

Case reports

Telecare for parents of children with autism spectrum disorder: A case report of a proposal for assisted waiting from DIR-Floortime

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ABSTRACT

This case report is on the effects of teleparental care on the evolution of the profile of parents and children with autism spectrum disorder (ASD), as a process of assisted waiting, in a study of three cases of children who were on the waiting list of the speech-language pathology school clinic and who, in the initial evaluation with the Labyrinth Scale, showed evidence of ASD. They were evaluated based on the levels of emotional functional development of the DIR-Floortime, the evolution of play and communication, before and after the intervention. Seven online intervention sessions were held with the parents, in which their demands regarding the development of their children were heard and guidance was given on how to provide adequate support for the evolution of children in play, social interactions, body control, reduction of restricted behaviors, communication and language, based on principles of the DIR-Floortime, enunciative principles and play. Progress was evidenced in both the profiles of the parents and the children. The children improved their playing and language skills, especially understanding. The approach was effective as a form of assisted waiting.

Keywords: Autism Spectrum Disorder; Therapeutics; Language; Telemedicine; Growth and Development

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INTRODUCTION

A study¹ analyzed the narratives of parents of children with autism spectrum disorder (ASD) about the protagonism and barriers to their children's care. It noted that several family members actively participated in the fight for their children's rights, but they highlighted the need to expand psychosocial care for their children, complaining of difficulties related to access, including transportation, service hours, frequency of appointments, lack of maintenance, and precarious physical space. This reality observed in Brazilian Psychosocial Care Centers for Children and Youth (CAPSi) is no different from that found in speech-language-hearing teaching clinics, where these children remain on long waiting lists and, when called, often experience the same difficulties accessing the service and having low-intensity care.

Treatment intensity is an important aspect in ASD cases, considering the characteristics that comprise the diagnostic criteria for these children, as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)². These include persistent deficits in social communication and social interaction across multiple contexts, such as socioemotional reciprocity (e.g., difficulty initiating, responding to, or maintaining social interactions and/or conversations), nonverbal communicative behaviors used for social interaction (e.g., limited or absent eye contact and difficulty understanding and using gestures), and difficulties developing, maintaining, and understanding relationships (e.g., difficulty sharing simple to complex symbolic play and partial or absent interest in children their own age group). They also have restricted and repetitive patterns of behavior, interests, or activities. The diagnosis also considers their hyperreactivity, hyporeactivity, and severity levels, which can range from little support (level 1) to a lot of support (level 3)².

The diagnosis is generally made by a physician based on a physical examination and additional tests³. Decree No. 55,995/2021 establishes the Identification Card for Persons with ASD (Ciptea) within the State of Rio Grande do Sul. By law, the diagnosis must be certified by a physician using the International Statistical Classification of Diseases and Related Health Problems (ICD-10), code F.84.0. This ensures families have the right to prompt care and priority access to public and private services, especially in the areas of health, education, and social assistance.

The Rio Grande do Sul Foundation for Supporting People with Disabilities⁴ recorded 4,358 requests from

June 18, 2021, to February 2022. Among these, 80.12% of those who requested Ciptea are male; 51.06% do not have private insurance; 31.30% have a per capita income of half a minimum wage to one minimum wage; and 94.50% are receiving specialized clinical care. Another important finding is that the vast majority were diagnosed between 2 and 3 years of age, which establishes the prevalence of early diagnosis⁵. This term "early" could be questioned, considering that the risk of progression to ASD can already be detected in the first year of life^{6,7}. Many of the children without a diagnosis are on waiting lists at teaching clinics, complaining of delayed language acquisition, as was the situation in the three cases in this study.

It is known that the social consequences of ASD can create a series of challenges for family care, as children have difficulty with routine changes, food selectivity, adverse reactions to sounds, and lack of response to interaction⁸. This calls into question a series of interventions for this phase between 2 and 3 years old. The intervention chosen for this study was DIR/Floortime^{9,10}, which is a non-intensive in-person care tool available in teaching clinics, suitable for interventions with parents, taking, at most, two weekly sessions.

DIR/Floortime considers family relationships a key factor in the development of children with ASD. It approaches the functional levels of emotional development (D), the individual profile of each child and their family (I), and their relationships with family members and other people in their lives (R), giving play and interaction a fundamental role in building social interaction and communication (floor time). This approach seeks to develop functional skills, the acquisition of affective-emotional competencies, the integration of children into social interactions, the development of sensory skills, psychomotor planning, and symbolic development, which includes language acquisition. This process is based on working with parents in sessions with a therapist and/or analyzing family videos and providing specific guidance.

This approach is compatible with language perspectives that prioritize drive and intersubjectivity, such as the enunciative perspective¹¹, which supports a place of enunciation for children with language disorders while simultaneously offering prompts that support language appropriation. Therefore, this study used the DIR/Floortime intervention method^{9,10,12,13} combined with speech-language-hearing enunciative principles^{11,14} due to the importance they give to the child's relationship with their caregivers.

The enunciative principles proposed by Souza¹¹ include the parents' support of a place of enunciation for the child by fostering the assumption/recognition of the subject and the assumption/recognition of the speaker of the language, using strategies that enable the child's engagement and communicational expression in playful activities of interest. This principle strengthens the child-family conjunction and disjunction relationships. The aim is also to facilitate the relationships of form and meaning across linguistic levels through requests that meet principles of lexical, morphosyntactic, phonological, and praxis processing. Thus, prosodic strategies can be used to focus on aspects of form and meaning in language associated with the emphasis on the speech continuum. The DIR/Floortime rule for language requests is to be at most one step ahead of the child's expression – i.e., if the child produces a word, they use statements of at most two words and always with obvious gestural and visual support.

DIR/Floortime establishes principles for developing functional levels based on the child's individual leadership and profile, and their relationship with family members. Thus, through playful activities, the intention for this age group is to develop the first five levels of emotional development: shared attention and self-regulation, engagement, bidirectional communication and complex problem-solving, and a sense of self, laying the foundation for the transition from the sensorimotor period to symbolism and language. What stands out at this level is language functioning appropriate for developing the ability to refer in language (second enunciative mechanism) and to initiate the process of establishing the subject in discourse (third enunciative mechanism)^{11,15}.

