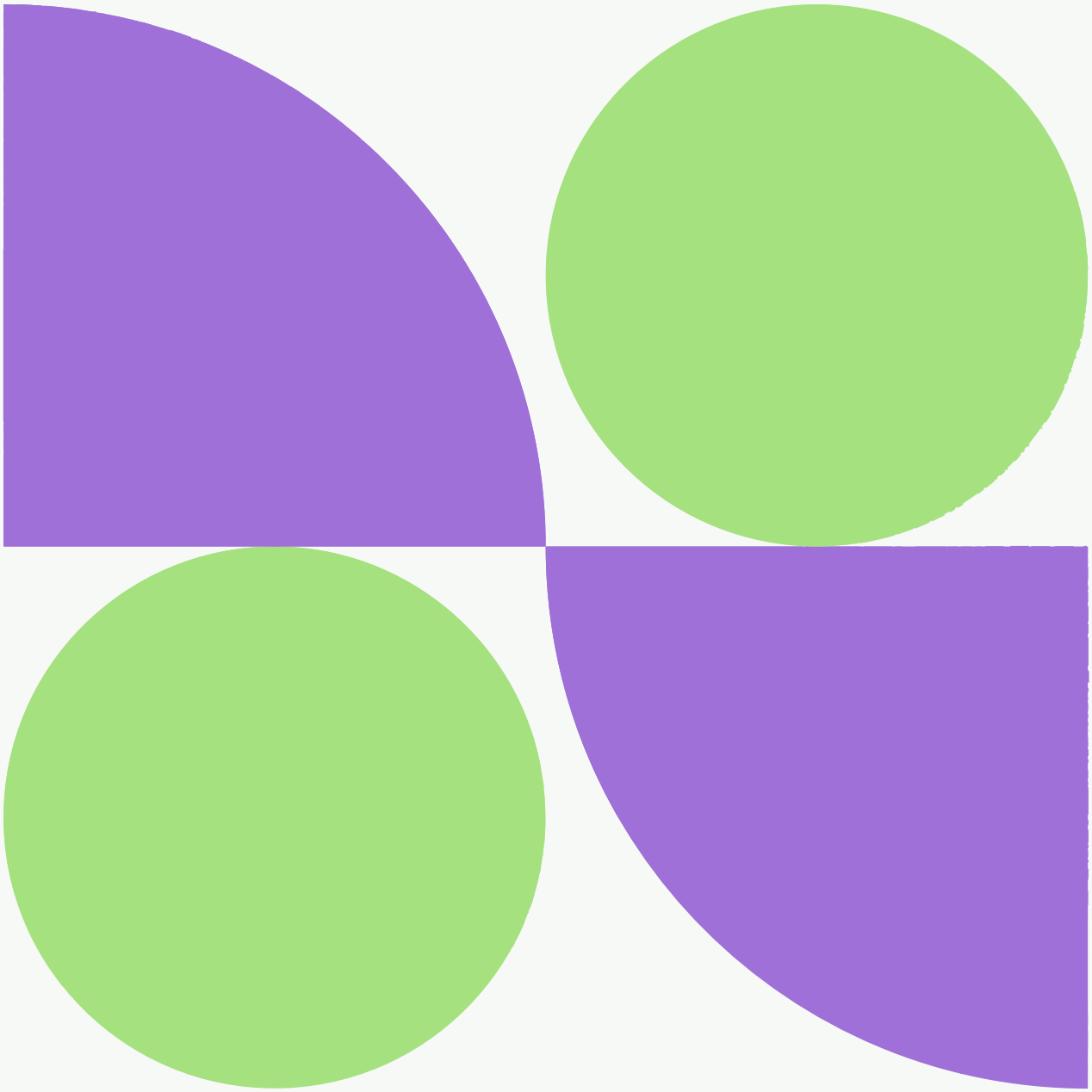
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SEX EDUCATION FOR ALL:

TRAINING SERVICE PROVIDERS TO SUPPORT AUTISTIC INDIVIDUALS

A guide for service providers on delivering Comprehensive Sexuality Education (CSE)



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Introduction

The project

Sex Education for All: Training Service Providers to Support Autistic Individuals is a multi-country collaboration that brings together teams to produce a practical guide for service providers delivering comprehensive sexuality education (CSE) with autistic learners (Project Number: 2024-2-LU01-KA220-VET-000287191).

This project aims to develop an autism-specific CSE guide, train teachers and other professionals working in the field of autism and foster a more informed, inclusive, and supportive environment for autistic individuals as they navigate their sexuality and relationships. By achieving these goals, the project seeks to foster sexual health and responsible behaviour in individuals on the autism spectrum.

Follow the project results on: https://sexed4all.eu/

Partnership

Funded by the European Union. Views and opinions expressed in this Guide are however those of the authors only and do not necessarily reflect those of the European Union or the European Education and Culture Executive Agency (EACEA). Neither the European Union nor EACEA can be held responsible for them.

The guide

The guide is organised into the following sections: Foundations of CSE, Understanding Autism in the Context of Sexuality, Core CSE Topics, Teaching Approaches and Tools, Resources. Each section is authored by different national teams, ensuring a broad range of expertise and applicability across settings.



The guide's purpose is to translate evidence and rights-based principles into explicit, ready-to-use training content for planning, delivering, and evaluating CSE adapted to autistic children, adolescents, and adults. Concretely, it helps providers to:

Ground their work in inclusive, learner-centred CSE standards (human-rights-based, age/developmentally appropriate, non-judgmental, participatory).

Use evidence-based methods to build skills (communication, decision-making, refusal/negotiation) and monitor outcomes to inform improvement.

Anticipate and support cognitive, sensory, and communication differences (e.g., explicit language, visual supports, structured teaching, graded exposure).

Integrate Augmentative and Alternative Communication (AAC) and alternative modalities so learners can express needs, preferences and boundaries.

Address risks tied to exclusion from sexuality education and misinformation by providing tailored, neurodiversity-affirming instructions.

Target group

This guide is written for service providers in educational, health and social-care settings, such as educators, therapists, psychologists, social workers and allied professionals, who design or deliver sexuality education or related support to autistic people. It is structured to be used in pre-service training, in-service professional development and multidisciplinary practice.

The professional posture

This project adopts a neurodiversity-affirming, rights-based, and evidence-informed stance:

- **Rights and inclusion:** Support bodily autonomy, dignity, and non-discrimination; ensure CSE that is human rights-based, inclusive of diversity (ability, gender identity, sexual orientation, culture), and tailored to developmental needs.

- **Accessible communication:** Use direct, concrete language; provide visual support and explicit teaching of social/abstract concepts; normalise and teach affirmative consent.

- **Communication diversity:** Integrate AAC where needed and recognise the "double empathy" perspective, which views communication as a two-way adaptation rather than a one-sided deficit.

- **Sensory-aware practice**: Anticipate diverse sensory profiles, design sensory-friendly learning environments, and teach consent through respect for sensory boundaries (e.g., "what touch feels good/doesn't feel good").

- **Safety and ethics:** Promote confidentiality, safeguarding and abuse-prevention competencies (e.g., recognising and reporting) throughout training.

These elements frame a practical guide for the classroom/institution, aligned with international CSE standards and responsive to the honest communication and sensory needs of autistic learners. Therefore, service providers can deliver clear, explicit, respectful and practical education.

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SECTION 1

Foundations of Comprehensive Sexuality Education (CSE)

What is Comprehensive Sexuality Education (CSE)?

CSE is defined by the United Nations Educational, Scientific and Cultural Organisation, United Nations Children's Fund, & World Health Organisation (2018) as:

"Comprehensive sexuality education (CSE) is an age-appropriate and culturally relevant process of teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality. CSE aims to ensure that young people receive a comprehensive, life-skills-based education that equips them with the knowledge and skills to make conscious, healthy, and respectful choices about relationships and sexuality. CSE includes education on human rights, human sexuality, gender equality, puberty, relationships, and sexual and reproductive health"

"CSE presents sexuality with a positive approach, emphasising values such as respect, inclusion, non-discrimination, equality, empathy, responsibility and reciprocity. It reinforces healthy and positive values about bodies, puberty, relationships, sex and family life." (United Nations Educational, Scientific and Cultural Organisation, United Nations Children's Fund, & World Health Organisation, 2018). Such education gives young people information about their sexual and reproductive health and rights, enabling them to make informed and responsible decisions in that matter and respect their rights and those of others. It includes different topics touching the sphere of sexuality such as body awareness, puberty, emotions, contraception, consent, diversity, relationships, and many more.

Sexuality education also helps to prepare for and manage physical and emotional changes as teenagers grow up, including during puberty and adolescence, while teaching them about respect, consent and where to go if they need help. This in turn reduces risks of violence, exploitation and abuse (World Health Organisation, 2023).



Sexuality education is a continuous learning process of acquiring knowledge, attitudes and behaviours around sexual health that foster well-being and personal fulfilment.

Principles of inclusive and evidence-based CSE

CSE is guided by globally recognised principles that ensure it is inclusive, rights-based, and evidence-based. The Principles of Inclusive CSE (UNESCO, 2018 and WHO, 2023) include:

- Human rights-based: Respects, protects, and fulfils the rights of all learners, including sexual and reproductive rights.
- Gender equality and equity: Promote equal opportunities, challenge gender stereotypes, and address power imbalances.
- Inclusion and diversity: Recognises and affirms learners' diverse backgrounds (including differences in culture, ability, gender identity, sexual orientation, religion, and socio-economic status).
- Age and developmentally appropriate: Tailored to the learners' cognitive, emotional, and social development.
- Non-judgmental and respectful: Provides accurate information without stigma, shame, or discrimination.
- Learner-centred and participatory: Engages learners actively, encourages dialogue, and builds critical thinking and decision-making skills.

Inclusive CSE ensures no one is left out, while evidence-based CSE ensures that every individual receives accurate, effective and proven education.

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SECTION 2

Understanding Autism in the Context of Sexuality

Understanding Autism in the Context of Sexuality

Sexual development is a natural process in both neurotypical and neurodiverse individuals. This invites a broader consideration of what neurotypicality itself entails. Even among individuals described as neurotypical, the assumption of uniformity is problematic, as human development is inherently diverse and no two individuals are identical. Accordingly, sexual development in neurotypical individuals is highly individualised, despite the presence of certain shared developmental features.

Similarly, within neurodiverse populations, while some common characteristics may be observed, such as increased anxiety, heightened tension, or difficulties in expressing emotional states, sexual development and sexuality remain deeply individual and variable. This variability highlights the need to understand sexuality as a personal and context-dependent process rather than a uniform developmental trajectory. Variability in the sexual development of neurodiverse people may be observed in the following aspects:

01



Differences in expression

02



Sensory hypersensitivity

03



Differentiating private and public behaviour

04



Communication and social signals

01
Differences in expression

Due to sensory peculiarities, social challenges or the way of processing information, the way of expressing sexuality can look different. Many neurodiverse people have the most significant difficulties in this segment. Often, due to unadopted norms of social behaviour, their way of expressing themselves is unacceptable, even though their intentions are entirely open and described in the only way they know how (inappropriate touching of other people, masturbation in unacceptable places, etc.).

02
Sensory hypersensitivity

Touch, smells, loudness can be pleasant or unpleasant in a very intense way, which affects intimate relationships. Although these phenomena are also possible in neurotypical people, they are significantly more pronounced in autistic people.

03
Differentiating private and public behaviour

Some people need clear instructions about the boundaries and context of behaviour. Not only during sexual maturation but, in general, throughout development, it is essential to emphasise private and public norms of behaviour.

04
Communication and social signals

Flirting, nonverbal cues and "unspoken rules" in relationships can be more challenging to understand, which leads to the need for clear and direct instructions, or understanding boundaries, which indirectly reduces the risk of manipulation and exploitation of people with autism.

> *Autistic people must become familiar with the norms and culture of the society in which they live*

(Swango-Wilson, 2008)

Due to all of the above, it could be concluded that it is essential to continuously implement support and education that includes clear and concrete language (use concrete examples and visual materials), implement gradual learning (introduce topics step by step with constant repetition) and to educate them especially about consent, as it plays an essential role in preventing sexualized violence.

Furthermore, it is essential to highlight the role of family members, educational institutions, and professionals in fostering open and stigma-free discussions about sexuality with autistic individuals. Such conversations should be conducted without shame or prejudice. School-based educational programmes should be adapted to individual needs and supported by professionals, such as psychologists, educational rehabilitators, and, where available, sex therapists, who can offer comprehensive guidance on understanding one's body, emotional experiences, and interpersonal relationships.

Deconstructing misconceptions about sexuality and autism

Many myths and misconceptions still shape how autistic people are understood. One of the most persistent misconceptions concerns sexuality. Too often, autistic people are either desexualised, seen as innocent, childlike, or uninterested in relationships, or hypersexualised, assumed to lack boundaries and self-control.



Both views are harmful simplifications that erase the diversity and humanity of autistic individuals. Further, their sexuality is posted as being problematic, in need of being 'treated' or managed in some way.

The Origins of the Misconceptions

Misconceptions about autistic sexuality are deeply rooted in outdated medical and cultural narratives. Early research often focused on autism in children, leading to the widespread image of autistic people as permanently childlike. This framing encouraged the belief that autistic adults either do not, or should not, engage in sexual or romantic relationships.

On the other side of the spectrum, portrayals of autistic people as socially “inappropriate” or “overly direct” have been exaggerated into assumptions of hypersexuality. Here are a few of the most common misconceptions:

"People with autism do not have sexual needs or desires."

This misconception assumes that autistic people are asexual by default. While some are (as in the general population), many have sexual needs, desires, and relationships. Autistic people's sexuality is diverse; it can include heterosexuality, homosexuality, bisexuality, pansexuality, asexuality, and more.

“Autistic people cannot meaningfully understand or express diverse sexual or gender identities.”

Yet, studies suggest that autistic individuals are more likely than the general population to identify as LGBTQ+. This reflects not confusion or naivety, but rather an authenticity in questioning and defining identity outside conventional norms.

Dismissing autistic people’s sexual orientation or gender identity as a “symptom” of autism invalidates their lived experiences. Respecting these identities is essential to affirming their autonomy and dignity.

"The sexual interest of an autistic person is inappropriate or obsessive."

Due to the tendency towards intense interests, the sexual interests of autistic people may be more pronounced, but this does not mean that they are automatically inappropriate. Education is needed, not pathologising sexual interests.

"People with autism cannot have romantic or intimate relationships."

This misconception denies the emotional and social capacity of autistic people. Many people with autism desire, develop, and maintain close relationships: friendships, romance, and sexual relationships, although communication and nonverbal cues can sometimes be more challenging for them.

"There's no need for sex education because people with autism won't have a sex life."

Being autistic will not stop an individual from developing sexually or from wanting to explore their sexuality. Besides, autistic people are often more vulnerable to sexual exploitation and relationship confusion, so they need clear, specific, and individually tailored sex education.

It is also mistakenly believed that by teaching sex education, autistic people will become overly sexualized and more likely to engage in sexual behaviour. However, there is no evidence to suggest that autistic people who receive sex education engage in more sexual behaviour than those who do not. Autism may influence certain developmental areas that are related to sexuality; however, this does not prevent autistic individuals from experiencing a fulfilling and meaningful sexuality.

"Autistic people are more likely to engage in deviant or violent sexual behaviour."

This unfounded prejudice stems from a misunderstanding of the impulses and behaviours of people with autism. Violent and inappropriate sexual behaviour is not a part of autism but oftentimes a result of a lack of education, support and understanding, just as with anyone else. Some problematic behaviours may occur due to a lack of knowledge of social rules, limited sexual education or experience, and sensory differences. Therefore, a tailored sexuality education is key.

