Parental Wellness Group

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A landmark court case that brought national attention to child abuse in the 1870's focused on a girl named Mary Ellen Wilson who was whipped and beaten by her foster family (Watkins, 1990). The attorneys argued that if there are laws protecting animals, there should be laws in place for protecting children. As a result of the ruling, in 1974 the newly established Department of Children and Families (DCF) helped establish and implement the Child Abuse Prevention & Treatment Act (Watkins, 1990).

Child abuse (CA), according to DCF, is defined as a non-accidental act of a caretaker on a child that endangers his or her physical or emotional health or any sexual contact between the child and caretaker (Mann, 2013). The different forms of abuse are physical, sexual, emotional, and neglect. Child sexual abuse (CSA) includes sexual acts committed against a child or sexual exploitation of them, such as showing a child pornographic material. Child physical abuse (CPA) is defined as inflicting physical injuries or excessive punishment, and could involve death or fracture of a bone. Lastly, according to the Administration of DCF, neglect can be categorized by purposeful negligence or inability to provide a child their basic needs, refusing to get them medical attention, food, shelter, education, etc., unless the perceived neglect is due solely to economic inability to provide (Young, 2104). Research suggests the effects of witnessing violence verse experiencing violence in childhood are similar.

For the purpose of the current review of the literature the term survivor refers to a child who has either seen or been a victim of abuse. In the United States there is a report of child abuse

every ten seconds, which indicates an average of 4-7 children dying every day (Child Abuse in America, 2011) and three million reports of child abuse are made every year (Child Abuse in America, 2011). Child abuse is still extremely prevalent in today's society causing long lasting effects.

If children are exposed to an abusive or violent environment their brain development may become impaired. According to the Child Welfare Information Gateway (2009), children's brains adapt to change, which is known as brain neuroplasticity. The child's brain is being changed and impressed upon by both environmental factors and by their caregiver's actions. The infant and child brain is constantly growing and taking in information. If they are in an unhealthy environment their brain is adapting and changing to the unsafe behaviors, which ultimately is not beneficial to the child (Child Welfare, 2009).

Unfortunately, not all children have positive interactions with their caregivers or witness appropriate behaviors. They can be subjected to the influence of the wrongdoings of adults. For the purpose of this literature review, the terms caregivers, adults, parents, mothers, and fathers are used interchangeably unless otherwise specified. The influence of parents may negatively impact future behaviors and brain development, and can manifest in perpetration of violence (Ehrensaft, Knous-Westfall, Cohen, & Chen, 2014). Research shows that CA positively correlates with negative effects on brain development, perpetration of child abuse, criminal behavior and perpetration of domestic violence (Milaniak & Windom, 2014; Edwards, Dixon, Gidycz, & Desai, 2014). This paper outlines the research done on these negative long lasting effects of abuse experienced in childhood.

Of the various effects of abuse, the potential to abuse one's own child is one of the most dangerous and lasting impacts (Ehrensaft et al., 2014; Malinosky-Rummell & Hansen, 1993;

Milaniak & Windom, 2014). One option to prevent this cycle from starting as well as from continuing is to focus on the parents of children who are particularly at risk. Children who have autism, sensory processing disorders, delays in receptive and expressive language, and other developmental delays are at an increased risk of abuse and negative parent-child interactions because their parents often experience much more stress, have a lack of support, and may spend an extensive amount of time with their child without breaks (Lesack, Bearss, Celano, & Sharp, 2014). Parents need to learn the best coping mechanisms for themselves, strategies to help their children, and to trust their support system. Severe, long-term effects on the children that are linked to experiencing child abuse include perpetration of domestic violence, continuing the cycle of child abuse, and criminal violence (Malinosky-Rummell & Hansen, 1993). Children with disabilities are especially vulnerable to being abused because of the variety of extra stressors that their parents often face (Lesack et al., 2014). Parenting groups aimed at teaching coping mechanisms, behavioral management, and stress reduction can be an effective prevention of child abuse, especially with children who have a developmental delay.

The Effect of Child Abuse on the Brain

When a child is exposed to ongoing violence in the home the connections in the child's brain can be altered (Perry, 1997). Interfamilial violence, neglect, and domestic violence (DV) are the most common forms of violence children witness, and most often occur in the home (Perry, 1997) which therefore increase the amount of exposure to abuse. Observing and later remembering this recurring violence may contribute to long-term aggressiveness both as a learned solution and a biological reaction (Garcia, Restubog, Kiewitz, Scott, & Tang, 2014).

When repeatedly exposed to violence, the child may go into a long lasting state of fear where he/she is constantly protecting him/herself (Perry, 1997). The child may then become

overactive and hypersensitive to his/her surroundings as self-preservation or a "fight or flight" response to the threatening environment (Perry, 1997). This can be very beneficial and adaptive because they are not sure when the next episode of violence will come from causing the child to naturally always be ready to protect themselves. Over time the repetition will cause the response to solidify in the central nervous system and create new neural pathways (Perry, 1997). This may lead to a predisposition toward impulsivity, reactivity, and violence (Perry, 1997).

Once the child becomes an adult this stress response may manifest itself as violence rather than defense, in which case the coping strategy is now considered to be maladaptive because the child is no longer in the threatening environment (Perry, 1997). The synaptic connections have been solidified (Perry, 1997), so the brain has no way of simply turning this strategy off until the brain solidifies newer, more adaptive coping mechanisms.

Emotional regulation also plays a significant role when discussing survivors who go on to act in violent ways throughout adolescence and adulthood. Parent-child relationships are crucial for emotional development and emotional regulation, as well as understanding and communicating emotions (Ehrensaft et al., 2014). Lack of nurturing combined with exposure to violence can cause problems in emotional regulation, which in turn can predict rejection, isolation, and problematic romantic relationships (Ehrensaft et al., 2014).

The parts of the brain that allow for empathizing may not develop correctly if the child has been exposed to neglect (Perry, 1997). Several of these problems during development can be combined and linked to perpetrating violence later in life (Perry, 1997). For example, Perry (1997) reported that the most dangerous combination of environmental factors are lack of nurturing, chaotic environments, physical threats, fear, witnessing negative power dynamics and violence. Some combination of these kinds of experiences may predispose children to express

their anger later on in their lives in maladaptive ways. Perry (1997) found that boys in a residential unit for problematic behavior who were exposed to DV in childhood expressed predatory and aggressive behaviors in adolescence.

It is important to note that in addition to studies that found there is a correlation that surviving violence affects the brain in the areas of fear responses, solidifying synaptic connections, and emotional regulations, studies have also found that there are many factors in a survivor's life, such as intensity of the violence, gender, personal experiences, and drug/alcohol use, that can contribute to how he or she is able to cope with situations in the future (Perry, 1997).