The DIR/Floortime method analyzes nine levels of a child's emotional and functional development. The first five levels were developed concurrently with suggestions for the expected ages of manifestation and consolidation in typical children, as follows:

- Level 1: Regulation and Joint Attention (0-3 months) - Establishing eye contact, smiling, and vocalizing demonstrates interest in social interaction, as well as the ability to remain calm, alert, and attentive. The child regulates their body and multiple sensory and emotional stimuli.
- Level 2: Mutual Engagement (2-5 months) - Develops interest and trust in others, enabling them to overcome emotional problems with their support.

- Level 3: Intentional Two-Way Communication (4-10 months) - Perceiving responses to gestures/speech and demonstrating emotions such as joy and anger, enabling engagement in communication with others.
- Level 4: Complex Problem Solving and Sense of Self (10-18 months) - Able to solve motor problems and acquire greater control over their body, representing actions and being able to anticipate them in the interaction process.
- Level 4: Complex Problem Solving and Sense of Self (10-18 months) - Able to solve motor problems and acquire greater control over their body, representing actions and being able to anticipate them in interaction.
- Level 5: Symbolic Thinking, Language and Emotions (18-30 months) - The child can understand the intention of others and respond through language, using gestures, verbalizing, or simply moving to communicate their ideas and desires.

According to a study¹¹, children with ASD experience significant obstacles in the first four levels, particularly physical ones, which impede the adequate and robust development of engagement, shared attention, and two-way communication. Therefore, although they can produce speech, they are not always able to address their productions to others and engage in a casual dialogue. This highlights the importance of combining this approach with the enunciative view of language, as it allows for the analysis of obstacles in the first three levels and promotes family-child synchrony. If synchrony is established, it can fuel the assumption/recognition of subject and speaker, providing compensation so that the child can master bodily spaces and create the cognitive conditions necessary to represent action and language.

The COVID-19 pandemic called attention to telecare, not only for already trained speech-language-hearing pathologists but also as an aspect to be developed in the training of future ones. A study on telecare¹⁶ highlights its potential in speech-language-hearing therapy in teaching clinics. Some studies have already been conducted specifically in cases of ASD^{17,18}, demonstrating that, despite limitations in some developments, parents can make progress in their interactions with their children through an approach that considers family videos and guidelines that conceptualize the profiles of both children and parents. In the first study¹⁷, although 60% of parents had difficulty completing the tasks, there was improvement in social interaction after

6 weeks of intervention. Another study¹⁸ states that intervention with parents can include observational learning, didactic workshops, and passive coaching. The authors researched the evolution of parents and children in terms of communicative intention and socio-communicative performance after 10 weekly telecare sessions.

Considering the positive results of telecare and the impossibility of accessing in-person care for some children, this case study aimed to analyze the effects of parental telecare as assisted waiting on the evolution of the profiles of parents and children presented with ASD.

CASE REPORT

This research is part of the project “The relationship between language acquisition delay and history of mental distress in children aged 2 to 4 years”, approved by the Research Ethics Committee of the Federal University of Santa Maria, RS, Brazil, under protocol number 5.057.051 and CAEE 52044121.6.0000.5346. The parents read and signed an informed consent form after understanding the research objectives, benefits, and risks. They also received the researcher’s confidentiality agreement. The study also followed the human research guidelines and regulatory standards as determined by the Brazilian National Health Council in its resolutions no. 466/12 and no. 510/16.

This section is divided into three subsections: the materials and methods used in the case studies, case history and initial assessments, and intervention results.

MATERIALS AND METHODS

Three children with ASD and their parents participated in this qualitative case study. Two 3-year-old twin brothers, identified as M. and D., and their parents (M; P); and a 3-year-old girl, A., and her parents (Ma, Pa). They were on a speech-language-hearing clinic’s waiting list.

The inclusion criteria were children diagnosed with ASD based on the core symptoms proposed in DSM-5², aged 2 to 4 years, on a waiting list for treatment at the teaching clinic, and whose parents/guardians agreed to participate in the study. Children with syndromic conditions, other comorbidities such as epilepsy, sensory or physical disabilities, and whose parents/guardians declined to participate were excluded.

The instruments used in the assessment were the Dimensional Inventory for Child Development

Assessment (IDADI)¹⁹ and the Labyrinth Scale²⁰, described below.

1 – The IDADI was developed and validated by Silva, Mendonça, and Bandeira¹⁹ for the Brazilian population

It consists of a comprehensive assessment of child development covering seven domains: cognitive, socioemotional, receptive and expressive communication and language, gross and fine motor skills, and adaptive behavior. The instrument, validated for the Brazilian population, collects retrospective information on child development through parental reports, offering a time-efficient, cost-effective approach to assessing the relational and communicative aspects of child development. The inventory includes items describing expected behaviors and skills for each age group and can be completed by parents, either self-administered or in an interview with the examiner. This assessment was administered before the online interventions.

2 – Labyrinth Scale

The Labyrinth Scale assessment consists of a structured medical history survey (attached) and videotaping of planned play activities with toys to assess core autism symptoms and comorbidities²⁰. The counselor provided training on the scale and administered it to the three research subjects during the initial assessment. The average application time is 30 minutes and consists of free play with toys to assess motor planning and execution, symbolism, intersubjective interactions with aspects such as shared attention and closeness to others, verbal and nonverbal communication, as well as the presence of rigid, repetitive, and stereotyped behaviors. It also identifies aspects related to sensory modulation, intelligence, and other developmental aspects. After the scale was administered, it was submitted to the Labyrinth team for its psychiatrists to review the score and issue a diagnostic report, which confirmed ASD in all three cases.

The Labyrinth Scale filming also allowed us to verify aspects related to the DIR/Floortime checklist items described below.

3 – DIR/Floortime checklists

The DIR/Floortime^{12,13} checklist for assessing children’s functional emotional development includes a gradual progression at each level, based on observation of the child’s behavior. It was applied during the

filming of the Labyrinth Scale assessment and observed during the online videos and in-person sessions to analyze the children's progress. The results description includes the attributions for the first and last filming.

The functional capacities assessed were:

- I- Self-regulation and attention
- II- Engagement and relationships
- III- Use of affect and two-way communication
- IV- Organization of behavior and problem regulation
- V- Creation and elaboration with symbols.