"Autistic people do not understand sexual consent."

Although some people with autism may have difficulty with social rules or abstract concepts, with clear and accessible education, they understand and apply the idea of consent very well. This prejudice is especially harmful because they can be unjustly stigmatised or excluded from sex education.

The Reality: Diversity and Individuality

Just as in the non-autistic population, autistic people's experiences of sexuality vary widely. Research shows that autistic individuals are just as likely to have sexual desires, relationships and families as anyone else. Some may identify as asexual or aromantic, while others may have strong desires for romantic or sexual connection.

Deconstructing these stereotypes requires a cultural shift: We must listen to autistic voices, challenge infantilization, affirm identity and expand sex education.



> *"We exclude and marginalise people with autism based on what we think we know about them and their sexuality"*

(MacKenzie, 2018)

Why These Myths Are Harmful

Misconceptions about autistic sexuality can lead to:

- **Denial of education**: Autistic young people are often excluded from comprehensive sex education, leaving them without essential knowledge about safety, consent, and healthy relationships.
- **Vulnerability to exploitation**: Treating autistic people as "asexual" can mean failing to prepare them for risks, while stereotypes of hypersexuality can wrongly label them as predators.
- **Erosion of autonomy**: When society denies that autistic people can form adult relationships, it undermines their rights to intimacy, marriage and family life.

When we fail to understand or gain insight into the experiences of a diverse group whose fundamental aspects of identity are denied, restricted, or viewed with disgust, the impact extends beyond misunderstanding. Many autistic individuals may internalise these negative portrayals of sexual and emotional inadequacy, which can lead to anxiety and withdrawal from areas where such misconceptions persist. (MacKenzie, 2018).

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SECTION 3

Tailored CSE to the specific needs of ASD individuals

Cognitive, sensory, and communication considerations

Autistic individuals may experience cognitive, sensory, and communication differences that shape how they understand intimacy, relationships, sexuality, and consent. Service providers should offer comprehensive sexuality education (CSE) that is clear, respectful, accessible, and empowering.

Cognitive processing differences

To better understand individuals with autism, it is essential to be familiar with cognitive theories. Cognitive theories can help develop a deeper understanding of how an individual with autism or with related support needs experiences the world and responds accordingly. The theories overlap and are not mutually exclusive; however, each makes a valuable contribution to understanding people with autism (Silberman, 2015).

- **Theory of Mind:** Differences in understanding others' perspectives and a non-literal communication (e.g., sarcasm, flirting) can lead to misunderstandings (Fletcher-Watson et al., 2014; Holt et al., 2021).
- **Executive function:** Difficulties with planning, sequencing, shifting attention, and working memory can affect learning and daily routines (Meltzer, 2018).
- **Weak central coherence:** Tendency to focus on details over the "big picture," affecting contextual understanding (Happé & Frith, 2006).
- **Context blindness:** Difficulty using situational cues in real time, leading to overly literal interpretations and challenges adapting rules across settings (Vermeulen, 2015).
- **Double empathy problem:** Miscommunication is mutual - non-autistic people may also misunderstand autistic communication (Milton, 2017).
- **Monotropism**: Strong "attention tunnel", preference for sameness, difficulty switching tasks, and getting stuck; can affect flexibility and learning (Murray et al., 2005).

Autistic people may also have higher rates of co-occurring conditions (e.g., sleep, GI, anxiety, ADHD), which can influence learning and well-being (Volkmar, 2021). Service providers should therefore prioritise clear, concrete language and support learning with visual support or social stories.

Practical strategies for service providers

Use clear, literal language:	Avoid idioms, metaphors, sarcasm, and euphemisms, which may cause confusion and use direct, concrete terminology instead (American Psychiatric Association, 2013; Attwood, 2007). Repeating key messages in consistent wording and providing step-by-step explanations helps reduce misunderstanding and anxiety (Silberman, 2015).
Use visual and structured supports:	Use visual schedules, diagrams, flow charts, social stories, consent cue cards, and concrete role-plays to reinforce learning (Gray, 2010; Nichols & Blakeley-Smith, 2009). Structured role-play scenarios allow learners to safely rehearse social and sexual communication and support generalisation of skills (Holt et al., 2021).
Work with monotropism:	Use strong interests to introduce sexuality and relationship topics and provide warnings for transitions between activities, topics, or routines (Murray et al., 2005). Building on focused interests supports engagement while gradually increasing flexibility and awareness of personal boundaries.

Support perspective-taking (Theory of mind):	Explicitly teach perspective-taking using scenarios that illustrate different viewpoints and highlight how others may think, feel, or react differently in relationships (Fletcher-Watson et al., 2014). Video modelling and peer mentoring can further support understanding of non-literal language such as sarcasm, jokes, or flirting.
Support executive functioning:	Break tasks into sequenced steps using task analysis (e.g., initiating a conversation, asking someone on a date, or practising safe sex) and provide reminders and structured checklists for daily routines (Meltzer, 2018). Allowing additional processing time can reduce anxiety and increase confidence during social or intimate interactions.
Teach context explicitly (weak central coherence and context blindness):	Help individuals connect specific details to the broader context of health, consent, and mutual respect, rather than focusing only on isolated steps (Happé & Frith, 2006; Vermeulen, 2015). Practising skills across multiple settings supports generalisation and reduces over-literal interpretations.
Address the double empathy problem:	Train both autistic and neurotypical peers or staff in mutual communication strategies, emphasising that miscommunication is reciprocal and not solely the autistic person's "deficit" (Milton, 2017). Co-creating communication rules within relationships promotes respect, balance, and shared responsibility.

Sensory Sensitivities and Sexuality

Sensory processing differences can strongly affect comfort with touch, noise, smells, and environments during intimacy. Sensory needs vary across people and can change over time. Sexual well-being improves when individuals can recognise and communicate what feels comfortable and what does not (Kirby et al., 2015; Byers et al., 2013). Consent should include **sensory boundaries**, not only agreement to sexual activity. Behaviours sometimes labelled "inappropriate" may reflect unmet sensory needs rather than intentional rule-breaking (Kapp et al., 2019).

Practical strategies for service providers

Normalise sensory conversations:	Introduce sensory discussions as part of routine sexuality education (e.g., "What kind of touch feels good or not good for you?"). This reduces stigma and builds comfort around expressing sensory needs (Nichols & Blakeley-Smith, 2009). Use simple question cards or worksheets to prompt reflection on sensory likes and dislikes.
Teach consent through sensory boundaries:	Expand the concept of consent to include sensory input. Encourage phrases like "I like firm pressure" or "Stop when I say stop." Consent is not only about sexual acts but also about respecting comfort zones (Byers, Nichols, & Voyer, 2013). Create visual cue cards (e.g., green = "keep going," red = "stop," yellow = "slow down/ask").
Use visual tools:	Provide body maps for learners to colour or mark the areas of the body they like, dislike, or are unsure about being touched. This supports communication, especially for those with limited verbal expression (Kirby, Dickie, & Baranek, 2015). Additionally, educators can use sensory preference scales with images of textures, sounds, and touch types (light touch, deep pressure).

Create sensory-friendly environments:	Adapt the teaching or therapeutic space to support comfort and focus. This can include dimming harsh lighting, minimising background noise, avoiding strong scents, and maintaining predictable routines. Sensory-safe environments help reduce anxiety and create conditions where learners can engage more openly (Robertson & Simmons, 2015). You can use a sensory environment checklist to regularly assess how classroom or therapy settings meet learners' sensory needs.
Teach graded exposure and flexibility:	Introduce new sensory experiences gradually, beginning with what the learner already finds comfortable and allowing them to set the pace. This approach builds tolerance and confidence while ensuring that the learner remains in control throughout the process. Graded exposure can reduce avoidance and anxiety, fostering positive and safe associations with physical closeness and intimacy (Crane, Goddard, & Pring, 2009).
Reframe "problematic" behaviours:	When behaviours such as self-stimulation or withdrawal occur, analyse them as responses to sensory needs rather than "misbehaviour." Pathologising sensory behaviours increases shame; reframing builds understanding and dignity (Kapp et al., 2019). You can develop reflection sheets for staff: For example, "What sensory need might this behaviour be meeting?"
Educate and involve partners:	Encourage partners to ask direct questions about preferences and to respect boundaries. Teach them to observe signs of discomfort (e.g., flinching, withdrawal). Shared responsibility creates healthier, more affirming relationships (Garcia & Houston, 2017). You can create partner-training handouts with sample scripts such as "Do you like this?" or "Should I stop?"

Recognise change over time:	Sensory preferences are not fixed, but they can vary across contexts, moods, and environments. Regularly revisiting each learner's sensory profile helps ensure that activities and discussions about intimacy continue to match their current comfort levels (Byers et al., 2013).

Communication styles, consent, and AAC

Autistic people may communicate through speech, writing, gestures, or Augmentative and Alternative communication (AAC), often preferring direct language and finding subtle cues (tone, facial expressions, body language) harder to interpret (Müller et al., 2008; Tager-Flusberg et al., 2005). This can affect dating, recognising interest, and navigating consent.

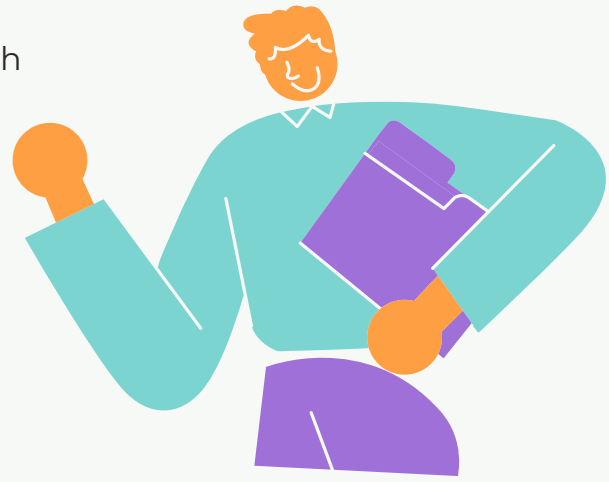
Implications for consent
Indirect refusals (pauses, uncertain tone) may be missed; teaching should emphasize explicit, **direct questions and answers** (e.g., "Do you want me to kiss you?") and practice affirmative/refusal language ("I want..." / "I don't want...") (Kern & Gaylord, 2006; Nichols & Blakeley-Smith, 2009).

AAC (Augmentative and Alternative Communication)

AAC must be fully integrated into sexuality education so people can express needs, desires and boundaries; exclusion increases the risk of misunderstandings and reduces autonomy (Blackstone et al., 2007; Friedman et al., 2019).

Practical strategies for providers:

- Use direct, unambiguous language.
- Teach what indirect cues can mean (with examples).
- Provide visual scripts and role-play supports for conversations.
- Encourage and model AAC use in consent/relationship topics.
- Teach reciprocal skills: how to ask, respond, and check in.
- Support partners/staff to build a shared "communication toolkit."



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SECTION 4

A « How to » on core topics in Sexuality Education

A « How to » on core topics in Sexuality Education

Comprehensive sexuality education (CSE) for individuals on the autism spectrum disorder (ASD) is a vital process that empowers them to navigate social relationships, understand physiological changes and develop safe, healthy habits. Due to unique sensory perceptions and communication styles, these learners require a structured, individualised and evidence-based approach. In this section, effective pedagogical methods tailored to the needs of autistic individuals are designed to facilitate the acquisition of new knowledge and skills.

Each technique was paired with practical exercises and actionable recommendations to ensure seamless integration into your professional practice. This holistic approach bridges theoretical principles with practical application, maximising the impact of the educational process.

Guidelines for Teaching Sexuality Education to Autistic Individuals

Pedagogical Approaches and Methods

1. Visual Support and Tools
2. Social Stories
3. Role-playing and modelling
4. Clear, step-by-step training
5. Positive Reinforcement and the Token Economy
6. Priming and Redirection
7. Prompting and Fading

Core topics in sexuality education

1) Body awareness, anatomical knowledge and interoception

2) Private and public spaces, boundaries, consent and bodily autonomy

3) Puberty, hygiene and menstruation

4) Sexual and gender diversity

5) Pleasure, masturbation and self-exploration

6) Relationships and social skills

Guidelines for Teaching Sexuality Education to Autistic Individuals

Start early	Early, age-appropriate education helps prevent misinformation and prepares young people for challenges before they arise.
Be explicit and concrete	Avoid vague explanations. Use direct language, visual supports, scripts, and role-play to teach abstract or social concepts.
Address sensory needs	Talk about how touch, sound, light, or other sensory inputs may affect comfort and physical reactions like arousal, and teach strategies to manage them (e.g., asking for predictable touch).
Cover more than biology	Include more interpersonal, social and emotional topics.
Normalise differences in sexual interest	Explain that some people feel a strong interest, while others feel very little, and that both are valid.
Respect autonomy and dignity	Emphasise rights, consent, and self-expression, ensuring autistic individuals feel their preferences and choices are valid.

Pedagogical Approaches and Methods

Effective sexuality education for autistic learners relies on simple, consistent, and visually oriented strategies. These principles help individuals demystify complex concepts regarding their bodies and social boundaries.

- **Concrete, direct language:** Avoid metaphors, idioms, and ambiguous terminology, as they can lead to misconceptions. Use scientifically accurate and specific language (e.g., using terms like "penis" and "vulva/vagina") to ensure clarity. Providing children with the correct vocabulary reduces confusion and promotes safety.

- **Consistency and routine**: Integrate sexuality education topics into daily routines to support gradual, context-based learning. For instance, discuss the concept of privacy while in a changing room or explain physical hygiene during daily self-care. Routine fosters a sense of predictability and security, which is essential for individuals with ASD.

- **Core teaching strategies:** The "Small Steps" Method (task analysis): Break complex topics into manageable segments. Devote individual sessions to specific concepts, such as "Understanding Privacy," "Defining Private Body Parts," or "How to Seek Help." This incremental approach prevents cognitive anchor/overload.

- **Parental Collaboration**: Engaging parents and caregivers is crucial for success. Provide families with resources such as guides, visual aids, or video modelling to ensure consistency across home and educational environments. This partnership reinforces the child's learning and emotional security.



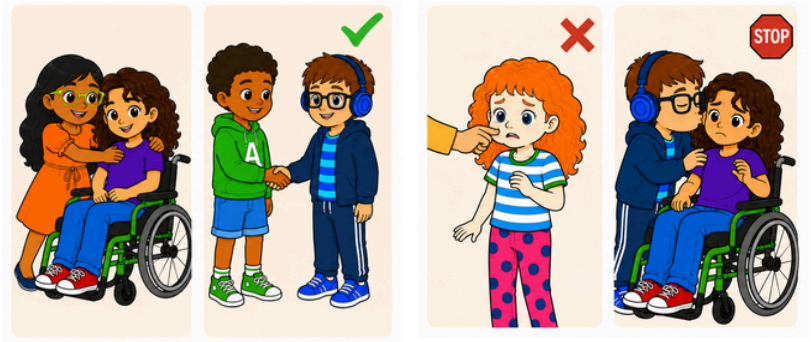
1 VISUAL SUPPORT AND TOOLS

Most autistic individuals are visual thinkers. Abstract concepts such as "personal boundaries" or "emotional regulation" can be challenging to grasp through verbal instruction alone.

