FLASH

Families Learning
about *Self Harm*

FLASH ASD PROTOCOLS

PROGRAMME SERIES PROTOCOLS

FLASH

Families Learning
about *Self Harm*

These protocols are **ONLY** to be implemented by professionals who have completed the **FLASH 3-DAY TRAINING**

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FLASH ASD Protocols First Piloted 2020

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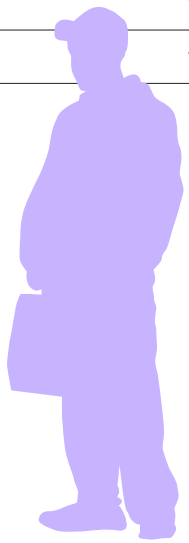
CONTENT LIST



FLASH ASD PROTOCOLS

INTRODUCTION

FLASH ASD protocols is based on the FLASH *Families Learning About Self-Harm* programme. The content has been adapted to consider the issues facing parents of a young person aged 11-19 years old with mild/moderate Autism and who are exhibiting self-harming behaviour.

The design is based upon the FLASH 10-week parenting programme. The protocols can be used as the model for a implementing a FLASH ASD group just for parents and carers with young people with ASD who are self-harming, or a group leader can use the ASD information as additional information in a standard group if they have a few parents in the group with a young person who has ASD and self-harms.

The FLASH programme aims to create better communication and personal relationships between parent/carers and young people. FLASH ASD protocols allows parents the opportunity to discuss the problem with people who understand and learn how to manage the concerns within their home.

It will include:

- Exploring what self-harm is, what the risks are and what the function of self-harm is in relation to ASD and additional educational needs
- Listening and self-esteem enabling skills
- Managing self-harm within the family environment
- How self-harm impacts on parenting and ways to manage it under stressful circumstances
- Coping strategies for parents and carers

HOW TO USE THIS SERIES PROTOCOLS

Each session has content topics listed and unless stated otherwise, the delivery of the content is in the same format as described in the standard FLASH manual. Additional information and group leaders' considerations are incorporated in these protocols.

There is an extra session (sensory processing). If the group all have parents who young person has ASD then it is recommended that this is implemented as an extra session. If only a few of the parents have a young person with ASD then there is the option of shortening the Parise session (week 5) and adding in some of the sensory processing information.

Each session incorporates hand-outs from the FLASH manual plus extra handouts which are included in these protocols. There are extra options, which the group facilitator can choose to use depending on the needs of the group.

Unless stated otherwise, forms such as consent, induction, sign up forms and the evaluation booklet are the same forms recommended in the standard FLASH manual.

TIMING

Each session lasts for approximately two hours. Time, however, should be allowed for the setting up of the group, the welcoming of the parents, allowing time for parents to leave and clearing up after the group. Time should also be given, preferably not on the same day as the group, for a full evaluation by the group facilitators. Time planning must also include supervision and self-reflection.

SESSION REFRESHMENTS

As in the standard FLASH programme high quality refreshments create a culture attentive environment within which everyone feels welcomed and valued. Conversations over a refreshment break provides opportunities for the parents to bond, plan, connect, and learn from one another.

IN-BETWEEN SESSION PHONE CALLS

As the sessions are a week apart, we recommend that every parent is contacted between each session (either via phone, text or email) to provide the parents with the opportunity of a little one to one consultation.

WHY THE NEED FOR FLASH ASD PROTOCOLS?

FLASH ASD protocols were developed from listening to the voices of parents who have attended the standard FLASH programme, they were requesting more advice/information on additional needs. In researching this we became aware that 20% to 30 % of people on the Autistic Spectrum will have self-harmed (SANCTUARY 2020), we learnt that certain conditions such as ADHD, Tourette's, global delay and OCD heighten the likelihood of self-harming. In the UK 14.9 % (NATIONAL STATISTICS UK 2019) of all pupils have special needs and statistics inform us that one in ten young people without the addition of special needs self-harm.

There are many contributing factors why a young person self-harms i.e. difficulty with articulating emotions/feelings, avoidance, attention, frustration, biochemical, repetitive behaviours and sensory stimulation. What we do know is communication can be therapeutic, however many young people with additional needs have communication problems. By giving the parents the tools to help their young person feel listened to may prevent or reduce self-harming behaviours in adulthood.

Parenting a young person with autism or additional needs can be hard and providing support at the earliest opportunity can only benefit both the parent and the young person.

Having additional needs can make many situations a struggle. 'Additional needs /learning disabilities' can cover a huge range of struggles; dyspraxia, dyslexia, autism, ADHD, downs syndrome . . . Whatever the struggle, behind it is a real person with humour, a smile, good days and sad days, perhaps though, the struggles are harder than many other people may face.

Statistically those young people with additional needs will have higher rates of self-harming behaviours than those without additional needs (KARIM & BAINES 2016).

No two-young people with additional needs are the same, their differing needs may hugely affect their daily lives and emotional ability to manage in many ways. For many parents the impact of having a young person who self-harms are considerable; these may include a narrowing of horizons, restriction of activities, day to day adaptations and stresses over and above those required by other parents.

Self-harm is very common for people with Autism Spectrum Disorders. It is also common for people with learning difficulties and there are a lot of similarities between the two. Nationally and globally there has been considerable concern regarding the apparent increase in the number of young people under the age of 18 who self-harm.

For autistic children and young people there are concerns from parents, carers and professionals that self-harm is an even greater problem, but the extent is unclear due to limited research. Significantly however, there are reports that suicidal ideation and suicide attempts are 28 times more common in autistic children than in non-autistic children.

Even the terminology applied to autistic children can sometimes be confusing, with self-harm and self-injury being used interchangeably with no consistency in the definition within available literature. According to NHS Choices (KARIM & BAINES 2016):

"Self-harm is when somebody intentionally damages or injures their body. It is usually a way of coping with or expressing overwhelming emotional distress".

It is thought that between 20-30% (SANCTUARY 2020) of people with autism will self-harm in some way, but this is often seen as something different to when we hear about someone cutting or burning as a coping mechanism. The medical profession seems to make the same distinction, and usually refers to it as "self- injurious behaviour" or SIB.

Self-injurious behaviour: "Self-injurious behaviour is described as when a person physically harms themselves. This might include head banging on floors, walls or other surfaces, hand or arm biting, hair pulling, eye gouging, face or head slapping, skin picking, scratching or pinching, forceful head shaking". About half of autistic people engage in self-injurious behaviour at some point in their life and can affect people of all ages.

It can be treated as a challenging, unwanted behaviour that is part of a condition. This approach perhaps depends on the severity of the diagnosis though, which varies between individuals, as described by the term "spectrum." Some studies have shown that both the prevalence and the type of self-harm also differs according to severity of the diagnosis.

SELF-HARM AND ASD/ ADDITIONAL NEEDS – THE DIFFERENCE

If we are looking for differences between self-harm in an individual with autism, and self-harm in an individual without these traits, the most notable differences would be seen in the type of harm, and its perceived cause. The more classic harming behaviours from an individual with autism would include actions like hand-biting, head-banging, hitting themselves on self or objects, excessive picking or scratching. Already this looks a little different to the commonly reported cutting and overdosing methods. When these actions occur in a very repetitive or rhythmic way, without an obvious cause, then it is suggested that one reason could be for stimulation. Some people function at a low level of stimulation and engaging in self-harm helps to increase this. Alternatively, if the person is sensitive to high levels of stimulation self-harm could act as a release of tension from this. The stimulation, or arousal theories of self-harm are more unique to those with learning difficulties or autism.

Other explanations look at more social causes, such as communication, a need for attention or avoidance. Autism is characterised by social deficits and communication difficulties and so it makes sense that a behaviour like self-harm might contain a social function for some. For example, it can act as a way of communicating a need, whether that is for attention or for gaining something tangible: this is reinforced when that need is subsequently met. In uncomfortable situations or if asked to do something unwanted, engaging in a harmful behaviour can help the individual to escape from the experience, or be a way of letting people know that they don't like something asked of them.

It is also important to acknowledge the frustration a person must feel if their feelings are not understood or if they are struggling to interpret the intentions of other people; this can be experienced across the whole spectrum of autism, regardless of language ability. An expression of sheer frustration might exhibit itself as self-harm, which is actually not too dissimilar to the type of self-harm that other people talk about: A teenager feeling frustrated at being misunderstood, or someone feeling angry and frustrated about the way that they are treated by people, or feeling helpless against more of life's let-downs. A person with autism can experience all of these – they are often treated differently by society – but can lack the emotional capacity to express or deal with it.

The treatment of Self-Harming Behaviour in autism depends on the particular function that it serves for that person. This can be identified by observations and/or conversations with the individual. Behavioural therapies are popular and involve using positive re-enforcement techniques – rewarding positive/safe behaviours and teaching alternative methods of communication. A stimulating environment may also help to prevent the behaviour as can medication if the problem is linked to an underlying mental health condition.

Communication problems can make it very hard for parents of a child with autism to know how to help their child, and it may take a long time for the right intervention to be found. Both autism and self-harm are under-researched areas and are not fully understood, so facing the two together can feel scary and isolating. Families and individuals dealing with these issues need lots of support and encouragement and it's important they are supported.

WHAT GROUP LEADERS NEED TO BE MINDFUL OF WHEN RUNNING A GROUP WITH PARENTS WHOSE YOUNG PEOPLE HAVE ASD.

Some parents may have ASD traits themselves and therefore may be very lateral in their thinking processes. Group leaders will need to be very clear when giving instructions.

Some of the parents may struggle with the metaphors used in FLASH due to lateral thinking (can be very black in white in their thinking processes) the key is to keep the metaphors simple and be prepared to adapt/change the metaphor to aid their understanding.

Group leaders should not worry if they have to reframe an instruction/question/metaphor during a session to enable parents to have a clearer understanding. This is positive role modelling for the parents, showing them what they may need to do at home.

FLASH WORKSHOP ATTENDANCE FORM

First Name (no surnames please)	1	2	3	4	5	6	7	8	9	10	Extra session

FLASH SESSION 1
PLAN & CHECKLIST

ITEMS REQUIRED	
Refreshments – tea, coffee etc.	
A3 FLASH session overview bridge picture (from original FLASH manual)	
Flip chart	
Pens	
Blue tac	
Name labels	
Attendance form	
Box/bag of shoes	
PARENT HANDOUTS:	
Autism and Self-Harm handout	
Local Useful Links for Advice handout (group leader to create local list)	
Evaluation forms (Pre and weekly) (from original FLASH manual)	

SESSION 1 IN DETAIL

WELCOME AND INTRODUCTION

REGISTRATION: ask parents to sign the attendance form and make a name label to wear

HOUSEKEEPING: explain fire, health and safety procedures

PRE SESSION EVALUATION FORMS: ask the parents to complete

EXPLAIN AGENDA FOR THE SESSION

Explain to the parents that it is important that they look after themselves. They are to be kind to themselves during and after each session, so they need to give themselves permission to have proper breaks and consider whether they need to respond to home calls and emails during break times. As their young person will have been left with a trusted person.

Group leaders should introduce themselves and then invite all parents to give their name and the age of the young person they are concerned about. A facilitator should record the age of each young person and then add up all the numbers. This number will equate to the number of years of parental experience in the room; highlight this to the parents. Explain the session has a collaborative approach. As group leaders we aim to provide the best evidence-based information and as a group we will share our thoughts and experiences, so we collectively put theory into our everyday family lives.

WARM UP

WALK IN MY SHOES – ask the parents to look though a box/bag of shoes (using smaller adult sizes) and see if they can find a pair that they can comfortably walk in – explain these are another person's shoes . . . who has very small feet. Have an open discussion as to whether we can walk in another person's shoes. Generally, we cannot walk someone else's journey, but only empathise and learn from each other.

OVERVIEW OF FLASH ASD PROTOCOLS

Explain background to the FLASH ASD protocols and how its foundation is based on the FLASH programme. Show the picture of the Bridge from the original FLASH manual. Explain how the sessions build on each other. Explain some of the handouts will be from the original FLASH manual.

GROUP MANNERS/RULES

Explain the need to be safe and comfortable in this session. In large group brainstorm the group manners and put up on flip chart.

GROUP LEADER CONSIDERATIONS: If parents are unsure of using the word "rule", alongside "manners" another suggestion is "good will agreement". Also, sometimes the agree to disagree can be a bit vague for some parents so a suggestion is "challenge the statement not the person".

PERSONAL GOALS

Ask each parent to state what their goal (best hope) is for attending the sessions. Write up each person's name and write their goal beside their name. Remember to return to their goals at the end of Session 4.

GROUP LEADER CONSIDERATIONS: *most parents/carers want the self-harm to just stop and/or to understand why. This is not always the safest option for the young person. As professionals we need to support the parents/carers to understand that a personal goal for the self-harm to stop or to understand why may not be reached during your work together or even ever. As professionals we must accept and validate the parent's disappointment, frustration and fear. As professionals we have to support the parents to understand that in the longer term it is more effective for the young person to have different strategies to replace the "feelings" the young person experiences from their self-harm acts.*

OPTIONAL- COMMON FEELINGS ICEBERG

Validating the parent's feelings at the start of the session.

Draw on the flip chart an iceberg. A quarter of the way down from the top of the iceberg draw a line across (to represent the sea) this represents the visual of the just the top of the iceberg is seen; the majority of the iceberg is under the sea. In the above sea level iceberg put a smiley face. Explain that the top of the iceberg is what people present for the world to see i.e. coping, happy, functioning family. But what is under the water? Ask the parents to say how they are really feel about coming to a self-harm session. Write in the words in the iceberg section below sea level.

GROUP LEADER CONSIDERATIONS: *this activity is only optional as it is very dependent on the group of parents. If the atmosphere feels flat or if as a group leader you are feeling some apprehension this is a useful activity to address parents' concerns. This activity may be delivered on session 2 depending on time and the mood of the parents.*

GROUP LEADER CONSIDERATIONS: *to be mindful that some parents may struggle with feeling empathic as they may have become detached from the emotions which occur around self-harm due to over exposure. These feelings should be validated.*

ACTIONS OF SELF-HARM BEHAVIOURS

Brainstorm in the large group what are the actions of self-half. Write up list of actions on the flip chart.

GROUP LEADER CONSIDERATIONS: *depending on the experience of the parents, you may need to add actions to the list in order to show the range of self-harm actions.*

"WHAT IS THE DIFFERENCE BETWEEN SELF-HARM AND SELF-INJURY?" (this replaces the normal and excessive risk-taking behaviour activity in the standard FLASH manual)

Group leaders to open discussion on "What is the difference between self-harm and self-injury".

Group leader to highlight the following points: Statistically young people with additional needs will have higher rates of self-harming behaviour than those without additional needs. Self-harm is very common in people with Autism Spectrum Disorders. For autistic young people there are concerns from parents, carers and professionals that self-harm is an even greater problem, but due to limited research the true extent remains unclear. Significantly however there are reports that cite suicidal ideation and suicide attempts are likely to be 28 times more common in autistic children. Even the terminology applied to autistic children can sometimes be confusing, with self-harm and self-injury being used interchangeably and no consistency in the definition within literature. According to NHS Choices:

"SELF-HARM is when somebody intentionally damages or injures their body. It is usually a way of coping with or expressing overwhelming emotional distress".

It is thought that between 20-30% of people with autism will self-harm in some way (SANCTUARY 2020), but this is often seen as something different to when we hear about someone cutting or burning as a coping mechanism. The medical profession seems to make the same distinction, and usually refers to it as "self-injury behaviour" or SIB.

SELF-INJURIOUS BEHAVIOUR: "Self-injury behaviour is where a person physically harms themselves. This might be head banging on floors, walls or other surfaces, hand or arm biting, hair pulling, eye gouging, face or head slapping, skin picking, scratching or pinching, forceful head shaking". About half of autistic people engage in self-injury behaviour at some point in their life, and it can affect people of all ages.

It can be treated as a challenging, unwanted behaviour that is part of a condition. This approach perhaps depends on the severity of the diagnosis though, which varies between individuals, as described by the term "spectrum." Some studies have shown that both the prevalence and the type of self-harm also differ according to severity
If we are looking for differences between self-harm in an individual with autism, and self-harm in an individual without these traits, the most notable ones are in the type of harm, and its perceived cause.

SUMMARY POINTS:

- Self-injury – to make an internal function stop – natural feeling
- Self-harm – to stop an emotional action to a thought or feelings
- There is a link to learnt behaviours
- There is an overlap as both function and outcomes are the same.

FACTORS

GROUP LEADER CONSIDERATIONS: *depending on the experience of the parents, you may need to move this activity until after the brain and development activities. If then time is an issue, then this activity can be moved to Session 2.*

Either in 2 small groups or in one large group brainstorm discussion on the factors that may increase a young person with ADHD/ASD and or LD risk of self-harming.

GROUP LEADER TO ENSURE THE FOLLOWING FACTORS ARE COMMENTED ON:

COMMUNICATION DIFFICULTIES

Finding the right words to express feelings, having confidence to ask for help, having limited verbal communication to speak are all huge obstacles for someone with an additional need to overcome. Having feelings trapped inside and feeling prisoner to them, can cause self-harming behaviour.

The person might have no other way of telling you their needs, wants and feelings. Head slapping, or banging the head on a hard surface, may be a way of telling you they are frustrated, a way of getting an object or activity they like, or a way of getting you to stop asking them to do something. Hand biting might help them cope with anxiety or excitement. They might pick their skin or gouge their eyes because they are bored. Ear slapping or head banging might be their way of coping with discomfort or saying that something hurts.

MENTAL HEALTH ISSUES

Some self-harming behaviour might indicate mental health issues such as depression or anxiety.

REPETITIVE BEHAVIOUR

Some forms of self-injury might be part of a repetitive behaviour, an obsession or a routine.

DEVELOPMENTAL STAGES

The person might still do some things that most people stop doing as young children, such as hand mouthing – putting their fingers or hand into their mouth – causing injury.

PHYSICAL NEEDS

The feeling of frustration at being unable to physically manage what others can; the fear of having people stare at us or treat us differently because our physical needs are different; the impact of living day to day with a routine focused on managing basics needs – all these will impact the mental health and wellbeing of a person with additional needs.

SENSORY NEEDS

Have you ever found noise too much? Hated someone hugging you? Wanted to hide in the dark to get away from people, sounds, and smells? If so, you may be able to understand the impact our senses have on us feeling overwhelmed. Sensory disorders are far more common than we think, and they can affect us by making us anxious of crowds, fear noises and hate strong smells. People who struggle with these areas find ways to soothe themselves, sometimes through harming behaviours.

In the discussion group leaders to make the group aware that the more classic harming behaviours within autism would include actions like hand-biting, head-banging, hitting fists on self or objects, excessive picking or scratching. Already this looks a little different to the commonly reported cutting and overdosing methods. When these actions occur in a very repetitive or rhythmic way, without an obvious cause, then it is suggested that one reason could be for stimulation. Some people function at a low level of stimulation and engaging in self-harm helps to increase this. Alternatively, if the person is sensitive to high stimulation (or arousal) self-harm could act as a release of tension from this. The arousal theories of self-harm are more unique to those with learning difficulties or autism. Other explanations look at more social causes, such as communication, attention-seeking, or avoidance.

The message from the discussion is whether the young person has an additional need or not, where it is referred to as self-harming or self-Harming behaviour, the key is understanding what the particular function is serving for that young person.

CLOSING THE SESSION

Remind the parents that it is important that they look after themselves, so they are to be kind themselves this evening, encourage them to think of something that they can do to switch off from "self-harm" and recharge themselves.

Give out the handouts.

GROUP LEADER CONSIDERATIONS: *the useful links handout will need to be adapted to the local region.*

GROUP LEADER CONSIDERATIONS: *to make parents aware that group leaders are available after the evaluations have been completed if any of the parents have any questions or want to share any thoughts/concerns which the day's session may have bought up.*

EVALUATION OF THE SESSION

Use the standard FLASH evaluation form (From the FLASH manual).

GROUP LEADER CONSIDERATIONS: *to be aware that the parents may say they feel tried or "full up". This is normal!*

Note: for next session, print out the group rules on A3 paper and also the parent's best hopes for attending the session. These can go up every time you meet as it can be encouraging for them to remind themselves why they are attending – or indeed encouraging for other group members if a member achieves their best hope during the life of the group.

hand out

AUTISM AND SELF-HARM

Adapted from article interview with Lucy Sanctuary who is a Paediatric Speech and Language Therapist.

WHAT IS SELF-HARM?

A parent recently told me that her child has been self-harming since infancy, but she had only just discovered that this was self-harm. She said that she thought self-harming was cutting yourself and she had not realised the definition was much wider.

The NHS define self-harm as: "When somebody intentionally damages or injures their body." Research suggests that 20-30% of autistic people engage in some form of self-harming behaviour, even if it is only once in their lifetime.

COMMON FORMS OF SELF-HARM INCLUDE:

- biting
- hitting
- head banging
- Excessive scratching or picking.

We often assess non-verbal children or children without much language, who bang their head, poke themselves in the eye and bite themselves.
It can be very distressing for families who often feel powerless.

MORE SEVERE FORMS OF SELF-HARM ARE:

- Eye pressing/gouging
- Hair/teeth/nail pulling
- Pica (eating non-food items)
- Cutting
- Stabbing
- Eating toxins

WHAT CAUSES SELF-HARM?

There is not one cause. It can be multi-factorial and vary from person to person – some of the main causes are outlined below.

Mental health difficulties. These can include anxiety, depression and/or OCD. 40% of the autistic population are reported to have at least one anxiety disorder compared with 15% of the general population (NAS, 2011).

SOCIAL COMMUNICATION AND INTERACTION DIFFICULTIES.

Difficulties understanding social rules and behaviour, a reduced awareness and understanding of others and a narrow focus on details rather than the whole can lead to isolation, bullying and mental health difficulties. This can contribute to self-harm.

SENSORY DIFFICULTIES. For example, heightened senses can cause pain, "Every time I am touched it hurts." (GILLINGHAM, G. 1995).

Executive function difficulties. These can impact on the ability to problem solve, to consider alternatives, inhibit impulses, etc.

Difficulties recognising, understanding and regulating emotions. I work with a boy who self-harms when he feels that he has let other people down. He feels strong emotions that he cannot process easily. He cannot reflect on the situation or problem solve. He becomes impulsive and cannot monitor his behaviour at all and he hits and bites himself and bangs his head on surfaces.

WHAT CAN HELP?

Look for ways to reduce stress and pressure on the young people, in order to enable them and help them to communicate easily and successfully. Key strategies are:

ADAPTING OUR OWN COMMUNICATION

Reducing the amount of language, we use, making sure it is at the young person's level and giving them time to process what you have said before you add more.

