ABSTRACT

SCHOOL SPEECH & LANGUAGE SERVICES FOR CHILDREN WITH AUTISM SPECTRUM DISORDER: AN ANALYSIS OF PARENT PERSPECTIVES ON THERAPY OPTIONS, IEP MEETINGS & SPEECH-LANGUAGE PATHOLOGISTS

By: Cathryn L. Shedden

The purpose of this study was to obtain information on parent perspectives on the speech and language services their children with autism receive in schools. Fifty-five parents of children with autism spectrum disorder completed a survey containing items concerning parental feelings regarding therapy options, IEP meetings, and speech-language pathologist (SLP) behaviors. Results suggested parents are satisfied with the speech and language services provided to their children with autism in five public school districts in southeastern Ohio. Results indicated significant correlation between parent feelings toward therapy and attitudes toward SLP attributes as well as between parent feelings toward IEP meetings and attitudes toward SLP attributes. Limitations of the study, future research, and clinical implications are discussed.
SCHOOL SPEECH & LANGUAGE SERVICES FOR CHILDREN WITH AUTISM SPECTRUM DISORDER:
AN ANALYSIS OF PARENT PERSPECTIVES ON THERAPY OPTIONS, IEP MEETINGS & SPEECH-LANGUAGE PATHOLOGISTS

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A Brief History of Autism

Autism has been recognized as a unique disorder for over a century. In 1906 a Swiss psychiatrist named Eugene Bleuler introduced the term “autism,” and it began to be used in the psychiatric literature (Manning-Courtney, Brown, Molloy, Reinhold, Murray, Sorensen-Burnworth, Messerschmidt, & Kent, 2003). In 1943, Leo Kanner used the term “infantile autism” to describe a group of patients at Johns Hopkins University where he worked as a psychiatrist. Kanner described three major symptoms of autism including social isolation, insistence on sameness and abnormal language (Kohler, 1999). At around the same time, Hans Asperger was researching a group of children in Austria with similar behaviors. The symptoms he documented included the use of inappropriate social approaches, intense circumscribed interests and a lack of two-way conversation (Spann, Kohler, & Soenksen, 2003).

During the 1950s, autism was widely believed to be caused by the way parents interacted with their children. In his book, The Empty Fortress, Bruno Bettelheim declared that the parents of children with autism were the cause of their children’s inability to relate to the world in a normal fashion. Bettelheim referred to the mothers of children with autism as being “cold and withdrawn,” and his theories were accepted into the 1960’s (Manning-Courtney et al., 2003). Toward the end of the 1960s, prevailing assumptions about autism were refuted and disproved. In the new view, which was corroborated by a link with epilepsy, autism was defined as a neurobiological disorder affecting the development of the brain and its associated functions (Bryson, Rogers, & Fombonne, 2003). In the early twenty-first century, autism came to be known as a disorder present from birth or very early in development that affects essential human behaviors such as social interaction, the ability to communicate ideas and feelings, imagination, and the establishment of relationships (Lord & McGee, 2001).
Five autism spectrum disorders fall under the heading of Pervasive Developmental Disorders (American Psychological Association, 2000). Pervasive Developmental Disorders (PDDs) are characterized by a range of severe and pervasive impairments in several developmental areas, including social interaction and communication skills. PDDs are often used synonymously with the phrase, “autism spectrum disorders,” to describe a range of similar behaviors. In addition to autism, the four disorders under the heading of PDDs are Asperger’s syndrome, Rett’s disorder, Childhood Disintegrative Disorder (CDD), and Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS) (Tanguay, 2000). The scope of symptoms resulting from PDDs is wide and often varies greatly even within each of the five individual disorders.

To understand the variety of individuals who have PDDs, it is important to examine the salient characteristics of each disorder. Asperger’s syndrome includes impairments in social interaction, the presence of subtle communication issues, and restricted interests and activities. In addition, a hallmark of Asperger’s syndrome is intelligence that can range from low average to well above average (Manning-Courtney et al., 2003). Rett’s disorder is a progressive disorder that primarily occurs in females. Very early development is normal, but in the first months of life head growth decelerates. A loss of purposeful hand movements occurs, and profound mental retardation is typical (Lord & McGee, 2001). CDD is a quite rare progressive disorder that occurs more often in males than in females. CDD is characterized by significant loss of previously acquired skills after a period of two to four years of normal development. PDD-NOS is a diagnosis that is often made when a child does not meet the criteria for another PDD. As such it can sometimes be used as a working diagnosis in very young children (Manning-Courtney et al., 2003). Children diagnosed with PDD-NOS generally have a severe and pervasive impairment in specified behaviors of communication and social interaction in addition to restricted interests. The spectrum model views autism as a disorder that can manifest with mild to severe symptoms. The concept of PDDs, or autism spectrum disorders, was originated to create an umbrella term for disorders that include similar impairments in basic social skills, but that may vary in severity or in the presence of communication delay and repetitive behaviors (Lord & McGee, 2001). However, the model may be
incorrect, and autism could represent several discrete genetic disorders that have a common, overlapping phenotype (Tanguay, 2000). The spectrum model allows generalizations as well as classifications to be made about individuals who may exhibit a range of significant impairments in communication, social interaction and the ability to accept changes in the environment. In this document, the spectrum of autistic disorders will be referred to collectively as autism for purposes of simplification.

Characteristics of Autism

Parents are typically the first individuals to notice developmental differences in children with autism. Almost four years may pass between the time a parent first becomes concerned with the development of their child to the time of diagnosis (Bryson, Rogers, & Fombonne, 2003). Health care professionals may use several different methods to diagnose autism. Screening instruments include the Checklist for Autism in Toddlers (Baron-Cohen et al., 1996), the Autism Screening Questionnaire (Berument et al., 1999), and the Screening Test for Autism in Two Year Olds (Stone, Coonrod, & Ousley, 2000). An example of an observation tool is the Autism Diagnostic Observation Scale (Lord et al., 2000). Diagnostic interview forms and checklists include the Autism Diagnostic Interview – Revised (Lord et al., 1994), the Childhood Autism Rating Scale (Schopler et al., 1980), the Autism Behavior Checklist (Krug, Arick, & Almond, 1980), and the Aberrant Behavior Checklist (Aman & Singh, 1986). Using the different assessments available, a team of professionals can make a diagnosis of autism in a child as young as eighteen months (Lord & McGee, 2001). Indications for immediate evaluation of a child are: no babbling by twelve months, no gesturing by twelve months, no single words by sixteen months, no two-word spontaneous phrases by twenty-four months, and any loss of language or social skills at any age (Manning-Courtney et al., 2003).

Although each child with autism exhibits characteristics unique to the individual, key features of autism can be broadly stated. The main characteristics that differentiate autism from other developmental disorders in the twenty month to thirty-six month age range involve deficits in or the absence of: eye contact, orienting to one’s name, joint attention, pretend play, imitation, nonverbal communication and language development (Lord & McGee, 2001). Children with autism have difficulties acquiring speech and
language as well as understanding and using nonverbal communication. Salient features of the disorder are increasingly manifested with age and include: delayed and disordered communication, atypical social interaction, restricted range of interests, and onset before the age of three years (Fombonne, 1997). Characteristics that vary in children with autism include: language disorders (echolalia), emotional disturbances (unusual responses to people, attachment to objects), and mental retardation. Approximately 70% of children with autism score within the range of mental retardation. (Coffey & Obringer, 2004; Fombonne, 1997).

Children with autism generally find social interaction disagreeable. Aversion to social interaction is commonly attributed to children’s overly sensitive central nervous systems that cannot tolerate the arousing qualities of emotional engagement (Lord & McGee, 2001). In 1979, three subgroups of autism were suggested based on the ways in which children with the disorder interact socially (Wing & Gould, 1979). The classifications continue to be used and consist of aloof, passive, and active but odd. The aloof group is indifferent to social interactions, particularly with other children, but will approach to have needs met. The passive category consists of children who make few social initiations but who respond positively to the approaches of both adults and peers. The active but odd classification involves children who make initiations and respond to others but are unusual in their odd language, obsessive topics and lack of understanding of others (Lord & McGee, 2001). A majority of children with autism lack the ability to understand others. It is this “theory of mind” deficit that causes individuals with autism to be unable to perceive or understand the thoughts, feelings or intentions of others.

Sensory-perceptual abnormalities among children with autism play a major role in the unusual affect that is characteristic of the disorder. Sensory-perceptual abnormalities reported by parents of infants with autism include lack of responsiveness to sounds, hypersensitivity to the taste of foods, and a lack of pain sensation (Lord & McGee, 2001). Children with autism display unusual sensory and motor behaviors including failure to respond to sounds, heightened sensitivity to loud sounds, watching hands or fingers for extended periods of time, and arm flapping repetitively (Volkmar, Cohen, & Paul, 1986).