Visual materials are not merely illustrations; they are essential tools for communication, social adaptation and self-regulation, helping the individual navigate a world that may otherwise seem unpredictable.

a) Visual Aids

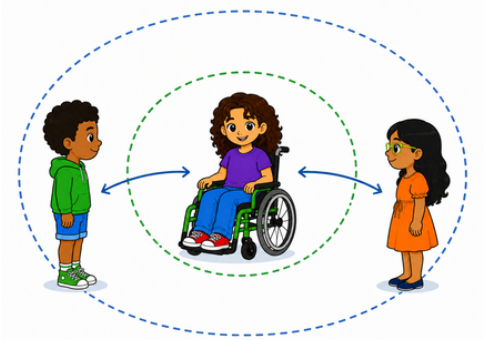
Use social stories, icons, and videos to transform abstract ideas into concrete images.



Safe touch **Unsafe touch**

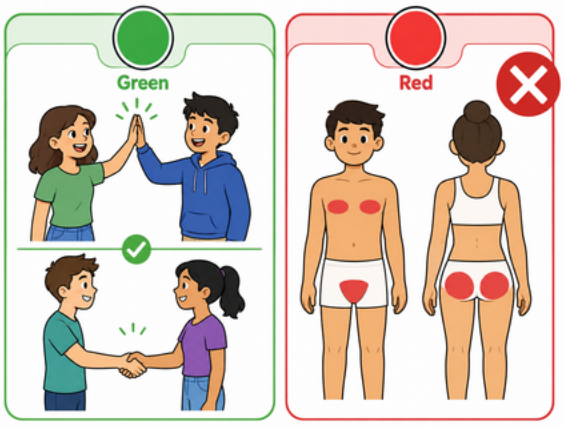
b) The Circles Concept

Instead of just explaining boundaries, use a diagram showing "safe zones" around a person to illustrate personal space.



c) Colour Coding

Use a "Traffic Light" system for physical contact: Green for safe/appropriate touch (e.g., high-fives, handshakes) and Red for private areas that should not be touched (by others).



d) Comics

Create your own social comics depicting privacy-related situations. For example, how a child goes to the toilet, closes the door, and then leaves. This helps to visualise the sequence of actions and their social context.



e) Visual schedules

Use schedules for hygiene procedures (for example, a daily schedule: "brush teeth", "shower", "put on clean underwear"). This makes the process predictable and reduces anxiety.



2 SOCIAL STORIES

Social stories are a powerful, evidence-based tool designed to help individuals on the autism spectrum (ASD) and those with neurodivergent profiles understand complex social nuances and behavioural expectations. Rather than merely listing rules, these stories provide a safe, predictable narrative that explains the What? How? and, most importantly, the Why? of specific social situations.

The effectiveness of social stories lies in their clear, consistent and person-centred structure. Each story focuses on a single, specific scenario, such as "Going to the Grocery Store," "Asking to Join a Game," or "Waiting for My Turn."

Social stories should be read regularly with the individual and are most effective when written in first-person language (e.g. “MY BODY IS MINE”). This allows the person to identify with the protagonist and internalise the message. Practitioners are encouraged to combine the text with clear visuals, symbols, or, where appropriate, the individual’s own photographs to support understanding.

When creating personalised stories, or Social Stories™ (the official term, protected by copyright), careful attention must be paid to the text and visual design. It is advised to use CAPITAL LETTERS, large, easy-to-read print and accessible fonts such as Arial or Calibri. Visuals should be simple, uncluttered and closely matched to the text to ensure clarity and reduce cognitive overload. By utilising concise language, visual cues, and repetitive reinforcement, social stories empower the child to:

- Understand Perspectives: gain insight into others’ thoughts, feelings, and expectations.
- Predict Outcomes - anticipate the sequence of events, which significantly reduces anxiety and sensory stress.
- Develop Coping Strategies - learn appropriate social responses and self-regulation techniques.

Ultimately, social stories transform the often-unpredictable world of social interaction into a series of manageable, logical steps. This builds the child’s confidence and fosters successful adaptation to various life environments, promoting independence and social inclusion.

Example: *Story "My privacy". "My body is mine. I have private parts that no one can touch. If someone wants to touch my private parts, I can say, "No. I do not want that." I can tell my mom, dad, or teacher about it. My private parts belongs to me."*

Practical exercise: *Make up a story together with the child. Use photos or drawings to make it as personalized as possible. Print it out and read it together so your child can refer back to it when needed.*

3 ROLE-PLAYING AND MODELLING

For individuals with autism spectrum disorders (ASD), learning social skills can be complicated. Role-playing and modelling are practical tools that help you translate abstract social concepts into concrete actions. Experiencing various situations in a safe, controlled environment gives the child a stress-free opportunity to practice skills that are difficult to learn only theoretically. It can range from greeting to waiting one's turn or resolving a conflict.

Modelling as a visual cue: This role-playing process becomes even more effective when used with modelling. It can be either a video recording of correct behaviour or a live example from an adult or another child. Individuals with ASD who are visual thinkers have an easier time absorbing information they can see. Modelling simplifies complex social scenarios into clear, step-by-step actions, making them much easier to follow. Thanks to this combination, the child not only remembers the rule, but also feels how it works in practice, which makes its adaptation to the social environment more successful and confident.

"*Polite refusal*" exercise: *Act out a situation where someone tries to violate the child's personal space. For example, "Someone wants to hug you, but you don't want to." Practice different answers: "No, I don'twant to hug", "Don't touch me" or simply "Enough!". Teach your child to walk away if possible.*



Exercise "***Knocking on the door***"*: Repeat the scenario: go to the closed door of the room (for example, parents), knock, wait for an answer, and only then enter. Explain: "Every person has their own personal space."*

4 CLEAR, STEP-BY-STEP TRAINING

Explicit, step-by-step instruction is a highly effective method based on the principles of Applied Behaviour Analysis (ABA). Its main idea is to break down complex skills or concepts into small, consistent, and easily digestible steps. This approach is helpful for learners with autism spectrum disorders (ASD) as it minimises the risk of information overload.

Advantages and applications: Instead of attempting to master a complex topic all at once, the child focuses on a single, manageable step. This incremental progression ensures early success, which is vital for building self-esteem and confidence. Only once a step is fully internalised does the educator introduce the next. This method goes beyond rote memorisation; it ensures a deep, functional understanding of the material. Each new skill is built on a solid foundation of prior knowledge, providing stable, reliable progress.

Exercise: *Create a checklist for performing hygiene procedures. After completing each step, the child puts a check mark. It gives a sense of control and achievement*

Key components of this approach include:

- Visual Cues: using prompts to guide the child through each transition.
- Positive reinforcement: consistently rewarding progress to maintain motivation.
- Individualisation: tailoring the pace and complexity to the unique learning profile of each child.

Example "***Hygiene Rules***": *Divide the process of taking a shower into separate steps: (1) Get into the bath, (2) Take off your clothes, (3) Turn on the water, (4) Wet your body, (5) Apply soap, (6) Wash off the soap, etc. A dedicated icon or pictogram should support each step.*



5 POSITIVE REINFORCEMENT AND THE TOKEN ECONOMY

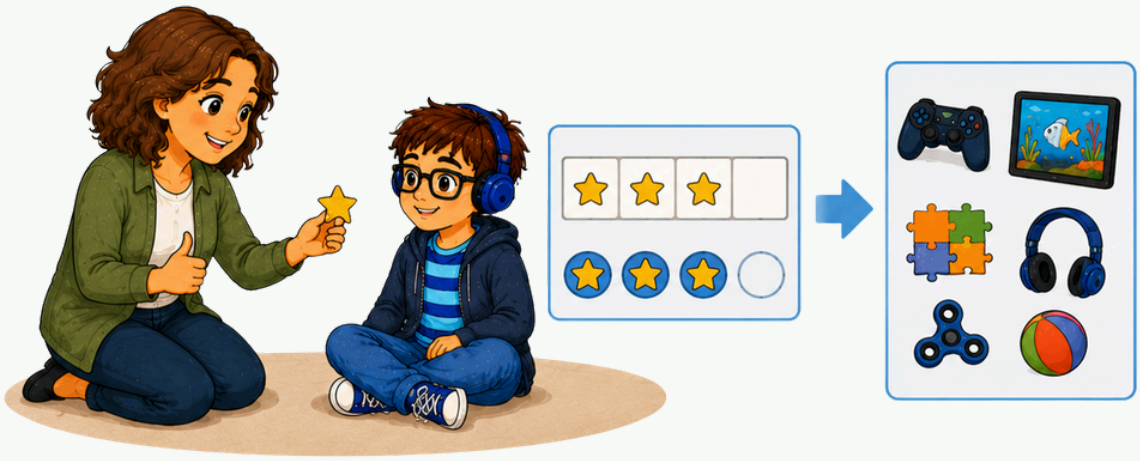
Positive Reinforcement is a cornerstone of motivation and skill acquisition. It operates on a straightforward principle: when a meaningful reward follows a desired behaviour, the likelihood of repeating that behaviour increases. Reinforcement must be highly individualised, aligning with each child's specific interests and sensory preferences.

Forms of Reinforcement:

- Social: Sincere praise, a smile, or a high-five (always respecting the child's sensory boundaries regarding touch).
- Activity-based: Access to a favourite game, a short video, or a preferred sensory activity.
- Material: Stickers, a small toy, or a favourite treat.

To be effective, reinforcement should occur immediately following the desired action. This helps the child build a clear connection between their behaviour and the positive outcome, fostering self-esteem and a sense of agency.

The Token economy: For complex or multistep tasks, a token system is highly effective. The child earns tokens for specific actions (e.g., following a privacy rule or completing a hygiene routine). Once a predetermined number of tokens is collected, they are exchanged for a larger reward. This system makes abstract, long-term goals tangible and manageable.



6 PRIMING AND REDIRECTION

Priming (Proactive Preparation): Priming reduces anxiety by making new situations predictable. If a puberty session is approaching, begin preparing the child several days in advance: "In two days, we will look at how the body grows and changes." Use visual schedules or short videos to familiarise them with the topic beforehand.

Redirection (Navigating Challenging Moments): If a child engages in socially inappropriate behaviour (e.g., touching private areas in public), it is vital to respond without shaming or punishment. Instead:

- Redirect Attention: Transition to a high-interest activity ("Let's look at this book together").
- Provide Clear Boundaries: Use neutral, factual language: "You are allowed to touch your private parts when you are alone in the bathroom or bedroom."
- Set a Framework: "We can talk about this more when we get home." This reinforces the distinction between public and private spaces.



7 PROMPTING AND FADING

The Prompting method guides a child from total support to complete independence through a "least-to-most" or "most-to-least" hierarchy.

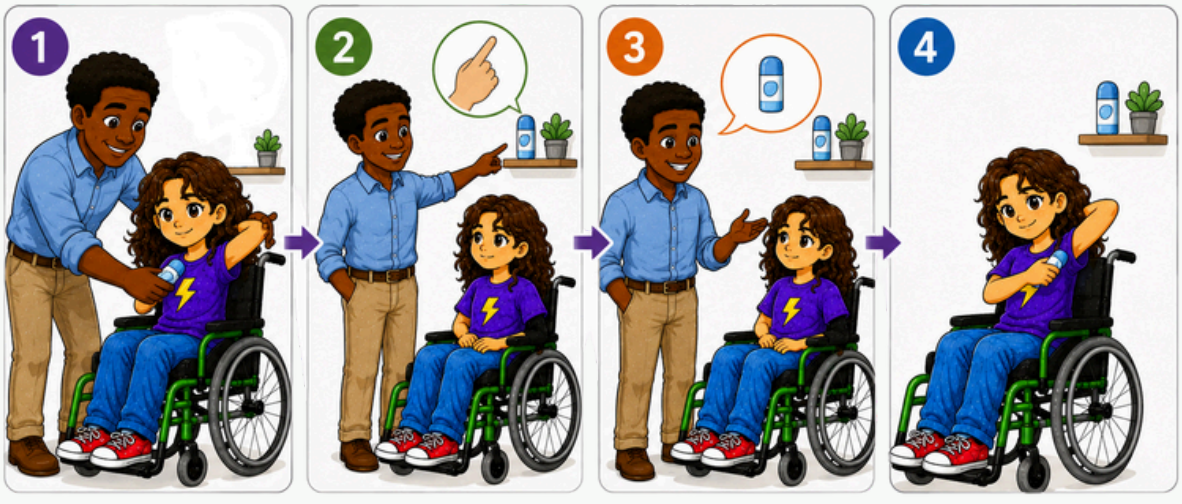
Example: Learning to use deodorant

- *Physical Prompt: Guiding the child's hand to apply the deodorant.*
- *Gestural Prompt: Pointing to the deodorant on the shelf.*
- *Verbal Prompt: Saying, "It's time for deodorant."*
- *Independent Action: The child completes the task without assistance.*

The goal is Prompt Fading - gradually reducing help until the child achieves autonomy. Conclusion: A Person-centred Approach

Education for learners on the autism spectrum must be individualised, consistent, and predictable. Every child is unique; an effective programme must leverage their strengths and interests while respecting their pace of development.

By combining visual schedules, clear instructions, and a supportive environment, we provide the child with a sense of safety and control. These methods, when used in harmony, create a foundation for lifelong confidence and social inclusion. Patience, empathy, and respect for the child's dignity are the most vital tools in this process.

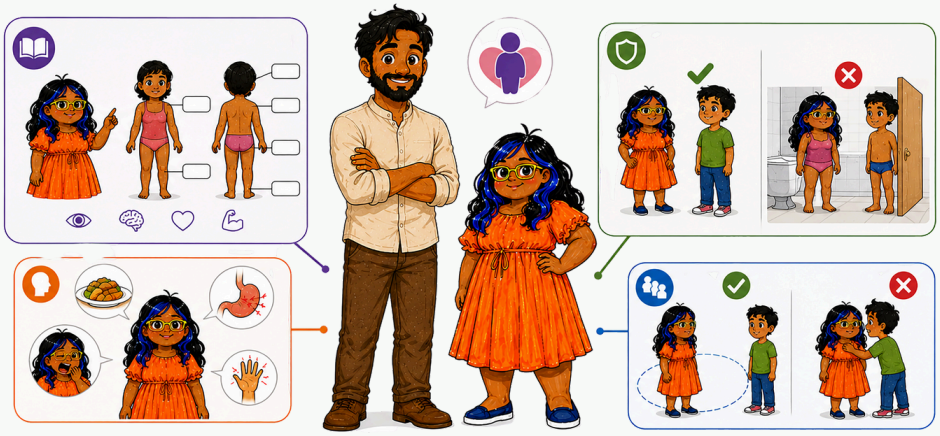


Core topics in sexuality education

1 BODY AWARENESS, ANATOMICAL KNOWLEDGE AND INTEROCEPTION

What is body awareness, and why is it important?

Body awareness is the ability to recognise, understand, and interpret the sensations, movements, and boundaries of one's own body. Body awareness is a foundation for healthy sexuality education. Developing body awareness can support self-understanding, independence, safety and positive relationships. When someone learns to notice and name body parts, sensations, and personal boundaries, they are better equipped to communicate needs, recognise discomfort and protect themselves from harm. It also fosters self-confidence and respect for their own bodies, which are central to developing autonomy and consent in social and intimate situations.



It includes:

- Knowing the names and functions of body parts.
- Understanding the difference between public and private body parts.
- Recognising physical signals (e.g., hunger, pain, arousal, fatigue).
- Being aware of personal space and others' physical boundaries.
- Understanding safe and appropriate touch in different contexts.

For autistic individuals, body awareness may not develop automatically. Differences in sensory processing, communication and social learning can make it harder to interpret body signals or to understand unspoken rules about touch and space.