Reducing the number of questions, you ask. It can be instinctive to ask questions when a child/young person is finding it hard to communicate, but this does not make it easier to talk. Instead it can put additional pressure on a child and increase anxiety and stress. The way that you talk can cause stress if you use language that is ambiguous, imprecise or open to more than one interpretation.

VISUAL SUPPORT

We all use visual support, for example calendars, lists, diaries, but it can be hard for families to use it in a structured, explicit way. Visual support takes many forms depending on the level of the young person. There is a lot of choice, which means families can find what works for them. You can use calendars to try to help young people accept unstructured time when we do not know what is going to happen, and to link uncertain events in the past with uncertain events in the present. For example, talk about the coming week and mark on the calendar what is happening on each day, such as school, karate after school, clubs etc. Leave some time at the weekend blank and say that you do not know what you will be doing then, but when you do know you will fill it in. Remind the young person of a previous time when you did not know and had to leave it blank, but you filled it in later when you did know what you would be doing, and it was okay. This is to try to help reduce anxiety about the unknown.

Help tips

PROVIDE SENSORY ALTERNATIVES

Build alternative sensory experiences into the daily routine. Jumping on a trampoline or swinging on a swing might provide a similar sensory experience to head shaking or slapping. Providing the person with a bag of safe objects to chew on – gum, carrots, raw pasta or sultanas – might reduce the need for hand or arm biting.

FLASH ASD PROTOCOLS – GROUP LEADER SESSION EVALUATION & REFLECTIONS

FLASH SESSION 1

What worked well	
What did not work so well	
What did we change	
What did we add	
What was different	
Comments	
Actions	

FLASH SESSION 2
PLAN & CHECKLIST

ITEMS REQUIRED	
Refreshments – tea, coffee etc.	
Lunch refreshments	
A3 FLASH session overview bridge picture (from original FLASH manual)	
Flip chart	
Pens	
Blue tac	
Name labels	
Attendance form	
Brain puzzle's (from FLASH manual)	
Brain picture and brain labels (from FLASH manual)	
ASD brain labels	
PARENT HANDOUTS:	
Brain & Teens development handout (from original FLASH manual)	
Self-harm spectrum (from original FLASH manual)	
Autism and Anxiety handout	
Self – Harm and ASD – some common questions/concerns handout	
Evaluation forms (weekly) (from original FLASH manual)	

SESSION 2 IN DETAIL

WELCOME AND INTRODUCTION

REGISTRATION: ask parents to sign the attendance form and make a name label to wear

HOUSEKEEPING: explain fire, health and safety procedures

PRE SESSION EVALUATION FORMS: ask the parents to complete

Explain agenda for the session.

Explain to the parents that it is important that they look after themselves. They are to be kind to themselves during and after each session, so they need to give themselves permission to have proper breaks and consider whether they need to respond to home calls and emails during break times. As their young person one will have been left with a trusted person.

FEEDBACK ON HOME TASKS

Either in two groups or in large group depending on the group size and dynamic ask the parents to feedback on their thoughts from the last session.

THE ROAD TO INDEPENDENCE

Put up on the flip chart: baby- child -teen- adult. Brainstorm with the age appropriate key developmental milestones. Highlight the movement between children to adult is more with ADHD/ASD and the young person will need more learning trails. ASD is generally a delayed development so brain development may be behind that of peers, affecting expected behaviours and understanding.

GROUP LEADER CONSIDERATIONS: *the milestones for baby and child to be factual with limited discussion as the time should be used to focus on the key milestones a teenager has to go through before becoming an independent adult.*

BRAIN DEVELOPMENT

BRAIN PUZZLE

Put the parents in pairs and give them the Brain Puzzle. Put a time limit on the task, then, in the large group, start a discussion about how little most parents and people in general know about a young person's brain development.

THE BRAIN EXPLAINED

Put the 'brain picture' (copied from the original FLASH Manual) on the flip chart. Put up the brain region sections one by one; each time ask the parents if they know what that regions function is then either confirm their answer or give brief explanation. Once all the sections are on the brain picture, protocols the parents towards understanding that the brain essentially matures from the back towards the front (or forehead area) – meaning that the prefrontal cortex (which controls reasoning and impulsivity) develops last (during the mid-twenties).

GROUP LEADER CONSIDERATIONS: *make sure the brain region sections are the same colour as the brain picture region sections. Put on the back of the region sections the main functions of that section as this makes it easier to remember.*

This activity is should be delivered in an interactive and collaborative style not in a formal teaching style. Draw and build from the group's knowledge ensuring that in the group discussions during this section that the key elements of the teenager brain are explained, these are:

1. The conventional view of brain development has been that most of this takes place in utero and in the first three years, with further development continuing until the brain was thought to be fully mature at around 10-12 years of age. The turbulence of adolescent behaviour has been deemed to be mostly caused by hormonal changes. However, evidence is now converging that the brain continues to grow and develop throughout the teen years and into the early twenties. Indeed, early adolescence appears to be a time of significant growth and development.

2. The vulnerability of the adolescent brain to drugs and alcohol is well-established. The picture that is now emerging is that adolescence is a time of heightened vulnerability partly because different systems are maturing according to different timetables – adolescence is a time when brain systems are out-of-sync, as it were. Adolescence is increasingly seen as a critical period for a reorganisation of regulatory systems. This reorganisation is both hazardous and also an opportunity.

3. Adolescence then is rightly seen as a time when we take our first steps on the path towards adulthood. But this cliché has a deeper meaning than we ever suspected. For one thing, an important part of brain development during adolescence concerns the pruning of unused neurons and connections, resulting in a strengthening of those connections that are most used. In other words, it's a time to lose the things we don't care about and strengthen those we do. Much of this process seems to occur in the frontal cortex, where our "higher" faculties, such as decision-making, goal-setting, and executive control, reside.

Maturation of the brain seems to occur roughly from the back to the front: the cerebellum (involved in motor skills) is the first to mature and the prefrontal cortex the last (possibly not until the mid-twenties). Poor decision-making, reckless behaviour, rule breaking, the tendency toward emotional outbursts, fewer organisational abilities, and lack of ability to process abstract concepts have all been associated with problems in pruning. The ability to multi-task continues to develop until ages 16-17. The delay in maturation of the prefrontal cortex has also been implicated in difficulties in rewarding emotional cues, which in turn has implications for teens' ability to communicate with others. In other words, we as adults may often expect too much from teenagers. We need to keep those cognitive limitations in mind, particularly when teens are confronted with demanding situations. Truly it has been said, the teenage brain is a work in progress, not a finished product.

4. When processing emotions, adults have greater activity in their frontal lobes. Adults also have lower activity in their amygdala than teens. In fact, as teens mature towards adulthood, the overall focus of brain activity seems to shift from the amygdala to the frontal lobes. The frontal lobes of the brain have been implicated in behavioural inhibition, the ability to control emotions and impulses. The frontal lobes are also thought to be where decisions about right and wrong are processed, as well as where cause-effect relationships are administered. In contrast, the amygdala is part of the limbic system of the brain and is involved in instinctive 'gut' reactions, including 'fight or flight' responses. Lower activity in the frontal lobe could lead to poor control over behaviour and emotions, while an overactive amygdala may be associated with high levels of emotional arousal and reactionary decision-making.

5. Research suggests that ADHD is present with dysfunctions in the prefrontal lobes of the brain. Young people with ADHD can experience a delay of three years in their emotional understanding of processes – this is NOT related to intelligence

ASD BRAIN

Explain to the group that autism occurs in every region of the brain, not a particular part or corner. It has several causes and plenty of forms. However, regardless of the kind it adopts, it seems to influence the complete brain. It spreads throughout the wiring and piping of the house, not just a single room (HEARING SOL 2019).

Refer back to the brain picture on the flip chart and then explain the "how does autism affect the brain facts". Using the additional coloured ASD brain labels (which match the colours of the brain picture in the FLASH manual).

HOW DOES AUTISM AFFECT THE BRAIN FACTS?

Each part of the brain uniquely reacts towards autism's impact on cognition, emotion and behaviour.

Note: Information on the brain taken from a range of sources (see reading sources in references).

ASD BRAIN LABELS

Group leaders to put up and explain the brain labels:

PLACE BRAIN LABEL 1 on the Frontal lobe section of the brain picture on the flip chart

PLACE BRAIN LABEL 2 on the Temporal lobe section of the brain picture on the flip chart

PLACE BRAIN LABEL 3 on the Temporal lobe section of the brain picture on the flip chart

PLACE BRAIN LABEL 4 on the Cerebellum section of the brain picture on the flip chart

PLACE BRAIN LABEL 5 on the Temporal lobe section of the brain picture on the flip chart

PLACE BRAIN LABEL 5 at the top of the brain picture on the flip chart

PLACE BRAIN LABEL 6 in the middle of the brain picture on the flip chart

Give the parents the Brain & Teens development (from the original FLASH manual)

HOME TASKS

Give out the home tasks Explain the tasks:

- Self-harm spectrum but ensure parents know they are not expected to feedback their scores on session two; what we want is for them to share their thoughts on doing the exercise.
- Time with young person doing something of their choice (low to no cost)
- To be kind to themselves

GROUP LEADER CONSIDERATIONS: *to ask the group to be mindful when searching online if they have young children around because age inappropriate content may appear.*

CLOSING THE SESSION

Remind the parents that it is important that they look after themselves, so they are to be kind themselves this evening, encourage them to think of something that they can do to switch off from "self-harm" and recharge themselves.
Give out the handouts.

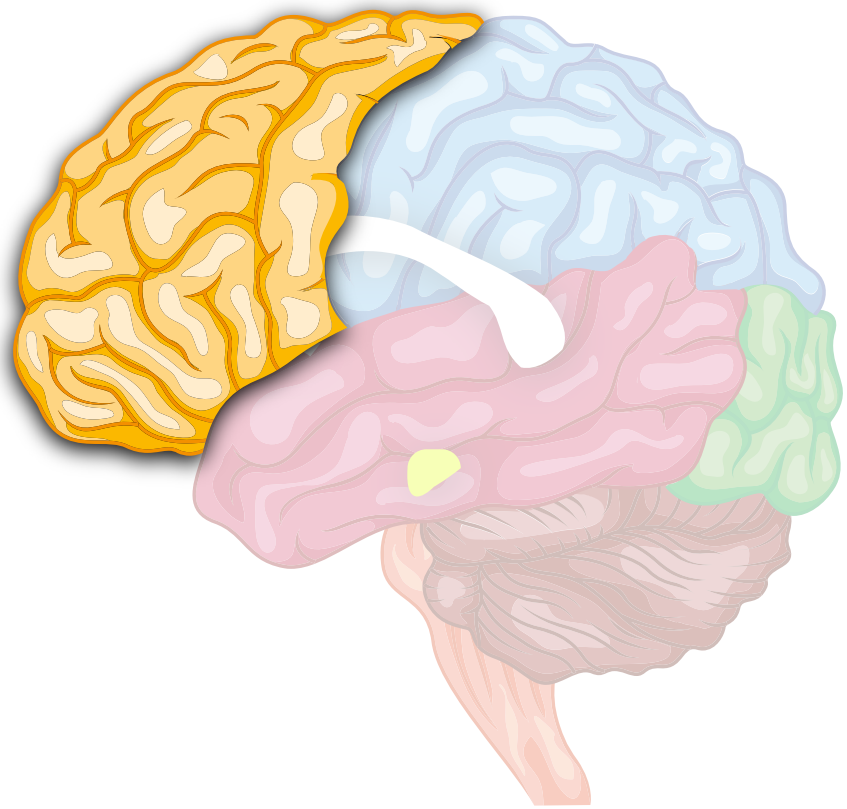
GROUP LEADER CONSIDERATIONS: *to make parents aware that group leaders are available after the evaluations have been completed if any of the parents have any questions or want to share any thoughts/concerns which the day's session may have bought up.*

EVALUATION OF THE DAY

Use the weekly evaluation from the FLASH manual.

GROUP LEADER CONSIDERATIONS: *to be aware that the parents may say they feel tried or "full up". This is normal!*

ASD BRAIN LABELS



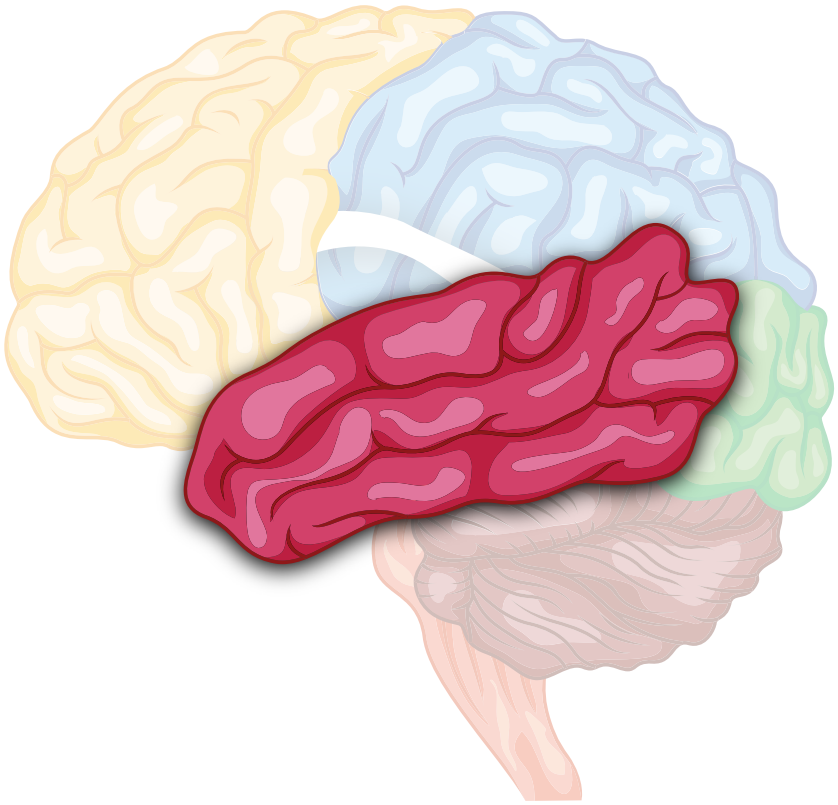
1) THE PREFRONTAL CORTEX – which is located just behind the forehead, may show some structural anomalies. A post-mortem analysis suggests that children with autism have more neurons in the prefrontal cortex than control children do. They may also contain patches of immature cells that do not show the layered organisation characteristic of the cortex.

ASD teens may process information differently. This can be all at once and be very overwhelming or underwhelming. May cause pain and can take longer to register and process.

It is often suggested that teens with ASD do not understand or recognise emotions, however, it is more they are not able to understand what the feeling is; for example, connecting that their hunger may induce their anxiety. They can also absorb and internalise other emotions, taking them personally.

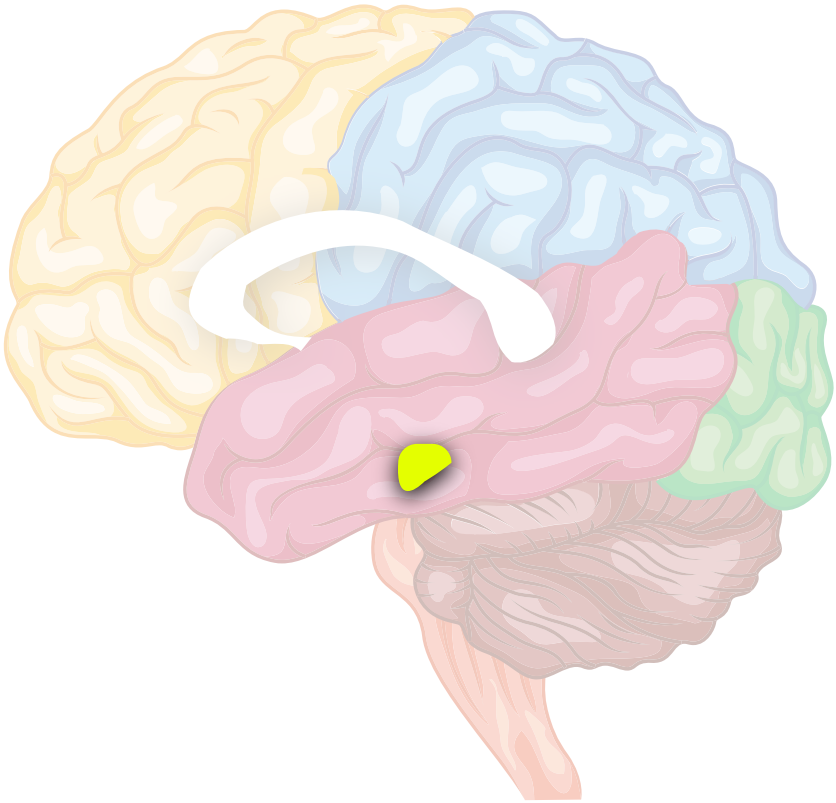
People with autism are affected by how they communicate and relate to other people. They experience difficulties reading the facial expressions of other non-autistic (neurotypical) people. In general, it appears that autistic and neurotypical faces may convey emotions very differently.

ASD BRAIN LABELS



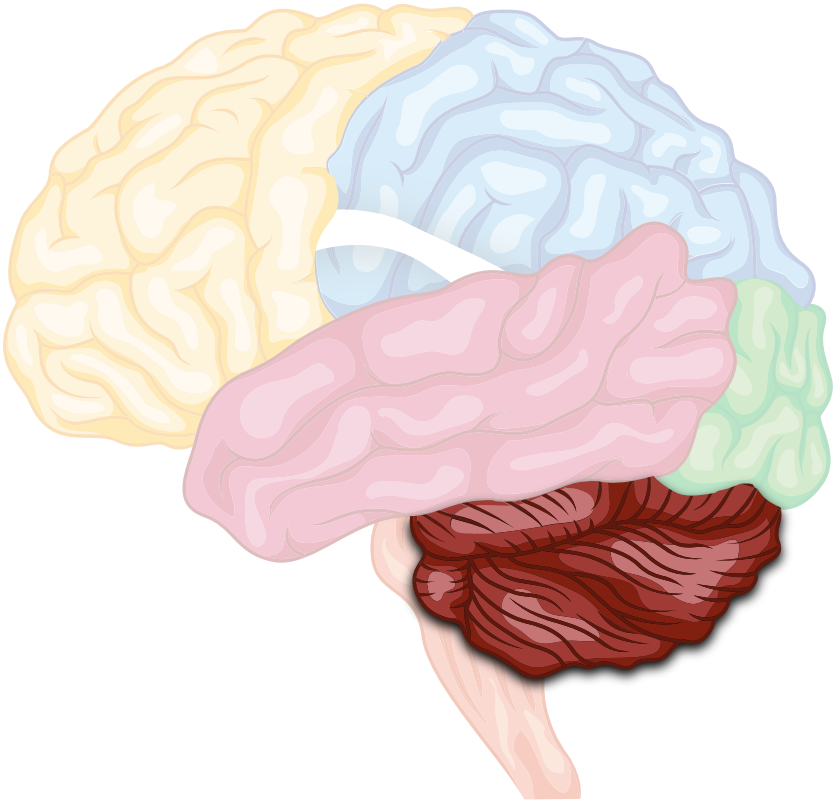
2) TEMPORAL LOBE – The temporal lobe is important for language, hearing and seeing. One part of the temporal lobe, called the fusiform gyrus, allows people to detect difference in the faces of individuals. Many studies indicate that this part of the brain has altered neurons and connections for people with autism.

ASD BRAIN LABELS



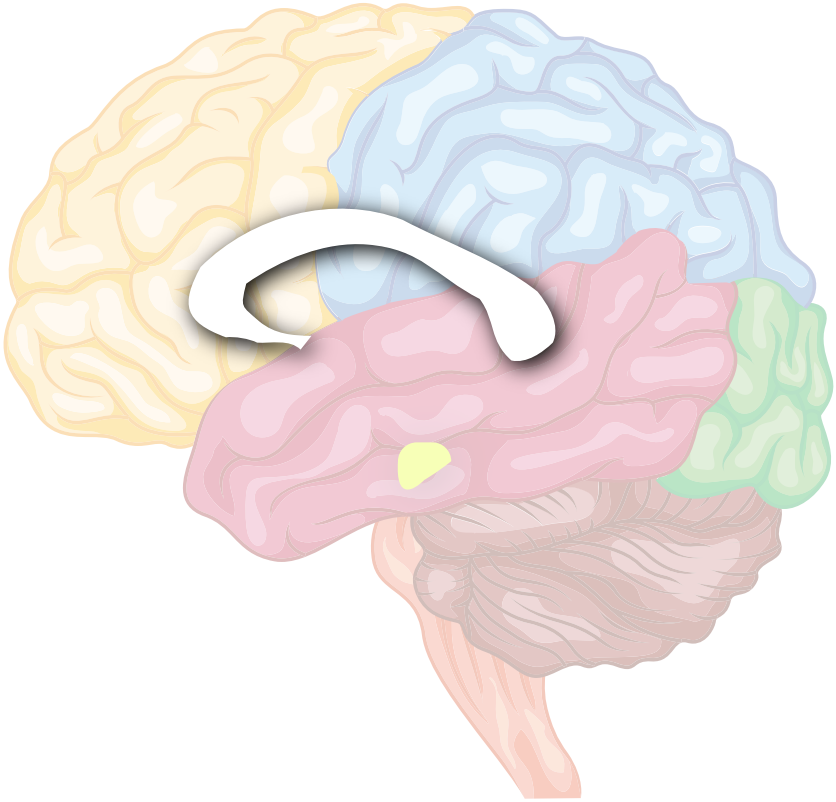
3) AMYGDALA – situated in the temporal lobe is the amygdala. The amygdala is the danger detector of the brain and may be responsible for the anxiety that is common in autism, the amygdala is often too large in young people with autism but is smaller in autistic adults.

ASD BRAIN LABELS



4) CEREBELLUM – The cerebellum has 100 billion neurons – the most of any region of the brain. These neurons control detailed movements of the body. About half of people with autism have a smaller number of a specific type of cell called Purkinje cells in the cerebellum. The malfunctioning of Purkinje cells has been associated with the reduced capacity for motor learning in children with ASD.

ASD BRAIN LABELS



5) THE CORPUS CALLOSUM – is an information superhighway that carries a large volume of neural traffic across the brain. It is a thick bundle of nerve fibres that bridges the right and left halves of the brain. It is also the brain's largest tract of white matter, the neuronal fibres that connect different brain regions.