The Effect of Child Abuse on Later Perpetration of Child Abuse

Survivors of CA are at a higher risk of abusing their own children later in life than parents who are not survivors themselves (Ehrensaft et al., 2014; Malinosky-Rummell & Hansen, 1993; Milaniak & Windom, 2014). Roughly 33% of survivors who experienced physical abuse or neglect go on to abuse their own children (Malinosky-Rummell & Hansen, 1993). This suggests that they are about 3 times more likely to perpetrate CA than parents who are not survivors (Milaniak & Windom, 2014).

Another study found that survivors are significantly more likely to be arrested for child abuse and also self-report child abuse in instances when there was no arrest made (Milaniak & Windom, 2014). Perhaps there is a gap in reporting when it comes to what type of child abuse was perpetrated (i.e. sexual, physical, mental). This may be due to social stigma in reporting or due to the lack of data about the kinds of violence. A study found that CA can result in depression and that depression can result in the survivor expressing negativity, hostility, and

coercive behaviors towards his/her own children (Ehrensaft et al., 2014). The literature described above suggests that experiencing CA is directly linked to perpetrating CA.

The Effect of Child Abuse on Later Criminal Violence

Children who are physically and/or sexually abused often become adolescents who physically externalize their emotions which may manifest through these adolescents exhibiting antisocial behavior, being involved in delinquency or having other conduct problems (Edwards et al., 2014; Ehrensaft et al., 2014). Criminal violence can be defined as crimes such as robbery, battery, assault, rape and murder (Milaniak & Windom, 2014). One study found that only physical abuse is linked with later conduct problems (Edwards et al., 2014) whereas a different study links both childhood physical abuse and childhood sexual abuse to conduct problems and conduct disorder (Ehrensaft et al., 2014).

Experiencing either physical abuse or neglect as a child correlates with an increased rate of criminal violence arrests (Milaniak & Windom, 2014). A study that focused on individuals who were physically abused and/or neglected as children found that no difference in amount of criminal violence arrests despite the differences in the type (physical or neglect) of childhood abuse (Milaniak & Windom, 2014). The abused individuals self-reported perpetrating criminal violence or were arrested for criminal violence almost twice as often as those who were not abused (Milaniak & Windom, 2014). Milaniak & Windom (2014) also found that criminal violence was more prominent than DV and child abuse combined and that over 60% of the individuals that were maltreated in childhood reported perpetrating violence.

Although most of the previous research focuses on later violence taking place in adolescence, it has been found that, "Rates of violent arrests of individuals who were abused and neglected in childhood more than doubled from adolescence to adulthood," (Milaniak &

Windom, 2014, p. 2). Unfortunately, the lack of detailed research of adult survivors perpetrating violence is not due to the nonexistence of evidence, but perhaps due to difficulty in accurately conducting such a longitudinal study between childhood and adulthood.

The Effect of Child Abuse on Later Perpetration of Domestic Violence

Children who have survived violence are more likely to perpetrate domestic violence later in life (Edwards et al., 2014; Malinosky-Rummell & Hansen, 1993; Milaniak & Windom, 2014; Perry, 1997). Domestic violence (DV), for the purpose of this literature review, involves two intimate partners and ranges from sexual and physical violence to psychological and emotional control. It is important to understand that DV is not just physical (Edwards et al., 2014). In fact, 77% of college men report perpetrating psychological violence towards an intimate partner, 33% report perpetrating physical violence, and 40% report perpetrating sexual violence (Edwards et al., 2014). One study found that perpetrators of DV report experiencing a higher rate of violence in childhood than do non perpetrators (Malinosky-Rummell & Hansen, 1993). Women survivors report both revictimization and perpetration of DV (Malinosky-Rummell & Hansen, 1993).

According to social learning theory, children who witnessed DV in the home will most likely be revictimized or perpetrate violence in the future (Garcia et al., 2014). This means children observed domestic violence learned that it was an okay behavior and perpetrated themselves. In fact, 75% of both male and female survivors used the same form of violence on their intimate partners as they either saw or experienced (Malinosky-Rummell & Hansen, 1993). This shows that CA may be an antecedent for perpetrating DV.

Similarly, researchers have looked into variables mediating a connection between experiencing abuse as a child and perpetrating abuse later in life. The results suggest that

interpersonal problems act as this mediator (Edwards et al., 2014). Hostile-Dominant Interpersonal Problems (HDIP), encompassing the variables of domineering, vindictive, and intrusive, were found to have a direct correlation with DV perpetration (Edwards et al., 2014). There is a strong link between children who either experience CSA or psychological abuse/neglect with young men experiencing HDIP (Edwards et al., 2014). HDIP then became a mediator, as the researchers found a correlation between HDIP and the perpetration of all of the varieties of DV studied, namely psychological abuse, sexual abuse, and physical abuse (Edwards et al., 2014).

HDIP does not mediate in all situations, as there was no link between CPA and later development of HDIP, but there was a direct relationship between experiencing CPA and perpetrating physical abuse toward an intimate partner (Edwards et al., 2014). Lastly, the study did not find a link between individuals who witnessed interparental violence as a child and having HDIP (Edwards et al., 2014). Since witnessing such violence in the household can contribute to long-term aggression (Garcia et al., 2014), which can manifest as perpetrating DV. There may be other mediators responsible for the connections between CA and perpetration of violence.

Developmental Delays and Disabilities

There are a wide range of developmental delays and disorders in toddlers, such as delays in motor skills, sensory processing, receptive and expressive language, cognition, down syndrome, autism and more. Unfortunately studies show rates of abuse is higher among children with disabilities (Davis, 2015). One in three children who have been diagnosed with a disability are victims of some type of maltreatment (Davis, 2015), meaning children with disabilities are 3.4 times more likely to be abused in comparison to typically developing children (Hershkowitz,

Lamb & Horowitz, 2007). Children who fall in these categories are more susceptible to maltreatment due to their extended need for their parents and guardians for a wide variety of needs (Hershkowitz et al., 2007). These types of children may not report abuse due to a lack of understanding or inability to verbalize and communicate they were abuse (Davis, 2015). Since toddlers and children with disabilities have a lesser ability to stand up for themselves, it is easier for abusers to maltreat children (Davis, 2015).

Parent Training

Studies show that since children with disabilities are especially difficult to manage they are at a greater risk of abuse (Hershkowitz et al., 2007). Up to 70% of children with autism act in a challenging way that can cause their caretakers to have high stress levels (Lesack et al., 2014). One way to prevent this extreme stress from developing into hostile and abusive interactions is by teaching parents stress management, positive parenting, and healthy interactions with the child. Parent training is an effective intervention for children with severe delays and/or autism because parents are with the child more than anyone else, they understand the daily struggles, and family interventions are proven to be more effective than approaches that only include specialists (Lesack et al., 2014). Including parents in the treatment of developmentally delayed children can produce more successful outcomes (Lesack et al., 2014). Some of these kinds of family trainings may include Parent-Child Interaction Therapy, Family Intervention for Improving Occupational Performance, and Applied Behavior Analysis (Harvey, Luiselli & Wong, 2009; Lesack et al., 2014; Waldman-Levi & Weintraub, 2015). In addition to trainings that focus on interventions within the family, it may be beneficial to teach individual stress management skills and the importance of parental support (Benn, Akiva, Arel, Roeser, 2012).

