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# Playing with WePlay!: Adapting a Caregiver-Child Group for Caregivers of Young Children with Early Signs of Autism Spectrum Disorder

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## Abstract

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**Abstract**

WePlay! Denver, a collaboration between the University of Denver's Graduate School of Professional Psychology and the Children's Museum of Denver, Marsico Campus, began providing caregiver-infant playgroups to the community in 2019. WePlay! and Nosotros Jugamos, the English and Spanish-speaking groups, teach caregivers with young children about play-based exploration, provide psychoeducation, and offer resources. Qualitative data from WePlay! Denver's initial groups and input from the WePlay! Denver team emphasized interest in expanding WePlay! to include families with children of varying developmental stages and who have specific developmental needs and considerations (Gross et al., 2021), such as autism spectrum disorder (ASD). ASD is a neurodevelopmental disorder consisting of social communication and social interaction deficits and restricted, repetitive patterns of behavior, interests, or activities. This paper adapts the recently published WePlay! Denver curriculum (Gross, 2023) to caregivers of young children who have early signs of ASD, with a new group entitled WeStart2Play.

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## Interventions for Autistic Children

Autism spectrum disorder (ASD) is a neurodevelopmental disorder[1] that, according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), has a prevalence of between 1% and 2% in the United States and approximately 1% of the population in other countries (American Psychiatric Association, 2022). Data from the Centers for Disease Control and Prevention's Autism and Developmental Disabilities Monitoring Network suggests that 1 in 36 eight-year-old children in the United States are autistic,[2] which is higher than previous estimates from 2000 to 2018 (Maenner et al., 2023). For a diagnosis of ASD, some features must be present in the early developmental period and are typically present by age two, although they may be seen earlier than 12 months or noted later than 24 months (American Psychiatric Association, 2022).

DC:0-5, a guide to infant and early childhood mental health diagnostic formulation, added Early Atypical Autism Spectrum Disorder as a classification (Zeanah et al., 2017). It identifies children under three years old who are experiencing early signs and symptoms of ASD without meeting full criteria for ASD (Zeanah et al., 2017). Early symptoms can include an apparent lack of social interest, shared affect, eye contact, gaze to faces, and response to name. Symptoms that typically develop after the first year of life include delays or deficits in gesture use, verbal communication, and imitation (Ozonoff & Iosif, 2019).

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[1] This paper uses the DSM-5-TR as a framework with which to define ASD. There are limitations to the medical model's assertion that disabilities are pathological, and there are alternative models of neurodiversity, including the social model and a neurodiversity approach (Dwyer, 2022).

[2] There is variability in autism-related nomenclature, with some people using person-first (person with ASD or person who has ASD) and others using identity-first language (autistic person). This academic paper primarily uses identity-first language when describing autistic individuals, following the American Psychological Association's Inclusive Language Guide (American Psychological Association, 2023). The guide states that individuals can use the preferred identity-first language of the autistic community, as many autistic individuals prefer identity-first to person-first language (Kenny et al., 2016; Taboas et al., 2023). This paper uses person-first language when referring to young children who have early signs of ASD because it would be inaccurate to refer to them as autistic.

While autism symptoms typically emerge around the first year or two of life (Ozonoff et al., 2010), the median age of diagnosis is around 49 months (Maenner et al., 2023). Thus, many interventions are focused on preschoolers or older children (see Gibson et al., 2021 for a review) who have received autism diagnoses. Existing autism-focused interventions include behavioral, developmental, and Naturalistic Developmental Behavioral Interventions (NDBIs).

Behavioral approaches, such as Applied Behavior Analysis (ABA) treatments,[3] are commonly used to improve autistic children's outcomes (Sandbank et al., 2020). These approaches can enhance children's intellectual abilities, communication skills, expressive and receptive language skills, adaptive behavior, and socialization (Makrygianni et al., 2018). ABA is typically highly structured, one-on-one, skills based, and intensive. Intensive early intervention encompasses interventions that are 25-40 hours a week for at least a year (Sandbank et al., 2020).

Developmental interventions, such as Developmental, Individual-differences, Relationship-based (DIR) Floortime Model, are also frequently implemented, following the research that early social deficits may lead to social interaction challenges between young autistic children and their caregivers (Sandbank et al., 2020). DIR Floortime can enhance children's social-emotional development (Boshoff et al., 2020). NDBIs, such as the Early Start Denver Model (ESDM), have theoretical foundations in both behaviorism and developmental psychology. A meta-analysis found a moderate and statistically significant effect size indicating benefits for children receiving the ESDM compared to children in control groups (Fuller et al., 2020).

[3] While research has shown the efficacy of ABA, individuals, including autism rights and neurodiversity activists, have raised concerns about its use (Leaf et al., 2022). Additional research is needed to ensure that its practices are neurodiversity-affirming.

While there are myriad interventions for older children, interventions should be provided as early as possible (Sandbank et al., 2020) because they can improve a child's developmental trajectory (Centers for Disease Control and Prevention, 2023; Zwaigenbaum et al., 2015). Zwaigenbaum and colleagues (2015) outlined particular practice and research recommendations for autistic children younger than three years old, who rely on in-vivo learning and play-based social interactions within their familial environments (Zwaigenbaum et al., 2015). They recommended that early intervention programs use a combination of developmental and behavioral approaches, specifically using play and imitation to target language skills, joint attention, and emotional reciprocity. Additionally, they recommended that interventions actively involve caregivers and consider sociocultural factors (Zwaigenbaum et al., 2015).

When the National Autism Center's National Standards Project (2015) released information on 14 established intervention practices that produced favorable outcomes for autistic children, only three demonstrated favorable outcomes for children younger than three years old: parent training, Naturalistic Teaching Strategies, and Comprehensive Behavioral Treatment for Young Children (CBTYC). Of note, Phase 2 of the National Standards Project reviewed studies between 2007 and 2012, and although further research on interventions for younger children has been conducted since then, the National Autism Center has not released an update (National Autism Center, 2015).