ASD BRAIN LABELS

6) SUMMARY – In the brain nerve cells transmit important messages that regulate body functions – everything from social behaviour to movement. Imaging studies have revealed that autistic children have too many nerve fibres, but that they're not working well enough to facilitate communication between the various parts of the brain. Scientists think that all of this extra circuitry may affect brain size. Although autistic children are born with normal or smaller-than-normal brains, they undergo a period of rapid growth between ages 6 and 14 months, so that by about age four, their brains tend to be unusually large for their age. Genetic defects in brain growth factors may lead to this abnormal brain development.

Scientists also have discovered irregularities in the brain structures themselves, such as in the corpus callosum (which facilitates communication between the two hemispheres of the brain), amygdala (which affects emotion and social behaviour), and cerebellum (which is involved with motor activity, balance, and coordination). They believe these abnormalities occur during prenatal development.

In addition, scientists have noted imbalances in neurotransmitters – chemicals that help nerve cells communicate with one another. Two of the neurotransmitters that appear to be affected are serotonin (which affects emotion and behaviour) and glutamate (which plays a role in neuron activity). Together, these brain differences may account for autistic behaviours.

ASD TEEN BRAIN AND DEVELOPMENT

THE BRAIN

Autism spectrum disorder (ASD) is generally a lifelong condition, but there is currently very little understanding of how the brain changes in people with ASD as they age.

While the brain is undergoing this 'upgrade' through adolescence, the typical teen is also expected to attend school, make friendships, gain knowledge, become more independent, take on more household chores and possibly gain employment. All of which can make the teenage years a difficult transition for all teenagers.

In individuals with autism, research has found that the connections between different areas of the brain are different from typically developing individuals.

These differences in the brain have been found to affect the way social information, emotional interpretation, language, memory, attention, anxiety, obsessive thinking, repetitive behaviours, eye motion control, arousal, compulsions, motor function and sensory stimuli are interpreted and processed.

Interpreting and processing information differently may result in individuals with autism selecting an unusual or sometimes inappropriate response.

TEEN DEVELOPMENT

ASD teenagers enter puberty at the expected time. Physically, they meet the same milestones as their peers, but many specialists believe that their emotional and intellectual milestones will be at least two years behind.

Let's take the emotional development of neurotypical teenagers. They grow more concerned over appearance and understand the importance of personal hygiene, when to wash and brush their teeth for example. They can be moody and opinionated but are usually able to recognise and verbalise their thoughts and emotions.

Most teenagers will begin to emotionally move away from their parents and place increasing importance on friendships and will desire to be independent and "out of the house". Some teenagers with ASD struggle to meet these milestones at the same time. They still feel the need to be prompted by their parents in terms of when to wash and what to eat and prefer to be at home where they feel safe with their family rather than socialise with their peers.

Autism is a broad spectrum, and adolescence will affect each child differently. If recent studies are an indication, parents generally can expect some of the following along their child's road to adulthood:

Behavioural improvements across the spectrum. Adults with autism have less hyperactivity and irritability, and fewer repetitive behaviours (such as lining things up) and maladaptive (dysfunctional) behaviours, than children with autism.

Improvements in daily living skills – such as getting dressed, keeping track of cash or making a sandwich.

Of course, adolescence brings special challenges. The teen years are a risk period for the onset of seizures in autism, although most teens do not develop epilepsy.

Childhood sleep problems may persist into adolescence, when insomnia and daytime sleepiness become the biggest concerns.

Anxiety is commonplace.

It is common to see ASD teenagers become obsessed with one particular interest.

Also, the gap between the young persons with autism and their peers widens in something called "executive functioning" during the teen years.

WHAT IS EXECUTIVE FUNCTIONING?

"If you think of your brain as an orchestra, executive functioning is the conductor, making sure all the parts are working together and working properly," People use executive skills when they make plans, keep track of time, remember past experiences and relate them to the present, change course if they hit a roadblock, ask for help, maintain self-control and work successfully in a group.

Teens with autism mature at a slower pace in executive skills, according to research. They may have particular trouble with flexibility, organisation, initiating activities and working memory. "In kids with autism spectrum disorder, cognitive flexibility is the standout problem for them and seems to remain a problem as they get older."[1]

It is important that parents recognise this emotional and intellectual delay, as this will have a great impact on the ASD teenager's ability to understand.

EMOTIONAL DELAY

Accept that there is a gap in the emotional development of ASD teenagers. Do not expect them to show the same maturity as their peers. This is particularly true of subjects that require inference and analysis.

Let them know that it is okay to have their interests. Let them talk about their hobby and show enthusiasm for their knowledge in their chosen area.

Encourage them to make friends with like-minded peers. Encourage them to share their interest with others so they can develop their social skills. This will avoid them being isolated or marginalised.

ROUTINE, STRUCTURE AND MELTDOWNS

Many parents will have witnessed an autistic young person have a "meltdown" this often increases as a result of a break in routine at school. It is important that we understand how routine and structure shapes and manages the ASD teenager's day and gives them a sense of security and control at school. The repetitive sequence and order of the school day is fundamental to their stability. If their timetable goes even a little bit off schedule, the effect can be devastating.

The break in the normal routine can result in the autistic teenager feeling completely overwhelmed and can lead to a meltdown or shutdown. A meltdown can be very sudden and occasionally violent. It can result in tears, or a panic attack, or shouting and screaming. A shutdown will lead to silence and non-cooperation. Either response can be very difficult to deal with and it is advisable that teachers recognises the importance of routine and structure before it is broken.

SOCIAL ANXIETY AT SCHOOL

It is tough being a teenager, especially when your very sense of being rests on which social group you belong to at school. At secondary school everyone is thrown together in a great social boiling pot and left to "make friends". This is second nature for some, but for children with ASD it is a time of great anxiety and often the beginning of many years of misery.

There are often different social groups at school i.e., the confident and often image-conscious, the sporty types who define themselves according to the sport they play, the academically orientated and driven, and the non-conformists who break the mould in terms of appearance/opinions.

But what about the young people who do not fit into any of those groups? They are often seen alone; they eat lunch on their own and disappear to the library to be alone.

They don't establish eye contact or say hello when you walk past them. They struggle to make close and meaningful friendships and are often the last to be included in group or pair work. It is likely that these young people are in suffering with social anxiety.

Most children with ASD in mainstream secondary schools are alone because they have been repeatedly rejected from social groups, so isolate themselves in order to protect themselves. The result of this isolation is often a social anxiety so crippling that they are debilitated in any social situation.

At school they fear being judged, rejected or victimised by others, whether it be in class, or the playground. They suffer from a fear of not knowing what to expect from the social situation and a fear of getting it wrong.

Typically, this social anxiety worsens with age. Studies have shown that more than 50 per cent of older teenagers with ASD never see friends out of school, are never invited to social gatherings and are never included in social media conversations.

Some people believe that ASD teenagers don't want friends, but they do. At the very least they want to be socially accepted and feel that they can come to school without the fear of being judged or excluded.

So, what can we to help these teenagers feel less social anxiety and teach them to connect with others both in and out of the classroom?

OVERCOMING SOCIAL ANXIETY

It is even more important for the young person to establish meaningful friendships with their peers and this often entails adult intervention.

Get to know your young person's talents, motivations and aspirations – for example, gaming or animation. Find, or create an opportunity for the young person to develop their interest in a social setting. Is there a gaming or film club at the school?

On a one-to-one basis, prepare the ASD teenager by telling them what to expect before they go to the club. When and where is it held? Who else goes to the club? Is there a kind young person in the club who they could go and talk to? Ask the person who runs the club to welcome the young person.

Rehearse an initial conversation with the young person in a role-play situation. Give them top tips: How can I start a conversation? What should I say during a conversation? How do I know when it is somebody else's turn to talk? How do I know if someone wants to end a conversation?

Give the young person positive reinforcement for attending the social event and talk through any situations which were confusing or uncomfortable. Talk about friendship and how friendships work. What can I expect from a friend? How can I be a good friend to somebody?

Reference; SEND: Teenagers with autism. Written by Kristina Symons, Published: 28 September 2016

SELF – HARM AND ASD – SOME COMMON QUESTIONS/CONCERNS ON HEADBANGING

WHY DOES MY YOUNG PERSON HEAD BANG?

It's important to determine why a young person on the spectrum is engaging in hitting before you can remedy it. First, you need to make sure your young person does not have any other medical issues that would lead to him/her inflicting harm. Ear infections, stomach ailments, and other pains in the body might also be the culprit. Some people with ASD may find it hard to recognise and interpret their pain, and then communicate to others.

It's also possible that the young person uses this behaviour as a way to communicate. Anxiety and hyperactivity are two other factors to consider.

SELF-HARM DUE TO SENSORY OVERLOAD OR SENSORY DEFICIT

A young person who is under stimulated, lonely, or bored might head bang to stimulate their vestibular systems. They stimulate themselves in a way the feels good to them. Under stimulated young persons may often seek attention from head banging, even if they know they will not receive positive reinforcement.

Parents can provide a distraction from head banging. A vibrating pillow, weighted blanket, gentle touch, or a well-secured bouncing chair, yoga ball chair, or rocking chair are some examples. Providing your young person with attention including positive reinforcement, **APPROPRIATE ACTIVITIES** and options on how to spend his/her time, may help redirect a young person who is head banging.

Additionally, some young person's head banging as a part of a routine they have developed to prepare for sleep. Young people with autism often find that repetitive movements tire and soothe them. Establishing a bedtime routine with your young person that includes some form of exercise or kinaesthetic movements may help prepare him/her for sleep. Stretching, yoga poses, leg flutters or balancing on alternating legs are popular options.

PHYSIOLOGICAL REASONS FOR HEAD BANGING IN AUTISTIC YOUNG PERSON

There are also some physiological aspects of autism and self-harm. Stephen M. Edelson, PhD, has some theories regarding autism and head banging. He suggested physiological reasons young people with autism who head bang include biochemical and genetic factors. He says that research has found that neurotransmitter levels may have a link to head banging and other self-injurious behaviors.

Edelson writes, "Beta-endorphins are endogenous opiate-like substances in the brain, and self-injury may increase the production and/or the release of endorphins. As a result, the individual experiences an anesthesia-like effect and ostensibly, he/she does not feel any pain while engaging in the behavior (SANDMAN ET AL., 1983). Furthermore, the release of endorphins may provide the individual with a euphoric-like feeling.

"Nutritional and medical interventions can be implemented to normalise the person's biochemistry; this, in turn, may reduce severe behavior. Although drugs are often used to increase serotonin levels or to decrease dopamine levels, the Autism Research Institute in San Diego has received reports from thousands of parents who have given their son/daughter vitamin B6, calcium and/or DMG. These parents often observed rather dramatic reductions in, and, in some cases, elimination of self-injurious behavior. Parents have also reported reductions in severe behavior problems soon after placing their young person on a restricted diet, such as a gluten/casein-free diet, or removing specific foods to which their young person showed signs of an allergic reaction."[2]

[2] Sited by Katherine G. Hobbs online January 2020.

While Edelson admits that researchers and medical professionals have not reached a clear consensus on whether dietary or even pharmaceutical interventions can address autism and head banging, he recommends exploring these options with your young person's pediatrician.

CAN HEAD BANGING CAUSE BRAIN DAMAGE?

For parents of young person with autism, brain damage is a common concern if a young person starts head banging. Young person under three years old will rarely cause long-term damage by head banging. Their heads are designed to handle impact from learning to walk, and head banging will rarely cause more trauma than a slip and fall accident at this age. However, as young person gets older, they are at a higher risk of causing lasting damage.

Young person who are strong enough to cause injury should receive a functional behavioral intervention to come up with a plan to replace head banging with healthy coping and communication strategies.

"[Self-injurious] behaviours can be physically dangerous for the individual who is head-banging . . . and self-injurious behaviour is very concerning for their caregivers who want to keep these young person's safe. In order to implement a behavioural treatment plan for self-injurious behaviours, a functional behavioural assessment should be performed to help determine the environmental and/or internal factors that are maintaining the behaviours. This information is then used to inform behavioural interventions in order to pre-empt the causes or replace the unwanted behaviours with ones that are more acceptable."

HOW CAN I PROTECT MY YOUNG PERSON FROM SELF-HARM?

It can be terrifying to witness when a toddler hits themselves in the head, but protective measures can be taken to remedy autism and self-harm. Some young people respond well to resistance exercises including chin-ups or lifting light weights. Tracking when your young person head bangs and to what extent will help determine what level of pain, he/she might experience after the episode.

Your pediatrician should be your primary source of information on how to best help a head banging young person. He/she will be able to assess the likelihood of self-harm, help you identify why your young person head bangs, and offer solutions and alternatives.

The Cleveland Clinic recommends consulting a doctor immediately if your young person hurts him/herself, leaves bumps or bruises, or if you think that the young person is having seizures.

If you are unsure if you're young person is head banging due to a diagnosis of autism or if it is developmentally normal at this point, partner with your pediatrician. He/she can refer you to other professionals who can help.

SELF-INJURIOUS BEHAVIOR TREATMENT STRATEGIES

Treatment for self-injurious behaviour in autism can take many forms and will most likely be a process of trial and error. In-home accommodations can be made to help an overstimulated young person. Some examples are:

- Noise-canceling headphones
- Low-lit, monochromatic environment
- Favourite piece of clothing
- Playing with sensory toys

It is vital for a parent or caregiver to seek professional help to correctly resolve autism and head banging. An occupational therapist (OT) can help you and your young person learn alternatives for head banging. Many young person's find sensory therapy with an OT to be helpful. For young person with autism, head banging strategies might also include yoga and rhythmic therapy in conjunction with routine sensory input under the guidance of an OT.

By Katherine G. Hobbs is a freelance journalist and university student studying English, with an emphasis on journalism, and psychology. You can find her online at *www.katherineghobbs.com*

hand out

AUTISM & ANXIETY OFTEN OCCUR TOGETHER

COPING STRATEGIES TO REDUCE ANXIETY
Calming strategies: deep breaths (practice with bubbles), redirect thoughts when able (i.e. what is your favorite film etc.)

VISUAL SUPPORT: lists and routines/schedules with pictures
CONSISTENCY: in routines and communication
SKILLS PRACTICE: role play the appropriate behaviour and responses.

Use the first and then command i.e. first you . . . then you . . .
POSITIVE REINFORCEMENT: lots of praise
GIVE SPECIFIC AND CLEAR COMMANDS/DIRECTIONS: keep it plain and simple
SENSORY BREAKS: make them part of the routine
SENSORY ENVIRONMENT: provide a safe space with limited visual and auditory stimuli.

FLASH ASD PROTOCOLS – GROUP LEADER SESSION EVALUATION & REFLECTIONS

FLASH SESSION 2

What worked well	
What did not work so well	
What did we change	
What did we add	
What was different	
Comments	
Actions	

FLASH SESSION 3
PLAN & CHECKLIST

ITEMS REQUIRED	
Refreshments – tea, coffee etc.	
Lunch refreshments	
A3 FLASH session overview bridge picture (from original FLASH manual)	
Flip chart	
Pens	
Blue tac	
Name labels	
Attendance form	
Photos of famous people (download from website)	
Statement quiz questions and answers	
True, False and Unsure signs	
PARENT HANDOUTS: FROM FLASH MANUAL	
Evaluation forms (weekly) (from original FLASH manual)	

SESSION 3 IN DETAIL

WELCOME AND INTRODUCTION

REGISTRATION: ask parents to sign the attendance form and make a name label to wear

HOUSEKEEPING: explain fire, health and safety procedures

PRE SESSION EVALUATION FORMS: ask the parents to complete.

Explain agenda for the session.

Explain to the parents that it is important that they look after themselves. They are to be kind to themselves during and after each session, so they need to give themselves permission to have proper breaks and consider whether they need to respond to home calls and emails during break times. As their young person one will have been left with a trusted person.

FEEDBACK ON HOME TASKS

Either in two groups or in large group depending on the group size and dynamic ask the parents to feedback on their thoughts from the last session.

SELF-HARM, WHAT DO WE KNOW?

TRUE, UNSURE OR FALSE STATEMENT

GROUP LEADER CONSIDERATIONS: *Due to the possible lateral thinking of some parents we recommend that an option for the parent to go to an UNSURE sign prevents parents having a feeling of "misled" when some of the answers in the quiz are unsure.*

Put the TRUE sign up on one side of the room and on the other side the FALSE sign, in the middle of the room put up the UNSURE sign. All the parents to be standing. Explain that several statements will be read out and they need to move towards whichever sign best represents their thoughts about each statement. Explain clearly that they may have questions on the statements, but these will not be answered until after all the statements are read and acted upon. When all statements are read out, ask the group to sit down. Group leader to go through the statement list giving the answers.

GROUP LEADER CONSIDERATIONS: *option to use some of the warmup statements from the original FLASH manual. When the group leader is reading out the statements the co-group leader should observe the group's reactions. When the group leader is going through the statement answers, the co-group leader should share their reflections to encourage an interactive discussion with the group.*

POEM, PERSONAL SELF-HARM SPECTRUM, PARENTAL FEAR, GOOD ENOUGH PARENT AND PROTECTIVE FACTORS – as in the FLASH manual.

CLOSING THE SESSION

Remind the parents that it is important that they look after themselves, so they are to be kind themselves this evening, encourage them to think of something that they can do to switch off from "self-harm" and recharge themselves.
Give out the handouts (from FLASH manual).

GROUP LEADER CONSIDERATIONS: *to make parents aware that group leaders are available after the evaluations have been completed if any of the parents have any questions or want to share any thoughts/concerns which the day's session may have bought up.*

EVALUATION OF THE DAY

Use the weekly form from the FLASH manual

GROUP LEADER CONSIDERATIONS: *to be aware that the parents may say they feel tried or "full up". This is normal!*

	STATEMENTS	STATEMENT ANSWERS
1	A young person taking 10 victim tablets has no intent to die	FALSE. The amount has no relation to the intent.
2	Self-harming is attention seeking behaviour.	FALSE. Self-harm is a way of expressing very deep distress.
3	Young people who self-harm want to commit suicide.	UNSURE. People often think that self-harm is closely linked to suicide however, the vast majority of people who self-harm are not trying to kill themselves. It is their way of coping with difficult feeling and circumstances. It is estimated that for everyone young person who has committed suicide, there are between 40 and 100 who have self-harmed. This supports the view that self-harm in most cases does not lead to suicide. However, adults/parents need to be mindful that that those who have self-harmed are 100 times more likely than the general population to die by suicide in the following year. The risk increases for those who self-harm repeatedly.
4	About 1 in 10 young people will self-harm.	UNSURE. It is true that studies suggest about 1 in 10 young people will self-harm, but it is difficult to provide accurate numbers on how widespread self-harm is among young people. This is because definitions of self-harm vary, so cases may be reported differently, but also because many cases of self-harm probably go unreported.
5	Self –harm is addictive	FALSE. However, young people who self-harm may discover that inflicting pain changes their mood, which then may become habit-forming. Cutting, for example, releases endorphins, which produce brief feelings of calm, and serotonin, which is mood-lifting.
6	Having a friend who self-harms or been part of some youth sub-cultures groups (emo, goth, punk) will increase chances of the young person doing it as well.	TRUE. It is held that self-harm is more common in some youth sub-cultures. This could be explained by young people emulating cultural icons or peers who self-harm. Alternatively, it could be explained by selection, in which young people with a particular propensity to self-harm are attracted to the subculture.
7	The more serious the injury, the more serious the problem.	FALSE. The nature and severity of the self-harm does not reflect the nature or severity of the problem.
8	Recent statistics show that young men who self-harm now outnumber young women.	FALSE. It is more common in young women than young men. However, it is important to note that males may engage in different forms of self-harm that could be easier to conceal, potentially accounting for the degree of apparent difference between genders.

9	Self-harm is due to the impact the Internet has on young people.	FALSE. Self-harm has been kicking around much longer than the Internet. People have struggled to express how they feel or come to terms with difficulties since the dawn of time, not just post-www. There are, however, unregulated websites and mainstream forums that permit that stuff to happen. Those sites fuel self-harm and make it harder for those affected to enter recovery. They create a community where people feel they belong, but the underlying message isn't one of recovery, but one of just accepting that self-harm is as good as life is going to get – THAT is the damaging message. THAT is what makes a website cross the line from helpful to dangerous.
10	Self-harm is more widespread today than 30 / 40 years ago.	UNSURE. Reports indicate that the number of young people disclosing self-harm has risen steadily since the mid-1990s, although heightened awareness of the issue by both young people and professionals may be responsible for some of the increase.
11	A young person taking 30 Paracetamol clearly has intent to die.	FALSE. As in Q1 the amount has no relation to the intent.
12	Self-harm is mainly done by young people (12-18 years).	FALSE. People of all ages self-harm. It becomes more common after the age of 16 but is still prevalent among teenagers.
13	If you have a young person that self-harms them, you should lock away all potentially harmful substances and the potential cutting instruments.	TRUE. In environments in which a young person is not supervised all medicines and potentially harmful substances should be locked away. Knives, razors and other potential cutting instruments should be removed or kept in a place where adults can monitor their use.
14	Young people who self – harm have mental health problems.	FALSE. Self –harm in itself is not a diagnosis. It is not a mental disorder; it is an emotional difficulty. So, they may be distressed but may not reach the criteria for a mental health diagnosis. Some people who have a diagnosed mental health condition may have associated self-harming behaviours as part of the diagnosis. Studies have shown there is a high prevalence of self-harm was found among children suffering from depression, conduct disorder and anxiety disorder. However, for the vast majority of young people who self-harm, it is an expression of difficult or unbearable emotions.
15	Self-harm is often an attempt to draw attention to underlying distress/crisis.	TRUE. As in Q2, self-harm is a way of expressing very deep distress
16	A young person with ASD who self-harming is just being naughty	FALSE. The self-harm is a response to a form of distress
17	If my young person with ASD self-harms does this mean they want to be dead?	UNSURE. This is dependent on the young person's concept and understanding of death. I.e. do they understand that death is irreversible. It is often a sign that they want the situation/feeling to end.

Answer soured from the following websites: www.selfharm.co.uk www.samaritans.org www.nice.org.uk
www.mentalhealth.org.uk/publications/truth-about-self-harm www.ncbi.nlm.nih.gov/books/NBK56385/

FLASH ASD PROTOCOLS – GROUP LEADER SESSION EVALUATION & REFLECTIONS

FLASH SESSION 3

What worked well	
What did not work so well	
What did we change	
What did we add	
What was different	
Comments	
Actions	

FLASH SESSION 4
PLAN & CHECKLIST

ITEMS REQUIRED	
Refreshments – tea, coffee etc.	
A3 FLASH session overview bridge picture (from original FLASH manual)	
Flip chart	
Pens	
Blue tac	
Name labels	
Attendance form	
Photos of famous people (download from website)	
Jam donuts	
Wet wipes,	
Napkins	
Paper plates	
A/B listening cards (from original FLASH manual)	
PARENT HANDOUTS:	
Listening test 1 handout Coping tips and distractions – (from original FLASH manual) A-Z list of distractionss – (from original FLASH manual) Listening tips (from original FLASH manual) I-Statements cards (from original FLASH manual) Home task handout	
Evaluation form	

SESSION 4 IN DETAIL

WELCOME AND INTRODUCTION

REGISTRATION: ask parents to sign the attendance form and make a name label and wear it.