How can I practice body awareness with autistic individuals?

Supporting body awareness requires a respectful, clear, and structured approach. Here are some strategies:

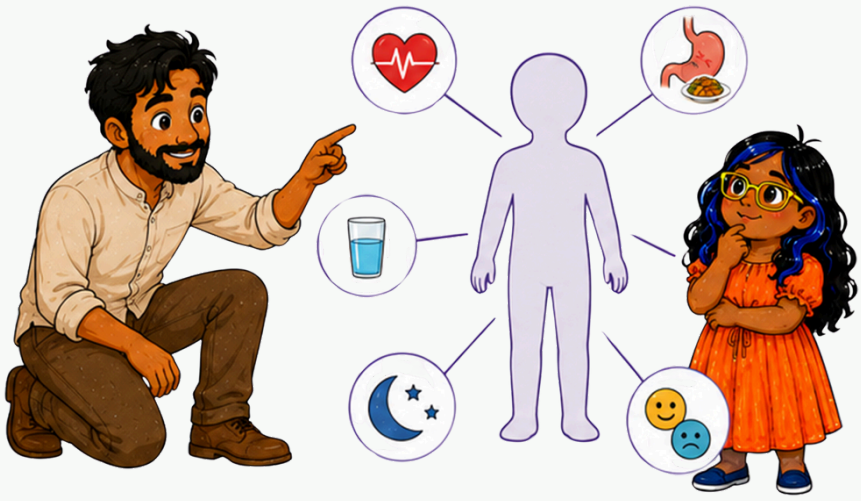
Use concrete language and visuals:	• Teach body parts using clear and correct terms (e.g. “penis,” “vulva”) rather than vague or confusing words. • Use pictures or social stories to illustrate concepts like private vs. public.
Practice identifying sensations	• Encourage individuals to notice and name how their body feels (e.g. “My belly feels hungry”, “My shoulders feel tight”, “My chest feels tight”, “My heart feels warm”, “My tummy feels strange”). • Use sensory check-ins, emotion thermometers, or visual scales to support recognition of internal states.
Teach personal boundaries	• Model and role-play safe ways to ask for and decline touch. • Use visual supports (like “stop” and “go” signs) to reinforce boundaries.
Create structured opportunities for learning	• Use daily routines (e.g., dressing, bathing, mealtimes) as natural moments to discuss body parts and body care. • Reinforce the distinction between private activities (like using the toilet or masturbation) and public activities.
Respect individual differences	• Adapt teaching methods to the person’s sensory needs, communication style, and developmental level. • Always prioritise dignity, consent, and the individual’s comfort.

By intentionally teaching body awareness, caregivers and professionals empower autistic individuals to develop self-knowledge, autonomy, and safer social connections. This lays the groundwork for healthy sexuality education that is inclusive, respectful, and protective.

What is interoception, and why is it important?

Interoception refers to the ability to perceive and process internal bodily signals, such as heartbeat awareness, hunger and fullness, thirst, temperature changes, physical manifestations of emotions, body cues, and other sensations. It represents a fundamental aspect of human consciousness and self-regulation. In ASD, differences in interoception can affect emotional regulation, social interactions and overall well-being (Neurofeedback Luxembourg, n.d.).

For individuals with ASD, interoceptive differences can also impact emotional processing, which is often linked to increased anxiety and alexithymia, a term that refers to difficulties in identifying and describing emotions. These differences can also influence empathy and perspective-taking, as it can be challenging to understand another person's perspective when one has difficulty interpreting one's own embodied experience. (Neurofeedback Luxembourg, n.d.).



A growing body of research demonstrates that interoceptive awareness can be improved through practice. For example, Mahler et al. (2022) found that autistic children who practised identifying body signals and linking them to their emotions were better able to regulate their feelings afterwards. This finding highlights the importance of exercises that strengthen interoceptive awareness and accuracy (Neurodivergent Insights, n.d.).

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ACTIVITY SUGGESTIONS

Body awareness, anatomical knowledge and interoception

Goals

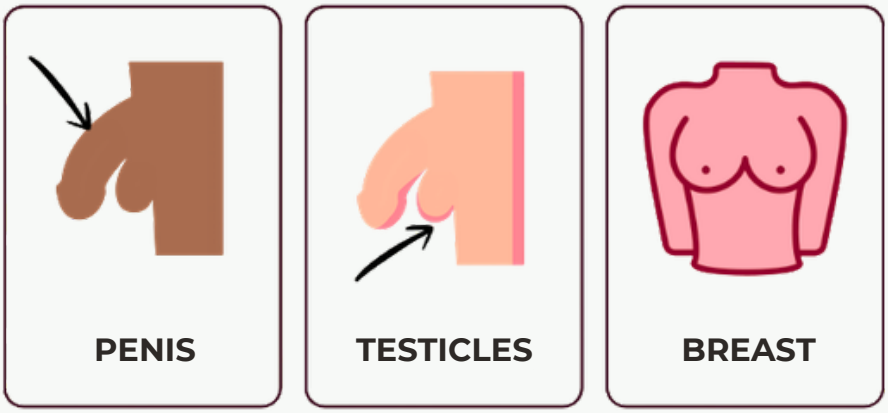
The goal of this chapter is to help individuals to:

- Identify body parts (both public and private)
- Understand basic body functions
- Develop a healthy sense of body ownership, safety, and autonomy
- Develop the ability to perceive and process internal bodily signals

Visual Supports

Using visual aids is one of the most effective strategies when teaching individuals with autism, especially for concrete and sensitive topics such as anatomy and body awareness.

Suggestions:
Use body charts, illustrated books, flashcards, digital apps, or realistic 3D models (e.g., dolls or mannequins).



Choose realistic and inclusive visuals that represent different body types, skin tones, genders and abilities to foster accurate understanding and respect for diversity.

Try interactive visuals, such as:

- Body posters with Velcro labels
- Flap books with hidden body parts
- Apps that allow learners to “dress” avatars or name body parts

Tip:
Labelling activities paired with songs or routines can help reinforce understanding.

To help individuals distinguish between public and private body parts, use:

- Colour codes (e.g., green = public, red = private)
- Symbols (e.g., padlock for private parts)

Social Stories

Social stories provide a safe, visual and predictable way to introduce new or sensitive topics. They are instrumental when teaching body ownership, privacy, and consent. Using concrete, straightforward language, social stories help learners understand what body parts do and support learning about safe and unsafe touch, personal boundaries, and public versus private behaviour.

Suggested topics for body awareness social stories:

- Naming My Body Parts
- Private and Public Parts
- When a Doctor Checks My Body
- Keeping My Body Clean
- Touching Rules
- I Can Say 'No'



Role-Playing

Role-playing helps learners practice different scenarios in a safe, controlled way. It allows them to rehearse real-life scenarios, such as:

- Saying "No" when uncomfortable
- Asking for help from a trusted adult
- Pointing to body parts during medical visits

Tips:
Use dolls or puppets if the child is hesitant to act things out themselves

Provide scripted phrases for common scenarios (e.g., "Please stop," "I don't like that")

Praise participation and repeat the role-play with variations

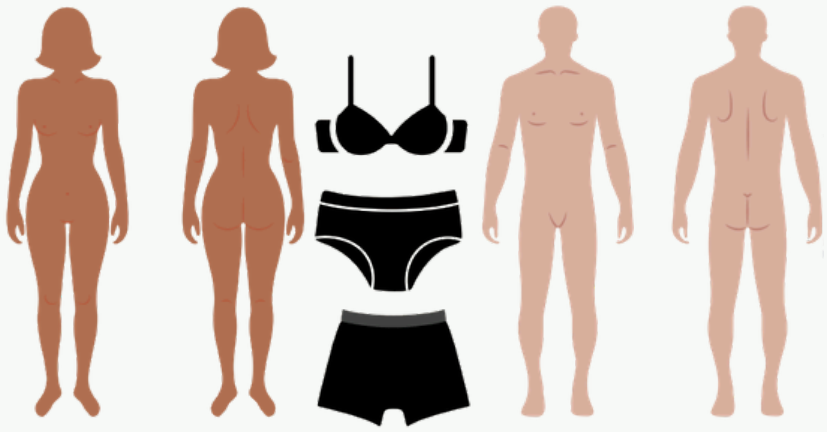
Positive Reinforcement

Positive reinforcement builds confidence and motivation, especially when learning topics that may feel unfamiliar or uncomfortable.

Celebrate every step of progress, no matter how small. Use:

- Verbal praise (“Great job pointing to your shoulders!”)
- Stickers or tokens
- Visual rewards (e.g., smiley faces, achievement charts)

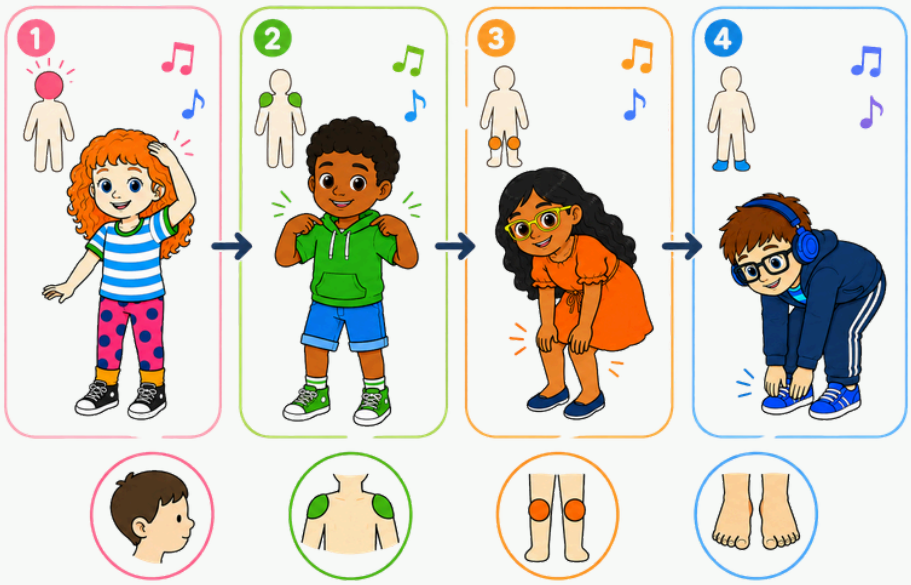
DRAW THE UNDERWEAR OVER THE PRIVATE BODY PARTS



Optional Materials to Create:

- **Body Part Flashcards:** Illustrated cards showing different body parts with both anatomical and socially appropriate names.
- **Interactive Body Charts:** Large posters or foldable charts with Velcro or flaps to label and uncover body parts.
- **Public vs Private Body Part Sorting Cards:** Cards featuring images or icons to sort into “public” and “private” categories, using colour codes or symbols.

- **3D Body Models or Dolls:** Realistic or simplified models for hands-on exploration and labelling.
- **“My Body” Colouring Pages:** Outline drawings of a human body for colouring and labelling activities.
- **Social Story Booklets:** Printable or laminated short stories on body ownership, boundaries, and hygiene.
- **Body Part Songs and Visuals:** Visual aids and lyric sheets for songs like “Head, Shoulders, Knees and Toes,” adapted with social/emotional cues.



- **Movement Game Cards:** Cards with body part movement prompts for games like Simon Says or Follow-the-Leader.
- **Private vs Public Space Posters**: Colour-coded posters that visually explain private and public zones on the body.
- **Personal Hygiene Visual Schedules:** Step-by-step illustrated guides for routines such as washing hands or brushing teeth.

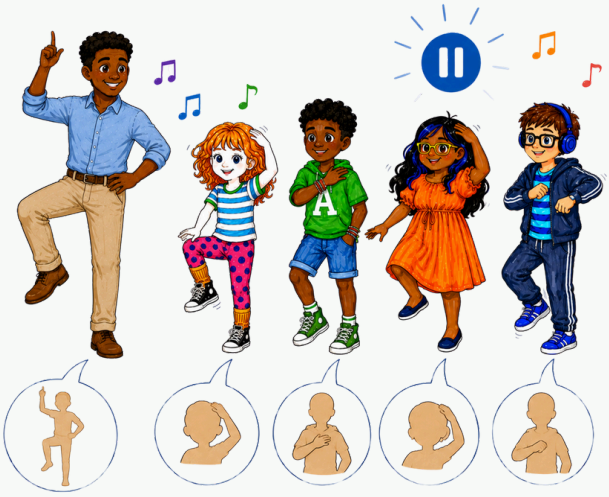
Suggested Activities

- Movement & Imitation Games

Simon Says: Give commands like “Touch your nose” or “Clap your hands.” Emphasise both public and private parts (using safe, respectful phrasing).

Follow-the-Leader: Have the leader perform movements using different body parts. Encourage learners to copy.

Dance & Freeze: Freeze when the music stops and name the body part you're touching.



- Hands-On Activities

- **Drawing or Colouring the Human Body:** Use outlines, with learners labelling or colouring different parts (e.g., “Colour your legs blue”).
- **Matching Body Parts:** Match images to parts on a chart, 3D models, or even on a doll.
- **Sorting Game – Public vs. Private:** Use cards or objects and have learners sort them into two baskets or labelled mats.





- Interoception Activities

Mindful Check-ins

Mindful check-ins can be brief, lasting only ten seconds, or extended into longer exercises. They involve observing sensations without judgment, identifying and labelling what is noticed in the body and gradually learning to connect these sensations with emotional states.

For instance, one exercise involves holding a hot or cold drink, noticing sensations in the hand and arm, releasing the cup, and then observing changes in sensation before repeating the process.

Body Scans

Body scans involve intentionally moving attention through different areas of the body, from feet to head, and noticing sensations with descriptive rather than evaluative language.

For example, instead of labeling a feeling as “anxious,” one might describe it as “tight,” “heavy,” or “springy.” This approach improves both body awareness and the ability to articulate subtle physical experiences.

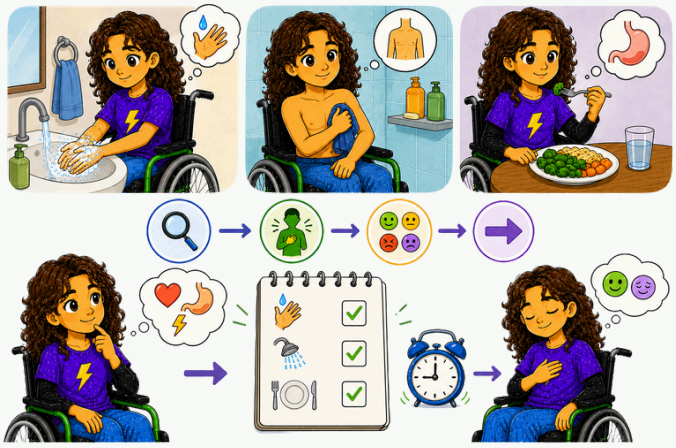


- Interoception Activities

Interoception on the Go

Quick check-ins during daily activities can also improve interoceptive skills. Activities such as washing hands, showering, or eating provide opportunities to notice sensations and later connect them to emotional states like hunger, irritability, or contentment.