Parents and professionals may find it difficult to deal with problem behaviors displayed by children with autism. In fact, it has been shown that parents of children with
autism experience more stress than parents of children with Down Syndrome or with children who develop normally (Dumas, Wolf, Fisman, & Culligan, 1991). Children with autism may destroy property, display physical aggression, self-injure, and throw tantrums. Such behaviors must be put into the context of communication and viewed as an expression of frustration by the child. For children with autism, difficulties in communication interact in complex ways with social deficits and restricted patterns of behavior and interests (Lord & McGee, 2001). Children may display difficult behaviors as their only way of communicating.

Children with autism typically have deficits in multiple areas of development, but encouraging research exists regarding specific skill areas. Approximately ten percent of children with autism display areas of marked ability or talent (Lord & McGee, 2001). Drawing, block design, musical aptitude and calendar calculation are skills that have been shown to be particularly high in children with autism. It is common for children with autism to be affectionate, particularly with familiar people such as family members (Fombonne, 1997).

Prevalence of Autism

Autism knows no racial, ethnic or social boundaries and its frequency is unaffected by family income, lifestyle or educational level (Manning-Courtney et al., 2003). Around the globe, autism occurs more often in males than it does in females. According to most reports the frequency is three to four times higher in males than in females (Manning-Courtney et al., 2003). Estimates of the total prevalence of autism spectrum disorders in the United States were found to range from one per 500 to one per 1,000 (Steuernagel, 2005). In 2006, the Centers for Disease Control (CDC) in the United States gathered data from two surveys: the National Health Interview Survey (NHIS) (Centers for Disease Control and Prevention, 2006) and the National Survey of Children’s Health (NSCH) (Centers for Disease Control and Prevention, 2006). The surveys were conducted from 2003-2004, and they asked parents to report on diagnoses of autism, Asperger syndrome or PDD-NOS for their children. The CDC analyzed data from the NHIS and NSCH and found that the prevalence of parent-reported diagnoses of autism was 5.7 per 1,000 children in NHIS and 5.5 per 1,000 children in NSCH (Schieve, Rice, Boyle, Blumberg, & Visser, 2006). The estimates suggest that as of 2003-2004 at
least 300,000 U.S. children age four to seventeen years had been diagnosed with autism. In a systematic review of studies conducted on the prevalence of autism around the world, estimates of 7.1 per 10,000 were found for typical autism and 20 per 10,000 were found for all autism spectrum disorders (Williams, Higgins, & Brayne, 2006).

Multiple factors can affect the results and influence data when examining the prevalence of autism spectrum disorders. Much of the variation among studies’ estimates can be explained by the age variances of children when screened, the diagnostic criteria used, the country studied, the location (rural or urban) and the style of case assessment (prospective or retrospective) (Coffey & Obringer, 2004). More children may be receiving diagnoses of autism instead of mental retardation than in the past. Eight consecutive birth cohorts in California demonstrated that as the prevalence of autism increased from 5.8 to 14.9 per 10,000 the prevalence of mental retardation without autism decreased from 28.8 to 19.5 per 10,000; thus, a shift of categorization is suggested (Manning-Courtney et al., 2003). Despite the factors that may affect prevalence data on autism, the disorder does appear to be more common than was once thought.

Legislation Affecting Children with Autism

The Rehabilitation Act of 1973 (PL 93-112) was the first public statement restricting discrimination against people with disabilities (Brill, 2001). In 1975 the Education for Handicapped Children Act (PL 94-142) established standards for allocating services to children with disabilities. The Education of the Handicapped Amendment of 1986 (PL 99-457) established incentives for states to serve all children with disabilities from age three to five years (Brill, 2001). It also made funds available to states that developed programs to serve children from birth through two years who were at risk of developing disabilities. A 1990 amendment to the Education for Handicapped Children Act, called the Individuals with Disabilities Education Act (PL 101-476), expanded and clarified critical services for children and youth with disabilities. Under this law, autism became a separate category, which entitled children to appropriate programming and placement by staff trained in autism (Iovannone, Dunlap, Huber, & Kincaid, 2003).

Treatments for Children with Autism

Multiple treatments options exist for autism and the efficacy data for each treatment ranges widely. One study (Green, Pituch, Itchon, Choi, O’Reilly, & Sigafoos,
determined that 111 treatments exist for autism. The most commonly used therapies reported were speech therapy, visual schedules, sensory integration, ABA and social stories (Green et al., 2006). On average, parents reported using seven treatments at one time for a child with autism with the highest number of different treatment options used by any one parent for a child, being forty-seven (Green et al., 2006). As the previous study shows, parents on average use multiple treatments for their children with autism. Of the many treatment options available, some are more popular than others among parents, and some have more research to support their efficacy than others. Empirically supported approaches include a range of procedures based on the principles of the Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH) program and applied behavior analysis (ABA). The following treatments will be discussed in order to provide a sample of available options: TEACCH (Schopler et al., 1980), ABA (Kerr, Smyth, & McDowell, 2003), the Picture Exchange Communication System (PECS) (Frost & Bondy, 1994), Floortime (Greenspan, 1998), the Son-Rise Program (SRP) (Williams, 2006), and Social Stories (Gray & Garand, 1993).

The TEACCH method (Schopler et al., 1980) emphasizes instruction that teaches to the strengths that children with autism have in visual-spatial understanding, object manipulation and enjoyment of highly structured, independent and routine tasks (Bryson et al., 2003). TEACCH relies on organization of the environment by use of clear, concrete visual information, including schedules and labeled objects in the environment. Early identification, parent training, education, community support, social and leisure skill development, communication training, and vocational preparation are significant elements of TEACCH (Mesibov, Browder, & Kirkland, 2002). TEACCH educational principles include conducting ongoing assessment of a child, using a child’s strengths and interests, and collaborating closely with a child’s family (Mesibov, Shea, & Schopler, 2004). Physical organization of the environment enhances the ability of students to function effectively in their surroundings at school and at home. TEACCH is not a curriculum but rather a framework in which vocational, social and living skills are taught (Schopler, Mesibov, & Hearsey, 1994). In fact, TEACCH has come to be used synonymously with the term “structured teaching” (Mesibov, Shea, & Schopler, 2004).
The emphasis of TEACCH is on the visual components of structure, because visual processing is a strength through which deficits in auditory processing and other deficits are minimized. Structured environments with strong visual aides provide more effective help to individuals with autism than typical educational settings because being organized and highly visual is closely related to the way in which people with autism process their surroundings (Mesibov, Shea, & Schopler, 2004). The originators of TEACCH aimed to increase and maximize independent functioning of children with autism and to reduce the frequent need for teacher corrections and reprimands. In addition to preventing behavior problems, different levels of structure can be adapted at every age and developmental level according to individual needs (Schopler, Mesibov, & Hearsey, 1994).

In a study conducted in Italy, two groups of children with autism were taught using either TEACCH programming or regular schooling with support teachers. Results suggested that the group of children who were taught with TEACCH methods had higher scores post-treatment in imitation, perception, gross motor skills, hand-eye coordination, and cognitive performance than the children who received regular schooling (Panerai, Ferrante, & Zingale, 2002). Studies have suggested that TEACCH has benefits for families as well as for the children with autism. In a study of families who had a son with autism under the age of six years referred to the TEACCH program, it was found that mothers who learned skills based on TEACCH methodology showed a decrease in depressive symptoms over time in comparison with a group of mothers not given training (Manning-Courtney et al., 2003). In another study, it was found that mothers typically take on a greater role in the carryover of TEACCH principles for their children than do fathers (Bristol, Gallagher, & Holt, 1988). Academic skills, such as reading, spelling, and math, may be taught as tasks embedded in computerized activity schedules which are an integral part of the TEACCH program (Stromer, Kimball, Kinney, & Taylor, 2006).

Applied Behavior Analysis, also known as Precision Teaching, involves the study of socially relevant behavior. Key elements of the ABA program include the: 1) pinpointing of targeted behaviors, 2) analysis of instruction and type of response called for, 3) realization of the importance of fluency (flowing, accurate and seemingly effortless behavior), and 4) design of the curriculum in terms of building upon pre-
requisite skills (Kerr, Smyth, & McDowell, 2003). Targeted behaviors are objectively defined and are reliably measured on a repeated basis as part of ABA programs. Increasing a child’s positive behaviors and decreasing a child’s negative behaviors may be skills that are targeted within the program (Manning-Courtney et al., 2003). Comprehensive ABA programs typically require 25 or more hours of child and family involvement per week for two or more years. In some cases it is the parents who manage much of the home-based ABA program with an outside consultant available to offer input periodically (Lovaas, 1987). The ultimate goal over the course of an ABA program is to change the clinical course of an autistic spectrum disorder, including preventing certain behaviors from occurring and reducing overall problem behaviors (Lord & McGee, 2001).