Reminder of housekeeping and group manners or group agreement.

Explain agenda for the session.

Explain to the parents that it is important that they look after themselves so they should be kind to themselves during and after the session; so they need to give themselves permission to have proper breaks and avoid responding to home calls and emails during break times. As with last week they will have left their young person with a responsible adult who cares for them.

WARM UP (optional)

PICTURES OF FAMOUS PEOPLE WHO SELF-HARM (if not done in previous sessions) ask each parent to pick up a picture, then all to take turns showing their picture and reading the information on back of card. Open discussion… do we always see the true picture? We can only empathise and learn from each other.

GROUP LEADER CONSIDERATIONS: *the pictures are of famous people in general and not famous people with ASD.*

OR "WHERE WOULD YOU BE TODAY". Ask each parent to share if they could be anywhere in the world where would they be, this acts as a good assessment as to the parent's energy and mood level.

FEEDBACK ON HOME TASKS

Either in two groups or in large group depending on the group size and dynamic ask the parents to feedback on their thoughts from the last session.

HOW ARE WE FEELING ICEBERG – (if not done in past session)

LISTENING TEST 1

Group leader to ask the group to listen to nine questions. Parents to write down the answers to each question. Explain that you will only repeat the question once and no further information on the question will be given.

After the nine questions have been given, group leader to give the answers.

Open discussion on if we really listen or do, we tune into the words/phases that we feel more comfortable with?

LISTENING IN PAIRS test – follow as in original FLASH manual
Group discussion on how to listen to teenagers – list of flip chart any top tips.

LEGO GAME – To follow the original FLASH manual format for this exercise.
Group discussion on the barriers of poor communication and third hand information.

GROUP LEADER CONSIDERATIONS: *to highlight the importance of agreed language.*

DONUTS

To follow the original FLASH manual format for this exercise.

Group discussion on the barriers of communication due to the parent's desire to know if the young person has self-harmed (are they safe) and the young person's impulse to self-harm.

Group brainstorm on ways parents/carer and young people could communicate whether they have self-harmed or not and/or their mood level without the parent/carer asking the question.

GROUP LEADER CONSIDERATIONS: *to be aware that parents may be concerned that: Asking about self-harm will lower the young person's mood.*

If the young person is in a good mood, asking the question will spoil it

- They will say the wrong thing and make it worse
- They don't want to hear the answer if it is negative, parent emotionally unable
- They will not believe what the young person says.

GROUP LEADER CONSIDERATIONS: *if a parent in the group for either medical or reasons of general discomfort does not wish to take part in the exercise then they become the third person in the pair where they can become an observer and then they can feed back on what it was like to observe the task and activity.*

Give out the Coping tips and distractions and A-Z list handout of distractions explaining the distractions need to link to what the person wants to feel.

HOW CAN WE SUPPORT THOSE WITH ASD/ADHD ADDITIONAL NEEDS TO TALK AND LISTEN?

Open group discussion, ideas to go on the flip chart. Group leader to ensure the following points are explored in the discussion.

Enable and enhance their ability to communicate – whether that's through using specific forms of communication (Picture Exchange Communication System (PECS), sign language, writing, and singing), have fun finding out the best ways to communicate together.

Find out what environment suits them best – somewhere with lots going on, somewhere quiet, group work or 1:1 chat, coffee shops or at home?

Gestures and facial expressions to be exaggerated. Ask the parents to think about what their "neutral face looks like" can you hold your neutral face. In pairs show each other their neutral facial expression. Open discussion on do the young person understand the facial gestures and what parents can do to increase listening and communication i.e. tone of voice, using young person's name.

Give out Listening tips handout.

I-STATEMENTS

Group leader to state to the group, "is it doable or reasonable for us (parents/carers) to do responsive listening with their young person?"

A helpful tool is I-statements sometimes known as "personal statements".

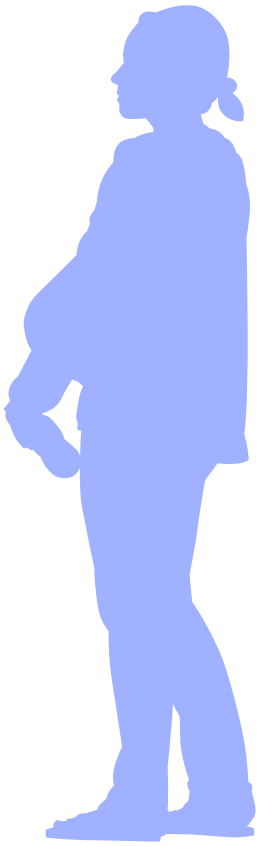
Explain the I-Statement.

Give out I-statement cards.

Have a group practice: group leader should explain that we are going to practice I statements as a group. Each person will take one part of the statement, dependant on where they are sat and what follows next . . . The first parent will start the I – statement "I feel . . . " (they say a feeling) the next parent responds with "when . . ." (they give an example).

The third parent says "because…" (they give an example) and the fourth parent says, "I would like…" (and gives an example). This continues around the assembled group; thus, the next parent will begin with "I feel" and so on; this is repeated so all the parents have had a go.

GROUP LEADER CONSIDERATIONS: *Parents often use the word "you" after the when word – this can change the I statement into an attack, or "you" statement ; it's helpful if you work together as a group to manage this and find a way around when you i.e.: when you swear can become when I am sworn at . . .*



CLOSING THE SESSION

Remind the parents that it is important that they look after themselves, so they are to be kind themselves this evening, encourage them to think of something that they can do to switch off from "self-harm" and recharge themselves.

Give out the handouts (from FLASH manual).

GROUP LEADER CONSIDERATIONS: *to make parents aware that group leaders are available after the evaluations have been completed if any of the parents have any questions or want to share any thoughts/concerns which the day's session may have bought up.*

EVALUATION OF THE SESSION

Use the weekly form from the FLASH manual.

GROUP LEADER CONSIDERATIONS: *to be aware that the parents may say they feel tried or "full up". This is normal!*

GROUP LEADER CONSIDERATIONS: *Group members often suggest that car journeys are often good times to talk with young person with ASD as they do not have to make eye contact. Caution the group that if they are discussing self-harm the emotional nature of the topic may affect the driver's concentration so it may be more appropriate to do another activity i.e., going for a walk. Highlight the emphasis creating an environment to talk. Often the more formal "let's sit down and have a chat" can make the young person feel pressured. Talking may happen more naturally around an activity.*

LISTENING SKILLS TEST 1

QUESTION	ANSWER
How many animals did Moses take on to the ark?	Moses didn't take animals on to the ark, it was Noah.
If a plane crashed on the borders of France and Spain, where would the survivors be buried?	You don't bury survivors
What country has a 4th of July, Britain or USA?	Both have 4th of July
Some months have 31 days, some have 30 days but how many have 28 days?	All months have 28 days
If you were alone in a deserted house at night and had a lamp, a fire and a candle and only had one match, which would you light first?	None of the three, you would light the match first.
As I left the Hilton Hotel 2 German tourists, 5 Japanese tourists and 3 Swedish tourists were entering, how many people in total left the hotel?	ONE – YOU
You drive a coach 2 miles with 3 passengers, at the first stop 1 passenger gets off and 5 get on. At the second stop three people get off and no one gets on. What is the name of the bus driver?	YOUR NAME
If it takes eight men ten hours to build a wall, how long would it take four men?	No time, because the wall is already built
If Mrs. John's bungalow is decorated completely in pink, with the walls, carpet, and furniture all shades of pink, what color are the stairs?	No stairs – she lives in a bungalow

FLASH SESSION 5
PLAN & CHECKLIST

ITEMS REQUIRED	
Refreshments – tea, coffee etc.	
A3 FLASH session overview bridge picture (from original FLASH manual)	
Flip chart	
Pens	
Blue tac	
Name labels	
Attendance form	
PARENT HANDOUTS: (FROM FLASH MANUAL)	
Evaluation form	

SESSION 5 IN DETAIL

WELCOME AND INTRODUCTION

REGISTRATION: ask parents to sign the attendance form and make a name label and wear it.

Reminder of housekeeping and group manners or group agreement.

Explain agenda for the session.

Explain to the parents that it is important that they look after themselves so they should be kind to themselves during and after the session; so they need to give themselves permission to have proper breaks and avoid responding to home calls and emails during break times. As with last week they will have left their young person with a responsible adult who cares for them.

Feedback on home tasks

Either in two groups or in large group depending on the group size and dynamic ask the parents to feedback on their thoughts from the last session.

PRAISE

Ask the parents to go into pairs. In the pairs ask them to turn to the other person and give them a genuine praise and then ask how it felt, etc. Open discussion about how uncomfortable praise can be and how we model rejecting praise e.g. your hair looks nice . . . oh I just washed it this morning!

Ask the group how this felt and then have a short discussion on how this may feel for their young people. List the barriers to self-esteem for young people today i.e. social media.

Explain how detailing praise will give the praise more meaning and have a greater effect. Role-Play the "detailed praise effect" (from the original FLASH manual). Lead into the importance of not taking away praise.

GROUP LEADER CONSIDERATIONS: *Highlight how difficult it may be for a young person to hear the praise if their self-esteem is very low; therefore, praise needs to be genuine, often and personal. For that reason, the wording and timing of the praise is very important, i.e. don't leave it too long and don't deliver it in front of others. Also, the use of non-verbal praise can be effective e.g. cards, notelets, small rewards, texts, e-mail, personal gestures, etc.*

Ask the parents to go back into pairs. In the pairs turn to the other person and allow the other person to share a genuine self-praise statement about themselves, then ask how it felt, etc. Open discussion about how uncomfortable it is to self-praise. Highlight the importance of modelling self-praise.

SELF-PRAISE – as from the FLASH manual

OPTIONAL – The Extra session
There is the option to shorten the praise session and add in some of the information on sensory processing to this session.

CLOSING THE SESSION

Group leader considerations: to make parents aware that group leaders are available after the evaluations have been completed if any of the parents have any questions or want to share any thoughts/concerns which the day may have bought up.

ENDING

Use the weekly evaluation form from the FLASH manual.

GROUP LEADER CONSIDERATIONS: *Highlight to group to be caution around just praising beauty and academic achievement. Instead focus on the effort rather than a quality that the young person cannot have control over.*

FLASH ASD PROTOCOLS – GROUP LEADER SESSION EVALUATION & REFLECTIONS

FLASH SESSION 5

What worked well	
What did not work so well	
What did we change	
What did we add	
What was different	
Comments	
Actions	

EXTRA SESSION SENSORY
PLAN & CHECKLIST

ITEMS REQUIRED	
Refreshments – tea, coffee etc.	
A3 FLASH session overview bridge picture (from original FLASH manual)	
Flip chart	
Pens	
Blue tac	
Name labels	
Attendance form	
Sensory body labels	
Large paper or wallpaper	
Heavy duty tape	
PARENT HANDOUTS:	
What Interoception Is handout The body sensory handout 8 Senses handout Proprioceptive activates handout	
Evaluation form	

EXTRA SESSION IN DETAIL SENSORY

WELCOME AND INTRODUCTION

REGISTRATION: ask parents to sign the attendance form and make a name label and wear it.

Reminder of housekeeping and group manners or group agreement.

Explain agenda for the session.

Explain to the parents that it is important that they look after themselves so they should be kind to themselves during and after the session; so they need to give themselves permission to have proper breaks and avoid responding to home calls and emails during break times. As with last week they will have left their young person with a responsible adult who cares for them.

FEEDBACK ON HOME TASKS

Either in two groups or in large group depending on the group size and dynamic ask the parents to feedback on their thoughts from the last session.

HOW OUR SENSES ARE AFFECTED

GROUP LEADER CONSIDERATIONS: *this activity is depending on the knowledge level of the parents. If the parents have late diagnosis of their young person (especially if they have daughters) they may have limited knowledge about sensory processing. The parents' responses from the "Factors" activity on session 1 will give group leader's guidance if more in-depth discussion/learning on sensory processing is required. Group leaders to be aware that if they do this activity, they may not complete the self-esteem activity in session 2 and therefore part of this session can be carried over to Session 3.*

If the parents have a good understanding of sensory processing, then group leaders can go straight to the sensory processing overload activity.

PRESTART OF THE ACTIVITY:

OPTION 1) Attach large paper or two lengths of wallpaper together with heavy duty tape to make the paper large enough to draw about a full-size adult. Lay the paper on the floor and draw around one of the group leaders.

OPTION 2) Draw a body on the flip chart.

Group leader to explain to the parents that young people with ASD typically have difficulty processing sensory information such as sounds, sights, and smells. This is usually referred to as having issues with "sensory integration" or having "sensory sensitivity". This is caused by differences in how the brain of a person with ASD understands and prioritises the sensory information picked up by the body's many sensory receptors. When this breakdown in communication becomes too intense, the person with ASD may become overwhelmed, anxious or even feel physical pain. When this occurs some with ASD may act out.

The over and under-sensitivity ASD people experience may affect some or all of the following eight senses:

- Sight(visual)
- Sound (auditory)
- Touch (tactile)
- Taste (gustatory)
- Smell (olfactory)
- Balance (vestibular)
- Body awareness ('proprioception')
- Interception.

Talk through how senses are affected using the body outline as a visual.

If using the large paper/wallpaper body: During the discussion encourage the parents to write and draw on the "body" how their young people are affected by their sensory issues.

If using a body drawn on flip chart: During the discussion encourage the group leader to write the words the parents used in describing how their young people are affected by their sensory issues.

Group leader to ensure the sensory body labels are either put on the paper body/flip chart body or commented on.

GROUP LEADER CONSIDERATIONS: *Most people are aware of touch, hearing, sight, taste, smell as senses but are less aware of balance ('vestibular') interception and body awareness ('proprioception') as part of our sensory system. Group leaders may need to expand on these areas in more detail.*

THE VESTIBULAR SENSE contributes to our ability to maintain balance and body posture. The major sensory organs (utricle, saccule, and the three semi-circular canals) of this system are located next to the cochlea in the inner ear. The vestibular organs are fluid-filled and have hair cells, similar to the ones found in the auditory system, which respond to movement of the head and gravitational forces. When these hair cells are stimulated, they send signals to the brain via the vestibular nerve. Although we may not be consciously aware of our vestibular system's sensory information under normal circumstances, its importance is apparent when we experience motion sickness and/or dizziness related to infections of the inner ear.

In addition to maintaining balance, the vestibular system collects information critical for controlling movement and the reflexes that move various parts of our bodies to compensate for changes in body position. Therefore, both proprioception (perception of body position) and kinaesthesia (perception of the body's movement through space) interact with information provided by the vestibular system.

These sensory systems also gather information from receptors that respond to stretch and tension in muscles, joints, skin, and tendons. Proprioceptive and kinaesthetic information travels to the brain via the spinal column. Several cortical regions in addition to the cerebellum receive information from and send information to the sensory organs of the proprioceptive and kinaesthetic systems.

PROPRIOCEPTION: this is the sense of the position of parts of the body, relative to other neighbouring parts of the body. Focuses on the body's cognitive awareness of movement for example, you step off a curb and know where to put your foot. You push an elevator button and control how hard you have to press down with your fingers.

KINAESTHESIA: this is awareness of the position and movement of the parts of the body using sensory organs in joints and muscles. Kinaesthesia is a key component in muscle memory and hand-eye coordination. It is more behavioural than proprioception. For example, you are aware of your arm movement while swinging a golf club. Focuses on the body's movements and not on the balance.

INTERCEPTION: is a lesser-known sense that helps you understand and feel what's going on inside your body. Interception is a similar concept to proprioception. Just as there are receptors in your muscles and joints, there are also receptors inside your organs, including your skin. These receptors send information about the inside of your body to your brain. This helps regulate our vital functions like body temperature, hunger, thirst, digestion and heart rate. Interception helps you understand and feel what's going on inside your body. For instance, you know if your heart is beating fast or if you need to breathe more deeply. You're able to tell if you need to use the bathroom. You know if you're hungry, full, hot, cold, thirsty, nauseated, itchy or ticklish. For young people with sensory processing issues, the brain may have trouble making sense of that information. They may not be able to tell when they're feeling pain or when their bladder is full. An itch may feel like pain or pain may feel ticklish.

Young people who struggle with the interoceptive sense can also have trouble "feeling" their emotions. They may not be as tuned in to the body cues that help interpret emotion. Without being able to feel and interpret those body sensations, it's harder to clearly identify the emotion. For instance, a child may not "feel" fear because he doesn't recognise that his muscles are tense, his breathing is shallow, and his heart is racing.

Having trouble with this sense can also make self-regulation a challenge.

Give the parents the 8 Senses handout and the 'What Interoception is' handout.

SENSORY PROCESSING OVERLOAD

Explain that the messages from different parts of our brain give messages to our bodies and back, it's a bit like the brain is the central computer that controls all the body's functions. The rest of the nervous system is like a network that relays messages back and forth from the brain to different parts of the body. It does this via the spinal cord, which runs from the brain down through the back. It contains threadlike nerves that branch out to every organ and body part.

Draw on the flipchart the outline of the brain with lines from different parts of our brain going through the brain steam and back.

Explain that when a message comes into the brain from anywhere in the body, the brain tells the body how to react. For example, if you touch a hot stove, the nerves in your skin shoot a message of pain to your brain. The brain then sends a message back telling the muscles in your hand to pull away. Luckily, this neurological relay race happens in an instant.

With young people with ASD who have sensory processing difficulties it is like there is a messaging "traffic jam" in the brain, (draw circles around the brain stem to visualise the traffic jam). This mayhappen when the young person is having difficulty responding appropriately to sensory input which can result in the young person having a sensory overload. Have a discussion on how their young people's sensory issues may increase a young person with ADHD/ASD and or LD risk of self-harming.

At least 1 in 20 children have sensory processing difficulties, it is not currently a medical diagnosis (OXFORD HEALTH 2014).

Refer back to the sensory body either on the large/wallpaper or on the flip chart and ask the parents for strategies they use to help their young person manage their sensory "overload" i.e. use earphones, distraction with music. Either write up the strategies on the paper or for the group leaders/ parents to write the strategies on postie notes and place on the body paper/wallpaper or flipchart body.

Group leader to explain to the parents that if appropriate to their young person proprioception strategies can be used to help with "needed feedback" rather than self-harm.

Give out the Proprioceptive Activates handout.

Optional: "The Spoon Theory" handout.

GROUP LEADER CONSIDERATIONS: *the parents may refer to Sensory overload and/or Sensory Hangovers. A sensory overload/hangover is a term to describe the state in which a young person with ASD may left in after being in an overwhelming place, environment, scenario, etc. It can leave the young person emotional and feel totally overwhelmed and stressed out. It has been described as "burn-out" "empty-battery" "frayed-wires sensation. It's like being hungover. The feeling of a sensory hangover may start immediately after an overwhelming thing and can last from a few minutes to even a few days.*

CLOSING THE SESSION

GROUP LEADER CONSIDERATIONS: *to make parents aware that group leaders are available after the evaluations have been completed if any of the parents have any questions or want to share any thoughts/concerns which the day may have bought up.*

ENDING

Use the weekly evaluation form from the FLASH manual.

SENSORY BODY LABELS – SOUND

SOUND: UNDER-SENSITIVE

- May only hear sounds in one ear, the other ear having only partial hearing or none at all.
- May not acknowledge particular sounds.
- Might enjoy crowded, noisy places or bang doors and objects.
- You could help by using visual supports to back up verbal information and ensure that other people are aware of the under-sensitivity so that they can communicate effectively. You could ensure that the experiences they enjoy are included in their daily timetable, to ensure this sensory need is met.

SOUND: OVER-SENSITIVE

- Noise can be magnified, and sounds become distorted and muddled.
- May be able to hear conversations in the distance.
- Inability to cut out sounds – notably background noise, leading to difficulties concentrating.

SOUND: YOU COULD HELP BY:

- shutting doors and windows to reduce external sounds
- preparing the person before going to noisy or crowded places
- providing ear plugs and music to listen to
- creating a screened workstation in the classroom or office, positioning the person away from doors and windows.

SOUND: SYNAESTHESIA

- Synaesthesia is a rare condition experienced by some people on the autism spectrum. An experience goes in through one sensory system and out through another. So, a person might hear a sound but experience it as a colour. In other words, they will 'hear' the colour blue.

SENSORY BODY LABELS – BALANCE (VESTIBULAR)

BALANCE: UNDER-SENSITIVE

- A need to rock, swing or spin to get some sensory input.
- You could encourage activities that help to develop the vestibular system. This could include using rocking horses, swings, roundabouts, seesaws, catching a ball or practising walking smoothly up steps or curbs.

BALANCE: OVER-SENSITIVE

- Difficulties with activities like sport, where we need to control our movements.
- Difficulties stopping quickly or during an activity.
- Car sickness.
- Difficulties with activities where the head is not upright, or feet are off the ground.
- You could help by breaking down activities into small, more easily manageable steps and using visual cues such as a finish line.

SENSORY BODY LABELS – BODY AWARENESS (PROPRIOCEPTION)

Our body awareness system tells us where our bodies are in space, and how different body parts are moving.

BODY AWARENESS: UNDER-SENSITIVE

- Stands too close to others, because they cannot measure their proximity to other people and judge personal space.
- Find it hard to navigate rooms and avoid obstructions.
- May bump into people.

BODY AWARENESS: YOU COULD HELP BY:

- positioning furniture around the edge of a room to make navigation easier
- using weighted blankets to provide deep pressure
- putting coloured tape on the floor to indicate boundaries
- using the 'arm's-length rule' to judge personal space - this means standing an arm's length away from other people.

BODY AWARENESS: OVER-SENSITIVE

- Difficulties with fine motor skills, e.g. manipulating small objects like buttons or shoelaces.
- Moves whole body to look at something.
- You could help by offering 'fine motor' activities like lacing boards.

SENSORY BODY LABELS – SIGHT

SIGHT: UNDER-SENSITIVE

- Objects appear quite dark or lose some of their features.
- Central vision is blurred but peripheral vision quite sharp.
- A central object is magnified but things on the periphery are blurred.
- Poor depth perception, problems with throwing and catching, clumsiness. Ways you might help include the use of visual supports or coloured lenses, although there is only very limited research evidence for such lenses.

