

her thoughts that it was too soon to start thinking about menstrual care since her daughter was only 10-years-old. However, upon reviewing the indicators that her daughter had begun showing the signs of puberty, including breast development and growth of body hair, she was open to the discussion. The teacher described the proposed intervention. The parent asked questions to clarify the procedure and for her role in the intervention, as well as staff's role. She was in agreement, and the formal intervention was developed. The intervention was first submitted to the Superintendent and Special Education Director for review. School administrators were supportive of the research study and approved the study within a few days. As a Board Certified Behavior Analyst (BCBA) conducting the research study, I am required by the Behavior Analyst Certification Board's Professional and Ethical Compliance Code (BACB, 2019), to "conduct research only after approval by an independent, formal research review board" (p. 18). In keeping with these requirements, I contacted the local university to ask if they were willing to review the research proposal. The local university agreed to review the research study and provided the required proposal forms and a request for parental consent and child assent. These forms were completed and submitted to the university. Once the proposal was reviewed by the local university's Institutional Review Board (IRB), additional information and edits were requested. Specifically, an additional Letter of Approval by the Superintendent was requested by the IRB and a simplified child assent form. The subsequent submission to IRB was approved. The approved parent consent form was then reviewed with the parent and consent was received. At the same time, the child assent form was reviewed by the parent and student, resulting in Maria providing assent.

## **Training for Caregivers**

Frequently, younger individuals with ID are receiving menstrual care instruction in school settings and by school staff (Rodgers & Lipscombe, 2005), yet there are no widely accepted teaching programs available to staff (Richman & Ponticas, 1986), and staff continue to report inadequate training. Carnaby and Cambridge (2002) reported that individual care plans included a description for the kind of menstrual care support and the frequency of support needed, but lacked a teaching procedure. This was found to be true in Maria's school district as well. No staff member had formally taught menstrual care skills to a student before. The staff discussed ways that they had taught their own children and discussed the way they changed their own menstrual pad. It was found that each person had a unique method to the process, though we all had the same end result. It became clear that, to provide formal and systematic instruction, we needed a guide. When looking for a commercially available curriculum to follow that explicitly taught menstrual care, none were found.

A program was found that reports a “systematic, curriculum-based support [for] social, emotional and physical changes of adolescence [with ID]” (Sheppard, 2006, p.121). This study found that following 20 weeks of instruction using the “Growing Pains Program”, personal hygiene improved the least. As part of this program the school surveyed parents and teachers to identify important topics/areas to be taught at school. Although personal hygiene, including menstrual care, was ranked as a high priority, the curriculum did little to address it. Sheppard recommended a greater emphasis on developing personal hygiene skills within and beyond this program, including training tailored to individuals’ specific needs, such as Maria’s learning needs around menstrual care.

## **Instruments**

Maria’s performance completing the menstrual care routine was measured using a checklist based on a task analysis. According to Cooper et al. (2007), a task analysis includes “the process of breaking a complex skill or series of behaviors into smaller, teachable units; (and it) also refers to the results of this process” (p. 706). The teacher or paraprofessional who worked with Maria completed the task analysis checklist each day when Maria had the opportunity to perform the targeted skill.

Staff were initially trained how to collect data, and when to collect data using behavioral skills training. Behavioral Skills Training (BST) is a training package that utilizes instructions, modeling, rehearsal, and feedback in order to teach a new skill (Sturmey, 2012). Nigro-Bruzzi and Sturmey (2010) evaluated the use of BST to teach staff to use mand training. The four components of BST were used to teach staff to implement an eight step mand-training task analysis. BST was found to be effective in this study in teaching staff to teach a skill to children with ASD. Therefore, BST was considered an effective method to teach the intervention to school staff who were also using a task analysis. For the study, staff were trained on data collection procedures till reliable. Reliability was determined by comparing point-to-point data with the researcher. One hundred percent accuracy was required to meet reliability. Once reliable, the staff were trained on the video modeling intervention using the same BST methods and reliability measures.

Each opportunity Maria had to complete the menstrual care routine was recorded using a checklist corresponding to the task analysis (see figure). The staff recorded a code indicating if Maria performed each step in the task analysis or not. Maria could complete each step independently (+), incompletely, or not at all (-). The staff then marked each step on the corresponding data sheet. At the end of the day, each completed task analysis was converted into a percentage by dividing the number of steps completed independently on the task analysis by the total number of steps in

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