For over forty years, ABA has been studied and has been found to be effective in reducing problem behaviors and teaching new skills to individuals with autism (Lord & McGee, 2001). In a 2004 study, parents who implemented ABA with their children found the program valid in its behavioral goals, appropriate in its intervention strategies, and important in its outcomes for the quality of life for the family (Dillenburger, Keenan, Gallagher, McElhinney, 2004). When first begun, ABA focused on the consequences of behaviors after they occurred, but increasingly ABA is concentrating on changing behavior before or between bouts of problem behaviors (Carr et al., 1999). ABA therapy is typically conducted between twenty and forty hours each week and can be done at a clinic, in the home or at another site with a trained individual.

The Picture Exchange Communication System (PECS) (Frost & Bondy, 1994) is an aided, picture-based communication system that is often used by children with autism (Mirenda, 2001). Children may use small cards with pictures of items that they want as part of the system. The child can give a card to a communication partner in exchange for the desired item. Once the child understands how to gain the requested item, the system can be used to teach abstract concepts (Bondy & Frost, 1998). The strengths of the system are that it can reduce passivity in children with autism and can help children with autism function more effectively within their environment (Tissot & Evans, 2003). Ganz and Simpson (2004) studied three children with autism and found that each child made
progress in mastery of the PECS system and had increases in average intelligible words spoken in trials.

Dr. Stanley Greenspan (1998) created one of the best known developmental autism treatment approaches known as the Developmental, Individual-Difference, Relationship-Based Model (DIR) or Floortime. DIR focuses on helping children master the seven developmental skills of: attention and focus, engaging and relating, nonverbal gesturing, affect cueing, complex problem solving, symbolic communication, and abstract and logical thinking (Greenspan & Wieder, 1999). The DIR model includes an interactive experience called floor-time that ranges from two to five hours per day. In addition, children attend speech therapy three to five times per week and occupational therapy two to five times per week.

The Son-Rise Program (Williams, 2006) is an intensive, one-on-one, home-based program that teaches parents and interventionists to demonstrate a loving and nonjudgmental attitude toward their children or students with autism (Manning-Courtney et al., 2003). The SRP encourages parents and interventionists to follow the child’s lead or actions while motivating the child to expand his or her world. A longitudinal questionnaire explored the effects on the family when parents implemented the SRP at home (Williams & Wishart, 2003), and found that pressures on parents’ time was the most frequent drawback to the program. Increased happiness in families still using the program a year after training was the most frequent benefit.

Social Stories (Gray & Garand, 1993) consist of short stories that describe different situations by explaining the social cues and appropriate responses of individuals through the use of pictures. Parents and professionals can use social stories to describe situations to a child; help a child learn to handle changes in routine; address appropriate behavior; and teach academic as well as social skills. Six different types of sentences may be used when writing a social story: descriptive, perspective, directive, control, affirmative, and cooperative (Soenksen & Alper, 2006). Descriptive sentences describe the “who,” “what,” “where,” and “why” of a situation. Perspective sentences describe the feelings of individuals involved in a situation. Directive sentences describe an expected social response to a situation. Control sentences are metaphorical and are written by the child to restate the story. Affirmative sentences express support for previous statements.
in a story. Finally, cooperative sentences identify individuals who have responsibilities in a child’s daily routine. Children with autism are able to learn about the unwritten rules of a variety of situations using different sentence types with references to different people with whom the come into contact daily.

The fact that there is no single, universally effective method of treatment for all children with autism is becoming increasingly evident (Simpson, 2005). Research on intervention techniques has failed to identify one particular treatment method that is effective for all children with autism (Iovannone et al., 2003). However, there are numerous treatments for parents to choose from when deciding on a plan for their child. Methods of treatment that may currently be used were not in existence ten years ago, and in the next decade there will undoubtedly be changes in current methods as well as new treatments available. Learning about and staying current on services for children with autism is a responsibility of professionals as treatment methods continue to evolve (Harris, 1994). Because parents of children with autism have been known to consider treatments that have not been established as effective-practice methods, new methods may gain momentum in the autism community without efficacy data (Simpson, 2005). Although many of the treatments available for autism offer proven efficacy data for improvement in children’s skills, parents and professionals must remain aware of the fact that a cure for autism is not in existence. Although early and intensive behavior intervention will help children, the professional community must not claim that such treatment will result in recovery or normal functioning (Shea, 2004).

*Educating Children with Autism*

Education is currently the primary means by which children with autism are treated. Education is defined as the “fostering of acquisition of skills or knowledge – including not only academic learning but also socialization, adaptive skills, language and communication, and reduction in behavior problems – to assist a child to develop independence and personal responsibility” (Lord & McGee, 2001, p. 12). Education for children with autism and should begin as early in development as possible. Currently most states in the U.S. provide services through school systems, and the challenges for districts are complex. Educational challenges include the need for cross-disciplinary teams to provide services, the necessity to train teachers in methods of
teaching/managing behavioral problems, and the call for social/emotional issues to receive attention (Bryson et al., 2003). Despite federal mandates for early intervention and treatment for children with autism, methods and resources may vary greatly between states and individual school districts (Manning-Courtney et al., 2003). Individuals living in states with mandatory services and excellent educational programs are likely to have better life-long outcomes than those residing in states with no mandated services and poor educational programming (Steurnagel, 2005).

In order for a child with autism to be able to be included in a mainstream setting, the child must have the ability to manage social experiences (Lord & McGee, 2001). Children with autism will be surrounded by adults and peers throughout the school day and must be able to handle the situations without the danger of impairing their own or others’ health and safety. Inclusive education is mandated by the Individuals with Disabilities Education Act because it reflects best practice and principles of normalization (Wetherby, Schuler, & Prizant, 1997). According to Jones, Thorn, Chow, Thompson, and Wilde (2002), inclusion combines the best of special and regular education by incorporating a high degree of social interactions and opportunities for relationships to form. Successful inclusion of children with autism into classrooms, even if only for a portion of the school day, requires planning and support.

Effective services for children with autism should vary by individual based on a child’s age, cognitive and language levels, behavioral needs and family priorities (Lord & McGee, 2001). Educational goals for children with autism should often address language, social, and adaptive goals that are not a focus of typical curriculum. For young children with autism in early intervention programs, Lord and McGee (2001) prioritized six kinds of interventions. First, functional and spontaneous interventions should be the primary focus of early intervention. Second, social instruction should be delivered throughout the day. Third, the teaching of play skills should focus on play with peers. Fourth, intervention strategies that address problem behaviors should incorporate information about the contexts in which behaviors occur. Fifth, instruction aimed at goals for cognitive development should be targeted. Sixth, functional academic skills should be taught when appropriate to the skills and needs of a child. Iovannone et al. (2003) found six essential themes to be important in effective educational programming for children
with autism: individualized support systems and services for students and families, systematic instruction, comprehensible and/or structured environments, specialized curriculum content, functional approaches to problem behaviors, and family involvement. Manning-Courtney et al., 2003) found the following to be common elements of model educational programs: curriculum content including five basic components (attention, imitation, comprehension and use of language, and social skills), highly supportive and structured teaching environments, predictability and routine, functional approaches to problem behaviors, plans for transition, and family involvement in treatment.

Coffey and Obringer (2004) made several suggestions for establishing a functional relationship between school and parents by analyzing the results of their study in children with autism. They believe that a working relationship should be established between parents and administrators to match the personality and characteristics of prospective teachers to the student. Home visits should be encouraged so that teachers can better understand family dynamics and appreciate challenges faced by parents. Frequent parent-teacher conferences should be scheduled so that parents and teachers agree on how to manage social and academic challenges. Small school size and a unified campus should be viewed as strengths rather than limitations. Classrooms emphasizing peer group support and maintaining reduced teacher-pupil ratio should be considered in a positive light. School policies for scheduling, homework, testing, and other issues should be flexible.