An overview of reviews examining interventions for children under three years old who were autistic or at a high likelihood for ASD found that child outcomes and intervention dose, setting, and delivery agent varied widely across studies (Franz et al., 2022). Franz and colleagues (2022) noted that early intervention approaches impact child developmental outcomes but that it is difficult to conclude which interventions are most effective due to limitations in the literature.

Nonetheless, the authors still found some support for NDBI and developmental interventions, whose incorporation of caregivers and commitment to natural learning experiences align with family-centered early intervention services. Although Franz and colleagues (2022) did not focus on interventions for caregivers, they emphasized the importance of involving caregivers in services and bolstering their mental health and wellbeing. Many interventions concentrate on children's outcomes, but it is critical to consider approaches that examine caregiver outcomes as well.

**Caregivers**

In addition to an ASD diagnosis affecting autistic individuals, it can impact caregivers in many different ways. The diagnostic process can bring clarity to what is happening for a child and confirm caregivers' suspicions of developmental differences (Crais et al., 2020). While some family members anticipate the diagnosis, however, others are shocked and experience difficulties post-diagnosis.

Certain studies show that caregivers of autistic children have higher levels of stress, depression, and anxiety than caregivers of non-autistic children (Bonis, 2016; Hayes & Watson, 2013; Ooi et al., 2016). Having an autistic child can impact caregivers' sense of self, and they can feel lonely and isolated (Woodgate et al., 2008). Some families find the diagnosis to be "devastating" (Crais et al., 2020, p. 149). Caregivers tend to feel overwhelmed and may be unaware of next steps or available resources (Bonis, 2016; Crais et al., 2020).

Some researchers have characterized family members' reactions following a diagnosis as mirroring symptoms of the grieving process (Bravo-Bénitez et al., 2019; Fernańdez-Alcántara et al., 2016). There can be a perceived loss associated with an ASD diagnosis; caregivers' expectations for their child and their child's future tend to change post-diagnosis. For example,

some caregivers have concerns about how independent and autonomous their autistic child will be (Bravo-Bénitez et al., 2019). The perceived loss triggers emotions, including denial, guilt, sadness, and anger (Bravo-Bénitez et al., 2019; Fernańdez-Alcántara et al., 2016). It is important for professionals to normalize this post-diagnosis process. They can work on decreasing parenting stress, which can improve families' overall functioning (Hayes & Watson, 2013). A meta-synthesis exploring caregivers' perspectives on raising an autistic child found that acceptance and problem-focused strategies were common coping skills for caregivers (Ooi et al., 2016). Acceptance is part of the post-diagnosis process; once caregivers accept their feelings and their child's diagnosis, they can consider specific goals related to what they want for their child (Fernańdez-Alcántara et al., 2016).

It is essential to consider resiliency and positive factors when attempting to understand parenting stress and overall family functioning post-ASD diagnosis (Hayes & Watson, 2013). Resilience, as defined in Kim, Dababnah, and Lee's (2023) study, included family members discussing what to do when facing challenges, collaborating to solve problems, knowing they had strengths, and remaining hopeful. Kim, Dababnah, and Lee (2023) found that the relationship between parenting stress and family resilience differed by race/ethnicity. An increase in family resilience correlated with a decrease in parenting stress for caregivers of African American and White autistic children, but the relationship was more pronounced for caregivers of African American children. The study highlighted racial and ethnic nuances in resiliency factors, as the construct of family resilience the researchers used may not have accurately measured family resilience across different races and ethnicities, especially within Hispanic families (Kim et al., 2020). Future research should continue to examine protective factors for families of all backgrounds who are raising autistic children.

Some caregivers feel supported by agencies and organizations, and studies have emphasized the benefits of a collaborative partnership between caregivers and empathic professionals (Bonis, 2016; Crais et al., 2020; Woodgate et al., 2008). These professionals deliver information and supply resources to help give caregivers a sense of control and empower them to advocate for their child (Ooi et al., 2016). Increasing parental self-efficacy, or caregivers' confidence in their ability to perform parenting tasks so they positively influence their child, can help caregivers and their children. Parental self-efficacy has been associated with positive outcomes related to the caregiver and child relationship, parental mental health, and child development (Albanese et al., 2019). Strong family communication, a unified approach to parenting, and robust social support can also aid families of autistic children (Bonis, 2016). Support groups can be a source of support that is particularly powerful. Groups can encourage caregivers, instill hope, and broaden their social circle amid potential feelings of isolation (Ooi et al., 2016).

In their systematic review and meta-analysis, Jeong and colleagues (2021) concluded that parenting interventions delivered before children turned three improved parenting knowledge, parenting practices, parent-child interactions, attachment, and early child cognitive, language, motor, and socioemotional development. The authors stated that intervention strategies aiming to improve child socioemotional development and reduce behavior problems should use evidence-based curriculum content and support caregivers' behavioral management skills, address parental mental health, and encourage nonviolent discipline (Jeong et al., 2021).

Limitations to the existing interventions leave opportunities for groups that better assist caregivers. Only 7% of the parenting interventions the authors reviewed included fathers (Jeong et al., 2021), which highlights a need for parenting programs to expand to apply to all caregivers.

The authors found that existing interventions reduced child behavior problems but did not significantly reduce parental depressive symptoms. They posited that the parenting interventions did not reduce parental depressive symptoms because only a few of the interventions had an explicit psychological component to address parental mental health. One existing parenting group intervention in Uganda that found some reductions in maternal depression incorporated responsive caregiving, parental emotion regulation, coping strategies, and principles of cognitive behavioral therapy (Jeong et al., 2021). New parenting interventions that contain these components can hopefully address parental mental health more directly. Additionally, the authors noted that most of the existing socioemotional and behavioral-focused parenting programs were delivered to caregivers who had preschool-aged children rather than younger children (Jeong et al., 2021) so there is an opening for programs that target caregivers of younger children.