The following gradations were assessed at each of these levels: 1. The child did not reach it; 2. They practically did not reach it; it is very intermittent, even with support; 3. They had points ("islands") of this capacity (40% present) with persistent and/or predictable support; 4. They reached it with structure and support, through high affect (60% present); 5. Level not expected for age, immature – fragmented, possibly cyclical, but returns to higher levels (70% present); 6. Level appropriate for age, but vulnerable to stress and/or with a restricted range of affects (80% present); 7. Level appropriate for age with a full range of affective states (90-100% present).

The DIR/Floortime checklist for assessing the functional emotional development of parents aims to identify parental capacity and attitudes toward their children. It covers five aspects:

1. Ability to provide comfort and ease them, staying regulated and helping the child regulate when they become dysregulated.
2. Finding the appropriate level of stimulation or request that the child needs based on their developmental level.
3. Engaging the child in a pleasant way.
4. Reading the child's emotional cues.
5. Tendency to encourage the child when faced with challenges.

Parental capacity was assessed at each level as being absent at the beginning, having islands of behavior, being moderate, becoming consistent, effective except under stress, or very effective. Levels were recorded before and after the intervention.

This is, therefore, a qualitative observational assessment applied during interactions with children and family members in session. However, family videos of routine situations were also used to verify the process at home.

The online intervention consisted of weekly meetings lasting approximately one hour via Google

Meet, links to which were sent to parents via WhatsApp. There were seven intervention sessions in total, six online and one in-person. Parents received guidance during four online sessions, one in-person session, and three online sessions.

Before the weekly meetings, parents were instructed to record family videos of free interaction and/or interaction with the therapist. At least two videos a week, each lasting no more than 10 minutes, were requested. The therapist and research supervisor could view these parent-child interactions via WhatsApp.

After viewing, they analyzed play conditions, verbal and nonverbal communication, and emotional functioning levels. Based on this analysis, they established guidance objectives and materials with pictures of toys, for example, to guide parents in their weekly Google Meet sessions.

The structure of the online sessions generally involved listening to parents about the previous week, during which the therapist would sometimes answer questions and request guidance. Following this, comments were made on the videos watched, always praising the positive aspects and encouraging parents to improve those aspects that required greater support in the interactions. During these sessions, suggestions for actions, toys, and ways to request and support language were made, particularly regarding the complexity of children's speech and the type of vocabulary most present in the proximal zone of acquisition.

The guidelines on play took into consideration the stages outlined in the Jasper methodology²¹, which consider indiscriminate, discriminate, and cause-and-effect exploratory play; combined play, pre-symbolic play, which encompasses functional use based on experience and the sequence in which actions from a single scheme are extended to different figures; and symbolic play, which encompasses make-believe with the substitution of objects present and absent, dolls that come to life, sociodramatic play, and fantasy role-playing.

The principles of DIR/Floortime encompass aspects such as following the child's natural emotional interests and creating heightened states of pleasure in playful interactions, which aligns with Couvert's drive clinic²⁰. It also provides for adapting interactions to the child's unique motor profile and sensory processing. Some of the strategies used are described in Table 1.

Table 1. DIR-Floortime levels and suggested strategies and resources

Level	Level Description	How to work	Activities
1. Regulation Joint Attention	The child should be calm and focused, able to filter out internal and external distractions. He/she will be more open to interacting and exploring the world.	The therapist follow the children's interests and engage in what they intend to do so that they can look and pay attention to the person they're talking to. It should be very enjoyable. Some of the precautions include calling their name, getting down to the children's level, and bringing objects close to their face. It's necessary to use facial expressions and mark when they look (I'm glad they looked at me)	Sing songs, leaving room for the child after a few repetitions - watch songs they like. Bowling, Bubbles Children's books, puppets Interesting games with cause and consequence Sensory and motor games with exchange - back and forth, playing ball, throwing, balloon games. Hide and seek with your body and with objects
2. Mutual Engagement	The child can engage with trusted caregivers, demonstrating a strong relationship and sharing care during a meaningful experience	The therapist adds layers to the joint play the the child creates and expands.	Use of mirrors Use of textures and water Painting Body games such as tag, trampoline, etc. Hot potato
3. Two-way communication	The child may engage with the caregiver in two-way communication using gestures, vocalizations, or other forms of nonverbal and verbal communication.	We must offer moments of silence, create communicative demands and encourage gestures to ask or indicate. We can talk about daily events in a simple, uncomplicated way that aligns with play or routine. Therapist take turns in all activities, alternating with child.	Activities that allow exploratory and combinatorial play are common at these levels.
4. Complex problem-solving - self-sense	The child has his or her own ideas and the caregiver supports them; the communication circles are stronger. The sense of self is strengthened.	Problems that emerge during play can be expanded and become more complex. The caregiver can support this solution by encouraging the child to think and providing support when necessary. The therapist never do things for the child without their attention. He/she works with the temporality of facts and actions.	Activities can be games, activities that involve setting up, for example, a tent, blocks, etc., where problems emerge to be solved. Puzzles, memory, drawing, stick-playing, building a tower, Lego, etc. are common.
5. Symbolic thinking Language Emotions	The child begins to imitate functional everyday actions and then moves on to more elaborate levels of original ideas and dramatizations.	The interlocutor must tune into the child's rhythm so that they can expand the thematic play. There are a series of guidelines and precautions for supporting enunciation with increasing complexity.	Thematic plays such as making food, transportation, and animals are very common at this level, which already encompasses pre-symbolic play in transition to symbolic play.

Enunciative principles¹¹ supported a place of enunciation and favored the appropriation of forms and meanings.

1) Supporting a place of enunciation for the subject with ASD

Because these children don't speak, it's common for people to think that imitation will help them learn to speak. However, the question is how they will communicate, based on what they want to express. Thus, following DIR/Floortime, the goal isn't to teach children to repeat words, but rather to progressively express themselves through levels 1, 2, and 3 of emotional development. If they possess two-way communication, they will develop the ability to converse, first nonverbally and later verbally, as all children do. Thus, the sensory routines that occur at the initial levels (especially 1 and 2) will lay the foundation for intentional communication at level 3. Then, symbolic skills will begin to emerge at level 5, which may take a long time to develop. Speech-language-hearing pathologists play a key role in providing access to verbal communication.