The Family's Perspective

Parents should have the opportunity to be active and equal participants in deciding on appropriate educational plans for their children. They know their children best and can provide valuable information to teachers and other professionals who will be educating their children. Collaboration between parents and professionals is essential because open communication can lead to better student progress (Geeter, Poppes, & Vlaskamp, 2002). Whatever the level of impairment, the educational program for an individual with autism should be based on the unique needs of the student, and thoroughly documented in the IEP. If this is the first attempt by the parents and school system to develop the appropriate curriculum, conducting a comprehensive needs assessment is a good place to start. Educational programming for students with autism often addresses a wide range of
skill development including academics, language, social skills, behavioral issues, and leisure skills (Billington, 2006).

Professionals working with children who have autism spectrum disorders should design therapy in ways that caregivers find to be the most helpful. In a study by Crawford and Simonoff (2003), parents responded that they valued interactive relationships with professionals that involved a valuing of ideas and a sharing of perspectives. Although children on the autism spectrum can have commonalities, many children are very unique in their set of symptoms (Beatson & Prelock, 2002) so professionals can be aided by the knowledge supplied by caregivers. Because no two children with autism are alike, it is helpful for speech and language pathologists (SLPs) to enlist the aid and advice of caregivers who have supported the child since birth. There are potential negative consequences for a child with autism spectrum disorders when professionals do not collaborate with parents in planning and implementing therapy (Kohler, 1999). One such consequence could be that communication goals may not be as individualized to a child as they could be if the SLP and the parent openly discussed the child’s abilities. Another negative outcome from neglecting to collaborate with parents could be that the SLP may not know how well progress in therapy is carried over into the home environment.

Parental involvement is important not only with the SLP but also with the child at home. A positive parent-professional relationship is fostered when the caregiver complements school therapy with at-home carryover and when the SLP communicates openly with parents. Over the past twenty-five years, a growing amount of literature has shown that parental involvement has had a positive impact on children’s learning and success in school (Spann et al., 2003). Assessments of parents’ perceptions and satisfaction are a high-quality method of evaluating the effectiveness of the important relationships between professionals and parents. As team models continue to be the trend in health care and educational settings, caregivers’ input must be valued and applied in therapy. Caregivers offer sound advice that comes as the result of a great deal of experience with various treatments for autism spectrum disorders.

Statement of the Problem

Currently approximately 300,000 children in the U.S. between the ages of four and seventeen years have been diagnosed with autism (Schieve et al., 2006). Given that
autism affects not only the lives of thousands of children but also the family members of those children, it is important to examine how parents feel about the government mandated services their children with autism receive in public schools. Over the years, parents have gradually obtained greater influence on their children’s education (Jones et al., 2002). Professionals working with children with autism must respect the parental perspectives and priorities and must consider parental opinions of proposed methods of intervention (Marcus, Kunce, & Schopler, 1997). Often it is not only important to understand how parents feel about services but also how they prefer to communicate. Professionals can look to the study by Singh (2003) who found mothers of children with disabilities preferred daily communications through a written log over any other form of interaction. Parents must be respected when determining appropriate treatments and when carrying out methods of therapy because parents are the ultimate legal guardians of children with autism.

Purpose of the Study

This study sought to determine the level of parent satisfaction with the programs offered in public schools for their children with autism through the use of a self-developed questionnaire. Parents are often children’s strongest advocates so it is important that caretakers are content with the services being offered in schools (Schall, 2000). Those who provide services for children with autism must be aware of the wishes and expectations of parents so that parents’ desired outcomes for their children can have the best chance of being realized (Beatson & Prelock, 2002). Participants in the study answered questions regarding their personal feelings regarding therapy options, IEP meetings, SLP characteristics, reasons for their child’s improvement/lack of improvement, and goals for their child.

Significance of the Problem

The difficulties entailed in educating children with autism continues to grow as increasing numbers of children are diagnosed with the disorder for a multitude of reasons. Because the U.S. government mandates that public schools provide treatment, numerous families turn to their local school districts for services. Hutton and Caron (2005) found that parents had difficulties finding well-trained professionals to provide services, receiving too little therapy, and traveling great distances to receive services. However in
a previous study, parents complained only about the diagnosis process and not about services received after diagnosis (Johnson, 2003). Parents are typically the constant in a child’s life while service providers may come and go as the child grows (Beatson, 2006). Therefore, it is vital that school personnel listen and respond to the wishes of parents as appropriately as they are able for the ultimate betterment of the child. The present study sought to answer the following questions:

1. How satisfied are parents of children with autism with the speech and language services their children receive in school?
2. What is the nature of the feelings that parents of children with autism have regarding IEP meetings for their children?
3. How satisfied are parents of children with autism with the SLPs who work with their children?
4. How do parents’ feelings regarding therapy as well as their attitudes about IEP meetings relate to how they view their child’s SLP?
Chapter II
Methods

Subjects

Subjects for this study included a sample of parents of children on the autism spectrum. Participation was based on the inclusion criteria that children had been diagnosed with autism, Asperger’s syndrome, Rett’s disorder, CDD, or PDD-NOS. Subjects were recruited for participation if their children attended one of following five Dayton, Ohio area public schools: Beavercreek, Centerville, Fairborn, Kettering, and Xenia. Only one parent per household could complete the survey. If children did not receive speech and language therapy at school, parents could only complete one question on the survey. If children received speech and language therapy at school, parents could complete all portions of the survey.

Procedures

Superintendents and/or Directors of Pupil Services in five school districts located in Dayton, Ohio were initially contacted regarding their interest in participation in the study. Permission was granted to survey parents, and the researcher distributed research packets to each of the five school districts. Research packets were sent by the school districts to individual households. Research packets were assembled by the researcher and each included: a cover letter, a survey, and a self-addressed stamped envelope to return the survey. The cover letter (Appendix A) introduced participants to the goals of the study and explained that participation was strictly voluntary and anonymous. A one-page survey tool (Appendix B) was used to attain parent feelings on speech and language services provided to their children with autism. The survey consisted of questions requiring a yes or no response, statements based on a five-point Likert scale, and open-ended questions. The questionnaire took approximately ten minutes to complete. The survey employed both quantitative and qualitative measurements. Parents were asked if their child received speech and language therapy as school. If “yes” was selected, parents were asked to complete the remainder of the survey. If “no” was chosen, parents were told to stop filling out the survey. Parents could check any or all of the following options for types of therapy received at school: visual schedules, social stories, AAC device, combination approach, and/or other. Participants were asked to select feelings towards
both the therapy options they had for their child and IEP meetings. Parents were asked to
describe the SLP who worked with their child by circling a number (one – five) to
explain how weak or strong they felt their child’s SLP to be in a variety of areas. Finally,
parents were asked two open-ended questions about their experiences with children with
autism. The survey format allowed the researcher to ask the same questions of every
subject, and it kept time spent by the caregivers to a minimum.

The total number of surveys sent out by each school district reflected the number
of children within the district that received services for autism. Surveys were tracked by
noting the school districts from which they came so that the researcher could determine
how many surveys were returned from each school district. All subject responses
remained confidential. All surveys were stored in a locked filing cabinet that could only
be accessed by the researcher.

Statistical Analyses

Descriptive statistics were used to analyze the respondents’ answers to survey
questions. Frequencies and percentages of answers that occurred among the participants
were described for each research question. In examining the responses to questions on the
Likert scale, a means procedure was performed to determine the average score given by
all the participants for each question. A Pearson Correlation of Coefficients was
completed to compare the association between parents’ feeling regarding therapy and
their attitudes about the SLP as well as parents’ feelings regarding IEP meetings and their
attitudes about the SLP. Results of the statistical analyses are fully summarized in the
following chapter.
Chapter III
Results

Subjects

A total of 171 research packets were sent to individuals with a return rate of 55 (32%) surveys. The school districts that participated in the study ranged in numbers of children on the autism spectrum. For example, approximately 15 students on the autism spectrum were enrolled in one school district while approximately 55 students on the autism spectrum attended another school district. Table 1 shows the number of surveys sent out by each school district and returned by parents. Further statistical analyses were not completed on individual districts in part due to the low number of responses from two of the school districts.

Descriptive Statistics

If the child was receiving speech and language services, parents were asked to indicate the types of therapies their child received in school. Parents could check any or all of the following options: visual schedules, social stories, AAC device, combination approach, and/or other. Figure 1 displays the number of parents who responded that specific treatments were used with their child. Table 2 shows the percent of parents who responded that specific therapies were used with their child. Results show that the most widely used approach was visual schedules (43.64%) followed by social stories (38.18%). AAC devices were used with the least frequency in the schools (16.36%).

Parents were next asked about the feelings they held regarding the school speech and language therapy their child received.