SIGHT: OVER-SENSITIVE

- Distorted vision - objects and bright lights can appear to jump around.
- Images may fragment.
- Easier and more pleasurable to focus on a detail rather than the whole object.
- Has difficulty getting to sleep as sensitive to the light.
- You could make changes to the environment such reducing fluorescent lighting, providing sunglasses, using blackout curtains, a space or desk with high walls or divides on both sides to block out visual distractions, using blackout curtains.

SENSORY BODY LABELS – SMELL

SMELL: UNDER-SENSITIVE

- Some people have no sense of smell and fail to notice extreme odours (this can include their own body odour).
- Some people may lick things to get a better sense of what they are.
- You could help by creating a routine around regular washing and using strong-smelling products to distract people from inappropriate strong-smelling stimuli (like faeces).

SMELL: OVER-SENSITIVE

- Smells can be intense and overpowering. This can cause toileting problems.
- Dislikes people with distinctive perfumes, shampoos, etc.
- You could help by using unscented detergents or shampoos, avoiding wearing perfume, and making the environment as fragrance-free as possible.

SENSORY BODY LABELS – TASTE

TASTE: UNDER-SENSITIVE

- Likes very spicy foods.
- Eats or mouths non-edible items such as stones, dirt, soil, grass, metal, faeces. This is known as pica.

TASTE: OVER-SENSITIVE

- Finds some flavours and foods too strong and overpowering because of very sensitive taste buds. Has a restricted diet.
- Certain textures cause discomfort - may only eat smooth foods like mashed potatoes or ice-cream.
- Some autistic people may limit themselves to bland foods or crave very strong-tasting food. If someone has some dietary variety, this isn't necessarily a problem. Find out more about over-eating and restricted diets.

SENSORY BODY LABELS – TOUCH

TOUCH: UNDER-SENSITIVE

- Holds others tightly - needs to do so before there is a sensation of having applied any pressure.
- Has a high pain threshold.
- May be unable to feel food in the mouth.
- May self-harm.
- Enjoys heavy objects (e.g. weighted blankets) on top of them.
- Chews on everything, including clothing and inedible objects.
- You could help by:
- For chewing, offering latex-free tubes, straws or hard sweets (chill in the fridge).

TOUCH: OVER-SENSITIVE

- Touch can be painful and uncomfortable - people may not like to be touched and this can affect their relationships with others.
- Dislikes having anything on hands or feet.
- Difficulties brushing and washing hair because head is sensitive.
- May find many food textures uncomfortable.
- Only tolerates certain types of clothing or textures.
- You could help by:
- Warning the person if you are about to touch them and always approach them from the front and remember that a hug may be painful rather than comforting.
- Changing the texture of food (e.g. purée it). Slowly introducing different textures around the person's mouth, such as a flannel, a toothbrush and some different foods.
- Gradually introducing different textures to touch, e.g. have a box of materials available.
- Allow a person to complete activities themselves (e.g. hair brushing and washing) so that they can do what is comfortable for them. Turning clothes inside out so there is no seam, removing any tags or labels.
  Allow the person to wear clothes they're comfortable in.

SENSORY BODY LABELS – (INTEROCEPTION)

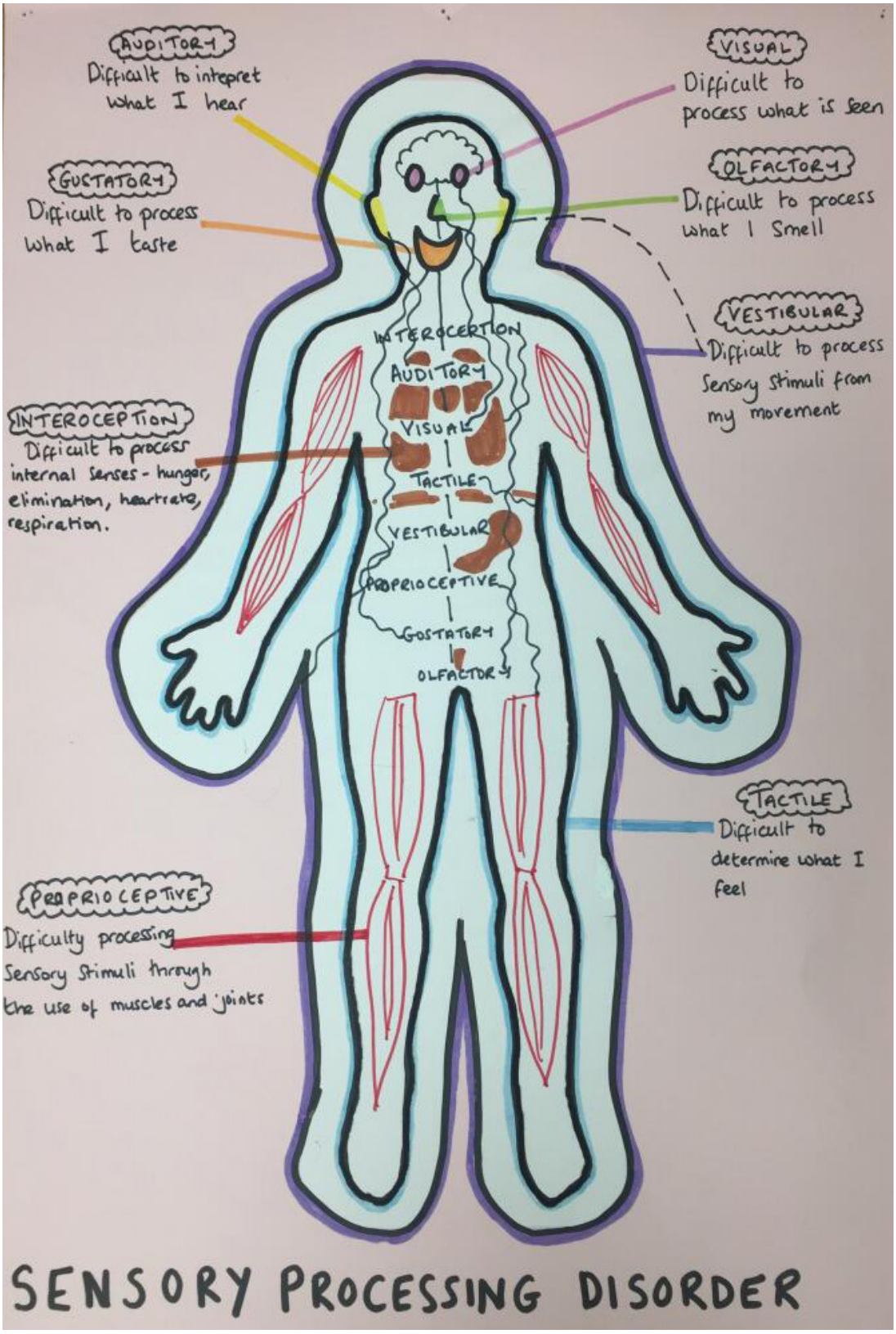
INTEROCEPTION

Is a lesser-known sense that helps you understand and feel what's going on inside your body.

Young people who struggle with the interoceptive sense may have trouble knowing when they feel hungry, full, hot, cold or thirsty.

Having trouble with this sense can also make self-regulation a challenge.

handout



The sensory body handout by Kayly Elmer, Market Field School, Essex

handout

THE SENSORY SYSTEM

The sensory system is basically comprised of the brain, spinal cord, and neurons. It is the neurological wiring by which we perceive and process sensory information coming from outside and even inside our bodies.

All the systems working together provide you with the "optimal level of arousal" which means you are able to perceive, process, and react to sensory stimuli and information in a timely manner.

When a person or child has a sensory overload or low arousal, this is often referred to as sensory processing difficulties or sensory processing disorder, once diagnosed by a doctor. It basically means that their brains are "wired" differently, and they have difficulty processing incoming sensory information.

WHAT ARE THE 8 SENSES?

1. TACTILE/TOUCH – This is often the most commonly recognised sensory system of the body and the one most people notice if they have an overactive or under-active tactile system. Anything you touch or feel is part of the tactile sensory system.

2. AUDITORY/HEARING – This includes hearing, listening, and being able to filter and selectively attend to auditory stimuli.

3. VISUAL/SIGHT – Using our eyes to see what is far or close to us. A typical person is able to use smooth and precise eye movements to scan and visually assess their environment.

4 & 5. TASTE/SMELL – grouped together because they are often very closely related. When we eat, we smell something first, if it smells good, we are more likely to try it. If it smells bad that sends a warning that we may not like it OR that it is dangerous for us to eat. Smell travels directly to the emotional brain or the limbic system which is often why our emotions are tied to smells and foods.

6. PROPRIOCEPTION – This is one of the internal senses of the body that comes from the joints, muscles, ligaments, and other connective tissue. The proprioception system allows you to know where your body parts are and what they are doing without necessarily looking at them.

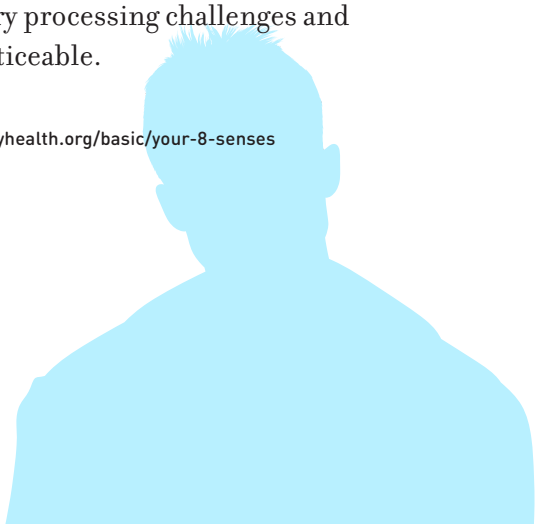
7. VESTIBULAR PROCESSING – The vestibular system is located in the inner ear and helps you to detect changes in regard to gravity. Are you sitting, standing, lying down, upside down, spinning, standing still etc? It is often referred to as the internal GPS system of your body.

It is also very closely linked to the proprioception, auditory, and visual senses of the body. So that is why when a person or child has sensory processing challenges, the Occupational Therapist will often start with addressing any issues they have with their vestibular system. (more on the Vestibular System and how it affects behaviour).

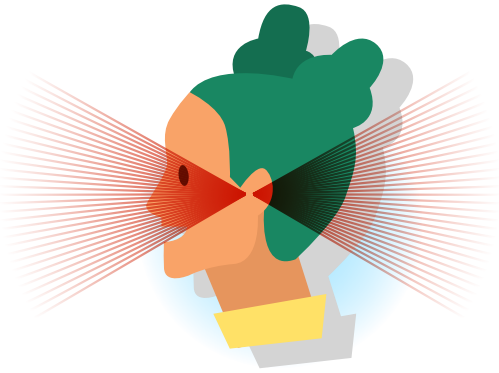
8. INTEROCEPTION – This sense is all about the physiological condition of your body. Are you hungry, thirsty? Do you need to use the bathroom? Is your heart racing or at a normal pace?

So, when one or more of these systems are not functioning properly, you can see how it would affect that person. Someone who is able to "self-modulate" would be able to handle most sensory input and react to it appropriately. However, if someone is over or under-responsive to sensory input in ANY of these sensory systems, that is often when sensory processing challenges and difficulties are noticeable.

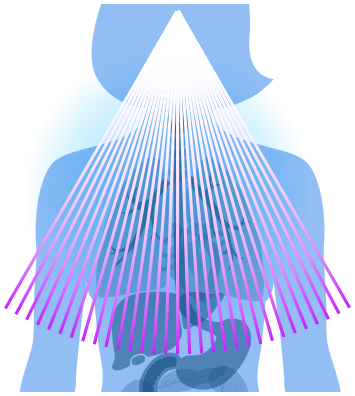
Reference: https://sensoryhealth.org/basic/your-8-senses



handout



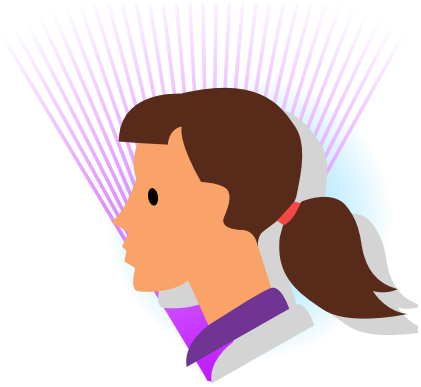
2. HEARING



8. INTEROCEPTION

3. SIGHT

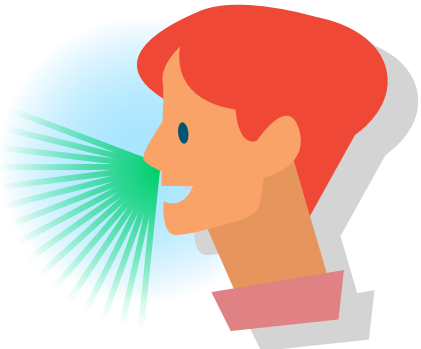
1. TOUCH



7. VESTIBULATION

4. TASTE

6. PROPRIOCEPTION



5. SMELL

WHAT INTEROCEPTION IS

Receptors in your muscles and joints tell you where your body parts are. That's the basis for your proprioceptive sense, which makes you aware of where your body is in space. When you take a step, for example, you know your foot is off the ground without having to think about it. Young people with poor proprioception have trouble with this. Interoception is a similar concept.

Interoception is a similar concept. Just as there are receptors in your muscles and joints, there are also receptors inside your organs, including your skin. These receptors send information about the inside of your body to your brain. This helps regulate our vital functions like body temperature, hunger, thirst, digestion and heart rate.

Interoception helps you understand and *feel* what's going on inside your body. For instance, you know if your heart is beating fast or if you need to breathe more deeply. You're able to tell if you need to use the bathroom. You know if you're hungry, full, hot, cold, thirsty, nauseated, itchy or ticklish.

For Young people with sensory processing issues, the brain may have trouble making sense of that information. They may not be able to tell when they're feeling pain or when their bladder is full. An itch may feel like pain or pain may feel ticklish.

Young people who struggle with the interoceptive sense can also have trouble "feeling" their emotions. They may not be as tuned in to the body cues that help interpret emotion. Without being able to feel and interpret those body sensations, it's harder to clearly identify the emotion.

For instance, a young person may not "feel" fear because they don't recognise that their muscles are tense, their breathing is shallow, and their heart is racing.

INTEROCEPTION AND SELF-REGULATION

Having trouble with this sense can also make self-regulation a challenge. When you're able to tell that you're thirsty, you know to take a drink. When you can feel that your bladder is full, you know to use the bathroom. When you feel a sense of frustration, you know to explain what's troubling you.

For some young people, this system doesn't work well, and they can't regulate certain responses. Some young people may experience bedwetting. Or they may not know why they're feeling off and can have meltdowns. Young people who struggle with these things may not be able to identify the real source of their discomfort.

REACTING TO INTEROCEPTIVE INPUT WITH SENSORY PROCESSING ISSUES

Young people who are sensory seekers may crave interoceptive input. They may move quickly because breathing fast feels right to them. They may not eat or drink as much as other young people because being hungry and thirsty feels comfortable to them.

But young people with sensory processing issues can react in other ways, too. Some young people may:

Find interoceptive input irritating. Young people who are hypersensitive to sensory input may overreact to interoceptive sensations. For instance, they may eat more than other young people to avoid feeling hunger pangs. They may also use the bathroom more often than necessary because they don't like the way a full bladder feels.

They may respond inappropriately to interoceptive input. Young people who are under-responsive to sensory input may not feel or respond to sensations when they should. They may take longer than other young people to learn to use the toilet or have more frequent accidents. They may not eat as often as others because they may not feel hunger or thirst.

HOW TO HELP YOUR YOUNG PERSON

Trouble with interoception isn't as well-known as other sensory processing issues. Experts are still learning what techniques can help young people who struggle with it. Some experts think that mindfulness activities like meditation can help young people be more aware of interoceptive sensations in their bodies.

Heavy work and a sensory diet may be helpful as well. But helping your young person really begins with knowing about treatment options and what to do if you're concerned your young person may have sensory processing issues.

KEY TAKEAWAYS

Young people with sensory processing issues may crave interoceptive input or they may find it irritating.

Experts are still learning about how to help young people who struggle with interoceptive input.

Mindfulness activities, heavy work and a sensory diet could be helpful options for young people who struggle with interoception.

PROPRIOCEPTIVE ACTIVITIES

Information taken from Yourkidstable.com. 80+ Powerful Proprioceptive activities.

HOW DO YOU KNOW WHEN A CHILD NEEDS PROPRIOCEPTIVE ACTIVITIES?

Proprioception is a big deal with young people who have sensory needs because it's the only sense that calms and helps improve focus almost across the board, when used the right way. The vast majority of young people like proprioceptive input, and many seek it out. And, even if your child doesn't have specific "sensory needs", proprioceptive activities can still be beneficial to help them calm down when they get upset or to relax before bedtime

Your child may especially benefit from proprioceptive activities if they fall into one of two categories:

PROPRIOCEPTIVE SEEKERS:

The first is seeking and is also the most common. Seeking means that your child is often trying to get more proprioceptive input. It's like their bodies can't get enough of it. Sometimes kids that love this type of input may be labelled as hyperactive. And they are sort of hyperactive as they are trying to get their sensory needs met.

Young people that are proprioceptive seekers may frequently:

- Chew on everything
- Hide in tight spots
- Love heavy blankets
- Play rough
- Crash into things on purpose
- Always try to jump on the couch or bed
- Be described as very physical or "wild"
- Over-step personal boundaries
- Hold onto writing utensils tightly

PROPRIOCEPTIVE LOW REGISTRATION SIGNS:

The second is called low registration which is less common but quite possible. Low registration or under-responsive means that the sensory input, in this case from the proprioceptive system, isn't registering. It's like the brain has turned the switch off. Let's look at some signs of low proprioceptive registration:

- Clumsy
- Generally low energy
- May not want to get out of bed in the morning
- Bumps into walls and objects, seeming not to notice them
- Very high pain tolerance
- If your child has several signs listed above under either category, then activities that target proprioceptive input will be meeting their needs and encouraging their development completely.
- Keep in mind that while most kids seek or at least enjoy proprioceptive activities in general, there may be some that they do not like. You should avoid forcing your child into any sensory activity or input. Many of these activities give input to multiple senses, like hugging or climbing. Hugging also gives input to the tactile system and climbing also involves a lot of vestibular input. If your child doesn't like or want either of those other types of sensory input, then they probably won't want to participate in that activity. And that's okay!

ACTIVITIES

These activities can be used to alert, calm down, and improve focus and attention in your young people but it's also possible that they can make your young person wild, as well. Sometimes jumping on the bed can get really silly and out of control. This will do anything but calm them down and that probably isn't what you're going for.

If you're looking to calm or to improve attention, then you may want to structure the activities a little bit, although this isn't always necessary. Try the following strategies if you notice that any of the proprioceptive activities are winding up instead of winding down:

Sing a rhythmic song like, "The Ants Go Marching One by One…" or some other song with a steady beat while your young person jumps or stomps. Jumping in particular can really stimulate some young people.

Give the activity purpose. Instead of saying, "Go run around the house" say instead "Can you run to the swing set and back?"

Powerful proprioceptive activities:

- Jumping/Trampoline
- Running
- Climbing /Stairs (running up and down) /Tree climbing /rock wall/backwards up a slide
- Hanging on monkey bars
- Pull up bar
- Rope swing
- Stomping
- Bouncing on top of a large ball (can use a yoga ball)
- Wheelbarrow walking
- Crab walking
- Using a pogo stick
- Pushing a scooter board (especially with hands while riding on belly)
- Kicking balls
- Crawling - through a tunnel
- Obstacle course
- Chewing gum
- Specially designed necklaces, bracelets and toys
- Crunchy foods (raw veggies, pretzels, etc.)
- Chewy foods (dried fruits, gummy candy, etc.)
- Drinking through a straw i.e. milkshake (thicker drinks give even more input)
- Squeezing stress ball
- Play dough/putty
- Stretching and pulling on stretchy band (like a yoga or Pilates strap)
- Chair push ups
- Jumping jacks
- Push ups
- Rolling on belly over a large yoga ball and using arms to hold up
- Yoga poses (here are some that target proprioceptive input)

HEAVY WORK ACTIVITIES

Heavy work activities mean exactly what the name implies, these activities require our young people to actively use their muscles to push, pull, lift, or carry objects that are heavy. When we use our muscles in this way, it creates resistance and pressure is inadvertently put on those proprioceptive receptors in the muscles and joints.

- Push/pull heavy objects i.e. laundry basket, wheelbarrow, lawn mower, vacuum, furniture
- Carry heavy objects i.e. bags or items from grocery store/pantry, book bag, loaded boxes
- Take rubbish bins to or from the curb
- Dig or rake leaves
- Load/unload the dishwasher

DEEP PRESSURE ACTIVITIES

Deep pressure activities are often passive and provide lots of calming sensations. They are often used when a young person has difficulty sitting still or transitioning to different activities. But, these types of activities aren't received well by all young people. Deep pressure also provides a lot of tactile input, and if your young person is sensitive to that, deep pressure may not be a good strategy for them.

If you aren't sure whether your young person will like these activities, experiment by putting a lot of blankets on them or try placing a heavy object on their lap. If they seem to like it, you may want to invest in (or make) some of the weighted item below.

- Getting or giving hugs
- Rolling up tightly in blanket like a sandwich wrap or burrito
- Sitting with a weighted lap pad or toy (Learn how and when to use a weighted lap pad with your young person).
- Wearing a weighted or pressure vest (You'll want to make sure you get the right size and if using weighted, the correct amount of weight.)
- Squeezing into tight spots

Lying under heavy objects i.e. couch cushions, pillows or weighted blanket (these are an investment, but for young people that respond well to them they can be worth every penny).