In any case, the first step is to provide a space for the subject to express themselves by:

- Following the child's lead – we provide a place for enunciation by letting them choose the activity and tuning in to it.
- Validating their feelings and all nonverbal expressions (gestures, gaze, vocalizations) as a form of participation in language to align the therapist's speech or comments with what they are feeling, seeing, and observing. This avoids imposing what one wants to teach, which the subject may not want to learn.

Sensorimotor play can be a powerful start in creating this space for enunciation in which there is joint attention, engagement, and a two-way street.

2) Construction of language knowledge through integration with non-verbal manifestations.

In this construction, nonverbal expressions such as gestures, symbols, filler gestures, and jargon can be combined with the production of the first words. It is important, however, to consider some principles:

- a) Understanding comes before production. Therefore, if the subject does not understand what you say, they can't converse with you.
- b) Nonverbal expressions must be in the order of two-way communication so that verbal expression can be developed through dialogue.
- c) The expressive ability to speak will occur during dialogue, and this must be attuned to the child's attention, expanding what they express in a way that is highly synchronized with their focus and respecting certain lexical, syntactic, and phonological rules across the board. In other words, a specific level is not required, as all levels occur together in the dialogue, even if the child only expresses words. Care should be taken not to overtalk and always offer "speech" by opening a level proximal to the child's current development – i.e., expanding their speech to something that is close in terms of language acquisition. Thus, if the child says a word, another one can be said that adds something to that word, respecting lexical, phonological, syntactic, and morphological strategies. Hence, pure, meaningless repetition, lacking communicative connection, is not effective in teaching children to express themselves verbally in dialogue. At most, they are training to repeat speech that they may not even understand.

Maintaining dialogue allows children to build language knowledge through practice, improving their grammatical skills, as they strive to make themselves understood by their addressee.

Table 2 summarizes principles and strategies for appropriating relationships of form and meaning.

Table 2. Strategies to facilitate relationships of form and meaning¹¹

Level	Principles	Strategies
Lexical	We must consider the prototype with which the child mapped the lexical item and expand to other examples. We can use mutual exclusivity strategies and visual and gestural cues.	We can present nouns in playful situations, encouraging comprehension and production. We vary the objects and presentation contexts. The therapist can associate the name with the object's functionality through pantomimes (look at the cow - moo).
Phonological	The therapist must consider what the child produces spontaneously and what she/he WANT to produce to try to sustain production. We can try to expand production by considering stages of phonological acquisition.	We repeat what the child says to improve their production. We encourage observation of the therapist's face and mouth to analyze articulation. We can use prosodic strategies such as music. Use strategies such as multigesture and prompting.
Syntax (morphology and empty signs)	Verb production is essential for the emergence of the sentence Sentence comprehension precedes sentence production. Morphology and personal pronouns develop from the sentence itself.	We can encourage the production of nominal or verbal complements to stimulate vertical syntax between adult and child. We should compare what the child says with the adult's correct production to encourage morphology. Personal pronouns should be practiced in dialogue, using naturalistic examples. Some games can facilitate the generalization of syntactic knowledge.

With these frameworks in mind, they were translated as objectively as possible into conversations with parents about the scenes they submitted. During the in-person session, we attempted to demonstrate some play situations to provide a model for parents, particularly regarding aspects that proved more difficult to address in the online session or for which behavior modification was more difficult.

The analyses presented in the results were based on the session recordings and a field diary kept by the researcher.

Case history and initial assessments

M. and D. are identical twin boys born on November 1, 2019, who were evaluated when they were 2 years and 8 months old. After the boys' in-person evaluation, their father lost his job, and in-person care became unfeasible, which suggested their inclusion in this research.

The boys' mother reported an unplanned pregnancy and rejection, suspecting that her diagnosis of depression was the cause. She blames herself for the children's language delays caused by this condition.

The twins were born at 34 weeks by cesarean section. D. weighed 2,540 kg, had a 45 cm head

circumference, and had a 1-minute Apgar score of 6 and a 5-minute Apgar score of 8. M.'s Apgar scores were 5 and 8, respectively, requiring resuscitation.

Both were admitted to the ICU for 20 days due to lung immaturity and were switched to formula instead of breastfeeding. The feeding transition went well at 6 months, and the only restriction now is that they do not eat vegetables.

Both boys slept well in their own room and wore diapers.

Regarding sensory aspects, M. and D. rotated around the axis. The boy M. liked to spin toy wheels, chop leaves into small pieces, and flap. D., on the other hand, had crying fits and screamed for no apparent reason or when upset.

D.'s main complaint was delayed language acquisition and inappropriate behaviors. M. also had delayed language acquisition and language regression, as well as inattention and lack of social interaction.

Both M. and D. were assessed using the Labyrinth Scale, and the results were consistent with ASD (see Table 3). M. and D.'s parents also completed the IDADI online.

Girl A., aged 2 years and 10 months, and her parents joined the research in the same year as D. and M., while they were waiting for in-person appointments.



The initial interview revealed that A.'s pregnancy was unplanned but accepted, and prenatal care began in the 11th week of pregnancy. A. was born at 39 weeks, weighing 3.290 kg, with a head circumference of 36 cm, and 1-minute and 5-minute Apgar scores of 9. She was breastfed immediately after birth and was exclusively breastfed until 6 months, when other foods were introduced. A. ate well, accepting foods from all nutritional groups.

The parents' main complaint was delayed language acquisition, although A. was already producing some words. The parents observed difficulties in social interaction, such as a preference for playing alone and a lack of initiative in seeking out other children, although she was receptive to others approaching. The mother also reported that all of A.'s games were repetitive, although she did not resent the change in routine. Sometimes, A. would get angry and throw tantrums when her demands, such as going somewhere or obtaining the desired object, were not met.

Regarding toilet training, A. still wore diapers when out of the home, but she preferred urinating at home, when she could be changed more frequently.

A. slept well, in her own bed, although some days she would wake up and go to his parents' bed to fall asleep again.

Regarding sensory aspects, A. would often spin around, shake her head from side to side when happy, squint her eyes, and occasionally walk on her tiptoes.