**Playgroups**

Playgroups involve regular facilitated group sessions for caregivers and their young children. They aim to enhance children's early development, promote positive parenting practices, support caregivers' social relationships, and help caregivers access community resources (Williams et al., 2018). Williams, Berthelsen, Viviani, and Nicholson (2018) conducted a systematic literature review of primarily Australian-based supported playgroup studies. Standard supported playgroups involve two-hour weekly facilitated groups without a specific curriculum. Caregivers play with their children, speak to each other, and participate in snack-time. Supported playgroups with specific interventions are playgroups with a certain curriculum delivered to caregivers and their children through play. The authors found the

strongest evidence of effectiveness for supported playgroups with specific interventions (Williams et al., 2018).

In their 2020 study, Armstrong and colleagues investigated core elements of therapeutic playgroups, which concentrate on the needs of a particular population. The researchers conducted focus groups and interviewed professionals with experience facilitating playgroups for children at risk of developing or with identified developmental delays and disabilities. Findings indicated that group facilitators should have a therapeutic background with specific experience with children and knowledge of child development. Playgroup psychoeducation was focused on child development, helpful developmentally appropriate strategies, the importance of play, and how to play. Structured talks and handouts supplemented informal conversations to ensure caregivers of all learning styles received information. Study participants also highlighted the importance of interpersonal skills, as certain facilitator characteristics engendered a strong relationship between caregivers and facilitators. Kind, friendly, welcoming, and nonjudgmental facilitators promoted a supportive and inclusive environment (Armstrong et al., 2020).

In addition to examining facilitator characters, Armstrong and colleagues (2020) explored family characteristics that increased playgroup engagement. Caregivers were more likely to attend and engage in groups when the group met specific expectations. One of the caregivers' expectations of participating in the group was to connect with other caregivers. The shared experience of parenting a child with developmental delays or disabilities was critical to fostering a sense of belonging. Additional expectations that caregivers had were for facilitators to provide information and build caregivers' confidence. Facilitators should be connected to the community, and they should provide appropriate referrals when necessary. Findings suggested that facilitators should also partner with and coach caregivers, which can help them recognize

their own expertise and set goals for themselves and their children. While facilitators offer support and information, caregivers lead groups and decide in which activities their children engage. Caregivers assume active roles in a successful therapeutic playgroup; they engage with their child, follow their lead, and support their exploration. Groups incorporated natural learning opportunities with available toys and equipment, as well as peer modeling and learning. Additionally, the authors described playgroups as most successful when they employed a consistent routine, such as having a welcome song, mat time, snacks, activities, free play, and a goodbye song or activity (Armstrong et al., 2020). WePlay![4] Denver is an example of a group that employs aspects of the successful playgroups Armstrong and colleagues (2020) delineated.

## Introduction to WePlay! Denver

WePlay! Denver, which was inspired by a similar group at the Chicago Children's Museum, offers facilitated groups for caregivers and their young children ages 6-36 months (Gross et al., 2021). Tracy Moran Vozar, Ph.D., IMH-E (IV-R), PMH-C, launched WePlay! Denver in 2019 and WePlay! DC in early 2023. WePlay! is a strengths-based support, play, and psychoeducational group that teaches children using materials in their natural environment. Facilitators also offer take-home materials and resources to the families. Groups are 90 minutes if held in person and 60 minutes if held virtually. Group guidelines include having at least two, but ideally four, facilitators for a total cohort size of around eight families (Gross, 2023). Families typically discover WePlay! Denver via referral or word-of-mouth. With support from grant funding, groups are free, and participants receive transportation access, snacks, and a year-long family membership to the Children's Museum of Denver.

[4] As of this paper's completion, WePlay! has not been copyrighted, but the team is in the process of filing for copyright.

WePlay! Denver rests on three foundational pillars: community engagement, cultural responsiveness, and evidence-informed practices. WePlay! was designed for the community and is caregiver-driven; aspects of the curriculum differ between the English and Spanish-speaking groups and are adapted depending on the needs of each group. Initial focus groups suggested that caregivers were interested in group content around "helping children socialize, meeting other parents, reducing stress, understanding early childhood development, managing our own emotions, and creating opportunities to play" (Gross et al., 2021, para. 4). Thus, facilitators incorporated that content in groups and shared information and best practices from nationally recognized early childhood organizations, such as Zero to Three.

WePlay! facilitators focus on a specific psychoeducational topic and type of play each week of the six-week group. Although psychoeducational topics differ based on participant input, facilitators typically integrate content from interventions such as Circle of Security (COS) (Hoffman et al., 2006) and Integration of Working Models of Attachment into Parent-Child Interaction Therapy (IoWA-PCIT) (Troutman, 2022). Play types include sensory, attunement, physical, object, imaginative, and creative.

As outlined in Gross's (2023) WePlay! manual, group goals for participants are to (a) increase knowledge of child development, (b) gain skills in effective parenting, (c) feel connected with other caregivers and create a support network, (d) increase self-reported caregiver self-efficacy, (e) positively affect the caregiver-child attachment relationship, (f) increase caregiver understanding of their infant, (g) provide resources for families to continue practicing the activities and types of play they learned at home, (h) have access to specialized mental health care services if needed, and (i) gain more familiarity and comfort with and increase access to the Children's Museum. Although WePlay! lists common cohort goals, groups are

participant-led, and goals are co-created. Thus, each group's goals differ based on participants' needs.

**Evidence-Informed Practices**

WePlay! Denver collects pre- and post-group data on indicators associated with positive outcomes for caregivers and children (Gross, 2023). Group facilitators initially collected demographic data, and caregivers provided quantitative and qualitative data through assessments and interviews. As caregivers of autistic children can have increased feelings of loneliness and experience stress, depression, and anxiety (Hayes & Watson, 2013; Bonis, 2016; Ooi et al., 2016; Woodgate et al., 2008), caregivers completed questionnaires to provide information regarding their mental health and wellbeing. Caregivers also completed measures to assess their child's social-emotional development.

