ABSTRACT

USE OF CHILD AND ADOLESCENT SELF-REPORT MEASURES BY SCHOOL-BASED SPEECH-LANGUAGE PATHOLOGISTS

by Lindsey Kathleen Brown

The WHO-ICF model and evidence-based practice principles, both endorsed by the American Speech-Language-Hearing Association, lend support to the collection of self-report measures by speech-language pathologists. A survey was created to determine if and how school-based speech-language pathologists currently utilize child and adolescent self-report measures, as well as speech-language pathologists’ attitudes and perceptions regarding the measures. The study surveyed speech-language pathologists who were members of professional organizations. Seven hundred and ninety one school-based speech-language pathologists completed the electronic survey and 54% of participants reported utilizing pediatric self-report measures in current clinical practice. Participants were most likely to employ self-report measures with students who have articulation and fluency disorders. The majority of participants stated that advantages and disadvantages of child and adolescent self-report measures were not addressed in university training. A descriptive summary of the results created a profile of how pediatric self-report measures are used in current school-based practices.
USE OF CHILD AND ADOLESCENT SELF-REPORT MEASURES BY SCHOOL-BASED SPEECH-LANGUAGE PATHOLOGISTS

A Thesis

Submitted to the
Faculty of Miami University
in partial fulfillment of
the requirements for a degree of
Master of Arts
Department of Speech Pathology and Audiology
by
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2013

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DEDICATION

For Sue and Kev, who taught me a valuable lesson: hard work brings good luck.
ACKNOWLEDGEMENTS

I would like to thank my thesis committee for their support and guidance throughout this challenging, but ultimately rewarding, process. My sincerest thanks to Dr. Geralyn Timler for sharing her passion for this topic with me, and for providing endless feedback and advice. Thank you to Dr. Brooke Spangler for her thoughtful revisions and to Mrs. Lisa Williamson for her invaluable input as a school-based speech-language pathologist. I would also like to thank the numerous professional organizations contacted throughout the recruitment process for assisting in survey distribution. I also have to express my gratitude to the hundreds of speech-language pathologists who took valuable time to contribute their knowledge and opinions to my thesis project.

I would also like to extend a special thank you to my friend and mentor, Mrs. Amy Kramer, whose constant words of motivation and encouragement were essential to the completion of this project.
Chapter I: Introduction

The magnitude of a communication disorder extends far beyond observable symptoms. The American Speech-Language-Hearing Association recommends that a comprehensive speech-language assessment involve the combination of several elements including clinician-administered assessments and client self-report measures (2004). The term “self-report measure” refers to an assessment method in which the client rates personal skills, abilities, behaviors, feelings, beliefs, and attitudes (Rosenthal & Rosnow, 2008). Self-report data is necessary to collect when the client is the sole source of information, and there is no alternate way to gather the information except asking the client to describe personal experiences and attitudes (Baldwin, 2000; Rosenthal & Rosnow, 2008). Self-report measures are important assessment tools for speech-language pathologists to utilize because every patient experiences communication disorders differently, and information regarding a patient’s unique experience of a disorder must be collected from the patient, as a proxy has not directly experienced the disorder (Baldwin, 2000; Rosenthal & Rosnow, 2008). Self-report measures give professionals valuable information that can inform both assessment and treatment of communication disorders. Evaluating the insider’s perspective of the disorder gives clinicians distinctive and important information about many factors including: the patient’s communicative participation, perception of abilities, and experience of internal symptoms (Dowell & Ogles, 2008; Eadie et al., 2006; Hartelius, Elmberg, Holm, Lovberg, & Nikolaidis, 2008).

**Pediatric Self-Report Measures**

The benefits of self-report use spread beyond adults to include both children and adolescents who also add valuable insight through self-report measures. Children and adolescents are able to provide information not available to other sources and can report on situations and behaviors across a variety of situations (Beitchman & Corradini, 1988; Danielson & Phelps, 2003; Hope et al., 1999). Historically, children’s self-report was generally viewed as inaccurate and unimportant due to immature cognitive development. Parent and teacher proxy report were viewed as the sole sources of reliable information regarding children’s experiences and skills (Herjanic, Herjanic, Brown, & Wheatt, 1975; Hope et al., 1999). Modern literature reflects a shift in thought, asserting that the historical view of child and adolescent self-report measures neglects the perspective of the child. Children and adolescents are considered to provide exclusive information and are valued as informants, reflecting the importance of

Validity & Reliability of Self-Report Measures

Self-report measures have long been criticized for vulnerability to bias, especially when completed by children. In the past, researchers have doubted the degree to which a child’s report reflects a genuine, true description of a given behavior or experience, which has been named as a limitation of self-report measures (Spence & Liddle, 1990). Researcher and clinician doubt regarding the validity and reliability of child self-report has been further compounded by findings of limited agreement between child self-ratings and proxy-ratings. Adolescents and children tend to rate personal behavior more positively than teachers or parents (Burgess & Turkstra, 2010; Kolko & Kazdin, 1993; Nicpon, Doobay, & Assouline, 2010). Self-report of behavior may also differ from standardized assessment findings (Threats, 2008). However, disagreement among raters is not a reason to disregard self-reported information entirely as there is no way to truly determine which source is ultimately correct. Each report represents each individual’s distinct perspective, and one viewpoint should not be favored (Kalyva, 2010; Li & Bornholt, 2009). The importance of all raters’ opinions lends support to the adoption of a multi-informant approach for assessment where the clinician considers each unique perspective evaluated (e.g. parent, teacher, and child) and values the important information provided by each informant. Child self-report measures are an integral component of the multi-informant approach (Dowell & Ogles, 2008; Eiser & Morse 2001; Gresham et al., 2011; Kalyva, 2010). Use of the multi-informant approach for assessment and intervention in speech-language pathology is endorsed in the American Speech-Language-Hearing-Association Preferred Practice Patterns (2004).