Figure 2 displays parent attitudes about school speech and language therapy. The most frequently occurring emotion was “satisfaction” as 25 respondents (45.45%) affirmed that they felt satisfied with the speech and language services for their child. The least frequently occurring emotion was “angry” as no respondents answered that they felt anger regarding the speech and language therapy their child received. Figure 3 illustrates the number of parents who responded with emotions related to IEP meetings. The most frequently occurring emotions were “satisfied” and “hopeful” as respondents replied with a frequency of 23 (41.82%) to each option. The least frequently occurring emotion was
Table 1.
Number of Surveys Sent to Parents by Each School District and Returned by Parents from Each School District to the Researcher.

<table>
<thead>
<tr>
<th></th>
<th>Beaver Creek</th>
<th>Centerville</th>
<th>Kettering</th>
<th>Fairborn</th>
<th>Xenia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of surveys</td>
<td>54</td>
<td>40</td>
<td>30</td>
<td>27</td>
<td>20</td>
</tr>
<tr>
<td>sent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of surveys</td>
<td>22</td>
<td>13</td>
<td>9</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>returned</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 1. Number of parents who indicated the type of therapy that was used with their child with autism.
Table 2.
Percent of Parents who Indicated that a Type of Therapy Approach was Used by Their Child with Autism.

<table>
<thead>
<tr>
<th>Type of therapy</th>
<th>Percent of parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual schedules</td>
<td>43.64</td>
</tr>
<tr>
<td>Social stories</td>
<td>38.18</td>
</tr>
<tr>
<td>AAC device</td>
<td>16.36</td>
</tr>
<tr>
<td>Combination</td>
<td>27.27</td>
</tr>
<tr>
<td>Other</td>
<td>25.45</td>
</tr>
</tbody>
</table>
“angry” as once again no respondents answered that they felt anger regarding the IEP meetings in which they had been involved.

The means of all Likert scores are listed in Table 3. The contents of the Likert scale questions on the survey included SLP characteristics. Parents were asked to describe the SLP who worked with their child by circling a number (one – five) to explain how weak or strong they felt their child’s SLP to be in a variety of areas. SLP behaviors were most frequently ranked five on the following two items: “Has knowledge about ASD,” and “Helps your child.” SLP behaviors were most frequently ranked four on the following five items: “Listens to you,” “Supports your requests,” “Shares your goals for your child,” “Is flexible to change,” and “Improves your child’s skills.” The number of parent ratings four or five were equal on: “Shows optimism.” SLP behaviors were most frequently rated three on the: “Schedules parent meetings” and “Sends updates home.” The mean score reported by parents was: the SLP “Schedules parent meetings” number of ratings three or four were equal on: “Stays current on research.” There were no SLP behaviors that parents most frequently rated one or two. An examination of the average scores reported by parents shows that the highest (average score = 3.39).

For the remaining two survey questions, parents were asked to answer open-ended questions relating to the factors they believe to have contributed most to their child’s improvement or lack of improvement as well as what they considered to be their long-term educational and life goals for their child. When asked about reasons for their child’s improvement, parents’ comments reflected several themes: 1) creative and knowledgeable SLPs, 2) structured school support, and 3) home/private speech and language therapy. A sample of parents’ comments on the reasons for their child’s improvement follows: “Maturity, flexible teaching staff, structure and consistency in school environment.”

A variety of themes emerged from parents’ responses to the question of their child’s lack of improvement. Parents voiced their concerns that: 1) not enough therapy time was provided by the schools, and 2) scheduling was inconsistent. The following is a sample of parent worries: “I feel that the school cuts corners because of funding and lack
Figure 2. Parent attitudes about school speech and language therapy.
Figure 3. Parent feelings toward IEP meetings.
Table 3.  
Mean Likert Scale Scores, Standard Deviations, Minimum Scores, and Maximum Scores for Parents’ Ratings of SLP Behaviors.

<table>
<thead>
<tr>
<th>SLP characteristic</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Minimum Score Reported</th>
<th>Maximum Score Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listens to you</td>
<td>4.15</td>
<td>0.85</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Schedules parent meetings</td>
<td>3.39</td>
<td>1.24</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Supports your requests</td>
<td>4.05</td>
<td>0.85</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Shares your goals for your child</td>
<td>4.16</td>
<td>0.84</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Sends updates home</td>
<td>3.45</td>
<td>1.13</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Is flexible to change</td>
<td>4.02</td>
<td>0.88</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Has knowledge about ASD</td>
<td>3.96</td>
<td>1.00</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Stays current on research</td>
<td>3.75</td>
<td>1.01</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Shows optimism</td>
<td>4.20</td>
<td>.83</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Helps your child</td>
<td>4.11</td>
<td>1.02</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Improves your child’s skills</td>
<td>3.98</td>
<td>1.10</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Overall total</td>
<td>3.90</td>
<td>.85</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>
of SLPs (one person divides herself between 3 schools). That does not give enough time for each child to receive required time that they need.”

Parents’ reflections on their long-term educational and/or life goals for their child were often poignant, straightforward, and thoughtful. Themes that were seen in this category consisted of: 1) a desire for normalcy, 2) hopes for independence, and 3) a dream for their child to be happy in the future. One parent responded in the following way: “He’s already a happy kid, and that’s what’s most important. But since he’s an only child, and I won’t be around forever, I also want him to be as independent as possible. My hope is that he’ll go on to college and find his place in the world, and even find a loving, understanding life partner with whom to have his own family.”

The open-ended questions included in the survey provided information that plainly shows parents thoughts, feelings and hopes for and about their children. Parents were open in responding to the questions posed to them, and these responses make it possible to obtain a better understanding of parent attitudes. Each parent response was unique and worthy of note. A listing of all the parent responses to the open-ended questions can be found in Appendix C.

Inferential Statistics

A Pearson Correlation of Coefficients procedure was completed to analyze the association between feelings toward therapy and attitudes toward SLP behaviors as well to examine the relationship between feelings towards IEP meetings and attitudes toward SLP behaviors. Tables 4 and 5 as well as Figures 4 and 5 display the correlations of the two factors examined. As can be seen in Table 4 and Figure 4, the sum of the respondents’ answers to each of the Likert questions correlated significantly to the way in which the sum of respondents answered the question about their feelings toward therapy. As can be seen in Table 5 and Figure 5, the sum of respondents’ answers to each of the Likert questions correlated significantly to the way in which the sum of respondents answered the question about their feelings toward IEP meetings.
Table 4.
Correlation of Likert Scale Scores on SLP Behaviors Reported by Parents to Parent’s Feelings Regarding the Therapy Provided to Their Child.

<table>
<thead>
<tr>
<th>SLP behavior</th>
<th>Correlation to feelings regarding therapy</th>
<th>Significance level</th>
<th>Significant *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listens to you</td>
<td>0.5411</td>
<td>&lt;.0001</td>
<td>Yes</td>
</tr>
<tr>
<td>Schedules parent meetings</td>
<td>0.5364</td>
<td>0.0001</td>
<td>Yes</td>
</tr>
<tr>
<td>Supports your requests</td>
<td>0.3765</td>
<td>0.0084</td>
<td>Yes</td>
</tr>
<tr>
<td>Shares your goals for your child</td>
<td>0.6166</td>
<td>&lt;.0001</td>
<td>Yes</td>
</tr>
<tr>
<td>Sends updates home</td>
<td>0.4027</td>
<td>0.0045</td>
<td>Yes</td>
</tr>
<tr>
<td>Is flexible to change</td>
<td>0.5298</td>
<td>0.0002</td>
<td>Yes</td>
</tr>
<tr>
<td>Has knowledge about ASD</td>
<td>0.6384</td>
<td>0.0001</td>
<td>Yes</td>
</tr>
<tr>
<td>Stays current on research</td>
<td>0.5544</td>
<td>&lt;.0001</td>
<td>Yes</td>
</tr>
<tr>
<td>Shows optimism</td>
<td>0.4772</td>
<td>0.0008</td>
<td>Yes</td>
</tr>
<tr>
<td>Helps your child</td>
<td>0.6370</td>
<td>&lt;.0001</td>
<td>Yes</td>
</tr>
<tr>
<td>Improves your child’s skills</td>
<td>0.6219</td>
<td>&lt;.0001</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* $\alpha = 0.05$
Figure 4. Overall Likert scale scores on SLP behaviors reported by parents related to parents’ feelings regarding the therapy provided to their child.
Table 5.
Correlation of Likert Scale Scores on Feelings Regarding IEP Meetings Reported by Parents to Parent’s Feelings Regarding the Therapy Provided to Their Child.