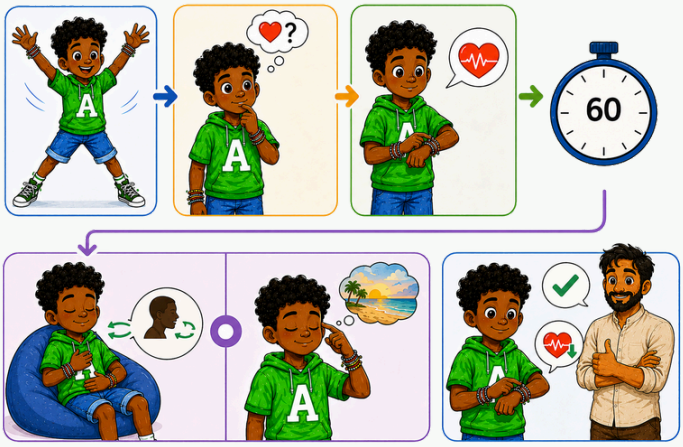
Setting reminders or linking check-ins to routine tasks helps build consistency and strengthens body-emotion connections.



How Low Can You Go

Kelly Mahler introduced the playful “How Low Can You Go” exercise, designed to increase awareness of heartbeat and practice nervous system regulation. The activity begins with raising the heart rate through movement (e.g., jumping jacks), estimating it, and then measuring it. With practice, participants aim to lower their heart rate within 60 seconds by experimenting with calming strategies such as slow breathing or visualisation.

Over time, this exercise trains the body to down-regulate more effectively, which can be especially helpful for neurodivergent individuals experiencing stress or sensory overload (Asher, 2018).



2 PRIVATE AND PUBLIC SPACES, BOUNDARIES, CONSENT AND BODILY AUTONOMY

For many autistic individuals, the distinction between private and public spaces is not always intuitive. These concepts involve, on the one hand, physical environments (where activities take place) and, on the other hand, social boundaries (what is appropriate to share or do in each setting). Professionals can play an essential role in helping autistic people understand and navigate these differences, promoting autonomy, safety, and social inclusion.

Defining private and public spaces

In the context of boundaries and appropriate/inappropriate behaviours, we will define these spaces as:

PUBLIC	PRIVATE
Public spaces are areas shared with others outside one's close circle, such as streets, schools, workplaces, parks, or even online public platforms. Social norms and community rules influence our behaviour in these spaces. 	Private spaces are personal or restricted areas, such as bedrooms, bathrooms, or private chats, where individuals have more freedom, privacy, and control over their behaviour. 

Visual aids (e.g., colour-coded maps or photos) can help illustrate the difference between these spaces.

Why is this distinction challenging for autistic individuals

Autistic individuals may experience differences in:

Social understanding: Difficulty interpreting unwritten rules about where and how certain behaviours are acceptable.

Sensory processing: Public spaces can be overwhelming or unpredictable, making them harder to navigate comfortably.

Generalisation: A behaviour learned as appropriate in one context (e.g., at home) may be repeated elsewhere (e.g., at school), without awareness of context change.

Privacy concepts: Understanding what information or actions are private (e.g., personal hygiene, emotions, body-related topics) and which are not, may require explicit teaching.

How to support learning about private and public spaces?

Professionals can use structured and concrete teaching strategies:

Visual supports: Use charts or symbols showing “private” vs. “public” spaces, behaviours, or topics (e.g., using the toilet, hugging, changing clothes, talking about personal issues).

Social stories and role-play: Model situations where one needs to decide what is appropriate depending on the setting.

Clear language: Avoid abstract expressions, say “You can do that in your bedroom, but not in the classroom” rather than “That’s not appropriate here.”

Consistency across settings: Collaborate with family, school, and caregivers to ensure the same language and rules are used.

Respect for autonomy: Conversations about privacy should aim to build understanding and provide practical tools for safe, informed decision-making, rather than to enforce social conformity

Topics to address
Depending on the individual's age and developmental level, topics can include:

- personal hygiene and changing clothes
- touch and affection (who, when, where)
- haring personal information (online and offline)
- personal belongings and boundaries
- use of technology and social media
- safe and respectful use of public facilities

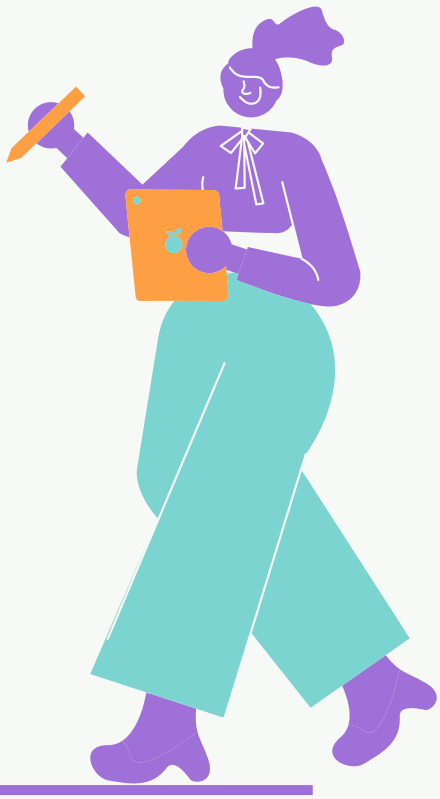
Consent and bodily autonomy in autism

Teaching consent and bodily autonomy are fundamental to support the safety, dignity, and independence of autistic individuals. These concepts may be complex to teach and navigate, as they involve abstract ideas about personal rights, relationships, boundaries, and social expectations. Caregivers play a key role in teaching these concepts clearly and respectfully, helping autistic individuals recognize and respect their own boundaries and those of others.

Defining Consent and Bodily Autonomy

Bodily autonomy means that every person has the right to make decisions about their own body, about what happens to it, who can touch it, and under what circumstances.

Consent means giving explicit, voluntary permission for something to happen. Consent is only valid if it is freely given (not under pressure, coercion, violence, or threats), informed (the person giving their consent knows what they are consenting to), specific (saying yes to one action doesn't imply consenting to other following actions), and reversible (it can be withdrawn at any time).



Both ideas emphasise that each person is the ultimate authority over their own body and has the right to say yes or no to an action involving their body. The main message here is: "My body belongs to me! "

Why can consent be challenging for autistic individuals?

Autistic people may experience difficulties related to:

Social communication: Verbal or nonverbal consent may be unclear or misinterpreted.

Literal thinking: Abstract concepts such as “permission” or “personal space” may need concrete examples.

Sensory needs and touch: Some individuals may seek or avoid touch for sensory regulation, which can affect how they experience boundaries.

Compliance history: Many autistic people have been encouraged to comply with adult requests (e.g., “give a hug,” “sit still,” “do as told”), which can make it harder to recognise or assert personal boundaries

How to support the understanding and expression of consent?

Professionals can help by:

- Teaching explicit language and signals for giving, refusing, or withdrawing consent (e.g., “I don’t want that,” “Stop,” or visual symbols).
- Using social stories, visuals, and role-play to model everyday situations, like greeting people, receiving medical care, or sharing personal space.
- Reinforcing autonomy by always seeking the person’s permission before touching, moving, or assisting them, and by respecting their response, from the earliest age on.
- Explaining context: Some situations (e.g., medical exams, hygiene care) may require specific actions, but consent should always be obtained beforehand, and comfort should still be prioritised.
- Encouraging self-advocacy by supporting the person to express preferences, set boundaries, and know they can change their mind.

Topics to Address

Depending on age, developmental level, and context, topics may include:

- Personal space and physical contact (hugs, handshakes, etc.)
- saying YES or NO to touch or help
- safe and respectful touch in relationships and friendships
- consent in healthcare or personal care situations
- online communication and sharing images or information
- recognising others’ right to consent or refuse

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ACTIVITY SUGGESTIONS

Private and public spaces, boundaries, consent and bodily autonomy

Goals

This chapter aims to support learners with autism in:

- Understanding the concepts of private vs public (spaces, behaviours, body parts)
- Learning to recognise and assert personal boundaries
- Understanding and practising bodily autonomy and consent
- Building confidence to express themselves and seek help when needed
- Developing a sense of empowerment and self-protection
- Understanding and practising digital boundaries, including safe online behaviour and privacy awareness

Visual Supports

See page 28 for a more detailed description

Use visual cues to explain public vs private behaviour, places, and body parts (e.g., toilet = private, classroom = public)

Display posters showing “safe touch vs unsafe touch” using age-appropriate visuals

Create personal space visuals with zones (e.g., green = OK for friends, red = only for family or doctors)
Use emotion charts to help learners express discomfort



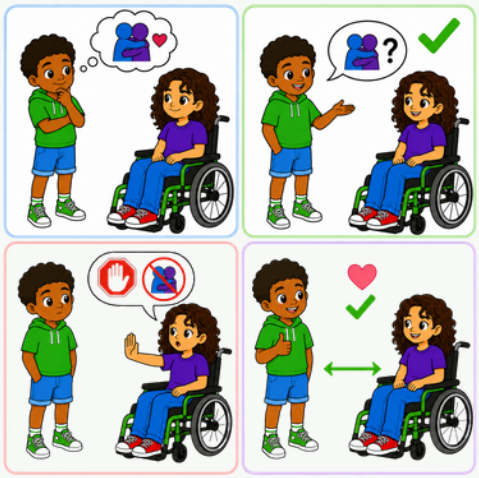
Tip: Use colour-coded signs or stickers to reinforce zones of comfort (e.g., red = stop, yellow = check, green = go).

Social Stories

See page 29 for a more detailed description

Suggested story topics:

- Saying No to Hugs
- Asking Before Touching Someone
- When It’s OK to Say Stop
- Safe vs Unsafe Secrets
- What is Public Online?



Role-Playing

See page 30 for a more detailed description

Some suggested scenarios to practice are:

- A peer wants to hug, but the child says, “No, thank you.”
- Someone stands too close, and the child says, “Please give me space.”
- The child asks, “Can I hold your hand?” and accepts a yes or no.

Tips:
Use dolls or puppets for learners who are uncomfortable with direct role-play

Offer clear, scripted responses (e.g., “I don’t like that,” “I need space,” “Can I sit here?”)

Encourage repeated practice with slight variations to build confidence

Positive Reinforcement

Boundaries and consent can be emotionally complex topics. Positive reinforcement helps build self-esteem and encourages appropriate, respectful behaviour.

To achieve that:

- Offer praise for using assertive communication: “I love how you said ‘no’ clearly and kindly.”
- Use token systems or visual reward charts to motivate the practice of consent-related skills.
- Celebrate when the child recognises their right to say no or asks for help.



Modelling Behaviour

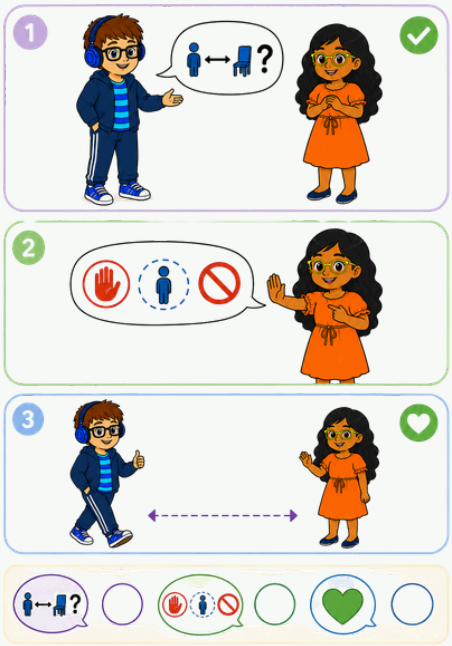
Learners with autism often learn best through concrete, observable examples. Modelling helps them internalise behaviours related to consent, boundaries, and autonomy.

Model the following behaviours:

- Asking: “May I sit next to you?”
- Saying: “No, thank you” or “I need space”
- Respecting when someone else says “no”

You can also use:

- Video modelling showing real individuals practising boundaries
- Daily modelling by adults and peers during school or therapy sessions
- Scripts and consistent routines that include boundary-respecting action



Optional Materials to Create:

- **Personal Space Bubble Posters:** Visual charts illustrating personal space zones with colour codes and simple explanations.
- **Assertive Communication Cue Cards:** Cards displaying common phrases like “Please stop,” “I need a break,” or “Can I have some space?” with icons or pictures.
- **Consent Role-Play Scripts:** Simple, scripted dialogues for practising asking for and giving consent in everyday situations.
- **Safe vs Unsafe Scenario Cards:** Illustrated cards depicting various social situations for sorting and discussion.
- **Trusted Adults Chart:** Personalised charts featuring photos or drawings of safe adults the child can approach for help.

- **Empowerment Affirmation Posters:** Positive message posters featuring statements such as “My body belongs to me” and “I have the right to say no.”
- **Digital Boundaries Sorting Cards:** Cards illustrating safe vs unsafe online behaviours, information sharing, and respectful communication.
- **Visual Social Stories Booklets:** Laminated or printable social stories covering topics like personal boundaries, consent, and digital safety.
- **Help-Seeking Cue Cards:** Cards that guide learners through steps to seek help, including identifying trusted adults and using simple phrases.
- **Interactive “What Would You Do?” Game:** A set of illustrated scenarios prompting learners to choose appropriate responses related to boundaries and consent.

Suggested Activities

- Movement & Imitation Games

Personal Space Bubble

Use hula hoops, yarn, or chalk to define each child’s “personal bubble.” Practice stepping in and out of bubbles to demonstrate “too close” vs. “just right.”

Tip: Let learners decorate their bubble space with stickers or drawings to represent their comfort zone.

Assertive Communication Role-Play

Practic using body language and clear phrases like:

- “Please stop.”
- “I don’t like that.”
- “Can I give you a hug?”

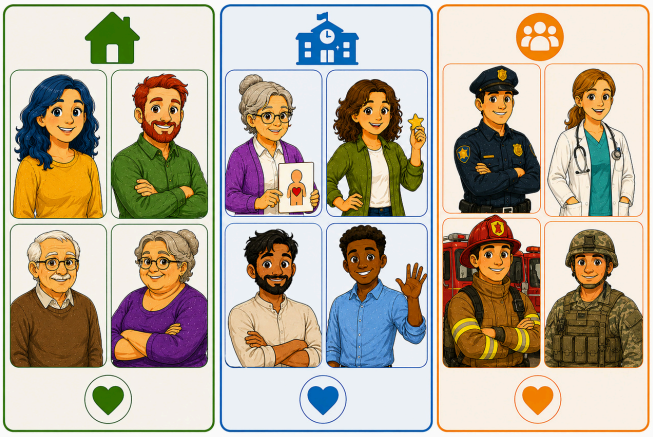
➡Use puppets or partner play to rehearse different situations involving personal boundaries.

- Hands-On Activities

Trusted Adult Chart

Create a chart with photos or drawings of safe adults at home, school, or the community.

➡ Ask learners: “Who can you talk to if you feel unsafe?” and practice asking for help using picture cues or social scripts.



Empowerment Posters

Provide paper, magazines, and markers for learners to create their own posters with messages like:

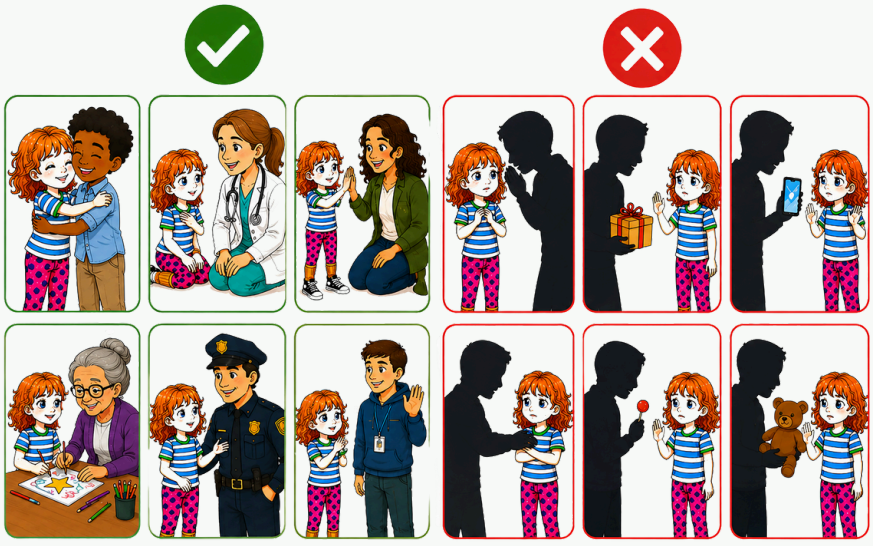
- “My body belongs to me”
- “I can say no”

➡ Hang the posters in the classroom or therapy space as daily reminders.