Support for Use of Self-Report Measures in Speech-Language Pathology

A communication disorder encompasses both the patient’s external physical symptoms and internal feelings and attitudes. In recent years, the profession of speech-language pathology has developed methods to document the overall impact of communication disorders on an individual’s life (Yaruss & Quesal, 2006). The World Health Organization (WHO) model, the International Classification of Functioning, Disability, and Health (ICF; WHO, 2001), gives clinicians a conceptual framework for defining an individual’s complete experience of a
disorder. The framework defines disability across three levels of human functioning: (1) Body Functions and Structures, which encompasses both anatomical parts of the body such as organs, limbs, and their components, as well as physiological functions of body systems; (2) Activities, defined as the ability of an individual to execute a task or action; and (3) Participation, which describes a person’s involvement in various life situations. These three levels of the human experience interact with personal and environmental factors which are comprised of the physical, social, and attitudinal environment in which people live and conduct their lives (WHO, 2001). Figure 1 displays a graphic representation of the relationships between factors included in the WHO-ICF model.

Figure 1. International Classification of Functioning, Disability and Health (ICF) model. Taken from: World Health Organization (WHO) (2001). International Classification of Functioning, Disability, and Health. Geneva, Switzerland: WHO.

Applying the WHO-ICF framework to speech-language pathology, clinicians examine how a communication disorder impacts the aforementioned levels of human functioning. In reference to speech-language pathology, the first level of the framework, Body Functions & Structure, refers to the status of all structures and processes related to the speech-language and hearing mechanism. Any disruption to the structure or function of this mechanism is referred to as impairment. Historically, impairments are the most studied outcome of speech-language pathology intervention (Eadie, 2001; Eadie et al., 2006; Threats, 2008). Examples of outcome measures for communication impairments include: biological status of the vocal folds and laryngeal mechanism, accuracy of spoken language comprehension, semantic and syntactic complexity of language, accuracy maintaining conversational topic, ability to move and position articulators accurately, and amount and type of disfluencies present in a given speech sample.
(Eadie et al., 2006). The second level of the framework, Activities, refers to an individual’s ability to execute tasks and actions. When a person’s disability interferes with the ability to complete activities, it is referred to as an “activity limitation”, according to the WHO-ICF model (WHO, 2001). In speech-language pathology, if a singer developed vocal nodules and as a result his or her range of notes decreased, it would be considered an activity limitation because the singer would be unable to complete the activity of singing (Eadie et al., 2006; Threats, 2008).

Participation, the third level of the WHO-ICF framework, refers to a person’s involvement in life situations. If an individual’s disorder disturbs his or her ability to experience involvement in life situations, the person is said to have a “participation restriction” (WHO, 2001). A child with autism may be not fully involved in an activity (i.e. a team or club), as he or she may have difficulty initiating and maintaining relationships with peers. The peers may treat the child with autism differently as a result, impacting the child’s experience and participation in a life activity. This scenario reflects an example of a communication disorder causing a participation restriction (Eadie et al., 2006; Threats, 2000; Threats, 2008). The WHO-ICF also examines environmental and personal factors which detail the context within or around a person that could affect the individual’s ability to communicate effectively. These contextual factors account for personal differences in experience (Eadie, et al., 2006; WHO, 2001; Yaruss & Quesal, 2006).

Examining structural, participatory, and contextual factors creates a framework which allows the clinician to describe all aspects of an individual’s communication experience, revealing the variety of changes and experiences that can occur during the course of assessment and intervention for individuals with communication disorders (Yaruss & Quesal, 2006). The WHO-ICF model also aids speech-language pathologists in measuring clinical treatment outcomes and describing effects of communication disorders at a variety of levels (Eadie, et al., 2006). As a result, the American Speech-Language-Hearing Association (ASHA) adopted the WHO-ICF as its framework for research and clinical practice in the Scope of Practice for Speech-Language Pathology (2007) and Preferred Practice Patterns in the Profession of Speech-Language Pathology (2004). Benefits of using the WHO-ICF framework include clinician adoption of a client-centered approach and the movement of the patient from a passive bystander to active participant in diagnostic and treatment processes. However, some professionals have stated that implementing the ICF framework in clinical practice is confusing and could be interpreted in multiple ways (Threats, 2008).
To address concerns regarding the ICF framework, the American Psychological Association and World Health Organization are publishing the *International Classification of Functioning, Disability, and Health Procedural Manual and Guide for a Standardized Application of the ICF: A Manual for Health Professionals* to assist in the consistent application of the framework across health and rehabilitation professionals (APA, in press). The Procedural Manual states that performance of skills must be assessed in one of the following ways: direct clinician observation of the behavior in a naturalistic setting; self-report of the client, preferably using an objective, standardized assessment tool; or proxy report, also utilizing a standardized measure (APA, in press; Threats, 2008). Traditionally, in speech-language pathology, objective and standardized assessments have been administered to assess a patient’s body structure and functioning through direct clinician observation (Hartelius, et al., 2008; McLeod & McCormack, 2007; McLeod & Threats, 2008). Measures examining an individual’s communicative activities and participation are more subjective, and direct clinician observation is often not possible, which makes self- and proxy-report the most frequently utilized methods for assessing the activities and participation domains (Threats, 2008). The patient with a communicative disorder is best equipped to evaluate personal restrictions in communicative participation, as the patient can report on situations and behaviors across different situations and environments. The patient is also able to convey a personal perspective on communicative abilities and limitations to the clinician, which further emphasizes the importance of utilizing self-report measures in speech and language assessment (Beitchman & Corradini, 1988; Danielson & Phelps, 2003; Hartelius, et al., 2008).

Evidence-based practice principles provide a second source of support for implementation of self-report measures in speech-language pathology. ASHA has issued a position statement regarding the implementation of evidence-based practice (EBP). EBP involves the integration of the needs, values, preferences, and interests of individual clients and families with current research evidence and clinical expertise when making clinical decisions (ASHA, 2005). Self-report measures provide speech-language pathologists with an opportunity to collect information regarding client opinions and interests, which are integral to EBP, regardless of the client’s age. When school-age children and adolescents are the consumers of speech and language services, it is imperative for clinicians to assess the child’s attitudes and values to provide the best possible evidence-based clinical treatment.
**Current Use of Self-Report Measures in Speech-Language Pathology**

Self-report measures are critical instruments which can facilitate integration of the WHO-ICF framework into assessment processes and allow for appropriate evaluation of the activities and participation domains (Eadie, et al., 2006; Threats, 2008). As the patient provides a unique perspective regarding communicative participation across situations, self-report measures would be the most frequently utilized methods of assessment of the activities and participation domain (Beitchman & Corradini, 1988; Danielson & Phelps, 2003; Eadie, et al., 2006; Hartelius, et al., 2008; Threats, 2008). However, development of self-report measures for use in the field of speech-language pathology remains scarce (Threats, 2008).