<table>
<thead>
<tr>
<th>SLP behavior</th>
<th>Correlation to feelings regarding IEP meetings</th>
<th>Significance level</th>
<th>Significant *</th>
</tr>
</thead>
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<td>Improves your child’s skills</td>
<td>0.3603</td>
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* $\alpha = 0.05$
Figure 5. Overall Likert scale scores on SLP behaviors reported by parents related to parents’ feelings regarding IEP meetings.
Chapter IV
Discussion

The purpose of this study was to identify parents’ attitudes about the speech and language services being provided to their children by the public schools. The study examined the ways parents feel about school therapy, IEP meetings and SLP characteristics/behaviors. In addition, the study analyzed parents’ perceptions of their child’s improvement or lack thereof as well as parents’ goals for their child’s future. Issues covered in the survey allow SLPs to gain insights on how parents feel about speech and language services provided within the school setting.

Results indicate the trend in types of therapies used in schools is the use of visual schedules (43.64%) and social stories (38.18%). Visual schedules and social stories can be used not only by SLPs but also by classroom teachers and aides. Visual schedules offer support to students who need routine during their school day and who are assisted by knowledge of what will occur throughout the day. Social stories may also be used by a variety of professionals within a school to help children with autism. SLPs are often called upon to create social stories for activities that a child with autism may need to participate in or to help reduce certain inappropriate behaviors. The study suggested that AAC devices were the least used form of therapy for children with autism within the schools surveyed in the Dayton area (16.36%). The low level of reported use may result from the expense and the intense training needed to use specific devices. Parents responded that combination approaches (including visual schedules, social stories, AAC, and methods not listed in the survey) were used (27.27%) and that therapies not listed in the survey were also employed within their children’s schools (25.45%). The data shows that school SLPs rely heavily on the use of visual schedules and social stories for children with autism.

Parents’ feelings regarding the speech and language therapy their children receive in school tended to be positive. Twenty-five respondents out of the 55 stated that they felt “satisfied” with school therapy, and only five respondents of 55 reported feeling “dissatisfied.” Similarly, 17 respondents out of the 55 selected “optimistic” while only two respondents of the 55 chose “pessimistic” on the questionnaire. The number of responses reflecting positive feelings toward therapy totaled 87 while the number of
responses reflecting negative feelings toward therapy totaled only 12 in comparison (sum of all boxes checked for this question was 99). The previous data shows that parents as a group were by and large positive regarding the therapies, including mostly visual schedules and social stories, that were employed with their children with autism. While school districts are not solely aimed at satisfying parents, the researcher’s goal was to find out how parents felt about speech and language services in order to determine whether parents held strong feelings on one end of the spectrum. The results indicating positive parent feelings show that school districts can feel content that they have met parent expectations for their children.

The attitudes of parents regarding the IEP meetings that have been involved in during their child’s schooling also saw a positive trend. Twenty-three respondents of the 55 stated that they felt “satisfied” with IEP meetings whereas only four respondents of the 55 aligned themselves with feelings of “dissatisfaction.” Twenty respondents said that they felt “optimistic” during IEP meetings while only one respondent reported feeling “pessimistic.” Interestingly, ten parents selected the “content” choice and ten parents also checked the “worried” choice. The number of responses reflecting positive feelings toward IEP meetings totaled 92, and the number of responses reflecting negative feelings toward IEP meetings totaled only 17 (sum of all boxes checked for this question was 109). Although parent’s negative response rate regarding IEP meetings was slightly higher than for that of therapy used in the school setting, the data shows that parents on the whole are positive about the IEP meetings they have attended. Because yearly IEP meetings are often the only time parents, teachers, support staff, and administrators convene, it is important for parents to feel that the meetings are effective and significant for their child’s education. Although stressful, IEP meetings should also be seen as a constructive and valuable tool for identifying problem areas and setting a plan in motion to help the child in the forthcoming year. School districts should be encouraged by the results that indicate parents typically hold positive feelings about IEP meetings.

Using the same answer choices as for feelings about therapy as for emotions associated with IEP meetings allowed for comparisons to be made between the two groups. As can be seen from the previous discussion, a majority of the emotions associated with both therapy and IEP meetings were positive. One-hundred and seventy-
nine of a total of two-hundred and eight responses were positive. A slightly greater percentage of positive emotions regarding therapy versus IEP meetings was noted; parents’s responses to therapy were 87.88% positive compared to 84.40% positive for IEP meetings. Parents tended to feel positive emotions toward both therapy and IEP meetings. School districts may be encouraged by the data that evidences parents’ positive feelings about therapy and IEP meetings. However, districts must remember that the return rate for this study was 32% so not all parent opinions were reflected in the results.

With high levels of parent satisfaction comes an increased likelihood that speech-language pathologists can build the type of relationship with parents that will foster more improvement in children. The collaboration of parents and professionals can result in higher levels of student progress (Geeter, Poppes, & Vlaskamp, 2002).

The statistics of parent responses on the Likert scale of SLP behaviors show what parents perceive to be SLP strengths as well as areas for improvement. The Likert questions will be discussed as a group since the results obtained from the individual questions were reported previously in Chapter III. The mean of responses by all parents was 3.9 on a scale ranging from one (lowest) – five (highest). Parents on average ranked their children’s SLPs highly. The highest mean score was 4.19, and the category that SLP behaviors ranked highly in was “Shows optimism.” The lowest mean score was 3.39, and the category the SLP behaviors ranked low in was “Schedules parent meetings.” SLP behaviors on average scored in the four range on six of eleven questions and in the three range on five of 11 questions. The number of respondents answering the Likert questions ranged from 44 to 49 people, indicating a majority of respondents completed the Likert questions. Because the mean of all Likert scores for SLPs was relatively high, parents feel mostly positive emotions regarding specific behavior and skill areas that their children’s SLP possesses.

The correlation between overall feelings about therapy and overall Likert scale scores shows that most parents who ranked SLP behaviors highly also ranked attitudes toward therapy highly. Similarly, most parents who ranked SLP behaviors low also ranked attitudes toward therapy low. The statistical correlation was 0.6504 with a significance level of <.0001. A majority of parents who ranked SLP behaviors highly also ranked emotions involving IEP meetings highly, and most parents who ranked SLP
behaviors low also ranked their feelings about IEP meetings low. The statistical correlation was 0.4679 with a significance level of 0.0007. The data shows that if parents have a positive opinion about their child’s SLP, they may as a result have a positive feeling regarding the therapy that their child receives as well as the IEP meetings that they attend for their child. The implication of this data is that SLP behaviors and characteristics can play a major role in how parents view therapy and the IEP process on a whole. SLPs must be aware of this correlation for two important reasons. First, SLPs should understand how strongly their own personalities, and not the therapy they give, can affect their relationships with parents. SLPs must be careful to supply parents with facts about the treatment methods and data about their child’s progress within the IEP so that parents have the data to make informed decisions for their child. Second, SLPs should remember that personality conflicts can and do arise between people. Parents may criticize the types of therapies used by SLPs or the therapy goals within an IEP when the true issue may be one of a personality conflict.

Finally, the open-ended questions show that parents care deeply about the speech and language services their children receive in the schools. A list of all parent responses to open-ended questions can be found in Appendix D. The themes that emerged from parent responses serve to explain what parents feel works for their children and what parents believe are setbacks to their children’s future success. Parents responded that they generally believed school districts and school SLPs were doing the best job possible under less than desirable conditions. Parents named lack of school SLPs, inconsistent scheduling and lack of school resources as problems in the speech and language services that were provided to their child. Parents also noted that they believed private speech and language therapy had been of greater benefit to their child than services in the school do to direct one on one contact and consistency. Some parents reflected strong emotions that they felt school speech and language services had not helped their child improve and that they were a “waste of time.” Although several parents responded negatively toward school speech and language services, the majority of parent responses were positive regarding the progress their child had made due to speech and language therapy at school.

Most of the parents surveyed responded that they had future goals for their children. SLPs must understand what parents freely expressed in their comments. SLPs
serve a vital role in helping parent’s goals and dreams for their children become a reality. Although parents can at times hold unrealistic expectations for their son or daughter, responses to the survey suggested that most parents have realistic and straightforward goals for their children with autism. Parents of children who were low-functioning recorded hopes that they wished for their child to be toilet-trained, to speak with words, or to live in a group home. Parents of children who were high-functioning reflected that they wanted normalcy and fulfilling relationships for their child. Whatever the wishes of the parents, SLPs can aid in setting IEP goals that correspond to reaching the parent’s dreams or by openly discussing the abilities of the child so that parents can begin to form realistic hopes. By learning about parental attitudes about therapy and goals for their children, SLPs can better serve the population of children with autism.

