes.”
Marcel Proust, French Novelist

VI. Welcome & Ritual

- a. Welcome everyone to the course and thank them for coming. Reintroduce yourself as the facilitator and tell them that: [I would like to begin with our opening ritual that we will do every week.](#) (See outline of session 1 for ritual details)

VII. Review Homework

- a. Address any issues that came up in the homework.

VIII. Session Theme: Parent Self -Care

- a. **Purpose**
 - i. To help parents identify and target everyday stressors when raising a child, especially one with special needs.
 - ii. To help parents improve the ability to utilize cognitive, emotional, and behavioral coping strategies to better manage stress.
- b. **What is Self Care?**
- c. **Self-Care vs. Selfishness**
 - i. How to identify and address the psychological and environmental roadblocks that foster stress and limit attention to self-care.
- d. **Stress**
 - i. **Define stress and parenting stress.**
 1. Having a child with special needs does increase the level of stress involved in parenting and especially if the child has behavioral problems or poor social skills.
 2. Potential risks of high levels of stress (e.g. low parenting satisfaction, less effective use of directives towards the child)
 3. Stress is natural and important part of life. Discuss benefits of stress.
- e. **Identifying Stressors**
 - i. Child Related (e.g. tantrums, inappropriate public behavior); Medical and Health (e.g. sleep disturbance, food tolerance); school (e.g. peer relationships, academics); marital (e.g. intimacy, non-child activities); single parenting (e.g. lack of support, limited dating opportunities); siblings (e.g. embarrassment, jealousy); financial (e.g. treatments, prescriptions)
- f. **Coping with Stressors**
 - i. Set aside relaxation time
 - ii. Relaxation is not automatic, but rather must be learned
 - iii. Importance of sleep and exercise(consistent and appropriate amounts)

IX. Q & A

X. Brief Break: 5 minutes

XI. Small Group Activity: Identifying Stressors

- a. During this activity, participants should pick three current stressors. First, have them identify what exactly caused the stress (i.e. tantrums or being late to work). Next, have them identify how they felt in the situation, physically, emotionally, and cognitively (i.e. tension in the stomach, thinking that their boss is going to yell at them, or feeling like a failure. Third, have them identify their reaction to the situation. Lastly, if their initial reaction did not help to quell their stress, have them identify two specific coping strategies that can help decrease their stress in these situations.
- b. Participants should be able to pull from knowledge covered in each of the previous sessions to complete this activity.

XII. Large Group Activity: Relaxation

XIII. Recap of information learned throughout the course

XIV. Closing Ritual: Talking Circle