Though universal implementation of self-report measures in speech-language pathology is limited, voice and fluency are two specialty areas of speech and language that more naturally integrate the client’s perception of their disorder into assessment and intervention processes due to known impacts of the disorders on the patient’s quality of life (Jacobson et al., 1997; Yaruss, 2010; Yaruss & Quesal, 2006). Specific self-report measures have been developed to measure intrinsic aspects of a patient’s experience with a voice or fluency disorder, including the Voice Handicap Index (VHI, Jacobson et al., 1997), the Voice-Related Quality of Life Scale (V-RQOL; Hogikyan & Sethuraman, 1999), the Overall Assessment of the Speaker’s Experience of Stuttering (OASES, Yaruss & Quesal, 2006), and the Communication Attitude Test-Revised (CAT-R, DeNil & Brutten, 1991). All of the aforementioned measures are normed on adult clients, but some fluency measures have been modified for use with the pediatric population including the Communication Attitude Test for Preschool and Kindergarten Children who Stutter (KiddyCAT, Vanryckegehem & Brutten, 2007) and the Overall Assessment of the Speaker’s Experience of Stuttering-Ages 7-12 and Ages 13-17 (OASES- Ages 7-12 and Ages 13-17, Yaruss, Coleman, & Quesal, 2010).

Yaruss & Quesal (2006) advocate for self-report measures, stating that examination of the broader patient experience of a disorder can give practicing clinicians more valuable treatment-based outcomes through greater understanding of both the disorder’s observable characteristics and experience of the disorder from the perspective of the speaker. Despite the development of self-report measures for specific disorders and benefits of utilizing self-report measures, there are limited choices for self-report measures across the broader field and other specialty areas of communication disorders (Threats, 2008). Lisa Williamson, a practicing
speech-language pathologist, states that many speech-language pathologists in the school environment favor use of informal and personally developed self-report measures to gather information regarding the child’s perceptions of their communication as compared to formal measures (personal communication, September 24, 2012).

Other disciplines have a greater variety of well-developed self-report measures than speech-language pathology, including psychology (Threats, 2008). The field of psychology does utilize self-report measures for school-age children, particularly in the area of social skills and problem behaviors. The Social Skills Improvement System-Rating Scales (SSIS-RS, Gresham & Elliott, 2008) is an example of a measure that was initially developed by other professionals that could be utilized by a speech-language pathologist. The SSIS uses a combination of parent, teacher, and child rating scales to assess each rater’s perception of the child’s social skill development across several domains including: cooperation, assertion, responsibility, self-control, communication, empathy, and engagement (Gresham, et al., 2011). Though the SSIS was developed by a team of psychologists, ASHA’s Scope of Practice for Speech-Language Pathology (2007) encompasses evaluation and treatment for pragmatic language and social aspects of communication, indicating that the SSIS is an assessment that speech-language pathologists could use to examine various informants’ perceptions of the student’s social communication skills (ASHA, 2012a). However, it is currently unknown how frequently these types of measures from other disciplines are employed by speech-language pathologists.

Recent research regarding self-report in speech-language pathology has focused on describing existing measures’ application to various clinical populations, validity and reliability constructs, and the connection between self-report measures, evidence-based practice, and preferred practice patterns (Burgess & Turkstra, 2010; Eadie et al., 2006; Francic & Bothe, 2008; Hartelius et al., 2008; McLeod & Threats, 2008; Yaruss, 2010; Yaruss & Quesal, 2006). Though use of self-report measures is supported through both the WHO-ICF framework and ASHA’s statement regarding evidence-based practice, little is known about if and how current professionals in speech-language pathology utilize of self-report measures, particularly with pediatric clients.

Statement of the Problem

Whereas the WHO-ICF Framework and evidence-based practice tenets support the use of self-report measures with all populations, a comprehensive review of the literature found no
published study which examined speech-language pathologists’ use of child and adolescent self-report measures and attitudes and beliefs regarding pediatric self-report measures. Self-report measures add valuable information to speech-language assessment and intervention (Baldwin, 2000; Dowell & Ogles, 2008; Eadie et al., 2006; Hartelius et al., 2008; Rosenthal & Rosnow, 2008; Threats, 2000; Threats, 2008). Understanding how speech-language pathologists currently use self-report measures in clinical practice is imperative to inform the development of future self-report measures for speech-language pathology.

**Purpose of the Study**

The purpose of this study is to obtain a better understanding of how pediatric speech-language pathologists use self-report measures in clinical practice. An original survey instrument was distributed to professional speech-language pathology community sites and organizations to collect data regarding: a) educational and clinical training in the use of pediatric self-report measures; b) informants consulted and measures utilized during the assessment process; c) speech-language pathologists’ attitudes and perceptions about child self-report measures; d) current use of child and adolescent self-report measures in speech-language pathology practice; and e) current intervention practices for children and adolescents with pragmatic language disorders. The findings of this descriptive study will provide information about how and why child and adolescent self-report measures are currently being used in the field of speech-language pathology, and SLPs’ perceived confidence, benefits, and barriers in using these measures. Results will also inform future development of self-report measures specific to the field of speech-language pathology.

**Research Questions**

This descriptive study seeks to answer the following questions:

1. Do speech-language pathologists receive educational and clinical training in the use of child and adolescent self-report measures?
2. What informants are consulted and what types of report measures do speech-language pathologists utilize when completing assessments?
3. What are speech-language pathologist’s attitudes and beliefs regarding the use of child and adolescent self-report measures?
4. How do speech-language pathologists currently use child and adolescent self-report measures in clinical practice?
a. What types of child and adolescent self-report measures do speech-language pathologists employ in clinical practice?

b. How frequently do speech-language pathologists utilize child and adolescent self-report measures in clinical practice?