Due to the COVID-19 pandemic, caregivers needed to complete assessments online using Qualtrics. This resulted in the team administering fewer measures. Thus, group members after March 2020 did not complete the child-focused screeners. In addition to providing quantitative information via questionnaires, caregivers gave qualitative feedback during a one-on-one interview after the final group (Gross, 2023).

When Gross et al. (2021) published their article outlining WePlay! Denver, there had been three in-person and two virtual WePlay! cohorts and one in-person and two virtual Nosotros Jugamos, formerly known as WePlay! Español, cohorts. Qualitative data suggested that caregivers appreciated that their children socialized with developmentally similar peers and that caregivers received materials and resources to use outside of the group. In addition to learning from other caregivers, they learned about self-care, parenting approaches, child development, and how to meet their children's needs. One of the recommendations was to expand WePlay! to

include families with children of varying developmental ages (Gross et al., 2021). This paper aims to adapt the original WePlay! Denver manual to meet the needs of some of those families.

Through its partnership with Rocky Mountain Human Services, a nonprofit organization that offers case management and direct service support to Colorado residents, WePlay! Denver conducted its first virtual cohort with families who had children with a higher level of developmental needs. Facilitators discussed the importance of early intervention in supporting young neurodiverse children and had community partners visit groups to help connect families to resources. Qualitative data from that cohort suggested that caregivers appreciated learning about psychoeducational topics, engaging in play activities, connecting with other families, and receiving validation around their parenting struggles. The group was held virtually, and participants highlighted the accessibility of virtual groups while expressing a desire to interact more with the other caregivers (Gross et al., 2021).

**WeStart2Play Adaptation**

This paper's adapted WePlay! group, WeStart2Play, is a new strengths-based, community-informed, culturally responsive play, psychoeducational, and social support group for young children with early signs of ASD and their caregivers. It is not a clinical intervention; rather, it is a caregiver-child group for community members. Similar to WePlay! Denver, WeStart2Play will represent a partnership between psychology team members from a local university and/or psychology training site and a local children's museum. The psychology and museum teams will collaborate to lead the groups.

The WeStart2Play curriculum incorporates aspects of Armstrong et al. (2020) and Zwaigenbaum et al.'s (2015) recommendations while separating itself from early interventions that intend to decrease symptoms of ASD. Aiming to decrease symptoms of ASD assumes that

aspects of ASD are problematic and need to be changed. That aligns with a more medical model approach of striving to cure or normalize people to make them more like typically developing individuals (Dwyer et al., 2022). While areas of challenge should be acknowledged, individuals should feel like they are accepted and valued, not deficient (Dwyer et al., 2022). WeStart2Play focuses on supporting and educating caregivers, and it uses a strengths-based approach with all participants.

WeStart2Play is developmentally focused, welcomes all parenting partners, supports parental wellbeing, and involves play, psychoeducation, and routines. It is brief, free for participants, and does not require formal training to administer. Though there are potential drawbacks to not having formal training in terms of facilitator competence and treatment fidelity, it makes groups more easily accessible. WeStart2Play group leaders are still expected to be knowledgeable in psychology (graduate student facilitators) and play (children's museum facilitators). Facilitators will also possess strong relational skills, which helps caregivers feel accepted and comfortable in groups (Armstrong et al., 2020).

Groups endeavor to supply caregivers with creative skills to interact with their child(ren), provide caregivers psychoeducation on several topics, and enhance caregivers' feelings of support, self-efficacy, and self-compassion. Families with children who have early signs of ASD will hopefully learn more about ASD and play, connect with others in a warm and accepting space, and identify their child's strengths. They may also help their child build functional skills. Play enriches children's psychosocial development and helps them learn about the world (Elbeltagi et al., 2023). Play therapy can encourage autistic children to engage in play activities in which they are interested and express themselves in ways that are comfortable and safe (Elbeltagi et al., 2023). WeStart2Play is not a structured play therapy intervention, but it will

supply caregivers with information about play and connect them to play therapy resources if families are interested in them.

While much of the ASD literature is focused on children with a formal diagnosis, children in WeStart2Play may not be diagnosed with ASD, as the group is for children who exhibit early signs of ASD, including difficulty making or sustaining eye contact, directing a variety of facial expressions to others, and responding to their name. Some children may have a diagnosis or receive one when they are older, while others may never be diagnosed with ASD. Caregivers of children who have a diagnosis who are willing to share their experiences can support caregivers whose children do not have a current diagnosis of ASD. For caregivers of children who are exhibiting early signs of ASD but will not receive a later diagnosis of ASD, they can still listen to, empathize with, and learn from the other caregivers.

## WeStart2Play Curriculum

### Purpose and Objectives

WeStart2Play aims to create a community where caregivers are empowered with knowledge about their children and feel connected to their children and other caregivers. It is important for facilitators to collaborate with group participants to refine and individualize the group objectives and curriculum. The curriculum is co-created so the proposed curriculum in this paper should be modified to best meet each group's needs. WeStart2Play's objectives are similar to those of WePlay! Denver with additions related to caregivers learning about ASD and play. Suggested WeStart2Play objectives are for caregivers to (a) strengthen their understanding of child development milestones, (b) improve their knowledge of play, (c) promote their insight into ASD, (d) learn skills to positively affect the caregiver-child relationship, (e) increase their

self-efficacy and self-compassion, (f) connect to other caregivers in the group, and (g) acquire community resources.

**Recruitment Procedures**

Gross (2023) outlines relevant recruitment partners, such as pediatricians, early intervention providers, resource centers, social media groups for families, daycares, and early childhood education centers. WeStart2Play will be piloted in a large metro area, such as Denver or Washington DC, where WePlay! Denver and WePlay! DC already have community partners to aid with recruitment. Fliers will be distributed physically throughout the area and virtually on social media. WePlay! Denver can add information about WeStart2Play to their website to help spread the word about this new group. Individuals can also self-refer to the program.