Safe vs Unsafe Sorting Game

Use illustrated cards showing different situations (e.g., hugging a friend, being asked to keep a secret, someone asking to take a photo).

➡ learners sort them into “Safe” and “Unsafe” categories.
➡ Discuss why each action belongs where it does.



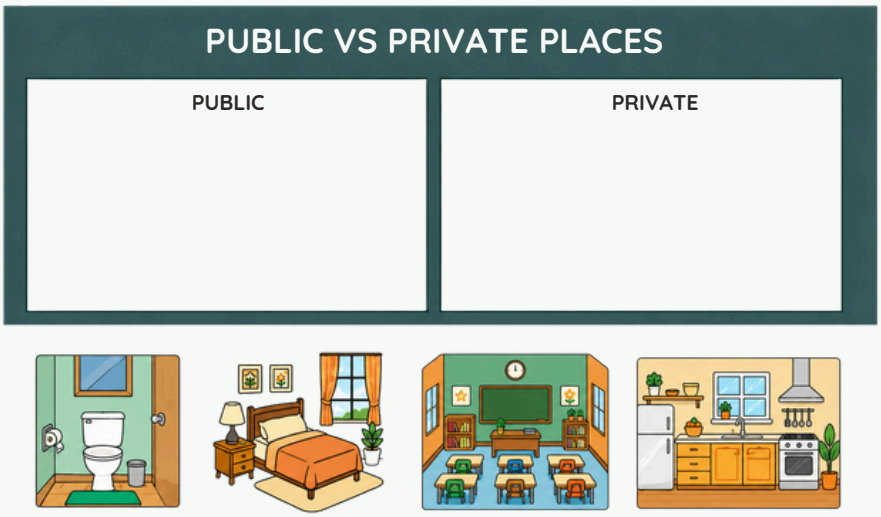
- Hands-On Activities

Private vs Public Spaces Sorting Activity

Use illustrated cards showing places (e.g., bathroom, park), actions (e.g., changing clothes, hugging), and body parts.

Create a sorting mat or two labelled bins: “Public” and “Private.”

Have learners place each card where they think it belongs and discuss each choice together.



Social Story Reading

Read stories on topics like personal space, consent, or safe touch. Use books like “My Body Belongs to Me” or custom-made social stories.

➡ Pause to ask questions like:

- “What part of the story showed good boundaries?”
- “What should the child do next?”

Digital Boundaries Sorting Game

Use printed or digital cards showing online actions (e.g., sharing a name, sending a photo, using kind words).

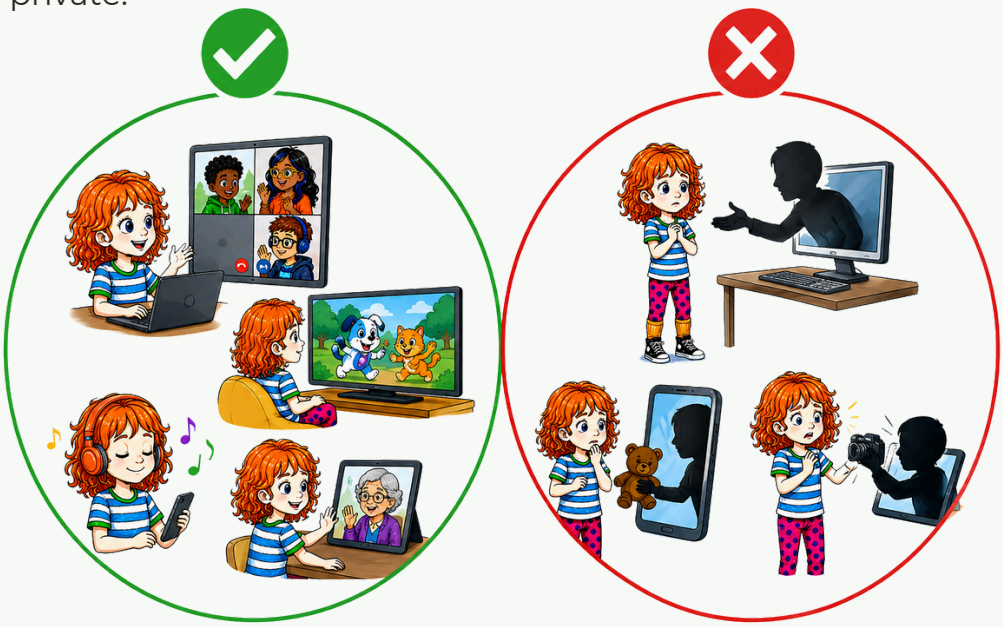
➡ learners sort them into “OK to share” and “Not OK to share.”
➡ Reinforce safety rules: “If it feels private, don’t post it.”

- Hands-On Activities

Online Safety Circle

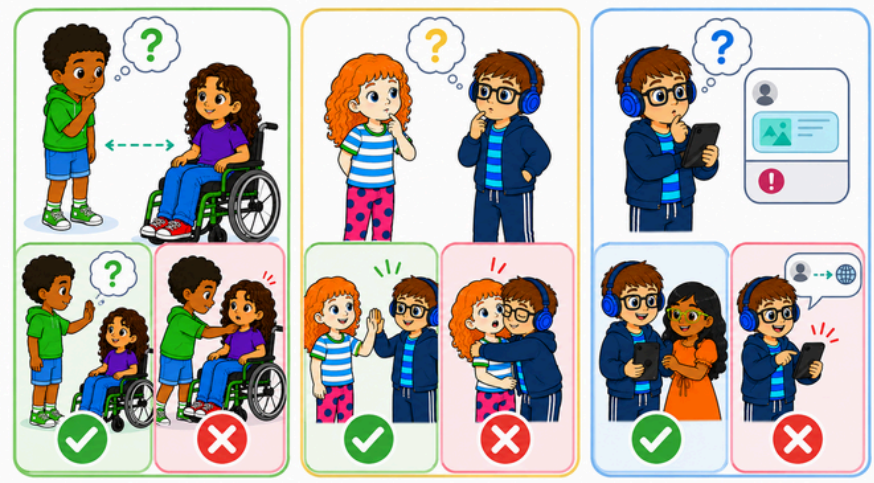
Draw two circles on a poster or board: “Safe Online” and “Not Safe Online.” Ask learners to place cards or stickers with examples into the correct circle.

➡ Discuss why certain information (e.g., address, full name) should be kept private.



Interactive “What Would You Do?” Game

Present illustrated social scenarios involving personal space, touch, or digital interactions. Ask learners to discuss or select what they would do in each scenario from multiple-choice options. Use group discussion or role-play to explore the consequences of each choice.



3 PUBERTY, HYGIENE AND MENSTRUATION

Puberty describes the transition from a child's body to an adult's body capable of reproduction. During this phase, the body undergoes physical, hormonal, and emotional changes.

Are there differences between ASD individuals vs. N-ASD peers?

The physical changes (hormonal shifts, growth spurts, sexual maturation) occur in a similar timeline for ASD and non-ASD individuals. Emotional fluctuations, self-consciousness and identity exploration are also common in both groups.

Although they mostly move through a similar development along the biological changes, autistic individuals may experience slower cognitive and social maturation than physical development compared to their non-ASD peers. This can cause a delay in awareness of pubertal and sexual changes happening to them.

To sum up, the biological process of puberty is essentially the same for autistic and non-autistic individuals, but autistic individuals often face additional sensory, social, emotional and safety-related challenges that require more explicit teaching, structured support, and sensitivity to their unique needs.

What are the specific challenges?

- **Sensory processing**

Adjustments to new bodily sensations (sweating, hair growth, breast development) are often less tolerable. Sensory sensitivities can make these changes overwhelming, for example, discomfort with body odour, new textures of body hair or wearing bras or menstrual pads.

- **Social and emotional understanding**

Difficulty interpreting social cues can lead to confusion about flirting, dating, and appropriate boundaries. They may miss informal peer learning and rely more on explicit teaching.

- **Emotional regulation**

Co-occurring conditions (anxiety, depression, ADHD) can intensify mood swings. Difficulties with identifying emotions make self-regulation harder.

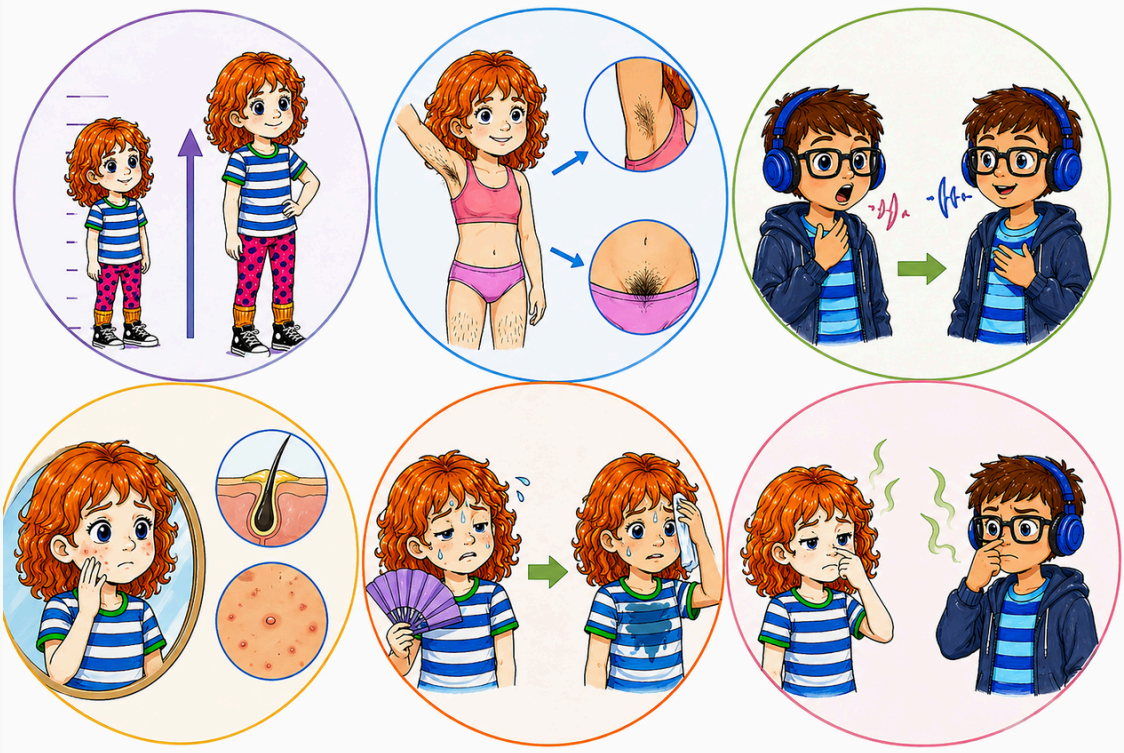
- **Gender Identity and orientation**

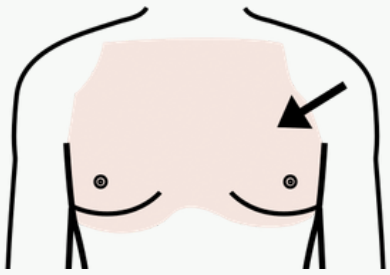
Research suggests autistic individuals may be more likely to identify as queer, which can add another layer of complexity during puberty.

What happens to the body?

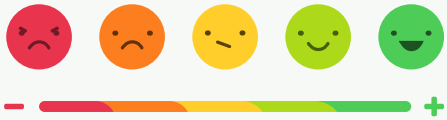
Here is a non-exhaustive list of the physical changes that male and female individuals have in common:

- Growth spurt
- Enlargement of testicles and penis/labia of the vulva, darkening of the skin in the genital area
- Growth of pubic, underarm, body and facial hair
- Voice crack: voice gets deeper
- Increased oil production in the skin, pimples and maybe acne
- More sweating and more pungent body odour



Specific changes for female individuals:	Specific changes for male individuals:
• First menstruation (Menarche) • Breast development 	• Sperm production and first ejaculation • Frequent erections 

What happens on an emotional level?



- Mood swings
- Stronger emotions and sensitivity
- Desire for more independence and privacy
- Greater self-consciousness about body and appearance
- Developing a stronger sense of identity
- Interest in romantic relationships and attraction to others
- Increased importance of friendships and peer approval
- Occasional conflict with parents or caregivers as independence grows
- Curiosity about sexuality and relationships
- Beginning to think more abstractly and critically (more adult-like thinking patterns)

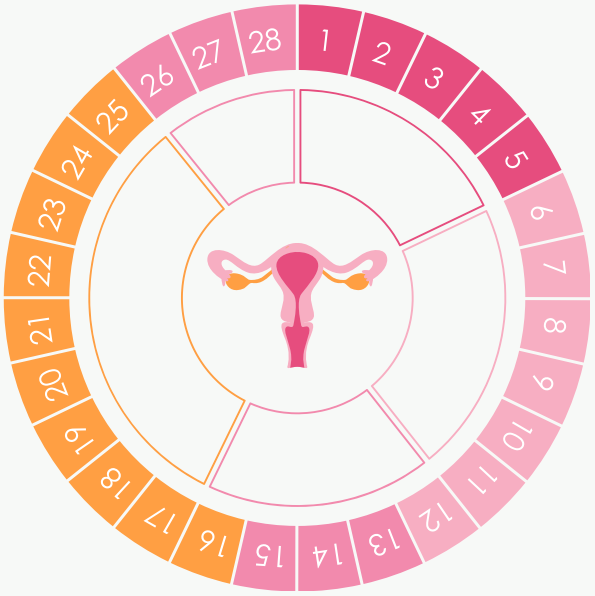
Although most individuals will face similar changes, they may occur at different timings, be present, and be experienced very differently from person to person.

MENSTRUATION

What is the menstrual cycle?

The menstrual cycle is a hormone-regulated process that begins at puberty and continues until menopause, preparing the body for possible pregnancy. Each cycle starts on the first day of menstruation and usually lasts 21–35 days, though cycles up to 40 days can occur during puberty. Cycle length is measured from the first day of one period to the day before the next.

Menstruation is the shedding of the uterine lining (endometrium), which builds up to support a fertilised egg. If fertilisation does not occur, the lining, blood, and unfertilized egg are expelled through the vagina, typically over 3–7 days.