After completing the interview, A. was personally assessed using the Labyrinth Scale, whose results were consistent with ASD, as seen in Table 1. The Labyrinth Scale assessments were conducted by certified speech-language-hearing pathologists and were analyzed in the Labyrinth group, with the participation of a child psychiatrist, who confirmed the diagnosis of ASD for all three children. A.'s parents also completed the IDADI online (see Table 4).

From a psychomotor standpoint, A. presented proprioceptive, balance, and visual-manual coordination failures, especially in fitting games and in assessing the distance from her body to objects, as she often stepped on them while walking, lost her balance when changing surfaces on the ground (mat to floor), and was unable to plan and execute changes in her body position to achieve motor objectives such as getting up to reach the top of a tower to fit another piece.

She would also sit in a W-shape, and sometimes her left hand rested on the floor while extending the right to maintain balance. She had difficulty articulating the two sides of her body and automatically maintaining postures. If the child turned too quickly, she could fall and lose her balance. These qualitative changes did not manifest in the mastery of major fine (typical) and gross (delay warning) motor skills on the IDADI (see Table 2).

No hypersensitivity was observed. She had tactile hyposensitivity, trying to explore objects with her hands and feet, and sometimes putting them in her mouth.

Regarding communication, A. presented vocalizations, which were mostly not addressed to parents or therapists, but rather for self-stimulation and self-regulation. Although A.'s parents reported that she could utter words such as "hi, hello, bye, mommy, mama, daddy, water, woof, meow, bear, jump," these were not observed in the initial assessments. A. requested actions on objects through gestures, such as asking for more bubbles, using iconic gestures (rounding the mouth), or handing over the jar of bubbles without eye contact.

Her focus was on the action on the object. She also didn't use smiling or eye contact as a form of social interaction. Therefore, she didn't open or close communication circles. She only engaged in the bubble activity and had difficulty maintaining attention in other activities with greater psychomotor demands, especially when faced with fine motor obstacles, quickly giving up on the toy.

She couldn't perceive actions in the environment, as she was always focused on the objects she was exploring.

A.'s parents provided excellent stimulation for her, but their greatest difficulty was in synchronizing their stimulation with what she could understand and produce. Often, her parents' speech was too complex, their suggestions were less suited to what A. could accomplish, or they still didn't understand what she wanted. Sometimes, she would express herself, her expression drifting, and her parents couldn't interpret or recognize what she was saying, leading A. to scream to be heard.

Table 3 shows the Labyrinth Scale data for the three children.

The IDADI results of the three children are in Table 4.

Table 3. Labyrinth Scale's results in the initial assessment

Domains	Score Pattern Cutoff point for ASD indication	Score M	Score D	Score A
Social Interaction	≥ 3	11	7	7
Verbal Communication	≥ 4	10	9	8
Nonverbal Communication	≥ 2	17	8	14
Rigid and Stereotyped Behavior,	≥ 4	8	7	15
ASD Diagnosis	≥ 12	46	31	44

Captions: ASD = Autism Spectrum Disorder M, D, and A = Children's initials

Table 4. Results of the Dimensional Assessment of Child Development Inventory

Dimension	M		D		A	
Cognition	63	significant delay	70	delay	68	significant delay
Socioemocional	31	significant delay	57	significant delay	64	significant delay
Communication and receptive language	10	significant delay	27	significant delay	48	significant delay
Communication and expressive language	23	significant delay	23	significant delay	47	significant delay
Gross Motor Skills	92	typical	95	typical	83	Alert for delay
Fine Motor Skills	95	typical	104	typical	105	typical
Adaptive behavior	47	significant delay	66	significant delay	90	typical

Captions: M, D and A = children's initials

The initial plan was for 10 guidance sessions, considering the parameter found in a study¹⁸. However, for operational reasons, the study had to be completed with seven sessions.

RESULTS

Seven online follow-up sessions were conducted between the initial and final assessments. The sessions

consisted of listening to the parents first and then discussing situations observed in the videos and reported by them.

Tables 5 and 6 describe the interventions implemented, considering the instructions provided for video production, the parents' comments on the past week, and aspects developed in the session based on guidance provided by the speech-language-hearing pathologist.