**Eligibility Criteria for Participants and Facilitators**

Once individuals note interest in being screened to participate in WeStart2Play, group leaders on the psychology team will conduct an eligibility screener via phone or Zoom. After individuals complete the screen, the WeStart2Play team will inform them whether they are eligible to participate. In Gross's (2023) WePlay! Denver manual, she suggests that caregivers must be at least 18 years of age due to consent considerations, caregivers must speak English for WePlay! groups, and children must be 6-15 months of age.

For WeStart2Play, caregivers must be at least 18 years of age, and they should speak and understand English. Caregivers must have some developmental concerns about their child, including not meeting social/emotional, language/communication, cognitive, and/or movement/physical developmental milestones as expected. Specific ASD-related concerns may include a perceived lack of shared affect or social interest, reduced or absent eye contact or gaze to faces, or limited or absent response to name (Ozonoff & Iosif, 2019). The noted

developmental concerns can be reported from a caregiver or pediatrician and/or be because the child has a sibling with a diagnosis of ASD due to siblings' increased likelihood of being autistic (Ozonoff et al., 2010).

The suggested WeStart2Play age range is 9-18 months. The American Academy of Pediatrics recommends conducting developmental screenings for all children at nine months of age and autism-specific screenings starting at 18 months of age (Hyman et al., 2020). Studies have suggested that while infants subsequently diagnosed with ASD and typically developing age-matched infants do not consistently exhibit significant differences at six months of age (Zwaigenbaum et al., 2005; Ozonoff et al., 2010), infants subsequently diagnosed with ASD exhibit declines in development from 6 to 36 months (Ozonoff & Iosif, 2019). There are various patterns of ASD development; some children exhibit social communication delays or differences in the first or second year of life, while others develop typically for some time before regressing (Ozonoff & Iosif, 2019). Another group may develop typically before plateauing in terms of skill development (Ozonoff & Iosif, 2019). With WeStart2Play's age range, child participants will likely exhibit features of ASD without having a formal diagnosis.

The WeStart2Play team should be composed of group leaders knowledgeable in psychology and play, such as psychology graduate students and children's museum staff members. The psychology team should have a thorough understanding of attachment theory, child development, and neurodevelopmental disorders. Advanced students specializing in working with children, especially neurodiverse children, are preferred. Before the first WeStart2Play group, the psychology team will provide psychoeducation to the children's museum team to ensure they have a general understanding of what ASD is and how early features can impact young children and their caregivers.

**Program Evaluation**

If individuals are eligible to attend the group, then group facilitators will begin the informed consent process and send out pre-group measures for participants to complete. Following the American Psychological Association's Inclusive Language Guide (2023), group facilitators should ask participants about their use of identity-first versus person-first language. Then, in group, facilitators should explain the difference and note why they are using certain terminology. If all participants prefer identity-first or person-first language, then facilitators will use the participants' preferred language. If there is a mixture of preferences, then facilitators should use both identity- and person-first terminology. This follows the Inclusive Language Guide's (American Psychological Association, 2023) recommendation that language should be selected based on individual preference.

Similar to WePlay! Denver, pre-group measures include a sociodemographic questionnaire; the Parenting Stress Index, Fourth Edition Short Form (PSI-4-SF) (Abidin, 2012); the Self-Compassion Scale-Short Form (SCS-SF) (Raes et al., 2011); the Assessment of Parenting Tool (Moran et al., 2012); and the Devereux Early Childhood Assessment (DECA) (Mackrain et al., 2007). WeStart2Play also incorporates the Infant-Toddler Checklist, a freely available parent questionnaire screener of communication in children ages 6-24 months that has been shown to identify autistic children (Wetherby et al., 2008). The Infant and Toddler Checklist helps identify language delays and might assist in identifying infant siblings of autistic children who are at increased likelihood of having ASD (Hyman et al., 2020).

After the six-week group, each group member will participate in a post-group interview with a group facilitator and complete post-group measures. The post-group interview for WeStart2Play is adapted from the WePlay! Denver interview. Interviews are about 10 questions

long and take around 30 minutes (Gross, 2023). The post-group measures are the same as the pre-group measures.

**Weekly Protocol**

Groups are 90 minutes if held in person and 60 minutes if held virtually. There should be at least two, but ideally four, facilitators with around eight families. At the beginning and end of each group, facilitators and participants sing songs as part of the weekly routine. Nursery rhymes related to the weekly group content can also be used to transition from play to psychoeducation.

Group sessions include (a) a greeting and welcome song, (b) a description of a play theme and a demonstration of various activities related to the weekly theme, (c) a designated amount of time for caregivers and their children to explore the materials and engage in play while facilitators move around the room to interact with and support participants, (d) a facilitator-led introduction of psychoeducational topic(s), (e) a participant discussion, and (f) a goodbye and closing song (see Appendix A for a group outline). Groups will have physical and virtual resources to share with families (see Appendix B for a resource list). Each week, the room should have a table with snacks and group materials, a large carpet or mat, and chairs. Group members typically sit in a circle on a carpet or mat. There will be a safe, quiet space in a corner of the room where caregivers and children can go at any point throughout the group if they need a break.

Week One starts with group facilitators and participants introducing themselves. Group leaders then explain the group and its format, and members collaborate to create group rules, which should include confidentiality. This is time for the facilitators to discuss their use of identity-first and/or person-first language. After the introductions and establishment of group expectations, facilitators will explain sensory play involving the five senses. Very young children

frequently use their senses to better understand their environment (e.g., putting body parts or objects in their mouth, listening to sounds, watching movements, touching play items). Young autistic children may be sensitive to sensory input, which is part of the ASD DSM-5-TR criteria (American Psychiatric Association, 2022). The children's museum team will describe and model various activity options (e.g., applying different amounts of pressure on body parts, interacting with sensory touch and feel books, playing with water and sponges in a bin or bucket) to accommodate children's preferences. The psychology team will acknowledge sensory sensitivities during the psychoeducational component of the group when they start a conversation about developmental delays and ASD. Facilitators can ask caregivers specific questions (e.g., "What brought you to this group? What have you observed with your babies? What do you know about ASD?"). Facilitators should explain early features of ASD, name potential difficulties and strengths associated with the diagnosis, and dispel common myths and stereotypes. This can involve a conversation about different definitions of ASD with resources available for families. Facilitators should ask caregivers what they want to discuss and learn about in future groups to help co-create the curriculum.