Parent-Child Interaction Therapy

In addition to parent training programs, teaching parents a variety of strategies to use with their children in order to increase the likelihood of compliance in their children may be helpful. One example of this is Parent-Child Interaction Therapy (PCIT). PCIT can be used with children who have been abused, have intellectual disabilities, or are diagnosed with autism and/or other severe developmental delays such as limited receptive and expressive language (Lesack et al., 2014). PCIT is successful in teaching these children because of its structure, focus on behavior, repetition, and flexibility to adapt to individual needs, and core philosophy of crucial parent interaction and involvement (Lesack et al., 2014). PCIT teaches positive parenting strategies including praise of good behavior ("Good job sitting still"), behavioral descriptions ("You are drawing"), and clarification of nonverbal communication ("So you want more?") while discouraging negative expressions ("I don't like your behavior"), negative questions ("Why aren't you listening?)", and negative commands ("No running") (Lesack et al., 2014). PCIT also uses behavioral strategies such as following the child's lead during play, ignoring the child after a negative behavior, and several phases and adaptations of time-outs (Lesack et al., 2014).

Specific case studies showing the effectiveness of PCIT can be generalized to the target population. In one study, after being trained in PCIT, the mother of a 5 year old boy with autism reported less disruptive behaviors and more compliance with parent commands as well as an increase in positive interactions and positive play between the mother and child (Lesack et al., 2014). Another study demonstrated that mothers at risk for maltreatment of their children, as indicated by factors including history of abuse and domestic violence, showed improvement in compliance, positive play, and overall behavior after PCIT training (Naik-Polan & Budd, 2008).

Family Intervention for Improving Occupational Performance

Experiencing domestic violence can negatively impact a mother's ability to parent and have positive interactions with her child (Waldman-Levi & Weintraub, 2015). An intervention called Family Intervention for Improving Occupational Performance (FI-OP), which focuses on child play functioning, was used in a playgroup with mothers who had experiences domestic violence (Waldman-Levi & Weintraub, 2015). The study found that mothers in the playgroups implementing FI-OP showed more sensitivity to their child's needs, abilities, and preferences as well as a greater ability to set limits in regards to disciplining their child as opposed mothers who participated in a playgroup that did not implement FI-OP (Waldman-Levi & Weintraub, 2015). The study also found that the children in these groups showed a significant improvement in their play skills including exploratory behavior, achievement behavior, practice play, construction play, and especially in symbolic play (Waldman-Levi & Weintraub, 2015).

Applied Behavior Analysis

One of the most commonly used treatments for developmental disabilities is Applied Behavior Analysis (ABA). ABA uses specific techniques involving modifying antecedents and consequences in order to shape behavior (Harvey et al., 2009). Tracking the occurrence of desired or undesired behaviors (i.e. aggression, vocal stereotypies, manding, tacting, attending) is used throughout the implementation of ABA but is especially important in creating baseline data because it is then developed into a treatment plan (Harvey et al., 2009). Strategies for increasing positive behavior often center on various forms of positive reinforcement. Ways of decreasing negative behavior include modifying antecedents, ignoring, or redirection, depending on the child and their behavior plan. The ongoing data collection on the behaviors is then analyzed to determine which programs are successful and which may need to be altered (Harvey et al., 2009). Teaching parents a shortened version of various ABA techniques can help their child to

develop and generalize their skills across different areas of their life. Similarly, parents can use a manipulated form of ABA in order to increase, decrease, or change their own positive or negative behaviors during interactions with their child.

Mindfulness Training

Although teaching parents to positively interact with their children is extremely beneficial, teaching parents effective coping mechanisms can be just as important. One way to achieve this goal is by reducing a parent's overall stress while increasing their ability to manage it. Research on Mindfulness Training (MT) of parents and teachers of children with developmental delays shows effectiveness in several areas in addition to reducing overall stress (Benn et al., 2012). Specifically, parents and teachers who successfully completed the MT program expressed that they felt more aware of their internal mental processes, less judgmental, lower rates of distress, increased self-compassion, personal growth, empathy, and forgiveness (Benn et al., 2012). The study concludes that as a result of mindfulness, participants became more aware of stressful triggers and were able to recover quickly and move forward from a particularly stressful incident (Benn et al., 2012). In addition to effective MT, parenting groups that focus on different support systems for parents may also lead to stress reduction and better coping mechanisms.

Parental Support

Parental support is a key component in stress reduction, reducing sense of loneliness, increasing sense of hope, and overall parental improvement (Shechtman & Gilat, 2015). Parenting groups that focus on different support systems for parents can lead to better coping mechanisms as well. Overall these groups are used to talk and gain feedback from others who are in a similar situation in a nonjudgmental supportive environment. A need for support is one of

the primary reason that motivate parents to join parental support groups (Dale, Drucker, Gabard, Smith, 1994). Mothers with children who have disabilities often have a lower satisfaction with their parental roles, lower self-efficacy and higher levels of depression because in most cases parenting is harder (Dale et al., 1994). Fathers in this situation often view the child's disabilities as less problematic and deny the problem (Shechtman & Gilat, 2015). Parents who attend support groups are able to have the support of other parents going through the same or similar struggles. By going to parental support group's parents experienced reduced child-related stress and reduction in feelings of social isolation (Dale et al., 1994).

Parents in support or counseling groups reported the emotional and social support was a meaningful contributor to the reduction of loneliness, stress and feelings of helplessness (Shechtman & Gilat, 2015). Often, parents gain a sense of acceptance and empathetic understanding from support groups which increases their self-esteem (Shechtman & Gilat, 2015). Improved self-esteem and self-efficacy, in turn, can improve parent-child interaction (Shechtman & Gilat, 2015). The support parents get from other parents in support groups can lead to a change in their attitudes and feelings toward their children. This can change their own behaviors and improve parental effectiveness (Shechtman & Gilat, 2015). In turn, this shows how effective supports from counseling groups can be and how they can help with knowledge and parenting. It is more important to address emotional needs of parents and information about their child's disabilities or delay rather than only providing them with one or the other (Shechtman & Gilat, 2015). Parents preferred the supportive aspects of parental support groups over information-based groups (Dale et al., 1994). These parenting groups are established as preventative programs instead of restorative programs (Dale et al., 1994). Combination groups serve as a program in which provide emotional support is provided as well as education on disabilities

relevant to the children's needs. (Dale et al., 1994). Many parents and caretakers join these types of support groups because of a need for education and/ or support for parents with a child who has a mild delay, or severe illness (Dale et al., 1994).