Limitations of the Study

This study was limited in its design and in the sample population. The respondents for this study resided in a small geographic area in southwestern Ohio. The sample used was not a representation of parents of children with autism on a national or state-wide level. Because the sample pool of participants only reflects the thoughts and emotions of 55 respondents, care should be taken in generalizing the results to the wide population of parents of children with autism.

Future Research

The subject of parent attitudes toward school speech and language services for children with autism should be further researched in order to promote best practice within the field of speech-language pathology. Although parents may not be completely knowledgeable on communication disorders, they are an important resource when it comes to their children. Parents may have the greatest awareness of a child’s abilities because they see their child in many different settings and at all times of the day and night. If school SLPs team with parents and establish a dialogue about a child, both parties’ desired goals may be achieved. Researchers could expand this study geographically as well as in the scope and breadth of the survey. Depending on the researcher’s aims, survey questions could be altered and expanded to gain more information than was collected in this study. For instance, future survey questions could ask parents to be more specific as to the types of therapies that were used with their
children in school. In addition, a future survey could have a list of specific items that parents liked or disliked about the therapy provided for their children and the IEP meetings in which they were involved.

**Clinical Implications**

School-based SLPs can use the information obtained in this study to develop skills that are suited to forming and maintaining positive relationships with parents. Parents of children with autism, as well as parents of children with various special needs, are aided by SLPs with whom they can openly discuss the abilities of their children. As members of a helping profession, SLPs often want to facilitate a great deal of positive improvement in those with whom they work. In order to do this most effectively, SLPs should enlist the help of those parents who have watched their children grow and who possess knowledge of their children in a variety of settings. When parents and SLPs communicate openly about the progress that a child is making and about how the child can continue to advance in his or her skills, then greater gains may be made (Beatson & Prelock, 2002).

The information gathered shows that parents feel positive about speech and language therapies used in schools, IEP meetings and their children’s SLPs. However, one area that stood out as lacking was the SLP’s ability to schedule parent meetings. A previous study showed that parental involvement with speech-language therapists is vital for the improvement of the child (Spann et al., 2003). This study showed that parents would like to meet with SLPs continually to discuss the progress of their child. SLPs must ensure that more frequent communication with parents takes place in schools through parent meetings and through written communication (Singh, 2003).

In summary, the results of this study show that parents who participated generally feel satisfied with the speech and language therapy offered by their child’s school districts, with the IEP meetings in which they have participated, and with the behaviors and skills of their child’s SLP. This study had limitations in its design and sample size so caution should be taken when generalizing results. Future studies may sample a larger population so that more generalizable conclusions can be made about parents’ perspectives on speech and language services for children with autism within schools. SLPs within schools should be encouraged by the results of this study, but they should
also take care to promote communication with children’s parents. Open communication between a child’s SLP and a child’s parents is optimal in order to give the child the best services possible.
References


Appendix A

October 10, 2006

Dear Parents,

An increasing number of children with Autism Spectrum Disorder (Asperger Syndrome, Autism, Childhood Disintegrative Disorder, Pervasive Developmental Disorder – Not Otherwise Specified, Rett’s Syndrome) receive speech and language services in school. It is important for school districts to be aware of parent views regarding these services.

I am writing to ask for your assistance in completing a survey regarding your perceptions of speech-language pathologists, IEP meetings and therapy options for your child with ASD. Your assistance will help provide an accurate representation of parent perspectives on speech and language services provided for children with ASD in Ohio public schools.

I know your time is very valuable, and I would greatly appreciate your assistance with my project. The questionnaire will take approximately 5 minutes to complete. I have provided you with the survey as well as a postage paid envelope for returning the survey.

Your answers to questions will be anonymous and will only be released in summary form. If for any reason, you feel uncomfortable with a question, you do not need to provide an answer. In addition, you may stop answering the survey at any time. Completion of the questionnaire constitutes your agreement to participate in the study. Please return the survey even if it is incomplete.

If you have any questions regarding your rights as a participant in this study, please contact the Office for the Advancement of Research and Scholarship by electronic mail at humansubjects@muohio.edu or by phone at 513-529-3734. If you have any questions or comments about this study, please contact Cathryn Shedden by electronic mail at sheddecl@muohio.edu or by phone at 937-427-9432 or Dr. Laura Kelly at kellylj@muohio.edu or by phone at 513-529-2505.

Sincerely,

_____________________________
Cathryn Shedden, B.S.
Miami University Graduate Student
Appendix B
CONFIDENTIAL

Does your child receive speech/language therapy at school? Yes  No
If No is circled, you do not need to complete the remainder of the survey.

How long has your child been involved in speech/language therapy at school? ____________
When was your child’s most recent IEP meeting? ____________

Please indicate the types of therapies your child receives in school (please check all that apply):
___ visual schedules ___ social stories ___ augmentative comm. ___ combination approach ___ other: ________

Please describe the behaviors of the school SLP who has worked with your child for the longest time:

<table>
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<tr>
<th></th>
<th>Very poor</th>
<th>Poor</th>
<th>Average</th>
<th>Good</th>
<th>Very good</th>
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<td>Schedules parent meetings</td>
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<td>Supports your requests</td>
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<tr>
<td>Shares your goals for your child</td>
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<td>3</td>
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<tr>
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<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Is flexible to change</td>
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<td>2</td>
<td>3</td>
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</tr>
<tr>
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<td>3</td>
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<td>5</td>
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<td>Stays current on research</td>
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<tr>
<td>Shows optimism</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Helps your child</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>Improves your child’s skills</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Regarding school speech/language therapy my child receives, I feel (please check all that apply):
___ satisfied ___ hopeful ___ angry ___ optimistic ___ upset
___ worried ___ pessimistic ___ pleased ___ dissatisfied ___ content ___ other: ________

During IEP meetings, I most typically feel (please check all that apply): ___ have not participated
___ satisfied ___ hopeful ___ angry ___ optimistic ___ upset
___ worried ___ pessimistic ___ pleased ___ dissatisfied ___ content ___ other: ________

What do you think has been the greatest reason for your child’s overall improvement or lack of improvement?

What are your long-term educational and/or life goals for your child?

Thank you for taking the time to complete this survey. Individual results will be kept confidential.
Appendix C

Parent Responses to Individual Likert Scale Questions Addressing Specific SLP Attributes.

SLP attribute: listens to you

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<th>Likert Score</th>
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<td>8</td>
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<td>4</td>
<td>21</td>
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<tr>
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SLP attribute: schedules parent meetings

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</tr>
</thead>
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<tr>
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<tr>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>5</td>
<td>11</td>
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</table>

SLP attribute: supports your requests

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<td>18</td>
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<tr>
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SLP attribute: shares your goals for your child

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<td>4</td>
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</table>

SLP attribute: sends updates home

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SLP attribute: is flexible to change

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SLP attribute: has knowledge about ASD

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SLP attribute: stays current on research

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SLP attribute: shows optimism

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### SLP attribute: helps your child

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### SLP attribute: improves your child’s skills

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<td>19</td>
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Appendix D

I. Reason for improvement or lack of improvement

B1. I feel that the schools have been the improvement. Last year he went to the public school preschool program and that really helped.

B2. The knowledge about his individual problems

B3. Combination of maturation, family support and encouragement; support and services in the public schools; excellent child care at the private Goddard School

B4. His improvement is largely from home – school provides only necessary means for improvement. He has gained confidence from handwriting skills and the OT!

B5. Our interventions at home have made the biggest impact – we’ve run an ABA program for the past 5 years.

B6. No response

B7. The greatest reason for my child’s improvement has been the influence of his peers in the regular classroom.

B8. I double schooled him – took him to an SLP outside the school system. He worked on cutting edge technology during that time. Parents taught him to read. When he learned to read, and read a lot, his language greatly improved. SLPs are a waste of my son’s time in school.

B9. No response

B10. Constant effort by educational staff

B11. The level of care and compassion the special needs teachers show

B12. He responds well when he knows his teachers truly care about him and when expectations are well-structured.

B13. The great support from school staff and special support

B14. Therapists and teachers lack of specific strategies/methods to work with an autistic child

B15. Consistency and the individualized, very personal attention she has received

B16. Private therapy – what insurance takes care of after the schools

B17. We believe the combination of all therapies at school and private has improved our son. Also we work with him at home to reinforce what is taught at school.

B18. No response
B19. Therapy, therapy, therapy – work, work, work. We are vigilant and tackle the problems head on.

B20. My son has always had strong support at home and school. As parents we have always been his advocates and worked with the school.

B21. I actually think the private speech therapy has better helped her.