5) How do speech-language pathologists provide intervention for students with pragmatic language disorders?
Chapter II: Method

Survey Development

Terminology

As the survey was conducted online and participants were not in direct contact with the researcher, the following definitions were provided to clarify the meaning of various terms in the survey. *Child/adolescent self-report measures* were defined as: formal or informal measures that are completed by clients between the ages of 5-18 to assess their own speech-language, social, or behavior skills including their perceptions and attitudes about these skills. The definition was provided on the survey invitation letter (Appendix A), and relevant pages of the electronic survey (Appendix B). *Formal report measures* were defined as: standardized and published rating forms that you might ask caregivers, teachers, other professionals and children/adolescents to complete as part of as speech-language assessment or evaluation. *Informal report measures* were defined as: non-standardized rating scales, clinician developed checklists, and interviews that you might ask caregivers, teachers, other professionals, and children/adolescents to complete as part of a speech-language assessment or evaluation. *Validity of child/adolescent self-report measures* was defined as: the child/adolescent’s self-report is accurate. *Reliability of child/adolescent self-report measures* was defined as: the child/adolescent’s self-report would be consistent over two weeks’ time, in other words, if the child completed the same self-report measure two weeks later, the child’s responses would be similar to the first completion. The definitions regarding types of report measures were provided in pertinent questions of the survey.

Instrument

To determine the current use of child and adolescent self-report measures in clinical practice and SLP attitudes and beliefs regarding pediatric self-report measures, an original 41-item electronic survey was created in SurveyMonkey (Appendix B). Both qualitative and quantitative data were collected through a combination of forced choice questions, 5-point Likert scale ratings, yes/no responses, and open-ended questions to allow for narrative responses. The first page of the survey presented an abbreviated version of the survey consent form. Participants who consented to be in the study were directed to the first survey question. Participants who did not consent to participate in the study were instructed to exit the Internet browser. All survey questions included a “No Response” option, to ensure that participants were free to decline to answer any question on the survey for any reason.
The 41-item survey was divided into six sections. The first section, Your University Training, elicited information about participants’ experience with child and adolescent self-report measures in university training and practicums. The next section, Current Use of Report Measures Completed by Others, contained questions regarding the clinician’s practice of routinely collecting formal and informal measures from multiple informants including: caregivers, teachers, other professionals, and the child/adolescent. Section three, Attitudes and Beliefs Regarding Child/Adolescent Self-Report Measures gathered information regarding the participants’ attitudes and beliefs about child/adolescent self-report including familiarity with the evidence-base, opinions of value added to assessment and intervention by pediatric self-report measures, as well as perceptions of the validity and reliability of such measures.

The fourth section, Current Use of Child/Adolescent Self-Report Measures, gathered information regarding if and how participants used self-report measures in practice. Participants who used self-report measures in practice shared populations with whom they have used the measures, as well as the types of self-report measures used and frequency of their implementation. The same participants shared their perceptions of the effects of using child/adolescent self-report measures in evaluation and intervention. Participants who used the measures in practice were also able to craft a narrative response further explaining and elaborating on their personal opinions and current use of pediatric self-report measures. Participants who did not use self-report measures ranked barriers to the use of self-report measures and provided a narrative rationale for not using the measures.

Section five, Intervention for Pragmatic Language Disorders, inquired about the participants’ experience treating pragmatic language disorders. Participants who did currently provide intervention for pragmatic language disorders completed questions regarding preferred clinical service delivery model, years of experience treating pragmatic language disorders, amount of children currently seen on the participants’ caseload with the diagnosis, and intensity of intervention for this population. The final section of the survey obtained a summary of the participants’ demographic data including education level, date of degree, ASHA certification, years of experience in the field, geographic location, current work setting, and current caseload.

**Recruitment**

Human participant research protocol was followed as indicated by Miami University policy. Efforts were made to recruit participants based on the following criteria: (1) speech-language
pathologist practicing in the U.S., and (2) employment setting treating pediatric populations including schools, pediatric hospitals, university clinics, and private practice. No specific attempts were made to sample for a participants’ religion, ethnicity, or otherwise recruit minority populations. Potential participants were contacted through electronic mailing lists and online communities of professional organizations. Specifically, the following were contacted: the American Speech-Language-Hearing Association (ASHA) Special Interest Groups (SIG) including ASHA SIG 1, Language Learning and Education and ASHA SIG 16, School-Based Issues, state speech-language-hearing associations, and State Education Agencies Communication Disabilities Councils (SEACDC). Moreover, recruitment efforts focused on obtaining a representative sample from the state of Ohio. As such, email invitations were sent to all SLP members of the Hamilton County Educational Services Center; the Ohio Supervisory Network, the Ohio Board of Speech-Language Pathology; the Ohio SEACDC; and Cincinnati Children’s Hospital Medical Center electronic mailing lists. Survey distribution was directed to these professional organizations to ensure that the sample was limited to speech-language pathologists. All speech-language pathologists were asked to voluntarily participate in the study. No incentives were offered to participants. Confidentiality and anonymity of all responses was ensured.

The survey was available online for this research study’s data collection at SurveyMonkey.com beginning on Monday, January 28, 2013. Data collection for this project continued until Monday, March 18, 2013. Survey distribution to professional organizations took place between January and March 2013 (Appendix C). The survey remained active after this period to allow for additional data collection, though results obtained after Monday, March 18, 2013 are not contained in this report.

Procedure

The study utilized a survey method to gain a better understanding of how speech-language pathologists currently use child self-report measures, as well as speech-language pathologists’ attitudes and perceptions regarding child self-report measures. The original survey instrument for the research study was created in SurveyMonkey. The researcher contacted the targeted organizations with an email message to be forwarded to each organization’s electronic mailing list of professional speech-language pathologists. The email identified the researcher and research team, and contained a description of the research study, instructions to complete the survey, and the link to the electronic survey (Appendix A). Following receipt of the researcher’s invitation to
distribute the electronic survey, each organization decided independently to distribute the survey to electronic mailing lists. A summary of the organizations that chose to distribute the survey electronically to speech-language pathologist contacts was generated (Appendix D). Permission was also obtained from the Coordinating Committees of the ASHA SIG 1 and 16 community sites to post the description of the research study and the link to the electronic survey available for all participants to view and access.