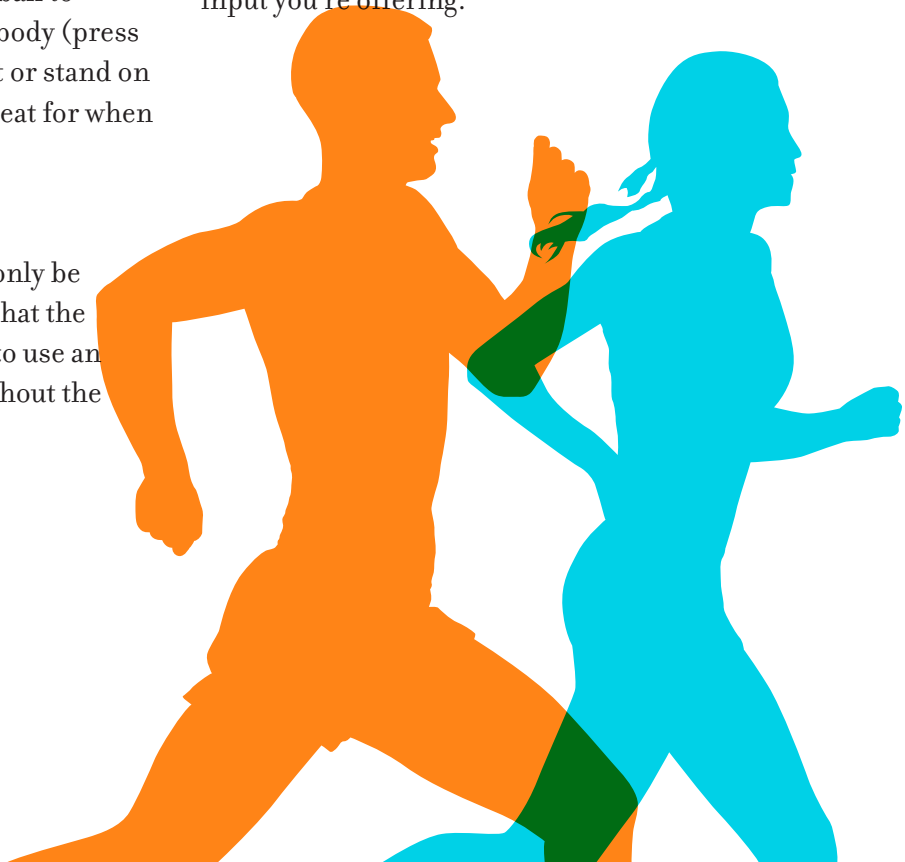
- Getting or giving a massage
- Joint compressions i.e. use a large ball to "steam roll" over a young person's body (press firmly, be careful with head). Or sit or stand on a wiggle seat or wobble cushion (great for when they need to sit still)

BE AWARE

Weighted vests, lap pads and toys will only be beneficial for about 20 minutes, after that the body gets used to the weight. It is fine to use an appropriately weighted blanket throughout the night though.

MUST READ TIPS BEFORE STARTING PROPRIOCEPTIVE ACTIVITIES

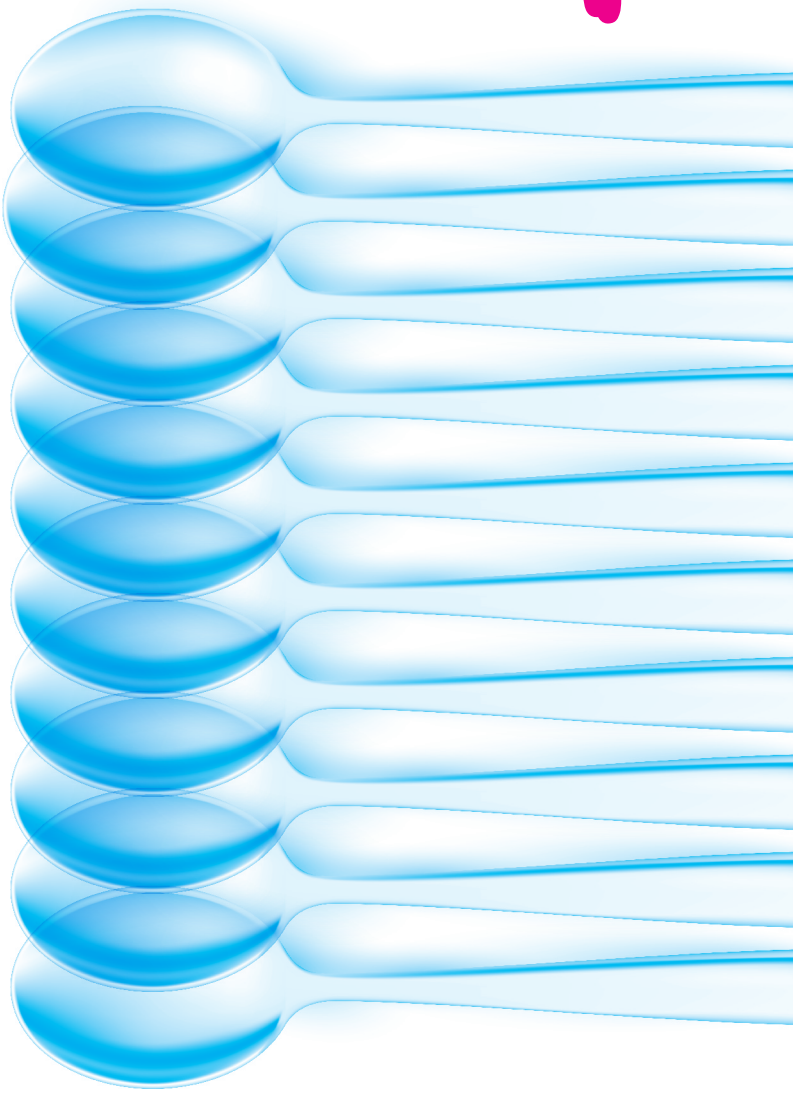
1. Any of the activities in the above list can be used as often or as little as your young person seems to need them. If you aren't sure when your young person "needs" these activities, consider reading about what sensory diets are. Even though they don't sound too pleasant, they can be quite simple and may even be life changing.
2. These proprioceptive activities will work for young people of all ages, but you may need to adjust them to fit your young person's development.
3. About half of the activities above are actively controlled by your young person. Meaning, they decide how long and hard to run, how many times to jump on the bed, or how many boxes they can pick up. This is ideal because they are determining what is the best level of input for their needs, and they know that better than anyone. However, some of these activities give passive proprioceptive input, like giving joint compressions, a hug, or a massage. That can also be a good thing, and may be necessary, but you have to watch for cues that your young person isn't uncomfortable or disliking the input you're offering.



hand out

"THE SPOON THEORY"

Thank you to Gillian Banks (FLASH trainer) for making us aware of this paper.



In 2003 a woman by the name of Christine Miserandino published an essay entitled "The Spoon Theory" which went on to change the way people think about mental and physical challenges. Here's the short and sweet protocols cited by Raede D (2018):

"Spoons" is a metaphor, a code word, to describe and measure how much physical and emotional capacity each of us has to get through the day. Imagine you start the day bright and early with ten Spoons. You use up one Spoon getting out of bed and getting ready, then another four to five Spoons throughout the day at work. Maybe the commute home was particularly long and stressful, so it used up three Spoons instead of the usual one. Then your last two to three Spoons get used up that evening making dinner, hanging out with the family, and working on a little project before going bed. At the end of the night, you collapse into bed just as you start to run out of steam. If you're lucky, you might even end some days feeling really good, and with a Spoon or two to spare.

Make sense? Cool.

Now imagine that your young person with Asperger's /ASD child/ person starts the day with five Spoons, instead of ten. They have to try to accomplish many of the same things you do with half the amount of internal resources. And let's not forget that they might have additional things like sensory issues or social anxiety that will sap their Spoons even further. For you, taking a shower might be rather cheap in terms of its cost to your Spoons. For your young person with Autism it might be a five-Spoon ordeal because of sensory issues (cold air, bright lights, weird textures, dry skin, just to name a few) and intense emotion, such as anxiety. They might even lose a Spoon just from the stress of thinking about taking a shower. And then another Spoon from the added stress of knowing they "shouldn't" be this stressed about something as simple as taking a shower. It's a vicious cycle.

When you extrapolate that simple idea to your young person's entire daily routine, then is it any wonder that they just look completely done when they come home after school? They might even have a meltdown! While it may only be the middle of the afternoon, they're exhausted, their Spoons are gone, and they have nothing left to give.

Granted, they might be able to get one or two Spoons back by taking some time to decompress and take care of themselves, but that's still not a lot when you're only half-way through the day. They really need five Spoons to make it until bedtime, but they're only able to recover one. As a result, they might find themselves trying to make the difficult choice between taking a shower or finishing one of their homework assignments because they're fairly certain they don't have enough Spoons to do both. If things get really tight, as they often do, they can always borrow from tomorrow's Spoons by pushing themselves past their limit, but they'll pay the price the next day and start with even fewer Spoons than usual. So, you see, while your young person's leg may not be broken, there might still be some things that they just don't have the capacity to do right now. And that's okay.

By the way, I say "right now" because I sincerely believe that one can overcome many of the challenges associated with Asperger's/ASD through knowledge, practice, and skill.

Additionally, your young person's emotional capacity for stress will naturally increase as they get older and their brain develops. Yes, it's important to recognize and understand your young person's limitations, and metaphorically speaking, understand how fast they are capable of running right now. However, please don't make the mistake of believing that they will be running at that same speed for the rest of their life, or even for the rest of the year.

FLASH ASD PROTOCOLS – GROUP LEADER SESSION EVALUATION & REFLECTIONS

FLASH EXTRA SESSION

What worked well	
What did not work so well	
What did we change	
What did we add	
What was different	
Comments	
Actions	

FLASH SESSION 6
PLAN & CHECKLIST

ITEMS REQUIRED	
Refreshments – tea, coffee etc.	
Lunch refreshments	
A3 FLASH session overview bridge picture (from original FLASH manual)	
Flip chart	
Pens	
Blue tac	
Name labels	
Attendance form	
Types of parent pictures (download from MoP website)	
Fisherman and keep safe net pictures (download from MoP website)	
Associated features pictures (download from MoP website)	
Reaction cycle (from original FLASH manual or download from MoP website)	
PARENT HANDOUTS:	
Triangular "think/feel/do" of reactions handout Reaction handout (from original FLASH manual) Messages from the past (from original FLASH manual)	
Evaluation form	

SESSION 6 IN DETAIL

WELCOME AND INTRODUCTION

REGISTRATION: ask parents to sign the attendance form and make a name label and wear it.

Reminder of housekeeping and group manners or group agreement.

Explain agenda for the session.

Explain to the parents that it is important that they look after themselves so they should be kind to themselves during and after the session; so they need to give themselves permission to have proper breaks and avoid responding to home calls and emails during break times. As with last week they will have left their young person with a responsible adult who cares for them.

FEEDBACK ON HOME TASKS

Either in two groups or in large group depending on the group size and dynamic ask the parents to feedback on their thoughts from the last session.

PARENTAL REACTIONS

What affects "parental" reactions. Follow the Fred role play as in the original FLASH manual. The key message is "Parenting – is not just based on the relationship between the parent and child". Refer to the triangular "think/feel/do" of reactions handout. Have a discussion with the parents.

TYPES OF PARENTS

Explain the types of parents as stated in the original FLASH manual.

POWER STRUGGLES - PARENTAL HOOKS

Explain the fisherman metaphor (as in the FLASH manual). Group leader to ask parents to share normal teenager behaviour hooks i.e. swearing.

Ask the parents if there are hooks related to their ASD i.e. young person feels the need to company parents.

Link back to the brain development of teens and the need for immediate gratification.

GROUP LEADER CONSIDERATIONS: *Potentially teens with ASD are not always able to express their need for attention and may just shut down /seek time out or they may just start with the bigger bait in the first place.*

Explain the keep safe net as stated in the original FLASH manual.

GROUP LEADER CONSIDERATIONS: *Young person are the fisherman and parents are the fish in the keep safe net.*

Open discussion on why it may be important for the parent to stay in the keep safe net i.e. if young person has high anxious feelings of separation (so parent is there, silent if needed). To highlight that when a young person is self-harming the parent may have to take the bait as the self-harm is an underlining stress, but it is the parent's awareness that they are taking the bait in order to keep their young person monitored.

RESPONDING AND ASSOCIATED FEATURES

Explain the miner, mannequin and honeybee metaphors as in the original FLASH manual.

Show and explain the reaction cycle as in the manual.

Group leader to explore with the group:

Is the young person getting the whole picture or just what's in front of them? Group leader to make parents aware that teens with ASD cannot process your (parent) reaction as fast as you can (parent) theirs. Therefore, the parent needs to explain their reaction in basic terms first and give time for their teen to process the whole picture.

Group leader to inform the parents that the process time is at least 5 seconds (can be up to 2 minutes).

Group leader to inform the process of change – takes at least 90 days.

Give out message from the past (from FLASH manual).

CLOSING THE SESSION

GROUP LEADER CONSIDERATIONS: *to make parents aware that group leaders are available after the evaluations have been completed if any of the parents have any questions or want to share any thoughts/concerns which the day may have bought up.*

ENDING

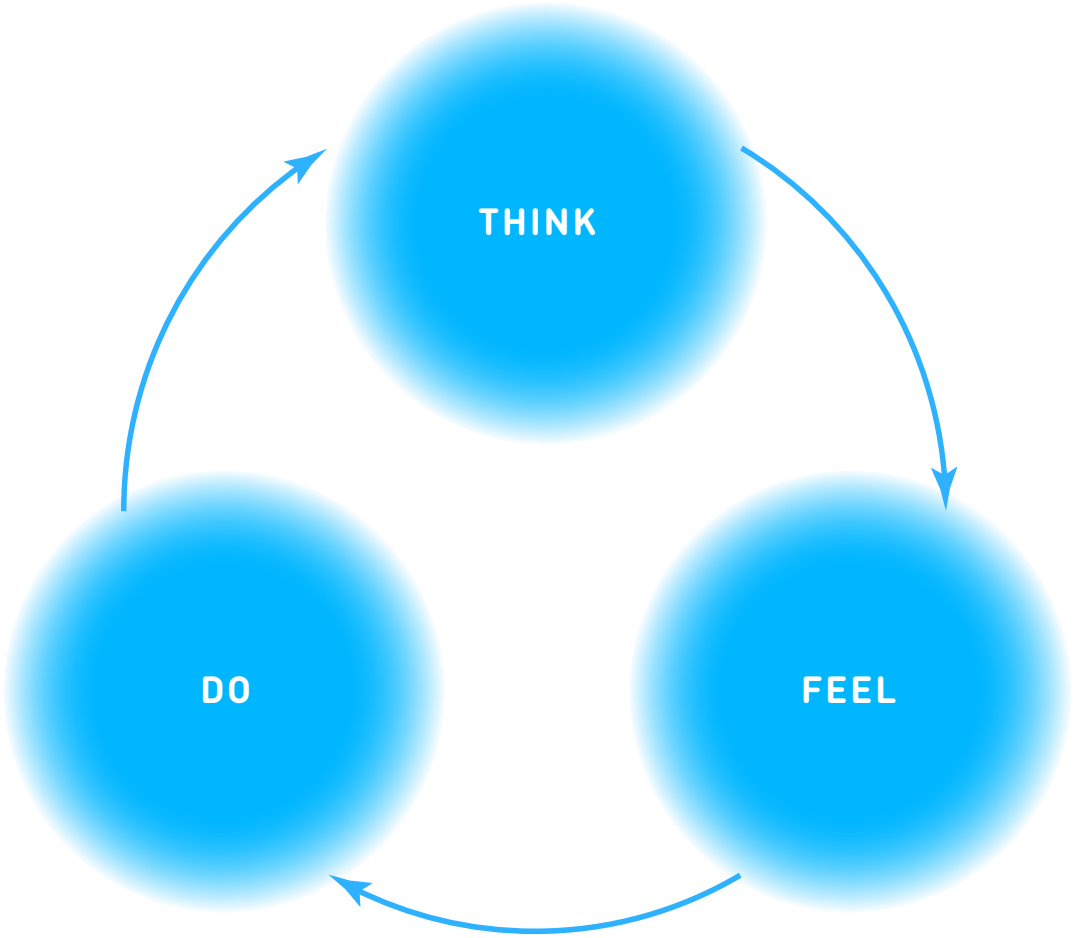
Use the weekly evaluation form from the FLASH manual.

hand out

TRIANGULAR "THINK/FEEL/DO" OF REACTIONS

SOME EXAMPLES:

THINK	FEEL	DO
I'm useless at meeting new people	I feel scared and nervous when I meet new people	I don't talk to them and go quiet
Nobody in my class form likes me	I feel sad and angry	I avoid going out at break and start to avoid going to school
I'm rubbish at maths	I feel dumb and fed up	I stop trying because I know I'll get it wrong



HOW YOU THINK ABOUT SOMETHING CAN INFLUENCE WHAT HAPPENS

We need to stop, think and reflect: Is this true? Can we change the way we think? Can we handle our problems differently to change how we feel and what we do? Can we gain more control over what happens to us in our lives?

FLASH ASD PROTOCOLS – GROUP LEADER SESSION EVALUATION & REFLECTIONS

FLASH SESSION 6

What worked well	
What did not work so well	
What did we change	
What did we add	
What was different	
Comments	
Actions	

FLASH SESSION 7
PLAN & CHECKLIST

ITEMS REQUIRED	
Refreshments – tea, coffee etc.	
Lunch refreshments	
A3 FLASH session overview bridge picture (from original FLASH manual)	
Flip chart	
Pens	
Blue tac	
Name labels	
Attendance form	
PARENT HANDOUTS:	
When it happens handout Consequences flow chart handouts (from original FLASH manual) When to say no handout (from original FLASH manual) Rules of logical consequences handout (from original FLASH manual)	
Evaluation form	

SESSION 7 IN DETAIL

WELCOME AND INTRODUCTION

REGISTRATION: ask parents to sign the attendance form and make a name label and wear it.

Reminder of housekeeping and group manners or group agreement.

Explain agenda for the session.

Explain to the parents that it is important that they look after themselves so they should be kind to themselves during and after the session; so they need to give themselves permission to have proper breaks and avoid responding to home calls and emails during break times. As with last week they will have left their young person with a responsible adult who cares for them.

FEEDBACK ON HOME TASKS

Either in two groups or in large group depending on the group size and dynamic ask the parents to feedback on their thoughts from the last session.

CONSEQUENCES: NATURAL AND LOGICAL CONSEQUENCES

Discuss the difference between natural and logical consequences (as in original FLASH manual).
Rules of Consequences – as in the original FLASH manual.

Group leaders to then ask the parents to:

- Think of a non-self-harming problem first i.e. if their teen refuses to have breakfast
- To think about how they can stay in control

Explain to the parents that if removal of an item is used as a consequence with a teen with ASD it is better to have this consequence fully discussed at a calm time, with visual reminders if appropriate or needed. Removal without consequence conversation could lead to further meltdown and thus regulate themselves by self-harming.

"THEORY OF MIND"

Group leaders to explain to the parents "Theory of mind". Theory of mind is the ability to understand mental states (intentions, emotions, desires, beliefs), and to predict one's own and others' behaviour based on these states. It is a skill that develops between 3 and 5 years of age in typically developing children. For children/young people with developmental delays, such as those with ASD, Theory of Mind may take a little longer to develop, and some higher-level skills may not be reached at all. For many of those with ASD a lack of Theory of Mind creates major barriers to communication and closeness. These barriers often lead to those nearest to the teen with ASD to feel, whether real or perceived, a lack of empathy from their teen.

The easiest way to think of Theory of Mind is when a child is playing games like hide and seek, they often think "If I can't see them, they can't see me." Of course, as they grow up, they learn that it is not the case. With young people with ASD it can be similar – "If I can't/don't feel it or perceive it, then they can't/don't feel it or perceive it" (or vice versa). (SORAYA L 2008).

Therefore, the commonly held belief that people with autism lack empathy is really a lack of understanding of what people with autism and Asperger's understand about others' state of mind.

Teens with ASD teens may not empathise with how their parents feel, and reason that their parents should feel the same way as they do. Get parents to think about how they could explain it in their teens frame of reference terms i.e. ask them "think how it would feel to you if…" Caution that they should only attempt this at calm times.

CONSEQUENCES FLOW CHART

Give out the consequences flow chart sheets and for the group leader to verbally go through the consequences flow chart.

GROUP LEADER CONSIDERATIONS: *Highlight that parents may feel they are giving in to behaviours but underpin the concept that with using the I-statements they remain in control. It is often helpful to practice the words of the I-statements when going through the flow chart. Give out the rules of logical consequences handout from the original FLASH manual.*

Give out the when to say No handout from the original FLASH manual.

CLOSING THE SESSION

Group leader considerations: to make parents aware that group leaders are available after the evaluations have been completed if any of the parents have any questions or want to share any thoughts/concerns which the day may have bought up.

ENDING

Use the weekly evaluation form from the FLASH manual.

FLASH ASD PROTOCOLS – GROUP LEADER SESSION EVALUATION & REFLECTIONS

FLASH SESSION 7

What worked well	
What did not work so well	
What did we change	
What did we add	
What was different	
Comments	
Actions	

FLASH SESSION 8
PLAN & CHECKLIST

ITEMS REQUIRED	
Refreshments – tea, coffee etc.	
Lunch refreshments	
A3 FLASH session overview bridge picture (from original FLASH manual)	
Flip chart	
Pens	
Blue tac	
Name labels	
Attendance form	
PARENT HANDOUTS:	
When it happens handout MOT handout (from original FLASH manual) Family care plan example handout	
Masks	
I statement cards	
Self-care gift	
Evaluation form	

SESSION 8 IN DETAIL

WELCOME AND INTRODUCTION

REGISTRATION: ask parents to sign the attendance form and make a name label and wear it.

Reminder of housekeeping and group manners or group agreement.

Explain agenda for the session.

Explain to the parents that it is important that they look after themselves so they should be kind to themselves during and after the session; so they need to give themselves permission to have proper breaks and avoid responding to home calls and emails during break times. As with last week they will have left their young person with a responsible adult who cares for them.

FEEDBACK ON HOME TASKS

Either in two groups or in large group depending on the group size and dynamic ask the parents to feedback on their thoughts from the last session.

MANAGING THE DIFFICULT TIMES – WHAT TO SAY

Follow what to say as in the original flash manual.

GROUP LEADER CONSIDERATIONS: *In the 'Mask' role-play section make sure BEFORE the parent's practice that they formulated a clear script of an I-statement and this is visual on the flip chart i.e.*

I FEEL . . . *e.g. Sad, worried, frightened, confused, concerned, angry . . .*

WHEN . . . *e.g. I see the cuts, I see the pain, there is blood . . .*

BECAUSE . . . *e.g. I don't know how to help, I thought this would not happen again, I am worried about the scaring . . .*

I WOULD LIKE . . . *e.g. You to stop, You to tell me what is wrong, You to tell me what I can do, You to tell me what is bothering you, You to give me the razor, You to hurt yourself less . . .*
When in practicing the consultant response group leaders to ensure they ask the parents about the personal space/touch comfortable for the young person.

Then in small groups for parents to practice (as in the original FLASH manual).