Table 5. Summary of intervention sessions with D. and M.'s parents

Sessions	Filming instructions	Parents' weekly comments	Guidelines given by the speech-language-hearing pathologist
First	Sensory-social play and everyday activities	D. spilled soda on the table, and M. looked for a cloth to dry it. Since he couldn't find it, he used his sleeve. D. kisses and hugs M. and encourages him by clapping when he understands his parents' requests. M. has started smiling more and seems to understand what's being said. The best interactions happen at mealtimes. They're dancing.	Establish eye contact and synchronize the child's play with the adult's speech, especially eye contact. Engage in more sensory-social and physical activities rather than more structured tabletop activities. Parents should realize that, despite being twins, they have different tastes and abilities, as they are attuned to M.'s language support but very directive with D. Explain age-appropriate books and how to read.
Second	Activities of daily living	Parents asked for toy ideas. They said their boys were having a birthday soon, and the family wanted to give them toys.	Discussion about play styles, how to align speech with play. General explanation of each person's play style.
Third	M. and D's favorite games, alone and with their father.	D. is saying vowels while watching "Galinha Pintadinha", saying "woof woof" for "dog", and "grandma." He has become interested in household chores. M. uses the "give" word functionally and has started pointing. "We couldn't get close to him before; he didn't like kisses and hugs; he lived in corners, and now he doesn't. His grandmother comes home, and he shows the books or whatever else he wants". M. has started hugging D. and looking for him to play with.	Presentation of toys suitable for both children and for each one, explaining where each child is in their development, with ideas for variations. Attentional and calming sensory games for both children aim to explore bidirectionality, increase eye contact, understand verbal commands, and develop motor skills. Also, simple action-reaction and disassembly games, and a simple functional presentation-matching game. For D, games and toys that refer to the pre-symbolic. Guidance on choosing books. Discussion about avoiding inappropriate behavior by anticipating routines for him. Empowerment and encouragement for the father to appear in the videos and play with them more.
Fourth	Discussing in-person care with family. No videos to watch this week.	M. is saying "didi" for "godfather" and "potato." They've stopped spinning the wheels on toys, objects, and their bodies. They're playing more functionally; D. always liked toy cars, and now M. likes them too. M. likes tearing leaves into ever smaller pieces. On a Children's Day outing, they loved playing on the trampoline, where only D. jumped and M. sat. D. tried to say "chicken."	Stimulate speech based on the environment and action, and continue encouraging motor play and motor imitation through dance. With D: use concrete objects and narrate them to improve pre-symbolic development; it's still very much in their body and that of others. With M., expand tactile exploration of objects. For example, M. can use play-dough to squeeze and make balls. D. can pretend to make food. Encourage them to choose games and participate in them. The child's motivation is essential to improving auditory memory and speech. Introduce functional words like yes and no, anchored in gestures, as it's necessary to understand the concept of the word in everyday life to use it.
Fifth	In-person observation of interactions with parents and modeling.	Questions about how to vary games and introduce two-way play	They received a gift from the therapist, an alligator with a toothache, encouraging two-way play and the functional use of some words. With M., more sensory-social games, and with D., more toy car games with variations.
Sixth	Next videos collage with a mosaic of M.'s shredded papers, and with D. with his parents playing and using different cars.	They learned to take turns playing with their parents, playing the alligator with a toothache game. Their mother says she has difficulty connecting with M. during games and prefers cuddling to interact with him. They began responding when called by name. They began solving problems like picking up a cup from the sink. Both also learned to blow bubbles and smell flowers. M. is understanding his parents' speech related to everyday needs.	D. really enjoys drawing, with an adequate attention span. His father was able to vary his toy car games and build towers well. M. likes to play by taking toys in and out of a jar, and we encourage variation by providing role-playing examples. It's important to learn to play both separately and together. Guidance on how to approach a child to play together. D. has cognitive rigidity, not accepting exchanges of games, unlike M., who exchanges with slight effort. D. has started to refuse to share toys with M. and has increased screaming and crying behaviors. Guidance on regulation and co-regulation is provided.

Sessions	Filming instructions	Parents' weekly comments	Guidelines given by the speech-language-hearing pathologist
Seventh	Free videos of play with parents and each other	M. engages well with any toy or interaction with others, unlike D., who needs affection and fun. After moving house and city, M. is having more fits. M. engages well and prefers to play with others. They're already understanding small commands like "get the pacifier for mommy." M. is saying "dada" to daddy and "mama" to mommy, and D. can say "one" and "two"; understands colors and tries to name them. They played with a child of the same age, also with ASD, and shared toys and shared small moments together, such as throwing the toy car back and forth. This two-way play emerged in the game of one throwing the ball and the other dropping it, and then switching roles in the game. They're able to cut their nails without getting out of control. The parents recognized and understood each child's profile and became confident.	D. and M. use the pacifier a lot – guidelines to try to reduce it; wait 3 seconds for a response after asking a question, if it doesn't come, then say the expected answer. Actively participate in play, always using action verbs and objective sentences. M. needs to improve stacking and nesting skills instead of always asking an adult for support without even trying, and D. needs to play more together and make more eye contact; in addition to expanding play into pre-symbolic play.

Captions: D and M = the children's initials

Table 5 shows that both boys progressed from the three initial levels, and that guidance focused on play, strategies for synchronizing speech and gesture, the introduction of bidirectionality, and psychomotor challenges, with some introduction of problem-solving.

Co-regulation and engagement were also expanded at times, particularly after moving house. All sessions cross-sectionally differed in each boy's profile.

Table 6 presents A.'s intervention sessions, which generally took place with her parents.