Upon initial viewing of the electronic survey, participants were directed to read abbreviated consent documentation (Appendix E). Participants were given the option of emailing the researcher in order to review the complete online survey consent form (Appendix F). Participants then chose to either authorize consent to participate in the study by continuing to complete the survey, or declining to complete the survey by closing the Internet browser. Participant completion of the survey was entirely voluntary, and participants were free to terminate participation in the survey by closing the Internet browser at any time. In addition, participants were free to decline to answer any question contained within the electronic survey by either leaving the item blank or selecting “No Response”. The survey took approximately 10-20 minutes to complete and was then submitted to the SurveyMonkey password-protected database. Access to the survey data was available only to the research team.

Data Reduction

Between Monday, January 28, 2013 and Monday, March 18, 2013, 1,167 responses to the survey were collected. At the conclusion of this period, it was determined that the majority of responses (67.7%; n=791) were collected from school based speech-language pathologists (SLPs). Further, 776 of these 791 participants completed the entire survey. As participation from pediatric speech-language pathologists practicing in alternate settings (e.g. hospitals, private practice) was limited, only the responses from school-based speech-language pathologists are presented in this paper. A focus on the school-based SLP sample allows for a more complete and specific description of how child and adolescent self report measures are being used within school settings. Descriptive data were summarized for each of the study’s research questions.

Analysis Plan

At the conclusion of the data collection period, survey results were exported into a Microsoft Excel spreadsheet. Responses from all participants for each survey item were averaged to obtain a mean response for each item. As participants were free to decline to answer any survey
questions, response numbers for each question varied. The average for each item was calculated using the total number of responses to each question, not the total number of individuals who completed the survey. A descriptive summary of the data was created for each research question.
Chapter III: Results

Demographic Information

A summary of participants’ demographic information is presented in Table 1. The 791 participants were practicing in 43 states across the United States at the time of survey completion. Each of the four geographically divided regions was represented to varying degrees, though the Midwest was the most commonly cited region (Northeast: \( n=35 \), West: \( n=73 \), Midwest: \( n=425 \), Southeast: \( n=250 \)). Ohio was the most represented state, with 326 survey participants (41.6%; \( n=326 \)). The majority of participants held a master’s degree (94.8%; \( n=750 \)). Few participants indicated that they held a bachelor’s degree (\( n=29 \)) and 10 participants had completed a doctorate degree (e.g. Ph.D., Ed.D., Ed.S.). Participants had earned their highest degree as early as 1969, and were grouped into five date-of-degree categories: 1969-1979 (\( n=75 \)), 1980-1989 (\( n=164 \)), 1990-1999 (\( n=200 \)), 2000-2009 (\( n=234 \)), 2010-2013 (\( n=107 \)). The majority of participants had earned their highest degree within the last 20 years (\( n=496 \)). The number of years that the participants had practiced speech-language pathology corresponded to the years in which the highest degree was earned: 1-10 years of practice (\( n=269 \)), 11-20 years (\( n=212 \)), 21-30 years (\( n=183 \)), and more than 30 years of practice (\( n=120 \)). Many participants (87.7%; \( n=685 \)) held the American-Speech-Language-Hearing Association Certificate of Clinical Competence. Participants worked in a variety of school-based settings including Early Intervention (\( n=44 \)), Preschool (\( n=327 \)), Elementary School (\( n=613 \)), Middle School (\( n=308 \)), and High School (\( n=218 \)).

Educational and Clinical Training

Participant responses regarding academic and clinical training and pediatric self-report measures are summarized in Figure 2. Nearly half of the participants (42.9%; \( n=340 \)) stated that advantages and disadvantages of child and adolescent self-report measures were not addressed in university training. Approximately half of the sample reported that pediatric self-report measures were not used in clinical training experiences while the other half reported that they were used.
Table 1

Summary of survey participants’ demographics.

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Distribution of geographic regions (n=783)</strong></td>
<td></td>
</tr>
<tr>
<td>• Northeast (CT, ME, MA, NH, RI, VT, NJ, NY, PA, DE, DC, MD)</td>
<td>4.5%</td>
</tr>
<tr>
<td>• Midwest (IN, IL, MI, OH, WI, IA, MN, MO, KS, NE, ND, SD)</td>
<td>54.3%</td>
</tr>
<tr>
<td>• Southeast (FL, GA, NC, SC, VA, WV, AL, KY, MS, TN, AR, LA, OK, TX)</td>
<td>31.9%</td>
</tr>
<tr>
<td>• West (AZ, CO, ID, NM, MT, UT, WY, NV, AK, CA, HI, OR, WA)</td>
<td>9.3%</td>
</tr>
<tr>
<td><strong>Highest degree completed (n=790)</strong></td>
<td></td>
</tr>
<tr>
<td>• Bachelors (B.S., B.A., B.Ed.)</td>
<td>3.7%</td>
</tr>
<tr>
<td>• Masters (M.A., M.S., M.Ed.)</td>
<td>94.9%</td>
</tr>
<tr>
<td>• Doctorate (Ph.D., Ed.S., Ed.D.)</td>
<td>1.3%</td>
</tr>
<tr>
<td><strong>When highest degree was completed (n=780)</strong></td>
<td></td>
</tr>
<tr>
<td>• 1969-1979</td>
<td>9.6%</td>
</tr>
<tr>
<td>• 1980-1989</td>
<td>21.0%</td>
</tr>
<tr>
<td>• 1990-1999</td>
<td>25.6%</td>
</tr>
<tr>
<td>• 2000-2009</td>
<td>30.0%</td>
</tr>
<tr>
<td>• 2010-2013</td>
<td>13.7%</td>
</tr>
<tr>
<td><strong>Length of time practicing speech-language pathology (n=784)</strong></td>
<td></td>
</tr>
<tr>
<td>• 1-10 years</td>
<td>34.3%</td>
</tr>
<tr>
<td>• 11-20 years</td>
<td>27.0%</td>
</tr>
<tr>
<td>• 21-30 years</td>
<td>23.3%</td>
</tr>
<tr>
<td>• 30+ years</td>
<td>15.3%</td>
</tr>
<tr>
<td><strong>Certification (n=781)</strong></td>
<td></td>
</tr>
<tr>
<td>• Holds ASHA Certificate of Clinical Competence</td>
<td>87.7%</td>
</tr>
<tr>
<td>• Does not hold ASHA Certificate of Clinical Competence</td>
<td>12.3%</td>
</tr>
<tr>
<td><strong>Employment Settings (n=778)</strong></td>
<td></td>
</tr>
<tr>
<td>• Early Intervention</td>
<td>5.7%</td>
</tr>
<tr>
<td>• Preschool</td>
<td>42.0%</td>
</tr>
<tr>
<td>• Elementary School</td>
<td>78.8%</td>
</tr>
<tr>
<td>• Middle School</td>
<td>39.6%</td>
</tr>
<tr>
<td>• High School</td>
<td>28.0%</td>
</tr>
</tbody>
</table>
Summary of participants’ academic and clinical training regarding pediatric self-report measures.