WHAT TO DO IF

Group leaders to brainstorm with the parents in a large group, what they should do if they feel their young person is in danger and/or them (parent) cannot stop them hurting themselves i.e. head banging. To write up the suggestions on the flip chart. In the discussion group leader to suggest to the parents to consider a "family care plan".

A family Care plan is an action plan which is prearranged so each member of the family is aware of what to do when the young person in the family self-harms. The rational for this is the plan can give reassurance to siblings in the event of an emergency and aids the event to be manged as calmly as possible.

Each family is different, so each family will have to consider their own plan. Recommend that they keep it very plain and simple, so it is very clear and without misunderstanding. Each child in the family can have their own copy. The plan should include emergency contact numbers and explain what each person's role is in the event. Coloured paper can be used but not patterned because it's used at serious times and needs to be put away for next time if it's ever used.

Give out the family care plan example handout.

Give out the "what to do" handout.

PARENT'S MOT

Give each parent the MOT handout sheet. Group leader to explain that the parents are not going to share their answers as this activity is just too make us more aware of our own self care needs. Group leader to read out the questions on the MOT and ask the parents to complete their own MOT sheet.

GROUP LEADER CONSIDERATIONS: *this activity is optional as time may be limited. If this is the case, then this activity to be done in the next session.*

CLOSING THE SESSION

GROUP LEADER CONSIDERATIONS: *to make parents aware that group leaders are available after the evaluations have been completed if any of the parents have any questions or want to share any thoughts/concerns which the day may have bought up. Ending*

Use the weekly evaluation form from the FLASH manual.

PARENT'S MOT

WHEN TO HAVE A PARENT MOT? When you are vaguely dissatisfied, depressed or tense. When you can't remember the last night, you had a good night's sleep, relaxed, or ate a healthy meal.

Do you usually get six to eight hours sleep?	
Do you eat something fresh and unprocessed every day?	
Do you allow time in your week to touch nature, no matter how briefly?	
Do you get enough sunlight, especially in winter? Do you drink enough water?	
Do you see your gynaecologist (or the equivalent) at least once a year?	
Do you see a dentist every six months?	
Do you know enough about your body and health needs?	
Do you get regular sexual thrills?	
Do you feel you get enough fun exercise?	
Are you hugged and touched amply?	
Do you make time for friendships?	
Do you nurture your friendships?	
Do you have friends you can call when you are down and who really listen?	
Can you honestly ask for help when you need it?	
Do you regularly release your negative emotions?	
Do you forgive yourself when you make a mistake?	
Do you do things that give you a sense of fulfilment, joy and purpose?	
Is there abundant beauty in your life?	
Do you allow yourself to see beauty and to bring beauty into your home and office?	
Do you make time for solitude?	
Are you getting daily or weekly spiritual nourishment?	
Can you remember the last time you laughed until you cried?	
Do you ever accept yourself for who you are?	

These questions are not meant to make you feel bad or guilty. They are only meant as kind reminders to help you see how you are currently caring for yourself.

©Louden 1992

hand out

WHEN IT HAPPENS

IN EXTREME CIRCUMSTANCES OR EMERGENCIES, CALL 999

RESPOND QUICKLY

Respond quickly and consistently when the young person self-harms. Even if you think what the young person is doing is to get attention, it's never appropriate to ignore severe self-harming behaviour.

KEEP RESPONSES LOW KEY

Limit verbal comments, facial expressions and other displays of emotion. Try to speak calmly and clearly, in a neutral and steady tone of voice.

REDUCE DEMANDS

The young person might be finding a task too difficult or overwhelming. If it's a task that needs doing, come back to it later when the person is feeling calmer.

REMOVE PHYSICAL AND SENSORY DISCOMFORTS

Smells, sounds or tastes might be causing the young person distress. If there's a smell that's bothering them, take the smelly thing away, or take the person to another room. If their clothes are uncomfortable, prompt them to change. If it's noisy outside, close the window or offer ear defenders. Provide relief for physical discomfort (e.g. pain killers).

REDIRECT

Tell them what they need to do instead of the self-harming behaviour, e.g. "John/Jane, hands down". Redirect to another activity that can't be done at the same time as the self-harming behaviour, e.g. an activity that needs both hands. Give praise when they switch to the activity.

PROVIDE LIGHT PHYSICAL GUIDANCE

If the person is having difficulty stopping the behaviour, provide light physical guidance, e.g. gently protocols their hand away from their head, using as little force as possible. Immediately try to redirect their attention to another activity and be prepared to provide physical guidance again. This approach must be used with extreme caution as it may escalate the behaviour or cause the person to target others.

USE BARRIERS

Place a barrier between the person and the object that is causing harm. For head slapping, place a pillow or cushion between the head and hand. For hand or arm biting, provide another object to bite down on. For head banging on a hard surface, place a cushion or pillow between the surface and the head. You can get removable padding that is placed temporarily on the floors or walls to minimise injury.

OUR FAMILY PLAN

Our Plan for when things are *difficult* in our house.

EMERGENCY CONTACT NUMBERS

EXAMPLE ...	
MUM	
DAD	
GP	
POLICE	
GRANDMOTHER	

OUR FAMILY ADDRESS INCLUDING POST CODE

Mum, Dad, Carer will look after XXXX . . .

. . . will take xxx (younger sister for example) away from the immediate area and look after her while Mum, Dad, Carer is attending to XXX. Mum, Dad, Carer will come and get you in a little while.

. . . will go to your room where you will watch a special DVD, take dog with you for company. Mum, Dad, Carer will come and get you in a little while.

. . . will go to your room. You will ring grandmother so she can come to the house. Mum, Dad, Carer will come and get you in a little while.

Once things are back to usual, we will all . . .

If xxx has hurt themselves and Mum, Dad or Carer are not in the house.

. . . will call 999, Mum, Dad or Carer. To stay with XXX until help arrives.

FAMILY CARE PLAN

TAKING CARE OF YOURSELF - KIT BAG

TIME OUT BAR: to remind you to take time out for yourself!
NIGHT-TIME TEA BAG: to aid a good night's sleep
A BOOST BAR: to give you a "boost" when you feel low in energy
A MAGIC SLATE: so you can write down some of the negative feelings you may have in the moment and then magic those feelings away
SOME BUBBLES: to remind you when you feel stress . . . take deep breaths
A CANDLE: to remind you to take care of yourself and no matter how dark it gets there is always light!

Take care of you.

FAMILY CARE PLAN

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Take care of you.

FLASH ASD PROTOCOLS – GROUP LEADER SESSION EVALUATION & REFLECTIONS

FLASH SESSION 8

What worked well	
What did not work so well	
What did we change	
What did we add	
What was different	
Comments	
Actions	

FLASH SESSION 9
PLAN & CHECKLIST

ITEMS REQUIRED	
Refreshments – tea, coffee etc.	
Lunch refreshments	
A3 FLASH session overview bridge picture (from original FLASH manual)	
Flip chart	
Pens	
Blue tac	
Name labels	
Attendance form	
PARENT HANDOUTS:	
PARYRUS safety plan booklets (download from website https://papyrus-uk.org/wp-content/uploads/2019/09/Stay-Safe-Plan-Print-out.pdf)	
Evaluation form	

SESSION 9 IN DETAIL

WELCOME AND INTRODUCTION

REGISTRATION: ask parents to sign the attendance form and make a name label and wear it.

Reminder of housekeeping and group manners or group agreement.

Explain agenda for the session.

Explain to the parents that it is important that they look after themselves so they should be kind to themselves during and after the session; so they need to give themselves permission to have proper breaks and avoid responding to home calls and emails during break times. As with last week they will have left their young person with a responsible adult who cares for them.

FEEDBACK ON HOME TASKS

Either in two groups or in large group depending on the group size and dynamic ask the parents to feedback on their thoughts from the last session.

PARENTS MOT – if not completed in past session

OPTIONAL TASK - KEEPING A YOUNG PERSON AS SAFE AS POSSIBLE

Put parents into pairs. Explain that they have one minute to write down all the ways a young person could harm themselves with a paper clip.
OPTIONAL – give each pair a picture of a room in a house and give each pair one minute to write down all the ways a young person could harm themselves in that room.

PROTECTIVE FACTORS

Either in two groups or in large group, depending on group size and dynamics, ask the parents to think about what the protective factors are and create a list of the factors under the 3 subheadings
1: to list Personal qualities i.e. temperament, compassion and empathy
2: to list Strategic; Government/service policy/local plans etc.
3: to list Personal protective factors; family, friends, school, key person etc.

Ask the group if the protective factors could also be risk factors. Group discussion.
To highlight the following:

- To increase the preventive factors around the young person
- To educate family members and share risk concerns

MANAGING THE RISKS

Group leaders to highlight the importance of being aware of the strong impulses a young person may have to self-harm and a delay in responding to an impulse (may be enough time for the young person to be distracted or redirected).

PREVENTION AND TRIGGERS

In a large group discussion ask the parents if they have previously noticed behaviours or signs that their young person may be at risk of hurting themselves. Write up the list of signs on the flip chart. Group leader to ensure the following are considered in the discussion.

Change in actions i.e. withdrawing from activities, not getting of bed etc.

Words they use i.e. saying they are no good, saying they don't care, saying it does not matter now, they want to see a person or pet who has died etc.

How they are feeling i.e. their body language indicates a change in mood.

Life events i.e. exams, transition to a new school or year group.

GROUP LEADER CONSIDERATIONS: to inform the parents that often parents don't see the signs as young people often try to protect their parents by hiding how they feel.

In a large group discussion ask the parents to consider the things they could do to do to reduce risk factors i.e. avoid leaving a young person alone for too long, have a decent first-aid kit at home, lock away medicines or tablets etc. Write up the list of ideas on the flip chart.

STARTING THE CONVERSATION

Explain that asking if someone wants to die or hurt themselves can be difficult especially for parents. A person with ASD is 20 times more likely to attempt suicide.

There are four stages to the conversation and the I-statement can be a good framework to structure the conversation.

STAGE 1) Acknowledge the concern i.e. I FEEL concerned.
STAGE 2) Reflect back what you have seen/heard i.e. WHEN you are very quiet BECAUSE it often indicates a low mood, or something has happened.
STAGE 3) Open questions i.e. I WOULD like to know how you are feeling, if you have hurt yourself . . .
STAGE 4) Asking "the" question. If the answers to stage 3 have raised concerns and you feel that your young person is feeling suicidal then it is recommended to ask a direct question. This can be difficult for parents as they may fear getting it wrong, or upsetting the young person, or for being uncomfortable with the word "suicide", or for being unsure if the young person understands the word suicide/self-harm or even the fear of giving the young person the idea.

Group leaders to explain that a question can be asked in 3 different ways:

DIRECT: A direct question can be answered (i.e. it is not a statement) and always ends in a question mark. For example: do you live in Colchester?
INDIRECT: A sentence with an indirect question might not end in a question mark, and it is often seen as less formal and more polite i.e. can you tell me if you live in Colchester?
NORMALISING: People may sometimes have difficulty in volunteering some information about their problem/issue, particularly if they are anxious or embarrassed about it. A normalising question is a question statement that 'normalises' their problem/issue, that they are not the only person to have the experience. For example: sometimes have been told it is easier to start with knowing where you live?

In pairs ask the parents to fill in the asking the self-harm asking the question sheet. Share thoughts in larger group. Optional – give out PARYRUS safety plan booklets.

OPTIONAL – GROUNDING TECHNIQUE

Group leader to explain that sometimes the young person is too anxious to even begin the conversation about how they feel. Discuss with the group that a "grounding technique" can be useful pre the conversation. Group leaders to give each parent the "grounding technique" handout and then the group leaders to demonstrate (act out) the "grounding technique". One group leader to be in role as a parent and the other group leader in role of a young person. If there's time, ask the parents to practice in pairs.

OPTIONAL - COMMUNICATION WITH PROFESSIONALS

Group leaders to explain that in the section the aim is to:

Think about how parents may approach "professionals" involved with their young person care so that they (parents) are able to feel heard.

How do they (the parents) enable the professional to hear what they are trying to communicate?

Brainstorm with the parent's effective methods of communication with professionals. Groups leader to ensure the following points are considered:

The language they use i.e. use of 'I' statements, having a glossary of terms so they understand the professional jargon Parents to have prepared their young person's history record.

Parents should be clear on what information they want from the professional and what that information may or may not be included.

Have an awareness of the law and the professional protocols lines of the service re information sharing.

Method of communication. To ask at the start what is the best method to remain in contact i.e. email, phone, text etc.

Write up positive suggestions on flip chart.

EMOTIONAL WELLBEING IS ALL SHADES OF GREY

Explain to the parents that no professional/service is perfect, and that emotional wellbeing contains all shades of grey. Empathise with the parents that this is so difficult to manage when it is the wellbeing of their young person. In a discussion format ask the parents to consider the following:

How they manage their frustration.

Parental responsibility – do they expect too much from the "professional" and/or "service".

Accepting the "no answer" or "no fix" reality of their young person/ family situation.

The line between being assertive and being aggressive.

How they can present themselves as a positive advocate for your young person, family and self.

Optional – how the age of their young person may affect their parental role in the eyes of services i.e. once young person reaches the age of 18.

Write up positive suggestions on flip chart.

THE OTHERS:

Encourage an open discussion and ask the parents to think about their parental and relationship roles:

MOTHER'S: In your relationship with your own young people do you struggle to share your role with others? Even with their father or other primary carer? Do you allow others to help manage the young person's behaviour or their self-harm? How do you feel about it when they do step in, e.g. family members, community nurses, school, etc. As parents are we holding everyone together (rather like a button) or avoiding everyone. How does the young person's behaviour affect how you "see" yourself as a mother and as a woman?

FATHER'S HURT TOO: How do they manage the self-harm? Is it different to mothers? Would it be different for Father's who have sole responsibility for their young person?

RELATIONSHIPS: How is the young person's behaviour influencing personal adult couple relationships?

FAMILY MEMBER: How is the young person's behaviour affecting others i.e. brothers, sisters, friends, etc? Highlight on flip chart how to let others become involved and what feelings this may evoke in parents.

CLOSING THE SESSION

Group leader considerations: to make parents aware that group leaders are available after the evaluations have been completed if any of the parents have any questions or want to share any thoughts/concerns which the day may have bought up.

ENDING

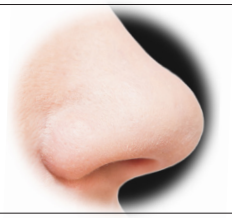
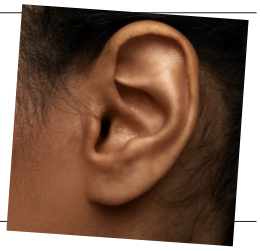
Use the weekly evaluation form from the FLASH manual.

handout

THE GROUNDING TECHNIQUE

A grounding technique can be very useful when a young person feels really anxious, particularly when the anxious feeling makes them feel very unreal or detached; or it feels like they are in a different situation to where they really are. By doing the grounding technique below you (the parent) can help to bring the young person back to the here and now, with an awareness of their own bodies. This strategy can help your young person to be in the present moment, in reality, rather than in the traumatic anxious experience of the past or current distress.

Sit close to the young person.

PARENT SAYS	YOUNG PERSON SAYS
Feet on the floor 	
Say what you see	says what they can see 
Say what you smell 	says what they can smell
Say what you taste	says what they can taste
Say what you hear	says what they can hear 
Say what you feel	says what they can feel
Repeat after me... I am ok	I am ok
Repeat after me... I am safe	I am safe
Repeat after me... I can do this	I can do this

This exercise can be repeated.

ASKING THE SELF-HARM QUESTION

List as many examples as you can in the following format.

DIRECT QUESTIONS	INDIRECT QUESTIONS	NORMALISING QUESTIONS
EXAMPLE: Are you thinking of harming yourself?	**EXAMPLE:** Do you feel like getting away from it all?	**EXAMPLE:** Sometimes the people are feeling distressed they think of suicide . . . is this something you have been thinking of

FLASH ASD PROTOCOLS – GROUP LEADER SESSION EVALUATION & REFLECTIONS

FLASH SESSION 9

What worked well	
What did not work so well	
What did we change	
What did we add	
What was different	
Comments	
Actions	

FLASH SESSION 10
PLAN & CHECKLIST

ITEMS REQUIRED	
Refreshments – tea, coffee etc.	
Lunch refreshments	
A3 FLASH session overview bridge picture (from original FLASH manual)	
Flip chart	
Pens	
Blue tac	
Name labels	
Attendance form	
PARENT HANDOUTS:	
Insole sheets Optional handouts – Sleep, ASD & Teens 9 reasons children with autism are extra vulnerable to screen time effects and tech addiction	
Certificates	
Parent gifts	
Volunteer reflection form	
Evaluation forms	

SESSION 10 IN DETAIL

WELCOME AND INTRODUCTION

REGISTRATION: ask parents to sign the attendance form and make a name label and wear it.

Reminder of housekeeping and group manners or group agreement.

Explain agenda for the session.

Explain to the parents that it is important that they look after themselves so they should be kind to themselves during and after the session; so they need to give themselves permission to have proper breaks and avoid responding to home calls and emails during break times. As with last week they will have left their young person with a responsible adult who cares for them.

FEEDBACK ON HOME TASKS

Either in two groups or in large group depending on the group size and dynamic ask the parents to feedback on their thoughts from the last session.

OPTIONAL: Give out optional handouts – Sleep, ASD & Teens 9 reasons children with autism are extra vulnerable to screen time effects and tech addiction.

PUTTING IT ALL TOGETHER: Refer back to the A3 picture of the bridge and then give a brief summary of the sessions. Open discussion to the group about what has been helpful.

WALKING IN YOUR OWN SHOES

Give out 2 copies of the handout from page 95 "walking in my own shoes" to each parent. Ask the parents to stand on one of the sheets write in the middle of the insole "the next step for them". On the second sheet write in the middle of the insole a "personal statement" which will inspire them to keep going.

Each parent to lay their insole sheets on the floor and share with the group what they have written.

ENDING

CERTIFICATES: Handout certificates and parent gift.

GIFTS: Recommended to give a small gift to each parent, to include the chocolate the parents named on the "what chocolate would you be" warm up activity as part of their completion gift.

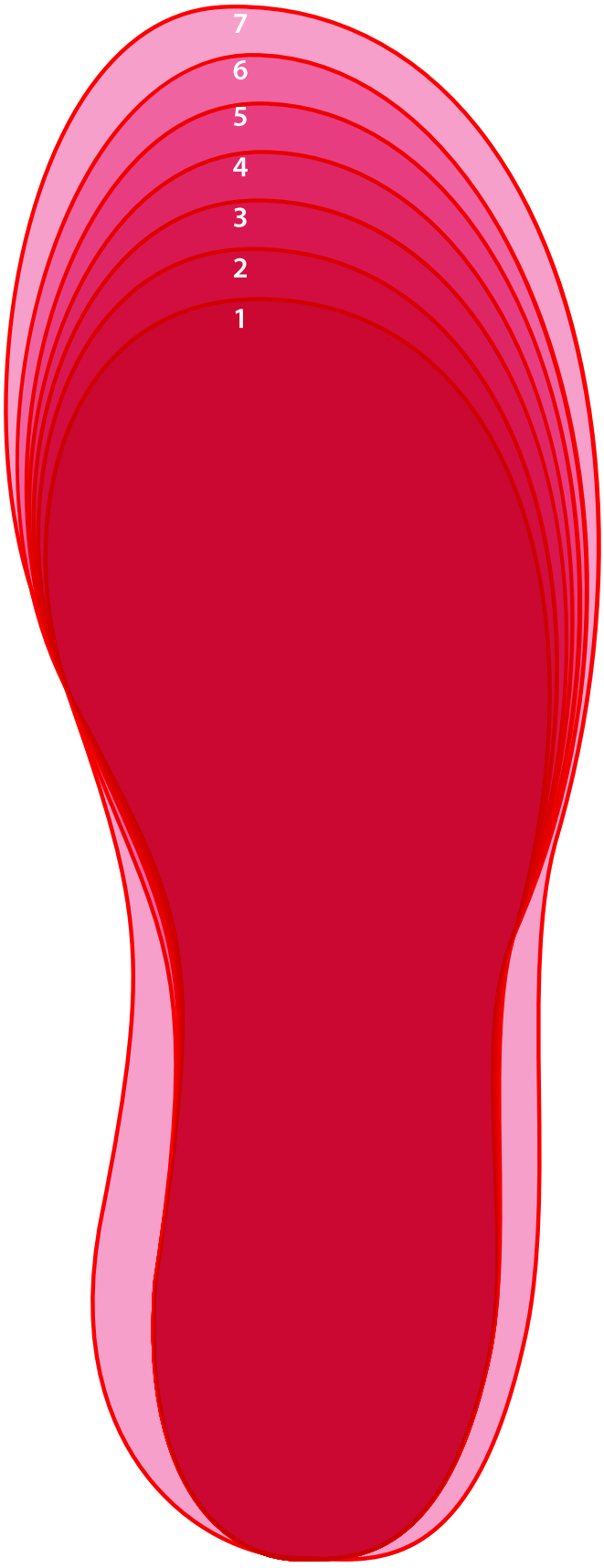
EVALUATION: Give out the Evaluation forms Finial evaluation forms.

Optional – if a professional volunteer has attended the sessions (student or professional observing as part of their learning) it is often useful to ask them for their feedback. Example template attached.

AFTER THE SESSIONS HAVE FINISHED

We recommend informing the parents of their pre and post evaluation scores.

WALKING IN MY OWN SHOES HANDOUT



SLEEP, ASD AND TEENS

Sleep is a major issue for many adults and children who have been diagnosed with autism spectrum disorder (ASD). Studies suggest that up to 80% of young people with ASD also have difficulty falling and/or staying asleep at night (RICHDALE A L & SCHRECK K A 2009). Lack of sleep can exacerbate some of the behavioural characteristics of ASD, such as hyperactivity, aggression, and lack of concentration. As a result, people with ASD who have a hard time sleeping may struggle at school.

COMMON SLEEP PROBLEMS FOR TEENAGERS

DEMANDS ON TIME: For many teens, the biggest problem with sleep is there just isn't enough time to get more than nine hours of sleep every night. They're balancing demands on their time including early school hours, heavy homework loads, extracurricular activities, jobs, home responsibilities, and more. Parents of teens who aren't getting enough sleep should carefully examine schedules alongside their teen to determine if any changes can be made, including dropping unnecessary activities.

CIRCADIAN RHYTHM SHIFT: When teens hit puberty, their circadian rhythm shifts to a later bedtime. Teens may be sleepy around 8:00 or 9:00 p.m. before puberty, but after puberty, they aren't sleepy until 10:00 or 11:00 p.m. This sleep phase delay can make teens feel like they're suffering from insomnia and make it difficult to get enough sleep before it's time to wake up for school.