Parental Involvement

Not only do parents need support from parents outside of the family they also need support from their child's other parent, assuming the child has two parents (Dale et al.,1994). Support from both parents can help a child's development as well as help the parents. Helping parents improve parenting skills can often help their children's intellectual development (Dale et al., 1994).

Children whose parents demonstrate cooperative co-parenting behaviors, meaning both parents use the same parenting strategies, tend to be more prosocial (Buss, Blandon, Scrimgeour, Stifter, 2013). Prosocial behaviors are behaviors such as sharing, comforting, cooperating, helping, and overall social competence. In most cases prosocial children are likely to be more accepted by peers and have better friendship qualities (Buss et al., 2013). Prosocial behaviors are learned and influenced by the child's family. Prosocial behaviors are learned in both observations of ongoing daily interaction by parents as well as parents directly teaching the child these types of behaviors.

Not only does co-parenting support a child's prosocial behavior it also influences social-emotional development (Buss et al., 2013). One of the main components in co-parenting is cooperation with each other. Studies show when the co-parenting relationship is positive and cooperative, children exhibit fewer behavior problems as well as more positive peer relationships. Modeling of social relationships enhances the child's feelings of emotional security within the family (Buss et al., 2013). Co-parenting is effective in both helping the child

learn prosocial and social-emotional behaviors as well as help the parents and give them a sense of support.

Interventions and parental support groups that require parents to practice skills with their child and focus on the importance of parental consistency are very effective (Bagner, 2013). These types of groups where both the mother and father were involved the child had a correlation of higher compliance in their child and lower maternal criticism of spouse (Bagner, 2013). The child also tends to have greater expressive language skills, educational outcomes, and higher cognitive language functioning (Bagner, 2013). Dual parental involvement can maximize the effect of treatments for children in the at risk population (Bagner, 2013). Involvement of both parents may help to release the burden off of one parent if they are both using the same co-parenting strategies and aren't leaving it for one parent (Bagner, 2013).

Conclusion

Three million children per day fall victim to abuse; three million children per day will face hardships related to this abuse at some point in their lives (Child Abuse in America, 2011). Children who suffer abuse are not raised in suitable environments in most cases and are not taught the correct moral code and societal standards at critical ages. Experiences led some to not be trusting of others or optimistic and in turn their development into functioning members of society can be seriously affected. Survivors may commonly suffer from mental illnesses such as anxiety disorders, or depression and many others act in a violent manner and are more likely to re-victimize another person or their own children than people who were not abused. People who suffer severe abuse may be drawn to suicide as a way to cope with the pain and trauma they experienced in their childhoods.

Not all of the three hundred abused children per day have such a dark fate. Only a small amount of abused kids who go on to be abusers themselves but it's still a number that affects later generations. People can be resilient, and many survivors are able to develop coping skills and positive connection to continue and maintain a normal daily routine. Survivors are capable, despite their painful and traumatic pasts, to lead a life free of the intense and difficult outcomes childhood abuse can cause.

There are resources in society that can help reduce this problem. Support and prevention groups are groups which can help both the child and the parent with a range of different needs. These types of groups are effective in changing the parent child interaction and overall reducing abuse (Balachova, Bonner, Brestan, Chaffin, Funderburk, Jackson, Lensgraf, Silvosky, Valle, 2004). Children with developmental delays and other diagnosis are extremely vulnerable and need more support than the average child. We will propose Riverside support group, which offers a program that teaches parents stress coping mechanisms, parenting skills and helps them interact with their child in a positive manner.

Grant Project Proposal

Given the stress that parents of children with developmental delays face, they are considered to be a population at high risk for perpetrating child abuse. This grant proposes a stress reduction support group for parents of children ages 2-3 diagnosed with a developmental delay currently enrolled in Riverside Early Intervention. The program, *Parental Wellness Group,* provides both support for parents as well as education about strategies to address developmental delays. This proposed grant aims to benefit the parents of children who are currently being treated at Riverside Early Intervention for developmental delays. These delays include autism, sensory processing disorders, expressive and receptive language delays, motor delays, and

various social-emotional delays. *Parental Wellness Group* will benefit the developmental needs of the child and the social and personal needs of the parents.

Staffing

Currently, a Developmental Specialist (DS) runs the play groups at Riverside Early Intervention. Two Program Coordinators will oversee *Parental Wellness Group.* They will be in charge of the hiring process, creating the detailed schedule and activities, recruiting the participants, purchasing the materials, and will be on-site during all group sessions should they be needed. One cleaning staff member will be hired and will be on site for one hour after each group session.

In addition to the DS, *Parental Wellness Group* will be run by a new Parent Coach (PC). The PC will have a minimum of 4 years prior experience as a parenting coach. They will have experience working with children with developmental delays, but will not need the formal training that the existing DS has. The PC will need to be able to discuss stress management in regards to parenting delayed children, importance of support systems, and mindfulness training, as well as specific techniques for improving the development of the children. Examples of parenting techniques that the coach should be familiar with may include Applied Behavioral Analysis, Family Intervention for Improving Occupational Performance, and Parent-Child Interaction Therapy, etc. The trainer must pass a CORI (see Appendix A), and hold a Master's Degree in psychology, social work, behavior analysis, or other relevant fields.

The hiring process will include several rounds of interviews, starting with a standard interview with the program coordinators, then moving to a panel interview with several existing Riverside developmental specialists, and completing after a task-oriented on-site interview. During this part, the candidate will be asked to participate in a mock parent counseling session

with the program coordinators. They will pretend to be parents at Riverside and each candidate will have the chance to implement their skills while talking with the "parents" about a variety of issues that are expected to come up. By the end of the hiring process, one PC will be selected to run *Parental Wellness Group.*

Purple Group

Our program will take place at Riverside Early Intervention located at 255 Highland Avenue, Needham, Massachusetts 02494. Riverside Early Intervention currently holds 12 playgroups for the children they serve. Each playgroup serves children with a common age and need. *Purple Group*, for example, is a toddler group that meets twice a week and focuses on children with social and language delays. *Purple Group* begins in the waiting room at 10:45 am on Mondays and Wednesdays. The children separate from their caregivers and walk into the gross motor room where they stay for the next 30 minutes. The children then transition into the art room where the parents can watch the children through a two-way mirror that is connected to the waiting room. The children spend 45 minutes in the art room. The group is over at 12:00 pm when children move into the hallway where they meet their parents and leave Riverside. Although this is how *Purple Group* currently runs, the proposed *Parental Wellness Group* will require small adjustments to the schedule in order to best serve the children and parents.