I was taught about the advantages and disadvantages of pediatric self-report measures during my university training.

- Agree: 27%
- Disagree: 43%
- Do Not Remember: 29%
- No Response: 1%

I used child/adolescent self-report measures in my clinical practica, internships, or externships.

- Agree: 42%
- Disagree: 46%
- Do Not Remember: 11%
- No Response: 1%
Use of the Multi-Informant Approach

Results indicated that the majority of participants reported collecting report measures from caregivers, teachers, and other professionals. Figures 3 and 4 display the frequency of participants’ distribution of formal and informal report measures to multiple informants. Informal report measures, including non-standardized rating scales and clinician developed checklists, were found to be used more frequently with all informants, compared to formal, standardized report measures. Participants were also most likely to have teachers complete formal and informal report measures when conducting an assessment; more than 80% of participants reported administering formal measures to teachers at least infrequently, and 99.6% of participants indicated collecting informal measures from teachers at least infrequently. Caregivers were cited as the second most likely informants when evaluating a child/adolescent; about three-quarters of participants reported at least infrequent collection of self-report measures from caregivers when assessing students and 97.3% stated that informal measures were collected from caregivers at least infrequently.

Approximately 67.9% (n=533) of participants reported collecting a formal or informal self-report measure from students themselves. Participants were more likely to administer informal self-report measures to children/adolescents than formal report measures. Approximately 36% of participants (n=266) reported never administering formal self-report measures to children or adolescents during the assessment process, compared to 13% of participants (n=98) who indicated never using informal self-report measures with children or adolescents during the evaluation process.
Figure 3

*Frequency of speech-language pathologists’ administration of formal self-report measures to various informants during the assessment process.*

<table>
<thead>
<tr>
<th>Category</th>
<th>Never (1)</th>
<th>Infrequently (2)</th>
<th>Sometimes (3)</th>
<th>Always (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver</td>
<td>23.10%</td>
<td>24.40%</td>
<td>37.50%</td>
<td>15%</td>
</tr>
<tr>
<td>Mean</td>
<td>2.44</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teacher</td>
<td>16.80%</td>
<td>17.00%</td>
<td>34.00%</td>
<td>32.20%</td>
</tr>
<tr>
<td>Mean</td>
<td>2.82</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Professional</td>
<td>27.10%</td>
<td>22.30%</td>
<td>35.60%</td>
<td>15.00%</td>
</tr>
<tr>
<td>Mean</td>
<td>2.38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child/Adolescent</td>
<td>36%</td>
<td>21.60%</td>
<td>24.80%</td>
<td>17.50%</td>
</tr>
<tr>
<td>Mean</td>
<td>2.24</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 4

Frequency of speech-language pathologists’ administration of informal self-report measures to various informants during the assessment process.

<table>
<thead>
<tr>
<th>Informant</th>
<th>Never (1)</th>
<th>Infrequently (2)</th>
<th>Sometimes (3)</th>
<th>Always (4)</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver</td>
<td>2.70%</td>
<td>12.60%</td>
<td>41%</td>
<td>43.90%</td>
<td>3.23</td>
</tr>
<tr>
<td>Teacher</td>
<td>0.40%</td>
<td>2.40%</td>
<td>66.00%</td>
<td>31.10%</td>
<td>3.63</td>
</tr>
<tr>
<td>Other Professional</td>
<td>6.20%</td>
<td>16.70%</td>
<td>23.20%</td>
<td>53.90%</td>
<td>2.94</td>
</tr>
<tr>
<td>Child/Adolescent</td>
<td>13%</td>
<td>18.80%</td>
<td>40.40%</td>
<td>27.80%</td>
<td>2.83</td>
</tr>
</tbody>
</table>
Attitudes, Beliefs, and Knowledge about Child and Adolescent Self-Report Measures

Figure 5 displays the participants’ familiarity with the evidence-base supporting the use of child/adolescent self-report measures. The majority of participants (58.6%; \(n=443/754\)) reported unfamiliarity with the existing evidence-base that supports the use of such measures.

Figure 6 displays participant opinions about the importance of obtaining the child/adolescent perspectives and opinion of communication skills. Nearly all participants (94%; \(n=694\)) agreed that children and adolescent’s perspectives and opinions regarding their communication skills add important information to both the evaluation and treatment processes.

Figure 7 shows the participants’ opinions regarding the validity and reliability of child and adolescent self-report measures. Half of the participants (49.8%; \(n=384\)) were undecided about the reliability of such measures, while 346 participants (44.5%) were undecided about the validity of the measures. A small percentage of participants (less than 8.1%) stated that child and adolescent self-report measures were neither valid nor reliable. A good number of participants (43%; \(n=331\)) stated agreement or strong agreement to the statement that pediatric self-report measures are reliable, and 47% of participants (\(n=369\)) reported agreement or strong agreement to the survey statement that child and adolescent self-report measures are valid.
Figure 5

Participants’ indication of familiarity with evidence supporting the use of self-report measures.