Week Two incorporates attunement play, which is focused on the caregiver-child relationship. Facilitators should define attunement and explain attunement play, including making eye contact, engaging in joint attention, modeling, imitating, and following their child's lead. This play may be challenging for families due to social communication and interaction differences. Caregivers can make faces and change their voice intonation to engage with their child, show their child a mirror, use opaque play scarves to play peekaboo, and more. Facilitators should emphasize that there is no "right" way to connect with children and that connection does not require eye contact or joint attention. Facilitators should introduce Circle of Security (COS)

(Hoffman et al., 2006) as a way to explore attachment and secure relationships. They can ask, "Tell me about your relationship with your child. How do you engage with your child?" Participants can share how and when they feel connected to their child.

Week Three concentrates on creative play with musical instruments and art. The room will have various child-friendly instruments (e.g., rattles, hand bells, and mini drums) and art supplies. Some neurodiverse children are sensitive to sounds and textures. Accommodations for sensory sensitivities can include headphones, large paint brushes, and wet wipes. Children who become dysregulated by noise or social exposure can go to the dedicated quiet, cozy space in the room. Facilitators will talk about child development, introducing developmental milestones and IoWA-PCIT PRIDE skills (praise, reflect, imitate, describe, enjoy) (Troutman, 2022). Facilitators can model each skill, and caregivers can spend time practicing them. These skills should be used in a neurodiversity affirming way. For example, caregivers can praise their children for who they are instead of focusing on praising concrete accomplishments. Reflections will not be as common if children have not started producing language. Caregivers can implement the skills that apply to their child, acknowledging that they may use new skills as their child gets older. Additionally, there can be a group discussion about caregivers' hopes and fears for their children. The conversation should include the potential gains and strengths that caregivers may have and discover because of their experience with their child.

Week Four covers movement with fine (e.g., scribble with jumbo crayons) and gross (e.g., interact with balls of various sizes) motor activities. Children with motor delays may have particular difficulty with this play, and it will be critical to monitor children's safety. Facilitators can consult an occupational therapist for additional support around how to adapt these activities in an inclusive and safe way. Psychoeducation is about parental mental health so facilitators will

lead a discussion on self-care, stress management, and mindfulness. Facilitators should introduce specific strategies, including deep breathing and Progressive Muscle Relaxation. Caregivers can share what they do to take care of themselves and choose a relaxation skill to try before the next week. Caregivers may be interested in participating in individual therapy, and facilitators will have a list of community providers who offer adult therapy.

During Week Five, caregivers and children will interact with a variety of objects, including toy cars, foam blocks, and puzzles. Children's museum staff will model ways to engage with the play materials, such as exploring the materials by holding, dropping, or shaking them. Facilitators will discuss and problem solve around routines such as sleeping and eating. They can introduce visual strategies like visual schedules to help children as they get older. Facilitators can answer questions within their scope and refer participants to their pediatrician for further discussion. Facilitators may bring in a pediatrician and/or an occupational therapist as a guest speaker, too.

Caregivers lead the Week Six play component in a show-and-tell manner. Facilitators and caregivers can bring toys or objects from home and share them with the group. This should lead to a discussion of group members' favorite toy or play item. This activity will hopefully help facilitate connection among members and allow opportunities for caregivers to learn from each other. It can also introduce creativity and flexibility to play, especially if the facilitators bring some household items that can be used in play (e.g., pots and a wooden spoon to make music, paper towel roll for an art activity, water bottle filled with pasta or beans to hold and shake, clothes hanger to create a mobile). As this is the final group, members can reflect on the group thus far. What have group members learned? What are group members' next steps? Facilitators will share community resources and discuss ways to advocate for children. Caregivers can ask

any questions they have and give feedback on the group. Caregivers can also exchange contact information if they have not done so already.

## Discussion

As ASD prevalence has risen in recent years and research has shown that features often emerge early in life, the need for effective services for young children and their caregivers has increased. While many interventions focus exclusively on autistic children, it is essential to assist caregivers of infants and toddlers who have a high likelihood of having ASD, particularly since caregivers of autistic children have higher levels of stress, depression, and anxiety than caregivers of non-autistic children (Ooi et al., 2016). This paper introduces a brief caregiver-child support, psychoeducation, and play group for young children who have early signs of ASD.

Although WeStart2Play is not a clinical intervention, and groups have not been offered yet, WeStart2Play hopes to improve caregivers' mental health and wellbeing and may enhance children's developmental outcomes. By the end of the group, caregivers should have learned information from the groups' psychoeducational topics and feel more supported, self-compassionate, and/or self-efficacious. These intended positive outcomes will be accomplished through playing with their children, interacting with caregivers who have shared experiences, connecting to appropriate resources, and learning more about ASD, child development, and parental self-care. Conclusions regarding group outcomes cannot be drawn yet but should be explored through research studies when the group is delivered.

### Future Directions

Future research is expected to involve piloting WeStart2Play and gathering data to assess its efficacy. Results from WeStart2Play's delivery will be utilized to enhance the groups for

future members. Specifically, pilot data from program evaluation will be used to apply for programmatic funding to be able to offer the program at no cost to families and build a sustainable program. Funding covers aspects of the group, such as the team's time, space to host group, materials, and transportation for participants.