Parental Wellness Group

Parental Wellness Group will run from 10:45 am to 12:00 pm on Mondays and Wednesdays for 8 weeks during the months of June and July 2015. The pre-existing *Purple Group* will continue to take place during that time period, but will be merged with *Parental Wellness Group* by inviting the parents of the children already in *Purple Group*. If any parent does not wish to participate in *Parental Wellness Group,* they may choose to stay in the parent

room throughout the duration of their child's time in *Purple Group.* Several changes will need to be implemented to merge *Purple Group* with *Parental Wellness Group.*

First, although traditionally only one parent comes to Riverside with the child, it is strongly encouraged that both parents and/or caregivers participate. In order to encourage both parents to participate in as many sessions as possible, an incentive gift will be given to each caregiver for each session that they attend. The incentive gift will be a $10.00 gift card to various stores including Star Market, Hess Gas Station, Target, and Toys-R-Us. With the maximum number of parents attending *Parental Wellness Group,* there is more room for parent growth, feedback, support, and effective evaluation of the trial group. Also, children with more than one caregiver receiving various types of support develop greater expressive language skills (Bagner, 2013) and prosocial behavior (Buss et al., 2013). The small incentive gift can benefit the program, the parents, and ultimately the child.

The second major change to the pre-existing Riverside group is that the parents will be trained in the conference room while their children are participating in *Purple Group.* The conference room has enough space for the parents to feel comfortable while discussing their child and him/herself. This room is available for use during the group time and will be cleaned by *Parental Wellness Group* cleaning staff after each use.

Third, the children will go to the art room before transitioning to the gross motor room (see Appendix B). This is because the Wednesday schedule includes time for the parents to work on their bi-weekly goals with the children during the second half of the group, but is only effective if the children are in the gross motor room. The parents will transition into the gross motor room with their children so they can actively practice the skills the parenting group is working on. The parenting coach working with the parents on Monday sessions and the first half

of Wednesday's session will then join the *Purple Group's* developmental specialist to help the parents in the groups implement the previously discussed goals and strategies.

Goals of *Parental Wellness Group*

Both parents and children will benefit from *Parental Wellness Group*. Parents will learn to identify, manage, and cope with their stress. They will help their children make progress in their individual goals and develop and maintain a strong parental support system. Children will benefit from this program in a few ways. They will bond more easily with their parents, learn to follow directions from their parents, and grow in a potentially healthier and more beneficial home environment provided by their parents after receiving the advanced training. The parents will fill out an evaluation form at the end of the 8 week trial group (see Appendix C).

Parental Wellness Group Schedule

On all Mondays and Wednesdays of group both the parents and the children will be greeted by the PC and the DS in the parent room (see Appendix B). A hello song will be sung and the children will be prompted to take their shoes off as independently as possible and place them in the shoe bucket. A picture schedule of what the children will be doing throughout the group will be presented to the children. Visual schedules help children with a delay in receptive communication understand the schedule, learn to wait for desired activity, expect what will happen while they are away from their parents, and separate easily with the promise of being reunited later on. The children will then walk into the art room (see Appendix D) with the DS and say a firm goodbye to their parent(s) as the parents continue down the hallway into the conference room with the parent coach. The *Purple Group* will run as it currently does with the exception of the order of each room and the parents joining the children for the second half of each Wednesday (see Appendix B).

The first day of group will run slightly different than other Mondays because much of it will be spent building rapport and completing necessary informational paperwork. Once in the conference room, all Mondays and Wednesdays of the *Parental Wellness Group* will begin with an icebreaker game (see Appendix E). The icebreaker will help the parents learn names, become more comfortable with each other, and break down barriers. The parenting coach will then introduce him/herself and explain how the group will run. A confidentiality agreement (see Appendix F) will be read out loud to all the parents and explained thoroughly. The parents will receive their own confidentiality form to keep and one for them to sign and hand back.

Next, the parents will participate in a round robin introducing both themselves and familiarizing the group with their child, their delays, and their goals as predetermined by Riverside Early Intervention Developmental Specialists. Although parents are encouraged to share, they are not mandated to do so and can pass. Parents will come up with several observable, measurable, and achievable goals (see Appendix G) for their own personal development that they are trying to reach while participating and enrolled in the *Parental Wellness Group*. After the personal goals are established, they will be recorded by the parenting coach to make the *Parental Wellness Groups* tailored to each parent's needs.

Next, a buddy system will be put into place. The buddy system will be predetermined prior to the first group session based on location of the family. It will be set up based on location in case a parent needs immediate support from their buddy. The buddy system will allow the parents to use each other as a support system on an as needed basis when they are outside of group. The parents will receive a booklet with all the parents' phone numbers and assigned buddies, but are encouraged to go to their assigned buddy first. Parents are encouraged to use their buddy whenever a stressful situation occurs, advice is needed or if they simply need

someone to talk to. This will provide an alternative outlet for the parents and as a stress reduction method. The parenting coach will next wrap up the group by summarizing what overall goals were established as well as how the Parent/Child group on Wednesday will work. The PC will then ask the parents to think about their goals at home and different strategies to achieve them.

The *Parental Wellness Group* has its own predetermined set of goals that will change weekly (see Appendix H). Each week the parents will spend two sessions working to achieve one goal. They will work on that goal with their child on Wednesdays in the parent-child group as well as at home for the rest of the week. Every session, parents will discuss specific strategies for implementing their weekly goal with the parental coach and each other. As always if a parent does not wish to share they can opt out. Each parent will have an opportunity to talk about themselves and the goal specifically to them and their child.

Parent-Child Time

On Wednesdays, after first half of group is over, the parents will meet their children in the hallway and transition together into the gross motor room. This will allow the parents a time to implement the new strategies they have learned with the supervision and support of the PC, DS, and other learning parents. The DS and the PC will offer support and guidance to implement the new strategies as well as help the parents reach their weekly goal (see appendix G & H). The children will follow their typical schedule in the gross motor room (see appendix B). Parents will assist their child in the centers and circle time. They will be encouraged to focus on their child but will be paying extra close attention to their own interactions with their child. They will implement strategies that they learned based on each week's goal, but will also work to maintain learned strategies from previous goals (see appendix G & H). If they have any individual questions or concerns, this time provides an opportunity for the PC or DS to address the issue by

teaching the skill in the moment. This focused time is one of the most beneficial aspects of *Parental Wellness Group.*

Conclusion

The *Parental Wellness Group* will benefit the children being served at Riverside Early Intervention as well as their parents. This will help to stop abuse from being perpetrated against children with developmental delays as well as prevent the cycle of abuse from continuing in parents who may have been abused in their childhood. Providing an atmosphere for parents to find support and learn more about how to best help their children is key to parent and child growth. To evaluate the effectiveness of *Parental Support Group,* parents will be given an evaluation form (see Appendix C) on their last day. These forms, along with the opinions of the parent trainer and developmental specialist will help to determine if the continuation of *Parental Wellness Group* will be beneficial for the families in Riverside Early Intervention.

This is a trial program aimed at developing into a permanent program within Riverside. If the program shows success (see Appendix C) then it will be run with a higher risk population such as groups with a low socioeconomic status or a history of abuse. Assuming the program demonstrates success, it will become permanent group at Riverside Early Intervention. Minor changes will be made if and when this program becomes permanent. For example, some groups will be held on the weekends to encourage parental involvement. Also, the monetary incentive will no longer be offered.