B22. Our SLP (Mrs. “X”) is incredibly creative. My son is very verbal and tends to perseverate on a few select topics (like who he’s going to marry, how many children he’ll have someday, etc. – and he’s only 11!). Mrs. “X” created ‘the brain box,’ a safe/secure place for him to ‘deposit’ his thoughts after committing them to paper. She’s assured him that they (his ideas) won’t be lost or forgotten. And she’ll return them to him someday when it’s appropriate to dwell on those topics. He’ll still mention his thoughts often, but when I remind him they’re in the brain box, he seems reassured and moves on to another topic. It has significantly reduced the amount of time we’ve spent discussing those subjects, and (correspondingly) has made our time together (mine and my son’s) much more pleasant and interesting (and less frustrating for me!). My hat is off to Mrs. “X” for her ingenuity!

C1. No response

C2. Improvement: classroom integration with typicals, 1:1 help. Lack of improvement: maybe slow pace between each trial or teaching moment

C3. The school groups behavior-related students together, such as behavior disorders with autistic children

C4. SLP has very limited understanding of the pragmatic language and processing difficulties my daughter has. Just because she is in high school does not mean services should disappear.

C5. No response

C6. One on one teaching has been the biggest help.

C7. Concentrated/intensive/individualized SLP and OT in combination thru private provider combined with services of equal caliber thru school
C8. Our son’s best therapy was 2 weeks of dolphin therapy in Florida when he was 4.5 years old. Our family has also made a commitment to being happy about our son and his abilities and “disabilities.” This has enabled all of us to move forward and reach for better things for our son. Feeling sorry, guilty, sad, regretful, etc. doesn’t enable us to move forward, so we’ve focused on his strengths and gifts and choose to celebrate those instead.

C9. The Centerville school system has been wonderful – from the speech pathologist to every teacher she has had in elementary school. We didn’t have a lot of 1:1 with speech therapists during 3rd–6th grade, but we’ve had very close contact with her IEP classroom teachers.

C10. We are new in the area and only met the SLP once. She seems to know a lot about Autism and I’m hopeful. I don’t think I could give you my full impression because of our recent move and learning to know the SLP. But so far I’m happy and can see that she will guide me and my child in the right direction.

C11. Our teachers have high expectations for our daughter even though she requires extra help a lot of the time.

C12. The teacher’s heart is in it, and she wants my child to succeed as much as I do.

C13. Maturity, flexible teaching staff, structure and consistency in school environment

F1. The education he receives and the early intervention program he was put into early in his life.

F2. Consistency – never-ending patience and ideas

F3. Having been diagnosed with Asperger’s and getting the special attention that he needs instead of being grouped with a bunch of other kids and ignored

F4. I think my child’s overall improvement has been the way she talks to everyone. When she first started speech most people could not understand her. Everyone can understand her now.

F5. No response

F6. I feel that the school cuts corners because of funding and lack of SLPs (1 person divides herself between 3 schools). That does not give enough time for each child to receive required time that they need.
F7. He is in a special education classroom with only 5 children and 3 teachers. He gets a lot of one on one time and seems to be improving overall when his attendance is regular.

F8. The attentiveness and willingness of the educators to work with my son

F9. Lack of improvement – not enough speech therapy at school. Improvement – private speech therapy for past 9 months.

K1: No response

K2: No response

K3: We live in an excellent school system with teachers who really seem to care for their students and have a true interest in the child’s learning and how they learn. So far every teacher has been great about keeping up with communication with parents. The teachers have had the utmost patience with my child. When my child started preschool at age 5 he could only say two words. He now talks constantly. I am so proud of how he has grown. I don’t think most parents realize how much teachers’ positive influence can have on a child.

K4. We changed school districts and I think this was a definite positive benefit. There are 8 children in the class with 1 teacher and 3 aides – he has more assistance and they have more resources available.

K5. Not having year-round school and having to fool around with mediocre summer programs that did nothing!!!

K6. I really don’t know at this point.

X1. Irregular scheduling confuses my child. He’s pulled from regular classes.

X2. No response

X3. The IEP! I had to fight at another school to get the IEP done. We moved before they ever did it. At the new school, it was no problem. The IEP was done immediately, and my son has been thriving since! Not only does the IEP provide work that is on his learning level, but he feels like he can accomplish more and actually master things at school now!

X4. Persistence, reinforcement

X5. Talking – he was a very late talker.
II. Long-term educational and/or life goals for child

B1. I see my child reaching whatever dreams he may have. I will do everything to make sure that will happen the best it can. I really like what our schools have done. Very happy!

B2. No response

B3. Our son is at the mild end of the spectrum and has made tremendous progress, especially in the use of language. Our goal is to help him reach his potential.

B4. I am going to see “John” complete a college education and live independently.

B5. He will do well in a vocational prep program – some measure of independence as an adult. He’s come so far that I feel optimistic about his prospects.

B6. No response

B7. I hope that when he finishes school, he will be able to live independently and have a job he enjoys.

B8. My son is now a Junior and wants to go to college to be a history professor and play football.

B9. Complete high school and perhaps a technical training program…one day live as an independent adult with perhaps an assisted residential set-up.

B10. To learn coping skills for life, especially when dealing with the general public

B11. I would like my son to achieve the highest possible educational level he wants. I want him to enjoy life, have true friends and be successful at what makes him happiest.

B12. Complete college in a field involving concrete thinking, i.e. engineering or pharmacy. I know he can be a happy, productive member of society.

B13. Work well and communicate; socialize well

B14. For our child to be a contributing member of society; happy socially and possibly employed; living with family a few years after graduation and then a shared apartment with friend or trained professional

B15. She will continue to make progress and mainstream without any therapists or assistance.

B16. To be a typical child and go on to college
B17. For our son to continue to work in the typical classroom with assistance as needed. We are hopeful he will progress through school and graduate!

B18. No response

B19. - To be/function at “typical” levels in the classroom and continue to overcome ASD difficulties
- Doing well with support of school; could not do it without them

B20. My son will attend college. He is currently learning more independent skills now that he is in high school.

B21. That she will not need an aid in the classroom or go to resource room

B22. He’s already a happy kid, and that’s what’s most important. But since he’s an only child, and I won’t be around forever, I also want him to be as independent as possible. My hope is that he’ll go on to college and find his place in the world, and even find a loving, understanding life partner with whom to have his own family.

C1. No response

C2. I would like to find techniques to teach him how to learn and retain info and use it. In short, I would like him to be “normal.”

C3. Support his exceptional academic abilities (and minimize stressful environments to encourage success) and to enable him to live independently in adulthood.

C4. That she be able to self advocate for her needs; that she go to college and graduate school if needed; that she be able to live independently and hopefully have a relationship to help her as she grows

C5. No response

C6. To be able to take care of himself

C7. Complete high school and college education and become gainfully/happily employed and to be independent maybe with his own family

C8. We want our son to be a compassionate, contributing citizen.

C9. To stay positive and happy and most of all healthy

C10. No response

C11. To be able to go to college and get a job she enjoys
C12. To be self sufficient one day; hold a job even though it may be simple; to feel
needed and wanted one day when we are not here
C13. To be able to have as normal a life as possible
F1. To one day attend college
F2. Workshop or monitored work; independent in a group home
F3. I want him to have a normal life (be able to live on his own, have a job, drive and
have a family). I want him to feel “normal” and be happy.
F4. My long term goal for my child is that hopefully she goes to a trade school. I want
her to be able to live on her own and have a good life.
F5. No response
F6. My son is 19 and is getting close to ending school years. I’m really worried about the
places that these kids go when they get out of school settings. There are very
limited workshops that they can go to and not enough options for parents to
choose from.
F7. To be toilet trained; to eat with utensils and a larger variety of food; to speak with
words
F8. To be successful and to be able to lead a productive life
F9. To be able to communicate her wants and needs and self-care. I don’t believe she will
ever be able to live in even a group home.
K1. No response
K2. No response
K3. I want my child to become a confident and happy adult and to be satisfied with
himself and his goals.
K4. To complete his public school education and then be able to function on his own with
a job.
K5. To achieve his potential and one day become a tax-payer!
K6. I feel a vocational school of some sort would benefit him greatly – reading at 1st
grade level – his speech is baby-like. But he can build anything. He can put
together complex things in a couple hours that would take an average person a
couple days.
X1. Normalcy, finish high school/college and get a job
X2. To be able to use pictures to help in speech and communication with others
X3. My son will go to college. He wants to be a scientist/inventor – which is great! These are really his goals, and I intend to support him in any way I can to ensure his success! My only goal is that he will be independent!
X4. To possess and utilize the necessary speech, social, reading, writing and motor skills and confidence to become a successful adult
X5. For him to be independent enough to live on his own