I am familiar with the evidence base supporting the use of self-report measures.

- Agree: 32%
- Disagree: 56%
- Do Not Remember: 7%
- No Response: 5%
Participants’ statements regarding important information added to speech and language assessment and intervention by the child’s perspective and opinion of communication skills.

Children’s and adolescent’s perspectives and opinions regarding their communication skills add important information to the assessment and intervention process.

- Strongly Agree (5) 37.90%
- Agree (4) 56.50%
- Undecided (3) 5.50%
- Disagree (2)
- Strongly Disagree (1) 0.10%

mean=4.32
Figure 7
Participants’ statements regarding the validity and reliability of child/adolescent self-report measures.
Current Use of Child and Adolescent Self-Report Measures in Clinical Practice

Slightly more than half of the participants (54%; \(n=424/789\)) reported using pediatric self-report measures in their current clinical practice, while 46% \((n=365)\) did not use such measures. Participants who utilized child and adolescent self-report measures in clinical practice were asked to provide more information about how, when, and with whom they utilized the measures. Of 335 participants who worked in elementary schools, 298 (89.0%) reported that they employed child self-report measures in the elementary school setting. Approximately 90% of 168 participants employed in middle school settings reported use of self-report measures with the middle school population. Of 144 participants who reported working with the high school population, 125 (86.8%) reported using self-report measures with high school students.

Participants also stated the areas of speech and language that they assess using child and adolescent self-report measures. Figure 8 displays the areas of speech and language along with the percentage of participants who reported using related self-report measures. The most frequent skills that were addressed by self report measures included articulation, fluency, and social/pragmatic language skills respectively.

The survey also gathered information regarding populations with whom participants employed pediatric self-report measures. Figure 9 shows the distribution of use of self-report measures according to patient diagnosis. Participants were most likely to utilize child and adolescent self-report measures with students who had articulation disorders (88.7%, \(n=354/423\)). Students with fluency disorders were the second most-likely population with whom the participants utilize the measures (71.2%, \(n=301\)). A notable number of participants also reported using child and adolescent self-report measures with students who have Asperger’s Syndrome (58.2%; \(n=246\)), learning disabilities (44.7%; \(n=189\)), autism (44.0%; \(n=186\)), specific language impairment (37.8%; \(n=160\)), phonological disorders (37.8%, \(n=160\)), and attention deficit hyperactivity disorder (34.8%; \(n=147\)). Participants were least likely to employ pediatric self-report measures with students who have dysphagia (1.2%, \(n=5\)).
Figure 8
Areas of speech and language to which participants indicated administering corresponding child/adolescent self-report measures.
Figure 9

Populations with which participants reported utilizing child self-report measures with in personal clinical practice.
Opinions Regarding Pediatric Self-Report Measures

Participants who reported using child and adolescent self-report measures in practice also stated opinions regarding the measures and the information added by self-report measures during assessment and intervention. Figure 10 displays participant opinions of information added to evaluation and treatment by pediatric self-report measures. The overall average scores for most statements indicated that the participants agreed with the statements, presented as three mean responses were greater than 4.0. Such responses suggest that the participants agreed that child and adolescent self-report measures have added useful information during the assessment process and when developing intervention plans; and the measures have improved the participant’s understanding of the student’s strengths and challenges. Slightly more participants were undecided about self-report measures providing useful information that improved intervention outcomes (25.8%, n=108/427), though the majority of participants still agreed with the statement (73%, n=306). The results signify that the participants have overall positive opinions regarding pediatric self-report measures.

The survey also asked participants to provide narrative comments that described overall opinions of child and adolescent self-report measures. Nearly 300 participants wrote comments regarding the measures (n=272). Over half of the comments (61%) shared positive experiences and opinions of pediatric self-report measures. Some participants (15.8%; n=43) stated mixed positive and negative experiences with the measures, while seven reported negative opinions of child and adolescent self-report measures. Common themes emerged from the participants’ narratives. Samples of responses aligning with the six identified themes are provided below.

The most frequently occurring theme was: self-report measures develop student’s self-monitoring skills and generalization. The idea was reported by 39.0% of participants (n=106) and consisted of responses such as:

“These measures help students develop meta-awareness of targeted skills, as well as help them become responsible for moving towards improvement in targeted areas.”

“It is vital for the student to be a part of their program for the ever elusive "carryover" to occur. Awareness of why they are receiving therapy makes it possible for them to feel more in control; willing to make the transition from monitored skill improvement to self-monitored skills; able to deflect taunts for receiving services. IMO [In my opinion]”.

28
“These measures help students develop meta-awareness of targeted skills, as well as help them become responsible for moving towards improvement in targeted areas.”

Approximately one-quarter of participants that self-report measures are helpful for assessing therapeutic outcomes (24%; \(n=64\)). Narratives included:

“Better outcomes are achieved when the client/student is aware of their goals and is a part of the ongoing analysis of their skills.”

“I think this is a necessary piece of assessment but more importantly in assessing outcomes during intervention. Checklists, rating scales, and questionnaires are valuable especially for transition planning for high school students.”

Many participants also stated that self-report measures are important parts of assessment and/or intervention (22.4%; \(n=61\)). The third most commonly occurring category consisted of responses such as:

“I think they are valuable because they directly involve the student being served.”

“I find them beneficial when writing my reports and sharing progress with the parents.”

The next category of responses was: self-report measures provide motivation for students, reported by 20.2% of participants (\(n=55\)). Participants shared:

“I feel that self-reporting motivates children to work harder and strive to beat their accuracy from the last session. I also feel that it gives them ownership of their IEP goals.”

“These give you good information about the child's opinions and motivators. They may not always agree with professionals and/or other adults in their lives, but at least you have a better idea of their perception.”

Approximately fifty participants stated that child and adolescent self-report measures help to inform intervention plans (18%; \(n=49\)). Narratives included:

“Self-report measures allow therapists to treat the whole client rather than just the impairment or disorder. Knowing the client's perceptions is very beneficial because they may include feelings that will hamper therapy progress. These measures also help give more information about clients which is useful when tailoring interventions for each individual's needs.”