This program will first be tried with a lower risk (Riverside EI parents and children) population because we do not know for sure who is a high risk parent. Finally, if the program does not work as a whole, changes will need to be made before working with a high risk population. Even though the first program is a trial group, it will still be beneficial to the parents

and the children because any person can become abusive, regardless of how high or low their risk level is. If this program is successful the permanent program will recruit parents be self-referral and through DCF.

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Appendix A

CORI Form

CRIMINAL OFFENDER RECORD INFORMATION (CORI)
ACKNOWLEDGEMENT FORM

TO BE USED BY ORGANIZATIONS CONDUCTING CORI CHECKS FOR EMPLOYMENT, VOLUNTEER, SUBCONTRACTOR, LICENSING, AND HOUSING PURPOSES.

is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective employees, subcontractors, volunteers, license applicants, current licensees, and applicants for the rental or lease of housing.

As a prospective or current employee, subcontractor, volunteer, license applicant, current licensee, or applicant for the rental or lease of housing, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY:
the may conduct subsequent CORI checks within one year of the date this Form was signed by me provided, however, that must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

SIGNATURE DATE

Retrieved from http://www.mass.gov/eopss/docs/chsb/fillable-cori-acknowledgement-form-201206.pdf

Appendix B

Parental Wellness Group Monday Schedule

I. Parent Room 10:45 a.m. - 10:50 a.m.

a. Greeting: Children and parents are greeted in the parent room. Staff will sing the "Hello" song and the "Take Your Shoes off" song (see Appendix I). Children are prompted to take their shoes off and put in the shoe bucket and get hand sanitizing lotion. Children are then told to say goodbye to their parent or caregiver and march to the Art Room.

II. Art Room 10:50 a.m. – 11:20 a.m.

a. Art Project: Based on the curriculum and theme the children will make an art project that corresponds. These can be individual projects or a group projects involving all the children (see Appendix D). After 10-15 minutes art time will end. Children will be instructed to clean up art and listen for centers.

b. Centers: Children will have a choice of centers, 1 involving the sensory table, and 1 or 2 others corresponding to the curriculum. This will go on for about 10-15 minutes.

c. Circle Time: Children will be prompted to find a mat for circle time and handed an instrument. The "Pat Pat" song will be sung which leads into the "Here We Are Together" song (see Appendix I) and the children will fill in their names when prompted. A short activity or song will be sung with the instrument they were given. Based on the theme the teacher will read a book to the children.

Circle time will then end and children will be prompted to line up at the door with their mats.

III. Gross Motor Room 11:20 a.m. – 12:00 p.m.

a. Centers: Children will gather on the circle rug and told about the possible options for center time based on the monthly theme. Example: Home theme centers would be, clubhouse, building houses with blocks, or a pushing station with a vacuum, cart and push car. Centers will go for 15-20 minutes.

b. Goodbye Circle: Children will get a chair and circle up for goodbye circle. A small group activity will be done involving all children to sing the "circle time" song. Children will then be prompted to say their names as we go in a circle. Another book will be read then shoes will be given out and the "goodbye" song (see Appendix I) will be sung. Children will then put their shoes on as independently as possible and push their chairs into the table. Children will then line up at the door and meet their parents or caregiver in the hallway.

Note: This is the Monday schedule for the *Parental Wellness Group.* Wednesdays will be structured the exact same way, except that parents will meet their children at 11:20 a.m. during their transition from the Art Room to the Gross Motor Room. Parents will stay with their children for the duration of the Gross Motor Room on Wednesdays.

Appendix C

Parental Wellness Evaluation Form

Please circle the appropriate response under each question.

1. *Parental Wellness Group* helped me become a better parent.

Strongly Disagree Disagree Neutral Agree Strongly Agree

2. *Parental Wellness Group* enhanced my knowledge of issues regarding my child and family.

Strongly Disagree Disagree Neutral Agree Strongly Agree

3. *Parental Wellness Group* was an effective use of my time.

Strongly Disagree Disagree Neutral Agree Strongly Agree

4. *Parental Wellness Group* was an effective use of my Child's time.

Strongly Disagree Disagree Neutral Agree Strongly Agree

5. *Parental Wellness Group* made me feel welcomed.

Strongly Disagree Disagree Neutral Agree Strongly Agree

6. *Parental Wellness Group* taught my skills which I will use in the future.

Strongly Disagree Disagree Neutral Agree Strongly Agree

7. I would recommend all parents join *Parental Wellness Group*

Strongly Disagree Disagree Neutral Agree Strongly Agree

Please answer the following questions as thoroughly as possible.

1. What are your overall thoughts and feelings about *Parental Wellness Group*?

2. How could Parental Wellness Group improve?

3. Additional comments.

Appendix D

Art Project Examples

Purple Group has art projects scheduled and set into place, here are a few examples.

Make Your Plate: Children will each get a paper plate along with different pretend foods made out of different materials (paper, cotton balls, tissue paper). Children will get glue sticks or finger glue to "Make their plate".

Brush Your Teeth: Children will get a picture of teeth with food, and junk on them. The children will each get white paint and a toothbrush which will serve as toothpaste and paintbrush. Children will paint or "brush" the teeth white again.

Butterfly Dot Dots: Children will get a picture of a butterfly and different colored Dot Dot markers. Children will decorate their butterflies with the Dot Dot markers.

House Decoration: Children will get a piece of paper with a house made out of popsicle sticks glued on it. Children are instructed to decorate their houses with different mediums such as markers, crayons, stickers, and feathers.

5 Little Monkey's: (Group project) A large sheet of paper which all children can work on will be taped down with a bed drawn on it. Each child will get a monkey cut out. They are instructed to color their monkey and paste it on the bed/white paper.

Appendix E

Ice Breakers

Week I: Name Game: Everyone in the group will write down their names on a piece of paper, fold it up, and place it into the hat. The teacher will pick from the hat and call out the name. Whoever is called will raise their hand, say the name of the person who just went, introduce themselves, where they are from and a fun fact about themselves. Once all the names have been picked and everyone has gone the ice breaker is finished.

Week 2: Self Care: One parent will start, and call on another member of the group so they can learn each other's names again. When a person is called on they will share what they do for self-care. This could be anything from running to watching their favorite television show.

Week 3: Two Truths & a Lie: Parents will come up with 3 statements about themselves. One will be a lie and the other 2 will be factual. Parents will go in a circle and share the statements. The rest of the group will try to figure out which statement is the lie.

Week 4: If I Were A Movie Star: Parents will decide if they were to be a movie star who would they be and what show would they would like to be in. Parents will go around in a circle and share. Example: If I were a movie star I would be Betty White and if I was to be in a show I would be in House of Cards.

Week 5: Quirks: Parents will go around in a circle and share one quirky or funny thing they do. Example: I still sleep with my childhood stuffed animal.