WeStart2Play will be piloted in a large metro area, such as Denver or Washington DC due to WePlay!'s establishment in both cities. Depending on exactly where WeStart2Play is piloted, its staff can partner with pediatricians and the local children's museum. WeStart2Play can then expand across the United States and internationally through program partners and collaborators. As the group develops, it will be important to examine cultural considerations. For example, some areas may not have public transportation access. Funding may be utilized to supply transportation or pay for participants' ride-sharing application use if they have ride-sharing access in their area.

It is critical to increase families' access to WeStart2Play and broaden its cultural application. Similar to WePlay! Denver's counterpart, Nosotros Jugamos, WeStart2Play's curriculum should be translated into Spanish (Nosotros Empezamos a Jugar) and other languages that benefit group participants with group content being adapted as appropriate. Nosotros Jugamos has facilitators and supervisors who are trained in offering evidence-based psychotherapy in Spanish and English, and the group accounts for culture-specific core values and stressors (Gross et al., 2021).

Research on previous Nosotros Jugamos groups determined that participants in Nosotros Jugamos were more likely than participants in the English-speaking WePlay! Denver group to share their personal experiences, including talking about challenges to accessing medical care (Gross et al., 2021). Participants were interested in learning about how to preserve their

culture(s) of origin while adapting to a new culture with some dissimilar parenting practices (Gross et al., 2021). Within Nosotros Jugamos groups, participants differed in their degree of acculturation and assimilation with American culture and in their desire to share experiences and details about their cultures. Though all members spoke Spanish, participants often spoke different dialects and had a range of abilities in speaking and understanding English. These intergroup and intragroup differences emphasize the significance of WePlay!'s flexible, participant-driven model. Psychoeducation and play topics should be geared toward group participants, and each group should be individualized based on the language and cultural norms of its participants.

In addition to expanding geographically, WePlay! is expanding demographically with efforts to adapt WePlay! for caregivers of children in the Intensive Care Unit (Cerqueira Aokalani, 2024). WeStart2Play can also be adapted for toddlers with a proposed 18- to 36-month-old group. While this group has not been created yet, it could be called WeAut2Play. WeAut2Play would likely comprise children who have just received a formal diagnosis of ASD. It is recommended that WeAut2Play be a therapeutic intervention with at least one licensed psychologist. If caregivers are interested in attending another group after WeStart2Play, they can join WePlay! Denver, WePlay! DC, or WeAut2Play depending on their location and their child's needs.

**Conclusion**

WePlay! Denver continues to expand geographically and demographically, and WeStart2Play aims to fill a WePlay! gap by providing services to caregivers who have young children with early neurodevelopmental challenges. The proposed curriculum in this paper is a living document. As WeStart2Play is piloted and researchers evaluate the groups, the curriculum

will likely change to reflect what researchers find to be most effective and helpful for participants. If WeStart2Play exhibits positive outcomes, then it should grow along with WePlay! Denver. The potential Spanish language group, Nosotros Empezamos a Jugar, and toddler group, WeAut2Play, are initial steps in WeStart2Play's expansion.

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## Appendix A

Weekly Protocol Outline

All groups start and end with a song sung to the tune of "The Farmer in the Dell." The welcome song is:

*"We clap [clap] and say hello [wave],*

*We clap [clap] and say hello [wave],*

*To all our friends at WeStart2Play [palm out to gesture to friends],*

*We clap [clap] and say hello [wave]."*

The closing song is:

*"We clap [clap] and say goodbye [wave],*

*We clap [clap] and say goodbye [wave],*

*To all our friends at WeStart2Play [palm out to gesture to friends],*

*We clap [clap] and say goodbye [wave]."*

The proposed curriculum, broken down by week, is below:

1. Week 1 *(Materials: snacks, name tags, markers, water, sponges, buckets/bins, towels, edible Play-Doh or putty, touch and feel books, sensory chew tools)*
    a. Welcome and Introductions
        i. Create name tags and go around the room doing introductions
        ii. Explain group format (welcome song, play, psychoeducation, closing song) and establish expectations
    b. Welcome Song
    c. Play
        i. Sensory play (engaging the five senses)

ii. Introduce that children may have a variety of ways they process sensory input, including being hyperreactive or hyporeactive to sensory stimuli

iii. Briefly discuss and problem solve around how sensory integration and regulation are related

d. Psychoeducation

i. Discuss developmental delays and ASD

1. What do caregivers know about ASD? What have they observed with their infants?

2. Explain the autism spectrum and neurodiversity, including language typically used in medical settings, in schools, and in psychology

3. Dispel myths and stereotypes

4. Describe potential difficulties and strengths associated with ASD

5. Ask caregivers what they want to discuss and learn about in future groups

e. Closing Song

2. Week 2 *(Materials: name tags, markers, opaque play scarves, mirrors)*

a. Welcome Song

b. Play

i. Attunement play (eye contact, joint attention, follow the child's lead) adapted to neurodiverse children's needs

c. Psychoeducation

i. Discuss attachment

1. What is attachment? How do ASD and neurodiversity influence attachment?
2. When and how do you feel connected to your child?
    a. Introduce Circle of Security (COS)

d. Closing Song

3. Week 3 *(Materials: snacks, name tags, markers, paper, edible paint, large paint brushes, computer/speaker, shakers and rattles, headphones, wet wipes)*
    a. Welcome Song
    b. Play
        i. Creative play (music, movement, art) with adaptations for children who have sensory sensitivities
    c. Psychoeducation
        i. Discuss child development
            1. What have people told you about your child's development?
                i. Share the CDC's developmental milestones
                ii. Introduce IoWA-PCIT PRIDE skills
            2. What are your questions? Hopes? Fears?
                a. https://www.emilyperlkingsley.com/welcome-to-holland This can be introduced as a starting point to help families explore their expectations for their children. The author uses disability language, though, and facilitators should note that the author's experience is not universal.
    d. Closing Song