NOT ENOUGH DAYTIME ACTIVITY: Though teens are usually incredibly busy during the day, they're often not getting enough exercise. Exercise is important for health and good sleep, so missing out means teens may not be ready to fall asleep when they should. Teens should participate in sports or commit to exercising independently to make sure they get enough physical activity during the day.

TOO MUCH SCREEN TIME: Teens often spend a lot of time on screens during the day and into the night. They're working on computers at school, texting with friends, watching TV, and doing homework on laptops at home. They may even take mobile devices to bed. But all of this screen time can interfere with their already confused circadian rhythms, making it difficult to fall asleep on time. Teens should pay attention to how much screen time they have during the day and take care to stop using screens an hour before bed.

HELPFUL SLEEP TIPS FOR TEENAGERS

MAINTAIN CALM TIME AT HOME BEFORE BED: It can be tough to wind down from a busy day, but it's important for teens to do so. Making the hours (or hour) before bed a calm time can help teens get into a sleepier mind-set and make it easier to fall asleep comfortably.

REGULAR SLEEP TIME: Sleep thrives on routine, so teens should try to keep a regular sleep time, even on the weekends. Teens should aim to fall asleep within the same hour each night to train themselves to become sleepy at bedtime.

KEEP FEW EVENING ACTIVITIES DURING THE WEEK: Teens can quickly become overwhelmed with weeknight activities that keep them wired and up well past their bedtime – even cutting into homework time so they have no choice but to stay up late to finish it. Carefully consider evening activities including sports, extracurricular activities, work, and home responsibilities, and how they have an effect on everyday sleep habits.

MAKE TEEN BEDROOMS CALM AND COMFORTABLE: Like younger children as well as adults, teens need bedrooms that are calm, cool, dark, and comfortable. Make sure your teen has a good mattress, soft bedding, and a healthy sleep environment free of distractions.

MAINTAIN A REGULAR EXERCISE ROUTINE: Teens should make sure they're getting enough physical activity every day. Experts recommend at least 30 minutes of activity every day for good sleep and overall good health.

KEEP LIGHTS LOW AT NIGHT: Before bed, teens should keep lights low in order to signal to their brain that it's just about time to go to sleep. In the morning they should let bright lights in to signal the start of the day and alert time.

LIMIT CAFFEINE USE: Too much caffeine can leave teens wired, especially in the evenings. Encourage teens to avoid consuming too much caffeine during the day and stop caffeine consumption after 4:00 p.m. This includes fizzy drinks and chocolate (which contain caffeine!).

ENCOURAGE SHORT NAP TIMES: Nap times can help sleep deprived teens feel refreshed and supplement night-time sleep. The key is to make sure that naps are kept short, typically under an hour, to avoid night-time sleep interference.

DISCOURAGE SMOKING, ALCOHOL, AND DRUGS: For general health, teens should avoid smoking, alcohol, and drug use. But it is especially important that teens avoid these substances for their sleep health. They can interfere with a teen's ability to fall asleep, stay asleep, or get restful sleep at night.

REDUCE ANXIETY: Teens often suffer from serious stress and anxiety, especially as they navigate increasingly complicated personal relationships and prepare to graduate and even go to college. For many teens, stress and anxiety aren't going away — and they can interfere with healthy sleep. Teens can reduce the negative effects of stress and anxiety by practicing stress relieving exercises including meditation, yoga etc.

CATCH UP ON SLEEP OVER THE WEEKEND – WITHIN REASON: While teens should try to maintain a regular sleep schedule every day of the week, weekends do present an opportunity to catch up on a few hours of sleep missed over the course of the week. Teens can safely add a couple extra hours of sleep on weekend mornings – but be careful not to overdo it. Sleeping in too late all weekend can make it difficult to wake up on Monday morning.

9 REASONS CHILDREN WITH AUTISM ARE EXTRA VULNERABLE TO SCREEN TIME EFFECTS AND TECH ADDICTION

Adapted from: Autism and Screen Time: Special Brains, Special Risks. Children with autism are vulnerable to the negative effects of screen time. Posted Dec 31, 2016 by Victoria L. Dunckley M.D. https://www.psychologytoday.com/us/blog/mental-wealth/201612/autism-and-screen-time-special-brains-special-risks

1. Children with autism tend to have low melatonin, sleep disturbances and screen time suppresses melatonin and disrupts sleep. Aside from regulating sleep and the body clock, melatonin also helps moderate hormones and brain chemistry, balances the immune system, and keeps inflammation at bay.

2. Children with autism are prone to arousal regulation issues, manifesting in an exaggerated stress response, emotional dysregulation, or a tendency to be over or under-stimulated; screen time increases acute and chronic stress, induces hyperarousal, causes emotional dysregulation, and produces overstimulation.

3. Autism is associated with inflammation of the nervous system and screen time may increase inflammation by a variety of mechanisms including increased stress hormones, suppressed melatonin, and non-restorative sleep. Light-at-night from screens also suppresses REM sleep, a phase during which the brain "cleans house."

4. The autistic brain tends to be under connected – less integrated and more compartmentalised - and screen time hinders whole-brain integration and healthy development of the frontal lobe. In fact, in tech addiction brain scan studies reveal reduced connectivity (via reduced white matter) and atrophy of grey matter in the frontal lobe.

5. Children with autism have social and communication deficits, such as impaired eye contact, difficulty reading facial expressions and body language, low empathy, and impaired communication; screen time hinders development of these exact same skills – even in children and teens who don't have autism. Screen time appears to directly compete with social rewards, including eye contact – a factor essential for brain development. Lastly, screen viewing, and even background TV has been shown to delay language acquisition.

6. Children with autism are prone to anxiety – including obsessive-compulsive traits, social anxiety – and screen time is associated with increased risk for OCD and social anxiety while contributing to high arousal and poor coping skills. Additionally, anxiety in autism has been linked to abnormalities in serotonin synthesis and amygdala activity and both serotonin regulation and amygdala changes have been implicated in screen time.

7. Children with autism frequently have sensory and motor integration issues as well as tics; screen time has been linked to sensory-motor delays and worsening of sensory processing and can precipitate or worsen vocal and motor tics due to dopamine release.

8. Individuals with autism are typically highly attracted to screen-based technology and are not only at increased risk for developing video game and other technology addictions but are more likely to exhibit symptoms with smaller amounts of exposure. Male teens and young adults with ASD are also at high risk for porn addiction, due to a combination of social deficits, isolation, and excessive computer time, and may develop romantic delusions or obsessions fuelled by being accustomed to immediate gratification and a lack of practicing in the real world. At the same time dopamine released by screen interaction reinforces these obsessive "loops."

9. Children with autism tend to have a fragile attention system, poor executive functioning, and "reduced bandwidth" when processing information; screen time likewise fractures attention, depletes mental reserves, and impairs executive functioning.

In addition to the above, screen time replaces the very things we know to be critical to brain development: *bonding*, movement, eye contact, face-to-face verbal interactions, loving touch, exercise, free play, and exposure to nature and the outdoors. Reduced exposure to these factors negatively impact brain integration, *IQ,* and *resilience* in all children.

VOLUNTEER REFLECTION OF THE FLASH ASD PROTOCOLS SESSIONS

As part of the monitoring requirements for the FLASH ASD protocols funding grant, we need to evidence feedback. No personal names will be entered on the monitoring form.

Can you please complete the following information?

HEADINGS:

Your service

Why you wanted to volunteer in the sessions

What you did i.e. how many session sessions attended etc.

Your observation on the parent's development in the sessions

Your observation on the sessions as a whole

What learning will you take away from the experience?

Any other comments

Many thanks Group leader

FLASH

Families Learning about *Self Harm*

THIS IS TO CERTIFY THAT:

_____

HAS SUCCESFULLY COMPLETED

THE

FLASH ASD PARENT TRAINING PROGRAMME

ON THE

_____

GROUP LEADER

_____

GROUP LEADER

_____

COMMUNITY FUND

THE MINISTRY OF PARENTING

PROMOTING CREATIVITY IN PARENTING SUPPORT A COMMUNITY INTEREST COMPANY

SESSION FACILITATORS NAMES:

VENUE - LOCATION:

PARENT'S FULL NAME:

START DATE:

START HERE

PLEASE START THIS BOOKLET AT THE START OF THE WHOPSHOP!

I hope you enjoy taking part in the sessions and I would be grateful if you would answer some questions about yourself and your family life, both now and upon completion of the course. This information will be used to evaluate and improve the facilitators' skills and will help secure funding to help other sessions, such as this one, in the future.

Please note that on completion of this booklet all names WILL be removed. We really appreciate the time you have taken to complete this booklet. Thank you!

PLEASE TICK THE BOXES BELOW WHICH BEST DESCRIBE YOU

YOU MAY TICK MORE THAN ONE BOX IF YOU LIKE

Please tell us your gender			☐ Female	☐ Male
Please tell us your age	☐ 16-20	☐ 21-29	☐ 30-34	☐ 35-39
	☐ 40-44	☐ >45	☐ Rather not say	

MARITAL STAUS: (PLEASE TICK THE RELEVANT BOX)

☐ Married	☐ Divorced	☐ Single	☐ Living with my partner	☐ Separated
☐ Other	☐ Rather not say			

PLEASE TELL US HOW OLD YOU WERE WHEN YOU LEFT FULL TIME EDUCATION? ☐ Years

HOW MANY CHILDREN/YOUNG PEOPLE LIVE IN YOUR HOUSEHOLD? ☐

PLEASE STATE YOUR RELATIONSHIP TO THE ABOVE YOUNG PERSON(S)

☐ Mother	☐ Family Member
☐ Father	☐ Family friend
☐ Step-parent	☐ Carer

PLEASE TELL US HOW YOU OCCUPY YOUR TIME?

☐ Employed outside the home - Full time	☐ Self employed - Part time
☐ Employed outside the home - Part time	☐ Self employed - Full time
☐ Full time home/family carer	☐ Not in paid employment
☐ Retired from paid employment	☐ Prefer not to say

PLEASE TELL US YOUR ETHNIC ORIGIN:

☐ White British	☐ Black Caribbean
☐ White European	☐ Black African
☐ Mixed	☐ Black other
☐ Chinese	☐ Pakistani
☐ Indian	☐ Prefer not to say
☐ Bangladeshi	☐ Other

ADOLESCENT WELLBEING - SCALE A

PARENTS PLEASE ANSWER THESE QUESTIONS ABOUT YOUR YOUNG PERSON

NAME OF YOUNG PERSON:

DATE OF BIRTH OF YOUNG PERSON:

	OFTEN	SOMETIMES	NEVER
1. DOES YOU YOUNG PERSON LOOK FORWARDS TO THINGS AS MUCH AS THEY USED TO?	☐	☐	☐
2. DO THEY SLEEP VERY WELL?	☐	☐	☐
3. DO THEY FEEL LIKE CRYING?	☐	☐	☐
4. DO THEY FEEL LIKE GOING OUT?	☐	☐	☐
5. DO THEY FEEL LIKE LEAVING HOME?	☐	☐	☐
6. DO THEY GET STOMACH ACHES AND CRAMPS?	☐	☐	☐
7. DO THEY HAVE LOTS OF ENERGY?	☐	☐	☐
8. DO THEY ENJOY THEIR FOOD?	☐	☐	☐
9. DO THEY STICK UP FOR THEMSELVES?	☐	☐	☐
10. DO THEY THINK LIFE ISN'T WORTH LIVING?	☐	☐	☐
11. DO THEY THINK THEY ARE GOOD AT THINGS THAT THEY DO? 6	☐	☐	☐
12. DO THEY ENJOY THINGS AS MUCH AS THEY USED TO?	☐	☐	☐
13. DO THEY LIKE TALKING TO FRIENDS AND FAMILY?	☐	☐	☐
14. DO THEY HAVE HORRIBLE DREAMS?	☐	☐	☐
15. DO THEY FEEL VERY LONELY?	☐	☐	☐
16. DO THEY HAVE AN ADULT THEY CAN CONFIDE IN?	☐	☐	☐
17. ARE THEY EASILY CHEERED UP?	☐	☐	☐
18. DO THEY EVER FEEL VERY BORED?	☐	☐	☐
19. DO THEY FEEL LIKE THEY CAN HARDLY BEAR IT?	☐	☐	☐
20. DO YOU THINK SELF-HARMING HELPS THEM TO DEAL WITH THEIR PROBLEMS?	☐	☐	☐

Thank you

AUTISM PARENTING STRESS INDEX

	STRESS RATINGS				
Please rate the following aspects of your child's health according to how much stress it causes you and/or your family by placing an X in the box that best describes your situation.	Not stressful	Sometimes creates stress	Often creates stress	Very stressful on a daily basis	So stressful sometimes we feel we can't cope
Your child's social development	0	1	2	3	5
Your child's ability to communicate	0	1	2	3	5
Tantrums/meltdowns	0	1	2	3	5
Aggressive behaviour (towards siblings, peers)	0	1	2	3	5
Self-injurious/harming behaviour	0	1	2	3	5
Difficulty making transitions from one activity to another	0	1	2	3	5
Sleep problems	0	1	2	3	5
Your child's diet	0	1	2	3	5
Bowel problems (diarrhoea, constipation)	0	1	2	3	5
Toileting issues	0	1	2	3	5
Not feeling close to your child	0	1	2	3	5
Concern for the future of your child being accepted by others	0	1	2	3	5
Concern for the future of your child living independently	0	1	2	3	5
SUBTOTAL					
TOTAL					

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STOP
DO NOT CONTINUE!
THE REST OF THE FORM WILL BE COMPLETED ON THE LAST SESSION

ADOLESCENT WELLBEING - SCALE A

PARENTS PLEASE ANSWER THESE QUESTIONS ABOUT YOUR YOUNG PERSON

NAME OF YOUNG PERSON:

DATE OF BIRTH OF YOUNG PERSON:

	OFTEN	SOMETIMES	NEVER
1. DOES YOU YOUNG PERSON LOOK FORWARDS TO THINGS AS MUCH AS THEY USED TO?	☐	☐	☐
2. DO THEY SLEEP VERY WELL?	☐	☐	☐
3. DO THEY FEEL LIKE CRYING?	☐	☐	☐
4. DO THEY FEEL LIKE GOING OUT?	☐	☐	☐
5. DO THEY FEEL LIKE LEAVING HOME?	☐	☐	☐
6. DO THEY GET STOMACH ACHES AND CRAMPS?	☐	☐	☐
7. DO THEY HAVE LOTS OF ENERGY?	☐	☐	☐
8. DO THEY ENJOY THEIR FOOD?	☐	☐	☐
9. DO THEY STICK UP FOR THEMSELVES?	☐	☐	☐
10. DO THEY THINK LIFE ISN'T WORTH LIVING?	☐	☐	☐
11. DO THEY THINK THEY ARE GOOD AT THINGS THAT THEY DO? 6	☐	☐	☐
12. DO THEY ENJOY THINGS AS MUCH AS THEY USED TO?	☐	☐	☐
13. DO THEY LIKE TALKING TO FRIENDS AND FAMILY?	☐	☐	☐
14. DO THEY HAVE HORRIBLE DREAMS?	☐	☐	☐
15. DO THEY FEEL VERY LONELY?	☐	☐	☐
16. DO THEY HAVE AN ADULT THEY CAN CONFIDE IN?	☐	☐	☐
17. ARE THEY EASILY CHEERED UP?	☐	☐	☐
18. DO THEY EVER FEEL VERY BORED?	☐	☐	☐
19. DO THEY FEEL LIKE THEY CAN HARDLY BEAR IT?	☐	☐	☐
20. DO YOU THINK SELF-HARMING HELPS THEM TO DEAL WITH THEIR PROBLEMS?	☐	☐	☐

Thank you

AUTISM PARENTING STRESS INDEX

	STRESS RATINGS				
Please rate the following aspects of your child's health according to how much stress it causes you and/or your family by placing an X in the box that best describes your situation.	Not stressful	Sometimes creates stress	Often creates stress	Very stressful on a daily basis	So stressful sometimes we feel we can't cope
Your child's social development	0	1	2	3	5
Your child's ability to communicate	0	1	2	3	5
Tantrums/meltdowns	0	1	2	3	5
Aggressive behaviour (towards siblings, peers)	0	1	2	3	5
Self-injurious/harming behaviour	0	1	2	3	5
Difficulty making transitions from one activity to another	0	1	2	3	5
Sleep problems	0	1	2	3	5
Your child's diet	0	1	2	3	5
Bowel problems (diarrhoea, constipation)	0	1	2	3	5
Toileting issues	0	1	2	3	5
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Concern for the future of your child being accepted by others	0	1	2	3	5
Concern for the future of your child living independently	0	1	2	3	5
SUBTOTAL					
TOTAL					

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OVERALL SESSION EVALUATION FORM

1. HOW DID YOU HEAR ABOUT THE SESSIONS?
2. WAS THE TIME OF THE SESSIONS OK? ☐ YES ☐ NO
3. WAS THE NUMBER OF SESSIONS OK? ☐ YES ☐ NO
4. WHAT FOR YOU, WAS THE MOST USEFUL ABOUT THE SESSIONS?
5. WHAT FOR YOU, WAS THE LEAST USEFUL?
6. DID THE SESSIONS MEET YOUR EXPECTATIONS? ☐ YES ☐ NO
7. ARE THERE OTHER TOPICS/ISSUE THAT IT WOULD HAVE BEEN USEFUL TO LOOK AT?
8. HOW HAVE THE SESSIONS CHANGED YOU AS A PARENT?
9. HAVE THE SESSIONS MADE ANY DIFFERENCE TO YOUR TEENAGERS' BEHAVIOUR?

   ☐ YES ☐ NO

   IF YES, PLEASE DESCRIBE OR EXPLAIN THE CHANGE
10. HAVE THE SESSIONS MADE ANY DIFFERENCE TO YOUR RELATIONSHIP WITH YOUR TEENAGER?

    ☐ YES ☐ NO

    IF YES, PLEASE DESCRIBE OR EXPLAIN THE CHANGE
11. WHAT WAS THE BEST MOMENT FOR YOU IN THE SESSION?
12. DID YOU FEEL SUPPORTED IN THE GROUP BY THE SESSION FACILITATORS?

    ☐ NOT SUPPORTED ☐ UNSURE

    ☐ SUPPORTED ☐ VERY SUPPORTED

ANY OTHER COMMENTS ABOUT THE SESSIONS AND/OR THE SESSION FACILITATORS:

FINISHED!!!!

REFERENCES

Dunckley V 2016, Autism and Screen Time: Special Brains, Special Risks. Children with autism are vulnerable to the negative effects of screen time. Posted Dec 31, 2016 *https://www.psychologytoday.com/us/blog/mental-wealth/201612/autism-and-screen-time-special-brains-special-risks*

Gillingham, G. (1995) Autism: Handle with Care! Understanding and Managing Behaviour of Children and Adults with Autism. Future Education Inc., Arlington. Hearing Sol 2019, how autism affects the brain, cited online *https://www.hearingsol.com/faq/autism-affects-the-brain/*

Hobbs, K G 2021 Autism, Head Banging and other Self Harming Behaviour *https://www.autismparentingmagazine.com/autism-self-harm/*

Karim K & Baines S 2016, Deliberate self-harm in autistic children and young people. Cited online *https://www.autism.org.uk/advice-and-guidance/professional-practice/deliberate-self-harm*

Sanctuary L 2020, AUTISM AND SELF-HARM cited online *https://www.beheadstrong.uk/info/autism-and-self-harm*

Miserandino C 2003, The Spoon Theory cited by Raede D (2018) Spoon theory & capacity issues *https://www.aspergerexperts.com/blogs/entry/29-spoon-theory-capacity-issues/NAS 2011*

National Autistic Society cited Sanctuary (2017) Autism and self-harm. Cited online *https://www.autism.org.uk/advice-and-guidance/professional-practice/self-harm*

National Statistics Department for education July 2019 cited online *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814244/SEN_2019_Text.docx.pdf*

Oxford Health NHS, 2014, Sensory Processing Children's Community Occupational Therapy *https://www.oxfordhealth.nhs.uk/children-and-young-people/wp-content/uploads/2014/05/Sensory-Processing-presentation-February-2014.pdf*

Richdale A L & Schreck K A (2009) Sleep problems in autism spectrum disorders: Prevalence, nature, & possible biopsychosocial aetiologies, Sleep Medicine Reviews 13 403–411

Soraya L 2008, Empathy, Mindblindness, and Theory of Mind, Do people with autism truly lack empathy? Reviewed by Kaja Perina *https://www.psychologytoday.com/us/blog/aspergers-diary/200805/empathy-mindblindness-and-theory-mind*

Yourkidstable.com. 80+ Powerful Proprioceptive activities. *https://105b31079a1ba381f52e-ac2ec5114feb632a1114f20df0e72453.ssl.cf2.rackcdn.com/Page/5e7b6e13-5778-4cf9-b381-29c90ad284e6/powerful%20proprioceptive%20activities.pdf*

BRAIN DEVELOPMENT INFORMATION READING SOURCES

Askham AV 2020, Brain structure changes in autism, explained cited online *https://www.spectrumnews.org/news/brain-structure-changes-in-autism-explained/*

Autism and the brain poster cited online *https://me.me/i/autism-and-the-brain-cerebral-cortex-temporal-lobe-the-30-8830193*

Deweerdt S 2017, Brain's bridge could yield clues to faulty wiring in autism, cited online *https://www.spectrumnews.org/news/brains-bridge-yield-clues-faulty-wiring-autism/*

Deweerdt S 2019, Brain's prefrontal cortex conducts symphony of social players cited online *https://www.spectrumnews.org/news/brains-prefrontal-cortex-conducts-symphony-social-players/*

Hearing Sol 2019, how autism affects the brain, cited online *https://www.hearingsol.com/faq/autism-affects-the-brain/*

Hobbs, K G 2021 Autism, Head Banging and other Self Harming Behaviour *https://www.autismparentingmagazine.com/autism-self-harm/*

Soke, G.N., Rosenberg, S.A., Hamman, R.F. et al. Brief Report: Prevalence of Self-injurious Behaviours among Children with Autism Spectrum Disorder—A Population-Based Study. J Autism Dev Disord 46, 3607–3614 (2016). *https://doi.org/10.1007/s10803-016-2879-1*

Symons K 2016, Teenagers with autism. *https://www.sec-ed.co.uk/best-practice/send-teenagers-with-autism/*

Watson S 2007 "Autism Basics" HowStuffWorks.com. cited online *https://health.howstuffworks.com/mental-health/autism/autism.htm*