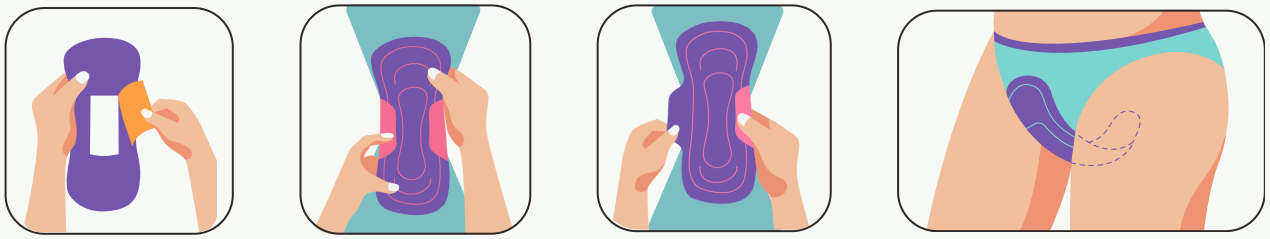
Pregnancy is possible during ovulation, when an egg is released and can be fertilised for about 12–24 hours. Ovulation usually occurs near the midpoint of the cycle, with most people ovulating about 14 days before their period begins (cf. Cleveland Clinic, 2022b; cf. Kumar & Singh, 2025; Cleveland Clinic, 2022a; Cleveland Clinic, 2022b).

When to see a doctor?

A health care provider should be consulted if menstruation becomes suddenly irregular or stops (outside of puberty or perimenopause), if there is severe pain or very heavy bleeding (requiring product changes every hour), unusual discharge, periods lasting longer than seven days, symptoms of toxic shock syndrome such as fever, shivers, or vomiting (cf. Cleveland Clinic, 2023), if menstruation has not started by age 16 or if pain medication doesn't help with the pain.

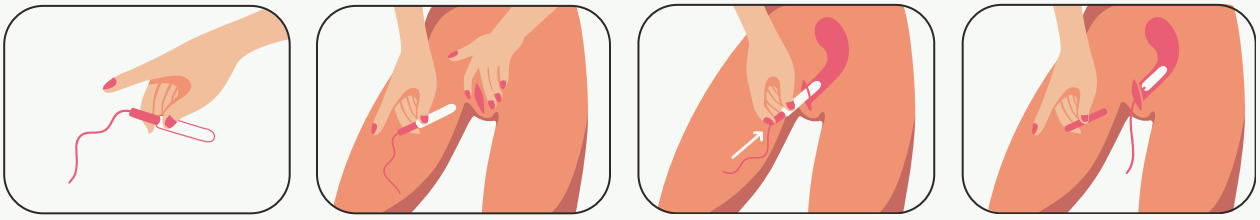
MENSTRUATION PRODUCTS

Pads: Disposable menstrual pads are designed to absorb the period fluid and to provide adequate protection. The pad is attached to the underwear with an adhesive strip on the back so that the soft, absorbent side is facing up towards the vulva. The pad should be changed regularly (every 4–6 hours). Wrap the used pad in toilet paper and dispose of it in a rubbish bin.



Tampons: Tampons are single-use intravaginal products that absorb the period fluid. They come with a string for easy removal. Tampons are available in different sizes and absorption levels, with or without an applicator.

Application: Wash hands before getting into a comfortable position (squatting, lying down, standing or with one leg raised). Remove the tampon from its packaging and pull out the small string. Insert the tampon into the vagina, aiming towards your lower back. The string must remain outside. The tampon is in place when you can no longer feel it. Wash your hands after inserting the tampon and change it regularly (about every 4 hours). To remove the tampon, gently pull on the string, wrap it in paper and dispose of it in the rubbish bin.

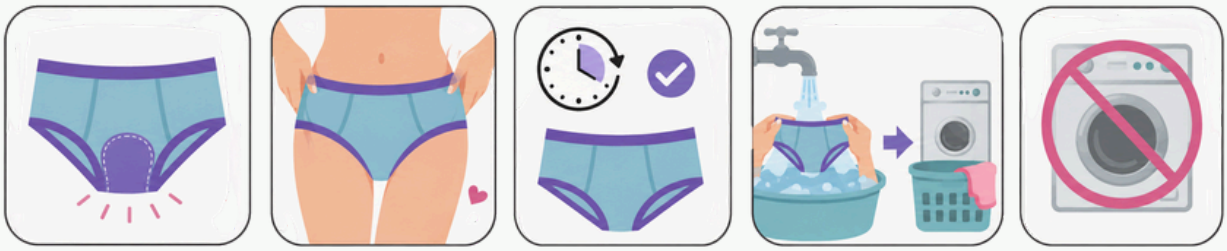


Menstrual cups: The menstrual cup is a flexible receptacle (made of natural rubber or medical-grade silicone) that is inserted into the vagina to collect menstrual fluid. It can be reused with each menstrual cycle and for several years.

Application: Wash your hands and get into a comfortable position (e.g., squatting or with one leg up). Fold the cup flat and carefully insert it into the vagina. Once in place, it must not be uncomfortable. To remove it, squeeze the bottom tip to release the seal and gently pull the cup out. Empty the contents and wash the cup with lukewarm water before inserting it back into the vagina. To sterilise it, the menstrual cup should be boiled with hot water at the end of the period.



Period underwear: Period underwear, also called menstrual underwear, resembles conventional underpants but features an absorbent, leak-proof layer. They come in different styles, a variety of fabrics and absorbencies. It is recommended to wear them for a maximum of 12 hours (depending on the flow) and to soak them in cold water afterwards before putting them in the laundry. Menstrual underwear should not be tumble-dried.



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ACTIVITY SUGGESTIONS

Puberty, hygiene and menstruation

Goals

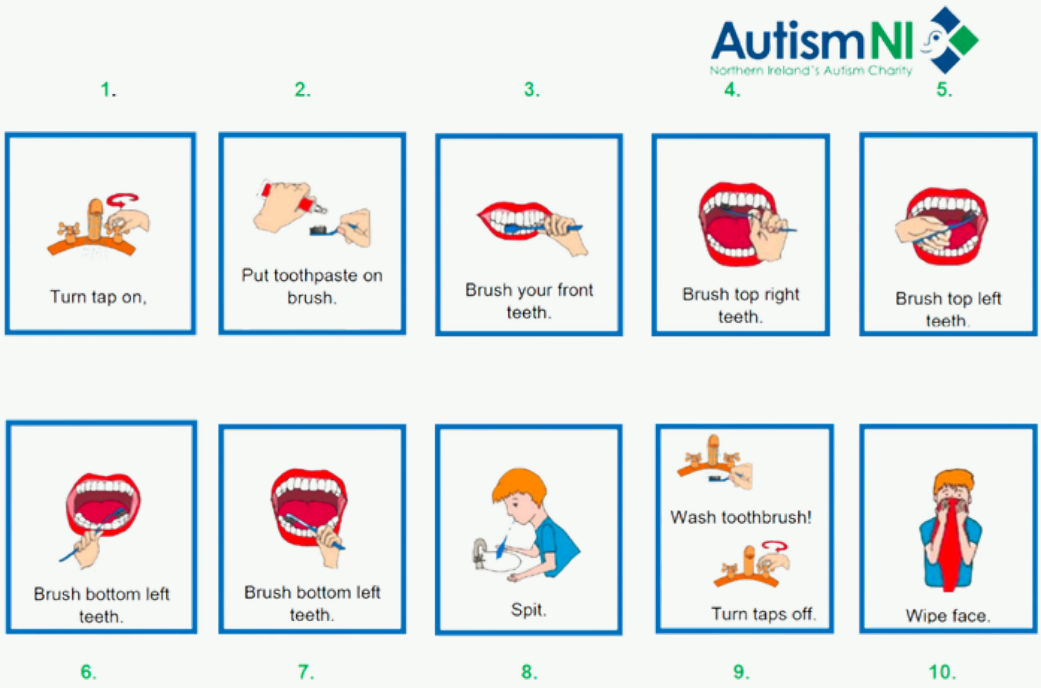
This chapter aims to support learners with autism in:

- Understanding the physical changes that occur during puberty
- Identifying and managing emotional changes
- Developing a healthy body image and self-esteem
- Learning about personal hygiene and self-care routines
- Understanding menstruation in a clear, supportive way
- Recognising and regulating mood swings
- Respecting their own and others' bodily autonomy
- Learning appropriate social and emotional responses.

Visual Supports

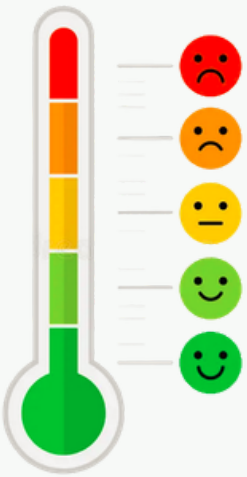
Puberty charts or illustrated books can be used to show physical changes in boys and girls.

Hygiene routines can be displayed visually (e.g., showering, deodorant use, changing sanitary pads).



Picture taken from:
https://autismni.org/help-support/resources/visuals-social-stories/self-care-resources

Emotion thermometers or faces can be used to recognise emotional states and link them to hormonal changes.



Using images of diverse bodies and natural changes can create body-positive imagery.

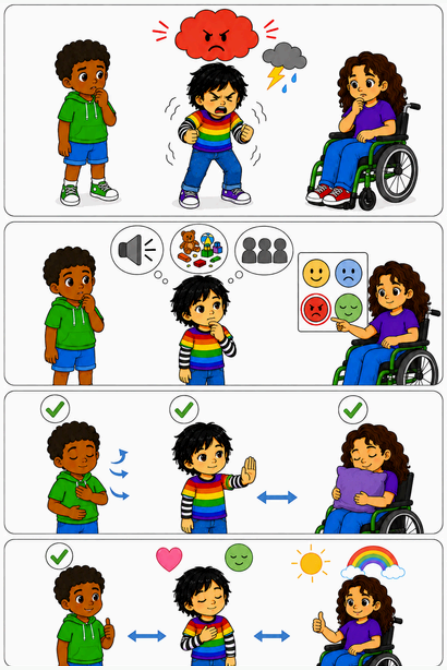
For menstruation: Diagrams, flowcharts, and sample menstrual products can be used in a non-threatening way.

Social Stories

See page 29 for a more detailed description

Social stories can be used to address:

- “What is Puberty?”
- “Getting My Period”
- “Shaving for the First Time”
- “Dealing with Body Odour”
- “Why I Feel Angry Sometimes”
- “Changing in the Locker Room”



Role-Playing

See page 30 for a more detailed description

Suggested Scenarios:

- Asking for help with hygiene needs (e.g., “Can you help me buy deodorant?”)
- Managing emotional outbursts (“I feel frustrated, I need a break.”)
- Responding to teasing about body changes
- Practising changing clothes in private spaces like bathrooms or locker rooms

Tips:
For indirect practice, you can use scripts and puppets

Always offer praise for expressing needs or managing feelings calmly

Positive Reinforcement

Remember to praise appropriate self-care habits, such as saying, “You remembered to brush your teeth, great job!” You could also use token systems to support consistent hygiene routines.

Modelling Behaviour

You can model skills such as:

- Washing hands, using deodorant, and changing clothes appropriately
- Using sanitary products (demonstrated on dolls or charts, not live)
- Expressing emotions calmly (“I feel nervous, so I will take deep breaths”)
- Using checklists or apps for daily hygiene and emotional tracking

Optional Materials to Create:

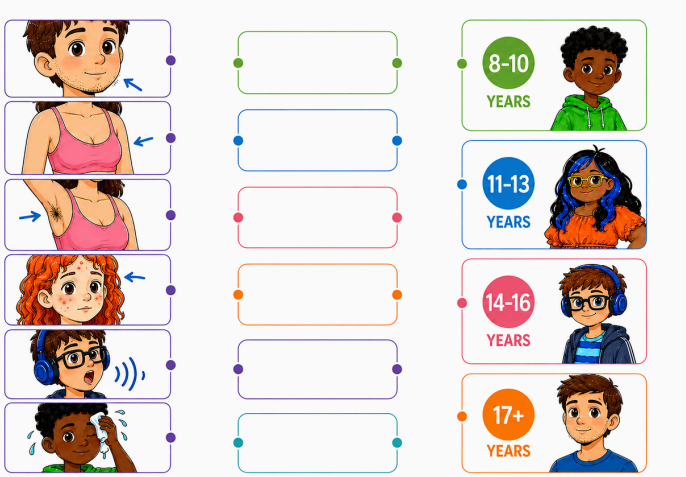
- **Puberty Flashcards:** Showing physical and emotional changes in a clear, respectful way
- **Hygiene Routine Charts:** Illustrated checklists for bathroom, shower, menstruation care
- **Emotion Thermometers:** Visual tools for identifying and scaling feelings
- **Menstrual Product Samples & Visual Guides:** For education and familiarization
- **Social Story Booklets:** “Getting My Period,” “Why My Voice Is Changing,” etc.
- **Mood Tracking Worksheets:** Simple daily forms to record and reflect on emotions
- **Body Image Affirmation Posters:** Inclusive posters celebrating different body types
- **Puberty Sorting Mats & Cards:** For interactive matching and group learning



Suggested Activities

- Movement & Imitation Games

Body Changes Matching Game
Use cards showing physical changes (e.g., facial hair, breast development) and match them to age/stage or name.



Puberty Sorting Game
Sort cards into “Happens to Boys,” “Happens to Girls,” and “Happens to Both.”

Menstruation Station
Explore pads, liners, period underwear, and step-by-step instructions using dolls or charts.

Hygiene Routine Sequencing
Provide cards showing steps such as “change underwear,” “use deodorant,” and “wash hands.”



- Movement & Imitation Games

Body Image "Me Collage"
Using magazines or drawings, learners create a collage of things they like about their body, identity, or interests. This helps build self-esteem and supports body positivity.

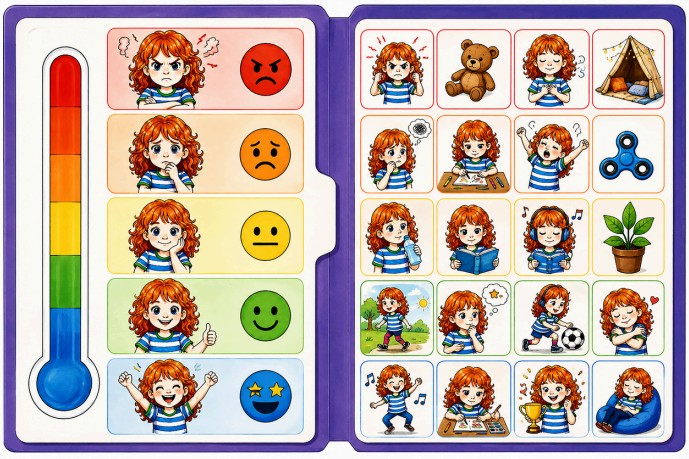


Scent & Sensory Exploration Station
Provide different hygiene products to smell or touch and rate them with smiley face scales. This helps sensory-sensitive learners find products they tolerate.

Yes / No / Maybe Boundaries Game
Sort actions like "someone wants a hug" into Yes/No/Maybe zones with traffic light colours. This supports decision-making about consent.

- Emotional Regulation Activities

Feelings Folder / Mood Thermometer
Create a colour-coded folder or chart to identify emotions and link them to calming strategies.



4 SEXUAL AND GENDER DIVERSITY

This chapter offers an introductory overview of the terminology of sexual and gender diversity, though it is not exhaustive. Please note that the meanings and connotations of the following terms have already evolved and will likely continue to do so in response to a rapidly changing society. In addition, the meanings of the terms may vary from person to person. Whilst some people might find significance and comfort in them, others might not or even resent the idea of labelling their identity (cf. LGBTQIA Resource Centre Glossary, 2025)

It is also important to note that experiences of sexual orientation and gender identity may be shaped by other aspects of identity, such as neurodiversity. For example, autistic and other neurodivergent people may experience, understand, or express gender and sexuality in ways that differ from dominant social expectations. This does not indicate deficit or confusion but reflects the diversity of human experiences and ways of relating to social norms and identity.