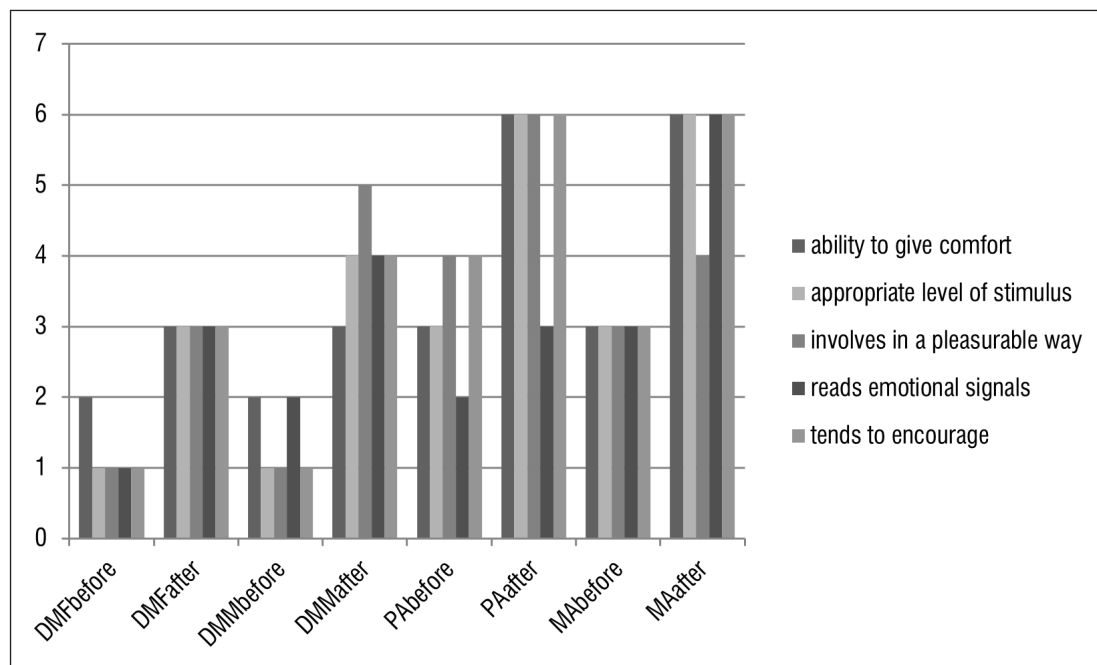


Table 6. Summary of intervention sessions with A's parents

Sessions	Filming instructions	Parents' weekly comments	Guidelines given by the speech-language-hearing pathologist
First	Pre-symbolic fitting game and free play	A. has increased eye contact and points more to make requests.	Sit at A.'s height for eye contact, implementing sensorimotor-social games, trying to increase the level of tactile arousal due to tactile hyposensitivity. Increase A.'s perseverance in play, with one object at a time. Explain levels of play development, making A.'s stage clear. Expand fitting and construction games. Simplify language—one phonologically simple, action-based word at a time.
Second	Free and tactile sensory play, such as play-dough, slime, and sand.	She started problem-solving; she grabbed a stool and took it to the kitchen to get some fruit. She began imitating TV choreography and everyday parental actions like washing clothes in the washing machine.	It was observed that A.'s difficulty with spatial awareness leads her to give up quickly to avoid frustration. Her parents were instructed not to anticipate requests and to let her ask for help somehow (by looking, gesturing, speaking, or saying the word "help"), waiting for her to come up with ideas. They were urged to continue sensory play and use functional words within the context.
Third	Game with motor skills	She has started talking about pee, using onomatopoeia and the first syllable of disyllabic words like "VA" for "vaca" ("cow"), and humming. She points and makes more gestures to ask for something. She's playing more elaborate games with dolls, fitting together geometric shapes, and persisting in the game for longer.	Reduce screen time. Use simpler words with sounds like 'p', 'b', 'm', 'd', and 'n' in monosyllables. Pronounce the word without diminutive or augmentative, and when she does, don't worry about the correct form, recognizing her pronunciation. Play motor games and encourage eye triangulation.
Fourth	Routine activities	Sometimes, she verbalizes within context ('poio' - ball, soap, 'no', 'ati' - 'here', 'refi', 'bread', and 'hi'). She addresses jargon with prosody to her parents. She repeats the syllable na to say no. She observes her parents more and has expanded her verbal and motor imitation. She began exploring modeling clay and played for 5 minutes. She enjoys spinning and somersaulting. She learned to throw the ball forward, as before she would drop it from her hand or it would fall to the side. Her eye contact has improved greatly, and she continues to explore extensively with her hands and feet.	Simplify your speech with her; instead of "bird," focus on "tweet-tweet," since the sequence consists of functional monosyllabic and disyllabic words duplicated in context. Expand functional vocabulary and improve eye contact.
Fifth	In person	Her parents say A. is attentive to the family routine and wants more autonomy, such as serving her own juice. She has begun to show interest in other children.	A.'s progress across all socioemotional levels led to the development of expressive language. She said 'fell,' 'found,' 'where is it,' 'go out,' 'grape,' and 'apple' in the expected environment. Stereotyped behaviors decreased, and problem-solving and self-awareness increased. She still has difficulty playing stacking and tower games; however, she has progressed. The foam puzzle was A.'s favorite activity, as she fit the pieces together easily (when she couldn't, it led to disruptive behavior, or she switched to another activity). She needed support when using the knife on the fruit. Individual sensory boxes were provided with plastic, cotton, grains, dried tree leaves, slime, play-dough, soft balls, and straw. She explored all textures.
Sixth	Filming plays	Assembling a wooden puzzle with two pieces made by her mother was easy, but she couldn't do it with more pieces due to poor motor skills. Her mother noticed that her balance was good some days, and poor others. She preferred to play by transferring liquids from one container to another.	Encourage turn-taking play with puzzles, towers, and other interlocking toys. If necessary, provide gestural support by saying the word "help." Follow the narration of action-reaction and pre-symbolic games. Always seek eye contact with A.
Seventh	Filming plays	She is socializing more. She observes the household routine and wants to participate. She saw two pools, showed two fingers, and said "water." She drops her toys less and fits her blocks together better. She has learned to regulate herself better; she often asks for slime to slide over her foot, showing her foot and saying "foot." She is producing verbs like "found" and "fell" functionally.	Do not solve everything for A., but help her when needed. Validate A.'s feelings.

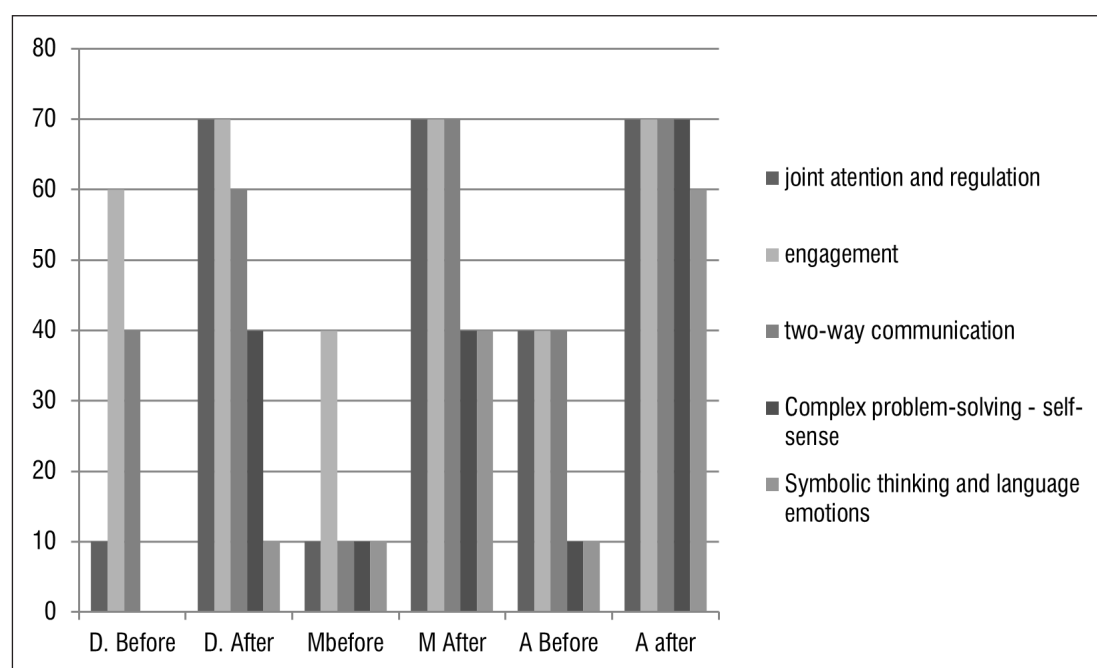
Caption: A = The child's initial letter

The interventions indicate a change in the profile of parents and children (A, D, and M), as seen in Figures 1 and 2.