4. Week 4 *(Materials: snacks, name tags, jumbo crayons, paper, pillows, balls of different sizes and textures)*
    a. Welcome Song
    b. Play
        i. Physical play using fine and gross motor skills with adaptations for children who have motor delays
    c. Psychoeducation
        i. Discuss caregiver self-care, stress management, and mindfulness
            1. Introduce relaxation strategies
    d. Closing Song
5. Week 5 *(Materials: snacks, toy food, toy cars, foam blocks, small boxes, puzzles)*
    a. Welcome Song
    b. Play
        i. Object play where young children explore and manipulate play materials (e.g., hold them, drop them, shake them, roll them, bang them together, stack them, knock them over) to help understand their properties
    c. Psychoeducation
        i. Explore routines with potential pediatrician/occupational therapist support
            1. Sleeping
            2. Eating
    d. Closing Song
6. Week 6 *(Materials: snacks)*
    a. Welcome Song

b. Play
    i. Play focused on toys and play items that facilitators and participants enjoy and recommend
c. Psychoeducation
    i. Group members share their child's favorite toys or play items from home
    ii. Facilitators discuss advocacy, provide community resources, and give information about ASD evaluations
    iii. Reflect on group. What have group members learned? What are group members' next steps?
d. Closing Song

## Appendix B

Group Resources

1. Week 1
    a. Sensory play https://health.clevelandclinic.org/benefits-of-sensory-play-ideas
    b. Sensory processing https://childmind.org/article/sensory-processing-issues-explained/
    c. ASD
        i. https://www.nimh.nih.gov/health/topics/autism-spectrum-disorders-asd
        ii. https://www.cdc.gov/ncbddd/autism/facts.html
        iii. 16 Early Signs of Autism by 16 months https://babynavigator.com/16-early-signs-of-autism-by-16-months-download-print/
        iv. A Parent's Guide to Autism https://www.autismspeaks.org/tool-kit/parents-guide-autism
        v. 100 Day Kit for Young Children https://www.autismspeaks.org/tool-kit/100-day-kit-young-children
    d. Myths
        i. https://adsd.nv.gov/uploadedFiles/adsdnvgov/content/Programs/Autism/ATAP/Autism%20Myths%20and%20Misconceptions.pdf
        ii. https://www.kennedykrieger.org/stories/myths-facts-about-autism-spectrum-disorder
2. Week 2
    a. Attunement play https://www.nifplay.org/what-is-play/types-of-play/attunement-play/

b. Attachment https://drive.google.com/drive/u/0/folders/1hMB5-E3MFRKWOobccLUN7lJ2zcLnBixt

c. COS https://www.circleofsecurityinternational.com/resources-for-parents/

3. Week 3

a. Creative play

i. https://www.pbs.org/wholechild/providers/play.html

ii. https://www.zerotothree.org/resource/distillation/beyond-twinkle-twinkle-using-music-with-infants-and-toddlers/

iii. https://www.actionforchildren.org/wp-content/uploads/2020/05/Infant-Toddler-Art.pdf

b. Child development https://drive.google.com/drive/u/0/folders/1awkMUy7UpRo501trnMReUVxZ9jnHTnLA

c. CDC's developmental milestones https://www.cdc.gov/ncbddd/actearly/milestones/index.html https://www.cdc.gov/ncbddd/actearly/pdf/LTSAE-Checklist_COMPLIANT_30MCorrection_508.pdf

d. Baby Navigator Milestones https://babynavigator.com/resources/

e. IoWA-PCIT PRIDE skills https://pcit.lab.uiowa.edu/sites/pcit.lab.uiowa.edu/files/wysiwyg_uploads/PRIDE%20poster.pdf

f. Positive parenting tips https://drive.google.com/drive/u/0/folders/1na5M4kZCg-OJl-nRKkvpClSGD9nvtb2C

4. Week 4
    a. Physical play https://raisingchildren.net.au/babies/play-learning/active-play/physical-activity-for-young-children
    b. Parental mental health https://docs.google.com/document/d/1KYp9pNEdJLuALCCatWUt74_GDlpTIuds4LeBaAtrWw4/edit
    c. Self-care for adults https://drive.google.com/drive/u/0/folders/1Ys3RGgU3Sbpfli2tVPNhVLzZ7_v3McnS
5. Week 5
    a. Object play https://childrensmuseumatlanta.org/impact-of-object-play/
    b. Parenting and caregiving https://drive.google.com/drive/u/0/folders/1UaUMmFMLObkiGyiJt-aSw8YcSKAGAN_S
    c. Sleeping
        i. https://safetosleep.nichd.nih.gov/resources/toolkit/partners
    d. Feeding
        i. https://www.aap.org/en/patient-care/newborn-and-infant-nutrition/infant-feeding-resources-for-parents-and-child-care-personnel/
        ii. https://www.cdc.gov/nutrition/infantandtoddlernutrition/index.html
6. Week 6
    a. Zero to Three https://www.zerotothree.org
    b. Parent to Parent USA https://www.p2pusa.org

c. Autism Speaks https://www.autismspeaks.org/

d. Autism Society https://autismsociety.org

e. The Organization for Autism Research https://researchautism.org

f. Autistic Self Advocacy Network https://autisticadvocacy.org

g. Early Intervention https://www.cdc.gov/ncbddd/actearly/parents/states.html

h. Center for Parent Information & Resources https://www.parentcenterhub.org/find-your-center/

i. Association for Autism and Neurodiversity https://aane.org

7. WePlay! Denver website https://new.express.adobe.com/webpage/lYTEABfgZpv3d?
8. Videos about play https://express.adobe.com/page/Vf03AEpgEMlZ0/
9. Perinatal through 5 years old https://docs.google.com/document/d/11lHTBe605o33Krbka7e3VermcP1bwbQOvvuMfo0fou4/edit
10. Early intervention by state https://www.cdc.gov/ncbddd/actearly/parents/states.html
11. Free materials from the CDC https://www.cdc.gov/ncbddd/actearly/freematerials.html#Children