In recent years, the visibility of concepts and terms related to sexual and gender diversity has increased in public discourse. Frequently discussed among them are, for example, the terms *sex assigned at birth, sexual orientation, gender, and gender identity.* Each term represents a distinct aspect of human identity, and together they contribute to the broader understanding of individual diversity.



For many people worldwide, their sexual and gender identities often correspond to traditional, heteronormative expectations of society. For example, a person might have been born with a vulva and was therefore assigned female at birth (sex assigned at birth), they identify as a woman (gender identity) and are sexually and/or romantically attracted to men (sexual orientation).

For many, this feels authentic and valid. For others, this is not the case - their experiences of sexuality and/or gender may be more diverse and differ from societal norms. A person may have been assigned female at birth, identify as a woman and be attracted to women. Another person might have been assigned male at birth, identify as a woman, and be asexual. All these experiences are valid expressions of gender and sexual diversity.

SEXUAL AND GENDER DIVERSITY TERMINOLOGY

Sex assigned at birth: At birth, infants are typically assigned a sex - female or male - based primarily on the appearance of their external genitalia. However, biological sex is not determined by external genitalia alone. Sex characteristics also include e.g. chromosomes, hormones or gonads. Some people are born with variations in sex characteristics that do not fit typical definitions of female or male; these variations are described as intersex (cf. Planned Parenthood, 2026a).

- **Intersex:** Up to an estimated 1.7% of the world's population is born with "*[...] sex characteristics (such as sexual anatomy, reproductive organs, hormonal patterns and/or chromosomal patterns) that do not fit typical binary notions of male or female bodies*" (OHCHR, 2026).



Gender: Gender can be defined as "*a socially constructed set of norms, roles and behaviours. These are associated with the sex assigned to a person at birth, which shapes their access to power, resources, and equitable enjoyment of rights, among other areas*" (Amnesty International, 2025). These norms are for example already reflected in expectations regarding newborn clothing and, throughout the course of a person's life, extend to areas such as hairstyles, appearance, accessories, body language, mannerisms, behaviours, care work, wage labour, and beyond. Gender as a cultural construct can vary across historical periods and between societies.

Gender Identity: Gender identity refers to a person's deep and inner sense of their own gender, which may or may not align with an individual's sex assigned at birth (cf. Planned Parenthood, 2026a).

- **Cisgender** describes people whose gender identity corresponds with the sex they were assigned at birth (GLAAD, 2026).

- **Trans or transgender**, on the other hand, is "*a gender identity and umbrella term for people whose gender differs from, or does not sit comfortably within, the gender they were assigned at birth*" (Amnesty International, 2019). Some, trans people may choose to affirm their gender socially, medically, and/or legally in order "*to bring their gender expression and/or their body into alignment with their gender identity*" (GLAAD, 2026, cf. idem.). This process is commonly referred to as transition.

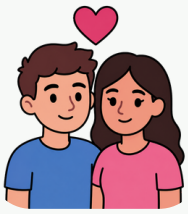


- The term **non-binary** refers not only to a gender identity but is also used as an umbrella term "*for people whose identity falls outside the gender binary. Some people do not identify wholly or at all with the gender they were assigned at birth – some people have no gender at all*" (Amnesty International, 2019).

Gender Expression: The ways in which an individual outwardly expresses or presents their gender. This can include, among other things, appearance, such as clothing, hairstyles, makeup, or accessories, as well as aspects of behaviour and communication, such as gestures or body language (cf. Human Rights Campaign, 2023).

Sexual Orientation: To describe someone's sexual, romantic, and/or emotional attraction to another person, the term sexual orientation is used. There are various sexual orientations. Please note that the following list is not exhaustive:

- **Straight (heterosexual):** sexual and/or romantic attraction to people of a different gender than one's own.



- **Gay:** referring to a person who is romantically and/or sexually attracted to people of the same gender. It is often used to describe men who are attracted to men, but can also be used more broadly by people of other genders.



- **Lesbian**: women who are sexually and/or romantically attracted to other women.



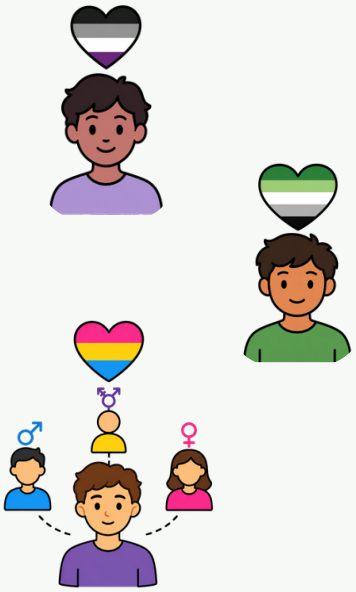
- **Bisexual:** sexual and/or romantic attraction to more than one gender.



- **Asexual:** refers to a person who experiences little or no sexual attraction to others

- **Aromantic:** refers to a person who experiences little or no romantic attraction to others (cf. Planned Parenthood, 2026b).

- **Pansexual:** sexual and/or romantic attraction to people regardless of their sex or gender (cf. Stonewall, 2026)



- **Queer:** Umbrella term which refers to a "variety of sexual/romantic orientations, gender identities, and gender modalities that are anything other than heterosexual and cisgender" (Planned Parenthood, 2026b). Over the course of the past decades, the word queer, which was once used as a slur to demean LGBTQ+ people, has been reclaimed by parts of the LGBTQ+ community and can now carry an empowering connotation for those who use it to describe themselves. However, not everybody feels comfortable using queer as a word for self-identification (cf. Planned Parenthood, 2026 & Stonewall, 2026.)

While some people have a clear understanding of their sexual orientation or gender identity, others may still be exploring them. This process of exploring and seeking clarity is known as **questioning** (cf. Human Rights Campaign, 2023).

IMPORTANT: Labels and self-identifications regarding one's own sexuality should always be understood as a personal decision and must never be assumed or imposed by others.

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ACTIVITY SUGGESTIONS

Sexual and gender diversity

Goals

This chapter aims to support learners with autism in:

- Understand differences between key concepts
- Build self-awareness and respect for differences

Visual Supports

1. Concept Sorting with Visual Cards
Provide cards with:

- Gender identity (woman, man, nonbinary, agender)
- Gender expression (clothes, hairstyle, voice)
- Sexual orientation (gay, straight, bisexual, asexual)
- Relationships (friendship, romantic, family)

Learners sort cards into labeled categories.

Why it works for autistic learners

- Clear structure
- Reduces abstraction
- Encourages pattern recognition

Adaptation: Use color coding or icons (e.g., hearts for attraction, mirrors for identity).

2. "Everyone Is Different" Identity Map
Create a personal identity map with optional sections:

- Things I like
- Things that feel important to me
- How I like to dress
- How I like to be treated
- Things that make me uncomfortable

Gender and sexuality are presented as optional, not mandatory.

Visual example how such an Identity Map can look:



5 PLEASURE, MASTURBATION AND SELF-EXPLORATION

What Is Masturbation?

Masturbation is when a person touches sensitive parts of their own body, oftentimes but not necessarily, including their genitals, for pleasure. There are plenty of reasons as to why people masturbate, some of which might be for pleasure, self-exploration, to relax or to learn what they like and feels good for them (cf. Planned Parenthood, 2026c).

Is it normal?

YES!
Masturbation is a common behaviour that people of all genders, ages, sexual orientations, and relationship statuses may engage in. While some individuals masturbate frequently, others do so rarely or not at all - and all these experiences are perfectly normal. For some, masturbation can be a way to learn about their bodies and what feels good to them. For others, it might hold no interest, and that's equally valid (cf. Cleveland Clinic, 2022c).

Why Do People Masturbate?

- To feel pleasure
- To release tension
- To explore what feels good
- To fall asleep or reduce stress
- To understand their body better
- To feel less bored
- To help with menstrual cramps

Many people are taught to feel bad or ashamed about masturbation - but those feelings often come from myths, religious or cultural beliefs. It is essential to keep in mind that everybody gets to decide for themselves whether they would like to explore their sexuality by masturbating or not (cf. idem).

Safety Rules: Whilst masturbation is something completely normal, it should only be done in private, such as in one's bedroom or bathroom. This is to ensure that one's own security, intimacy, and privacy, as well as those of others, are protected.



Safety & Hygiene Tips

- Masturbation should only be done in privacy
- Hands should be washed before
- Fingernails should be rounded
- Body limits should be respected
- For additional lubrication, no other product but the actual lubrication gel should be used
- Sex toys should be sanitised and body-safe
- No sharp or harmful objects should be used to prevent injury

Side note:
It is okay to masturbate as well as to masturbate regularly. However, if it becomes compulsive and starts to interfere with one's daily life and/or causes harm to oneself, it is advised to consult a doctor or psychologist (cf. idem).



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ACTIVITY SUGGESTIONS

Masturbation and self-exploration

Goals

The aim of this chapter is to support autistic individuals in:

- Understanding that pleasure and self-exploration are natural aspects of human development
- Learning what masturbation is and where it is appropriate
- Identifying the difference between private and public behaviours and spaces
- Exploring concepts of personal and sexual expression safely and respectfully
- Recognising and respecting personal boundaries and those of others
- Developing emotional safety, confidence, and self-regulation around their bodies

Visual Supports

Visuals can be used to make abstract ideas concrete and understandable:

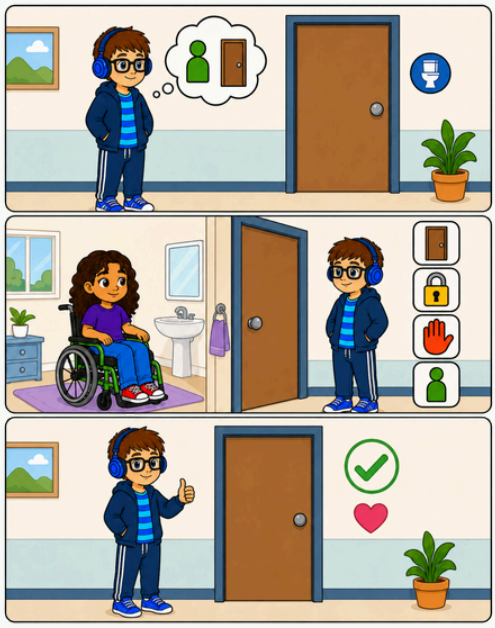
- Visual schedules or cue cards for “private time”
- Public vs. private behaviour charts
- Simple body diagrams with neutral, factual labels
- Clear visual rules (e.g. “PRIVATE PLACE,” “DOOR CLOSED”)

Social Stories

See page 29 for a more detailed description

Social stories offer structured ways to introduce sensitive topics such as:

- What masturbation is (described and factually)
- When and where it is appropriate (e.g. “Only in my bedroom or bathroom”)
- Privacy rules (door closed, alone, hands washed afterwards)
- Understanding that other people’s bodies are private



Role-Playing

See page 30 for a more detailed description

Role-play helps learners practice appropriate responses:

- You can use dolls or puppets
- Prepare and practise scripts for different scenarios

Positive Reinforcement

Positive reinforcement should be used to:

- Encourage following the privacy rules
- Support appropriate communication about body needs
- Reinforce self-regulation and use of private spaces

Suggested Activities

- Movement & Imitation Games

Story-Based Learning

Create a Personal Privacy Rules Book: A small booklet showing rules like “I close the door,” “I keep private things to myself.

Visual & Sorting Activities

Public vs. Private Sorting Game
Sort behaviours into categories such as:

- OK IN PUBLIC
- ONLY IN PRIVATE

Examples may include changing clothes, hugging, and touching genitals.

Body Mapping with Feelings

Use body outlines to identify:

- Areas that feel OK
- Areas that are private
- Areas the child does not want others to touch
- Personal Boundaries

Use cards or dolls to show:

- OK
- ASK FIRST
- NOT OK

Optional Materials to Create

- Public vs. Private Behaviour Posters
- “MY PRIVACY RULES” personalised booklet
- Social Stories (PDF or laminated versions)
- Body Mapping Worksheets with Emotions
- Consent and Boundaries Cards (YES / NO / ASK FIRST)
- Visual Door Signs (e.g. “PRIVATE,” “DO NOT ENTER”)
- Visual Cue Cards for Privacy and Emotional Regulation

6 RELATIONSHIPS AND SOCIAL SKILLS

Relationships and Social Skills

Autistic individuals often want and value relationships just as much as their neurotypical peers, but they may face unique challenges in forming and maintaining them. These challenges are linked to differences in communication, social understanding, and the ability to process emotional signals. While family, peer, and romantic relationships are possible and essential, they are often shaped by these social differences (Travis & Sigman, 1998).

Types of Relationships

Research shows that many autistic people have a strong interest in friendships, intimacy, and romantic partnerships (Soares et al. 2021). However, they may experience delays in starting romantic relationships, have more difficulty maintaining them over time, and often worry about their ability to adapt to intimacy (Bennett et al., 2019; Beato, Sarmento, & Correia, 2024). This is not due to a lack of desire for closeness, but rather to challenges in navigating the “rules” of relationships.



Within families, bonds are typically present, but communication differences can make interactions more directive and less reciprocal. For example, parents may need to guide more, and children may find it harder to anticipate others’ responses. This can limit opportunities to develop a shared understanding in the parent-child relationship (Travis & Sigman, 1998). Difficulties in conversation, play coordination, and emotional sharing with peers can reduce the likelihood of building long-lasting friendships. In adolescence and adulthood, these same challenges can make it harder to experience intimacy and trust in close relationships.

Social Skills

Social skills are at the centre of these difficulties. Many autistic people struggle to interpret nonverbal communication, manage conversations, recognise personal boundaries, and handle social anxiety. As a result, they may find it harder to understand flirting, to initiate a relationship, or to respond to rejection (Beato et al., 2024). These challenges can also create confusion about different types of relationships. For example, distinguishing between friendship and romance or exploring one's sexual orientation.

Practical Implications for Professionals

For professionals working with autistic individuals, it is essential to recognise that the desire for relationships is present, but that specific support may be needed. This includes:

- Teaching and modelling how to recognise social cues (e.g., flirting, setting boundaries).
- Supporting conversations around identity, intimacy, and sexual orientation.
- Helping to break down relationship skills into concrete, teachable steps.
- Encouraging families and peers to interpret differences in communication as part of autism, not as disinterest.

By addressing these social and communication needs, professionals can help autistic people build healthier and more fulfilling connections across all types of relationships.

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Additional Resources

Educational & Practice-Based Materials

- King County Public Health. Special education sexual health resources
- https://kingcounty.gov/en/dept/dph/health-safety/health-centers-programmes-services/birth-control-sexual-health/sexual-health-education/flash/special-education
- Planet Puberty. Interactive games.
- https://www.planetpuberty.org.au/interactive-games/
- Family Planning NSW. Private and public behaviours
- https://www.fpnsw.org.au/sites/default/files/assets/factsheet_05_private_and_public.pdf

Interoception & Body Awareness

- Neurodivergent Insights. What is interoception?
- https://neurodivergentinsights.com/what-is-interoception/
- Neurofeedback Luxembourg. Interoception and autism
- https://neurofeedback-luxembourg.com/understanding-autism-interoception-internal-body-awareness-and-neurofeedback-interventions/

Social Stories

- Able2Learn – Behaviour Management Social Stories
- https://able2learn.com/categories/behaviour-management/new-category.html

Video Resources

- https://www.youtube.com/watch?v=fWLZi-lloZY
- https://www.youtube.com/watch?v=zNTUMNKSNwk

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