Captions: F=father, M=mother, D, M, A=children; 0=did not achieve, 1=beginning of skill, 2=isolated development, 3=moderate presence, 4=becoming consistent, 5=effective except when stressed, 6=very effective

Figure 1. Evolution of the parents' profile before and after the intervention



Captions: D, M and A = children

Figure 2. Evolution of children's functional emotional development

In addition to the noticeable developments in their profiles, it's worth highlighting the observations made by D. and M.'s parents: "We arrived there desperate for them to talk, and through the sessions, we realized through their progress that they don't need to speak to communicate. Today, they are both happy."

This statement is confirmed in a scene sent by the mother in which M. and D. playfully hit each other's heads with a pillow. One brother hits, and the other waits, then simulates a fall, and both laugh, watching and sharing the scene with their parents. This scene highlights several aspects of the boys' development, such as their beginning to play together, their sense of self, as there is simulation and appropriate use of the body, and, most importantly, the pleasure in play mentioned by the mother.

Moreover, A.'s parents became more attuned to her needs and synchronized their speech with their daughter's actions. The parents noticed that she had significantly improved her social interactions. One report was of a visit to a gathering with friends during the World Cup games, where A. interacted more with people, explored the area, wanted to see the pool, and was able to communicate better. In A.'s case, there was no direct approach to the ASD diagnosis with her parents, but rather a focus on the girl's potential, considering that her parents rarely asked her about the topic.

DISCUSSION

Despite the positive results in this research, the fact that it is a case study does not allow for greater generalization for the population with ASD and establishes interpretative limits to be investigated in research with a larger number of subjects.

Another limitation to be highlighted is that this approach requires a lot of time to prepare the guidelines, in terms of watching the videos and analyzing the materials to be offered and discussed with the parents, which needs to be anticipated in professional services.

Significant progress was observed in the three children, considering the first three levels of DIR/Floortime. They became more robust in their possibilities of mindfulness, regulation, engagement, and bidirectional exchange with others^{12,13}. This confirms what the literature states about the relevance of DIR/Floortime for intervention in this age group^{9,10}.

All evolved in problem-solving and sense of self, although D. and A. evolved a little more. This is possibly because M. was less evolved at all levels of functional

emotional development than D. and A. at the beginning of the intervention.

Only A. progressed in creation and elaboration with symbols, but with support. M. began his development, and D. advanced one level further than his brother. This slower progress at this level seems to be explained by the fact that development at previous levels did not reach expected levels for their age, although the children advanced at all levels. It is also explained by the fact that A.'s play was more advanced at the beginning of therapy, as she had moments of pre-symbolic play, as classified in the Jasper methodology²¹.

Overall, the program was noticeably effective for both couples to find more productive and appropriate ways to play²¹ and provide enunciative support for their children¹⁵. This was reflected in the progress of fathers and mothers in relation to the items on the parents' checklist.

D. and M.'s parents started at levels that reached a maximum of 40% before the intervention and developed to moderate capabilities. A.'s parents, on the other hand, went from moderate capabilities to highly effective in most of the items assessed. These differences highlight the importance of individually assessing parents' profiles, ensuring progress at home based on the support each family needs.

It is believed that the DIR/Floortime approach^{9,10} can bring important contributions to work with parents and children precisely because it does not focus on skills, but on integrative forces of development based on the relationship between the child and their family members^{12,13}.

This work suggests telecare's potential for parental work, as already conducted in other studies^{17,18} based on the reality imposed by the pandemic. It can have important effects on the training of future speech-language-hearing pathologists¹⁶ and approaches compatible with the current conditions offered by the Brazilian Unified Health System (SUS). Telecare can constitute a hybrid approach, alongside in-person care, to enhance the progress of children who sometimes have limited access to diagnosis and treatment with the necessary intensity¹⁻⁴.

Another important aspect to highlight in this approach is that DIR/Floortime is compatible with an active subject perspective, as advocated by the enunciative approach. In the latter, the dialogue attuned to the child¹⁵, following their lead in play²¹, evolved the conditions for the emergence of a place of enunciation¹¹ in D. and M.'s play, vocalizations, and communicative

gestures. A., on the other hand, moved from a displayed reference to a spoken reference¹⁵, evidenced by the production of the first words.

Finally, this work highlights the process of mourning and re-idealization²² that was possible with D. and M.'s parents, who began to better understand what it means to have children with ASD, identify their children's potential, and value their overall development, seeing beauty, competence, and a future for their boys. More aware than A.'s parents of their children's ASD, they were able to speak more openly about the challenges their children's condition imposed on the whole family. A.'s parents, however, had not yet addressed the topic, although the research supervisor had confirmed the presence of ASD traits in A.'s first assessment. They seemed uninterested in a diagnosis. They preferred to focus on what A. needed to develop. This highlights each family's unique journey and the need to consider this in therapeutic approaches, whether general developmental, such as DIR/Floortime, or specific to speech-language-hearing therapy, such as the enunciative standpoint.

FINAL CONSIDERATIONS

Telecare for parents was effective as a form of assisted waiting and can be a good practice, both for children on waiting lists and for those who cannot attend in-person care more than once a week, due to family socioeconomic conditions. This can be crucial for situations like those encountered in the Unified Health System (SUS), as was the case with the twins who initially motivated this study because they could not afford to commute to the teaching clinic. This approach, based on DIR/Floortime and associated with principles of play and an enunciative view of language, was also effective in assisted waiting for all three cases.

The results suggest that online guidance with parents, based on viewing family videos, can be an effective strategy in conjunction with in-person care when children begin treatment at teaching clinics. This combination can enhance children's progress. Overall, the study highlights the importance of including parents in the therapy of their children presented with ASD.

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VJPV: Conceptualization; Data Analysis; Project Administration; Writing - Original draft.

APRS: Conceptualization; Data Curation; Data Analysis; Project Administration; Supervision; Writing - Review & Editing.

Data Sharing Statement:

The research data are in a video format, as they were virtual parenting sessions recorded on Google Meet. They are not available to third parties due to participant confidentiality. All data were transcribed, and a session log was created, which is summarized in the article.