Week 6: Food: Parents will go around and share what their all-time favorite food is.

Week 7: Who I'd Want to Meet: Parents will think about someone, anyone in the world they would like to meet. This person could be dead or alive, famous or not famous and why. Parents will then go around in a circle and share.

Week 8: Parents will go around in a circle and share one thing that makes them happy.

Appendix F

Parental Wellness Confidentiality Agreement

Parental Wellness is a group in which parents and children should feel safe to be themselves without judgment and worries. *Parental Wellness Group* often discusses difficult and emotional topics. Parents will often disclose important and personal information. All things that are shared in group must stay confidential between the people who were in group. *Parental Wellness Group* should be a comfortable safe place for parents to share these types of things.

Confidentiality will be broken if you state you have, are, or are planning to hurt yourself or anyone else in any way. We are mandated to report it to other counselors and administration. If these types of statements are said to another parent in the group that parent is obligated to tell a staff member as soon as possible. Failure to abide by these confidentiality rules will result in a termination of the program immediately. This is to ensure our group is able to have open dialogue and for parents to feel comfortable in sharing these difficult things for support.

(Please sign below. A copy will be made and handed back to you once signed)

I _____Agree to the *Parental Wellness* Confidentiality Agreement.

(Signature)

Date: _____

Appendix G

Parental Wellness Group Personal Goals

This form is to help identify personal goals while enrolled in *Parental Wellness Group.* These goals will help the Parent Coach as well as the Developmental Specialist get a sense of what you want to improve upon as well as learn about. This will help guide the group in the appropriate direction.

1. My main goal(s) I want to accomplish while in *Parental Wellness Group* is (are)…

2. I would like to receive help from the Parent Coach and Developmental Specialist with…

3. I would like to learn more about…

4. Additional thoughts or comments.

Appendix H

Weekly Goals

Week 1: What You Want to Bring to Group

As an introduction to *Parental Wellness Group,* each parent will discuss their own goals that they identified on the Goals Worksheet (see Appendix G). All parents will provide feedback on the goals and have them in mind when working with the children while with them in the gross motor room on Wednesday. This time will also be a time for the parent trainer to develop baseline data for the interactions between parents and children.

Week 2: Recognizing Individual Stressors

Part of *Parental Wellness Group* is teaching parents how to deal and cope with stress. To do so, parents must be aware of what triggers their stress. Each person has different triggers. This goal will help parents realize what sets them off. Once they are able to recognize what makes them stressed we can teach them coping mechanisms to deal with the stress and lessen it.

Coping mechanisms may be:

- Mindfulness training (Benn, Akiva, Arel & Roeser, 2012)
- Support from family and friends
- Support from assigned buddy
- Personal time
- Deep breathing
- Take a step back

- Meditation
- Exercise

Week 3: Individualized Stress Plan

The children enrolled in Riverside Early Intervention each have their own service plan created for them. Similarly, parents in *Parental Wellness Group* will each create their own service plan. They will work as a team to develop strategies to deflate a stressful situation, apply previously learned coping mechanisms, and make progress towards their goals.

Week 4: Recognizing Children's Strengths

Often times, we get frustrated with the things we cannot do. Children with delays often cannot do things that children who have developed appropriately can. Although this can be frustrating we cannot only focus on the things the child cannot do. This goal is implemented to help parents realize and think about the things the child can do and their strengths instead of their delays and areas for improvement. Parents will get their child's progress notes which are written by the developmental specialist after each session their child has attended. These notes talk about what their child did well during group as well as things they worked on and things they struggled with. Reading these notes will give the parents a sense of how much their child has grown and concrete examples on what their child's strengths are.

Week 5: Acceptance of delays & Disorders

Many parents seem to be in a state of denial when their child is diagnosed with a developmental delay or with autism. They may make excuses for the specific behaviors or blame themselves.

This week will focus on learning to accept their children. This will include teaching the parents about specific delays, creating a normalcy feeling, and encouraging a positive outlook. This week is where parents will be able to support each other greatly. Since all the parent's children are there for some sort of delay they realize they are not alone.

Week 6: Communication with Child

This week, parents will learn specific strategies to communicate with their children. These strategies will be very important to focus on when working with the children in the gross motor room on Wednesdays. The parent coach can also give the parents a list of helpful websites and resources they can use to further their knowledge at the home if asked.

They will be taught the importance of:

- Eye contact
- Sign language
- Slow and short sentences: Slowing down speech and talking in small sentences
- Body language: Calm body language, no clenched fists or arms crossed
- Tone of voice: Neutral tones, no angry tones
- Regulation of speed and volume of voice
- Listening skills

Week 7: Alternatives to Punishment

Punishment is never as effective as reinforcement. This week, parents will learn how to reinforce positive behavior. Parents will also be taught to think about the patterns of their child to figure

out if negative behaviors are displayed for attention, a lack of knowledge, or other reason. The parent coach will individually help the parent come up with a sense of what strategies could be most effective based on why the child is displaying negative behaviors. Prior to this group the PC will meet with the DS to talk about the strategies the DS has been using on specific children that has been effective. For example, if Bobby refuses to participate in circle time because he is not getting individualized attention this is mostly likely a behavioral problem. The DS would give him two choices, he can be helped back to circle or he can come back by himself instead of going over and trying to reason and give him something to come back because he is aware of his expectations. These things will be explained to the parents so they have a sense of effective strategies for their child.

Strategies include:

- Learning antecedents
- Learning consequences
- Rewards system
- Operant conditioning
- Always being consistent within different environments
- How to avoid punishment

Week 8: Overview of Weekly Goals

As the last week concludes, the parents will be reminded of the previous groups, goals, and progress. They will talk about strategies to apply their new behaviors to other settings and other

children. A great deal of focus will be put on progress since the baseline data was taken in order to show the parents that there is always room to grow and that change is possible.

Appendix I

Song Book

Hello Song

Hello friends

Hello friends

Hello friends

It's time to go to school

Shoe Song

We take our shoes off

We take our shoes off

And we put them in the box

Pat Pat Pat

Pat pat pat

Pat pat pat

Pat pat pat

It's circle time

Pat pat pat

Pat pat pat

Pat pat pat

It's time to hold hands

And shake shake shake them

Loose!

Here We Are Together

Here we are together

Together together

Here we are together

Together at school

With (each child takes a turn saying their own name)

Center Time

Center time, center time

Come out to play

Come out to play

Come out to play

Oh, center time, center time

Come out to play

What can we play today?

March to art

We're gonna march march march to art

March march march to art

March march march to art

March march to art class

Where Is My Chair

Where oh where

Is my chair

Where oh where

Is my chair

Where oh where

Is my chair

Let's find a chair for art class

Goodbye Song

It's time to say goodbye

Goodbye goodbye goodbye

(Child's name) can say (Let each child say goodbye)

Based on Riverside Early Intervention's curriculum songs

Budget for *Parental Wellness Group*

Personnel Requirements

Title	**Quantity**	**Pay Per Hour**	**Total Hours**	**Total Cost**
Parenting Coach	1	$60	80 (5 hours per session including preparation time) 5 hours x 2 weekly sessions x 8 program weeks = 80 hours	$4,800
Program Coordinators	2	$50	200 80 hours overlap with Parenting Coach, split between each coordinator 60 hours administrative work per each coordinator	$10,000
Cleaning Staff	1	$20	16	$320

Personnel Total: $15,120.00

Supplies Requirements

Item	**Cost Per Unit**	**Quantity**	**Total Cost**
Bic Round Stic Ballpoint Pens	$7.49/box of 60 pens	1	$7.49
Staples Manila File Folders	$7.49/box of 100 folders	1	$7.49
3" Avery Heavy-Duty View Binder	$14.49	1	$14.49
Staples Thermal Laminating Pouches	$54.99/per 100 pouches	1	$54.99
Copy Paper 8 ½" x 11"	$45.99/case of 5,000 pieces of paper	1	$45.99
Canon Black Toner Cartridge	$45.99	1	$45.99
Standard Staples	$6.49/pack of 25,000 staples	1	$6.49
Paper Clips	$2.29/pack of 100 clips	2	$4.58

Lysol Multi Purpose Cleaner	$5.59	2	$11.18
Bounty Paper Towels	$12.99/per 8 rolls	1	$12.99
Glad Garbage Bags	$16.99/per 100 bags	1	$16.99
Softsoap Antibacterial Hand Soap	$1.99	3	$5.97
Quilted Northern Bathroom Tissue	$14.99/per 30 rolls	1	$14.99

Supplies Total: $249.63

Miscellaneous Requirements

Item	**Cost**	**No. of Potential Attended Sessions**	**Total Cost**
Participation Incentive	$10.00/per caregiver per session (max 2 per child)	16	$320.00

Miscellaneous Total: $320.00

Grand Total: $15,689.63

REBECCA L. BISSONNETTE

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SUMMARY

Highly motivated Psychology student with extensive experience in abnormal and delayed child development, ABA, family services, and child therapy. Proven skills and abilities in implementing IFSPs, problem solving, and analyzing behavior and development.

EDUCATION

Lasell College, Newton, MA — May 2015 (Expected)
Bachelor of Science in Psychology
Focus in Diversity & Inclusion and Child & Adolescent Studies
Cumulative GPA: 3.92/4.0
Related Coursework: Abnormal Psychology, Case Management and Counseling, Adolescent Psychology, Child Development Brain Function & Dysfunction, Psychology of Diversity
Achievements: Dean's List, Presidential Scholarship, Psi Chi National Psychology Honors Society

Bond University, Gold Coast, Australia — January 2014 – April 2014
Study Abroad

RELEVANT EXPERIENCE

Realizing Children's Strengths, Natick, MA — February 2015 – Present
Behavior Therapist and After School Lead Instructor

- Provide ABA therapy to children diagnosed with Autism
- Run individualized ABA programs
- Take data on the progress of each client
- Work to develop social skills in the after school program

Riverside Early Intervention, Needham, MA — September 2014 – Present
Developmental Specialist Intern

- Coached children ages 2-3 with developmental delays
- Implemented behavioral strategies to develop social and cognitive abilities
- Planned programs designed to focus on specific individual needs

Residential Life-Lasell College, Newton, MA — September 2012 – Present
Residential Assistant

- Coordinated mediations with students experiencing conflict
- Developed community programs to encourage personal growth of students
- Identified and reported misconduct and mental health problems

Walker Home and School, Needham, MA — September 2013 – December 2013
Onsite Behavior Management Intern

- Coached children ages 8-12 with severe emotional and behavioral disturbances
- Advocated for the needs of children and professional staff
- Adapted to various environmental stressors to prioritize needs

Second Step-Lasell College, Newton, MA — September 2011 – December 2013
Mentor

- Volunteered with children ages 1-15 who have been victims of domestic abuse
- Facilitated training and social events for students and clients

America Counts-Lasell College, Newton, MA — September 2011 – May 2012
Math Tutor

- Tutored and identified specific academic needs of children ages 7-8 in a one-on-one setting

MICHAELA FERRO

56 Carl Road Walpole, MA (508) 633-5463 mmferro@yahoo.com

EDUCATION

Lasell College Newton, MA
Intended Graduation: May 2015
Psychology Major
Course work in Psychology, Child Development, Human Services and Liberal Arts
Cumulative GPA 3.4/4.0 Deans List 2014

Barcelona International College Barcelona, Spain
May 2013 – July 2013 star
Summer abroad, Intensive Spanish program

~~**Walpole High School** Walpole, MA~~
~~Graduated: May 2011~~

EMPLOYMENT HISTORY

Riverside Early Intervention Needham, MA — September 2014 – Current
Behavior Specialist Intern
Coach children ages 2-3 with a variety of developmental delays
Implement behavioral strategies
Create curriculums designed to fit the needs of individuals
Create progress notes for individual children

Nanny/Babysitter Newton, MA — July 2012 – January 2015
15- 25 hrs/week

Conseal International Norwood, MA — May 2014 – September 2014
Administrative Intern
Assist with invoices, bank statements, filing, online postings and other office duties

Walpole High School Walpole, MA — September 2013 – December 2013
Special Education Intern – 150 hours
Assisting students and teachers with their daily activities and routines.
Organize and documenting progress notes.
Aid supervisor in writing student assessments, and IEP's.

Bokx 109 American Prime Newton, MA — July 2012 – September 2012
Cocktail Waitress

VOLUNTEER EXPERIENCE

Global Ambassador, Lasell College — January 2014 – May 2014
Assisting students planning to study abroad in Barcelona with questions or needs they have. Providing students with information about Barcelona and my experiences abroad.

Barry Price Center, Newton, MA — September 2013 – May 2013
Mentor
Mentor adolescents and adults with a wide range of disabilities during their time at Lasell College once a week.

CERTIFICATION

Domestic Violence Advocate
Trained Domestic Violence Advocate
25 hours of baseline training from the essential components of the State Of Massachusetts best practice training for staff and volunteers put forth by Northnode 2008.

Biographical Statements

Rebecca Bissonnette (Becca) was born on February 28th, 1993 in Newport Beach, CA. She is attending Lasell College and anticipates graduating in May, 2015 with a Bachelor of Science degree in Psychology. After graduation she intends to begin her career as a behavior specialist or as a developmental specialist at an early intervention site. She plans on completing a Master's Degree in a related field after more experience. In her spare time, Becca enjoys running, swimming, and reading.

Michaela Ferro was born on July 14, 1993 in Newton-Wellesley, MA . She is attending Lasell College and anticipates graduating in May, 2015 with a Bachelor of Science degree in Psychology. After graduation she intends to have a job working with disabled children. In her spare time, Michaela likes to run and travel.