“Must assess student's level of awareness so you know where to start during intervention. Must compare awareness and skills to the adult's level of awareness.”
Many participants stated that the ability to self-report varies greatly among students (15.4%; n=42). Participant’s responses stated:

“Varies with type of child you are working with. Many are not that aware of their overall errors or are not a maturity level to care.”

“It varies per student, and the situation.”

“I find that their successful use with students seems to highly correlate to intellectual ability to self-reflect.”
Figure 10

Opinions regarding self-report measures as indicated by participants who utilized child and adolescent self-report measures in clinical practice.

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Strongly Agree (5)</th>
<th>Agree (4)</th>
<th>Undecided (3)</th>
<th>Disagree (2)</th>
<th>Strongly Disagree (1)</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provided useful information that improved intervention outcomes</td>
<td>0.20%</td>
<td>1.40%</td>
<td>1.40%</td>
<td>2.60%</td>
<td>2.00%</td>
<td>3.91</td>
</tr>
<tr>
<td>Added useful information to develop effective intervention plans</td>
<td>21.40%</td>
<td>67.30%</td>
<td>9.90%</td>
<td>1.40%</td>
<td>1.40%</td>
<td>4.07</td>
</tr>
<tr>
<td>Improved my understanding of the child’s or adolescent’s communication strengths and challenges</td>
<td>19.10%</td>
<td>53.90%</td>
<td>25.80%</td>
<td>0.20%</td>
<td>1.00%</td>
<td>4.04</td>
</tr>
<tr>
<td>Added useful information during the assessment process</td>
<td>20.70%</td>
<td>65.60%</td>
<td>11.20%</td>
<td>1.40%</td>
<td>1.40%</td>
<td>4.09</td>
</tr>
</tbody>
</table>
Types of Self-Report Measures

Participants were asked to identify formal pediatric self-report measures used in their clinical practice. Figure 11 shows the published self-report measures that participants reported using in practice. Approximately one-third of participants (30%; \( n=110/364 \)) gave no response to the question. Over 100 participants (28%; \( n=103 \)) stated that they were unable to recall the name of published self-report measures that they use at the time of survey completion. Similarly, 28% of participants (\( n=103 \)) also indicated use of personally adapted self-report measures. Of the published measures named, Self-Evaluation of Fluency Form (Williamson, 2011) (\( n=41 \)) and the Overall Assessment of the Speaker’s Experience of Stuttering Ages 7-12 (Yaruss, Coleman, & Quesal, 2010) (\( n=38 \)) were the most commonly utilized among participants. More than 30 participants (\( n=33 \)) reported use of the Social Skills Improvement System-Student Form (Gresham & Elliot, 2008) which corresponds to the area of pragmatic/social language.

Additional information was collected concerning the types of informal pediatric self-report measures employed by the participants. Figure 12 presents the informal child and adolescent self-report measures utilized by participating speech-language pathologists. Nearly all participants (95%; \( n=399/418 \)) reported completing interviews with students regarding speech and language skills. Approximately 200 participants (47.4%) indicated they had developed their own or utilized another clinician-made checklist of speech and language skills completed by the student, while 169 participants (40.4%) used a clinician-made rating scale completed by the student. Some participants reported that they adapted published caregiver/teacher report measures for use with children and adolescents. Few participants (4%; \( n=13/364 \)) reported adapting each of the following for use as pediatric self-report measures: the Clinical Evaluation of Language Fundamentals–4th Edition (CELF-4) Observational Rating Scale and Clinical Evaluation of Language Fundamentals–4th Edition (CELF-4) Pragmatics Profile. A limited number of participants (1.4%; \( n=5 \)) indicated using adaptations of Michelle Garcia-Winner’s Social Thinking checklists and double interview technique for child and adolescent self-report measures. Other published measures that participants reported adapting for pediatric self-report included: Pragmatic Language Skills Inventory (\( n=4 \)), Perceptions of Stuttering Inventory (\( n=2 \)), Listening Inventory for Education (\( n=2 \)), A19 Fluency Attitudinal Scale (\( n=2 \), and the
Cognitive, Affective, Linguistic, Motor, and Social Assessment for School-Age Children who Stutter \((n=2)\).

Participants also stated the number of different pediatric self-report measures utilized in their clinical practice. Table 2 displays the descriptive statistics related to the number of separate self-report measures used by participants. On average, the participants used 3.6 unique child and adolescent self-report measures in practice.
Figure 11

*Published child/adolescent self-report measures participants indicated using in clinical practice.*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Response</td>
<td>30.20%</td>
</tr>
<tr>
<td>I use a report measure that I have</td>
<td>28.30%</td>
</tr>
<tr>
<td>I use published child self-report measures</td>
<td>28.30%</td>
</tr>
<tr>
<td>SEFF (Williamson, 2011)</td>
<td>11.30%</td>
</tr>
<tr>
<td>OASES- age 7-12 (Yaruss, Coleman, &amp;...)</td>
<td>10.40%</td>
</tr>
<tr>
<td>SSIS- Student Form (Gresham &amp; Elliot, ...)</td>
<td>9.10%</td>
</tr>
<tr>
<td>CSRS (Spitzberg, 1995)</td>
<td>7.10%</td>
</tr>
<tr>
<td>OASES- age 13-17 (Yaruss, Coleman, ...)</td>
<td>6.90%</td>
</tr>
<tr>
<td>CAT-R (DeNil &amp; Brutten, 1991)</td>
<td>6.60%</td>
</tr>
<tr>
<td>Social-Emotional Skills Rating Scale (Spitzberg, 2011)</td>
<td>5.00%</td>
</tr>
<tr>
<td>CS4 (Danielson &amp; Phelps, 2003)</td>
<td>3.30%</td>
</tr>
<tr>
<td>KiddyCAT (Vanryckeghem &amp; Brutten, ...)</td>
<td>2.50%</td>
</tr>
<tr>
<td>TPI-UV (Clark &amp; Patton, 2006)</td>
<td>2.50%</td>
</tr>
</tbody>
</table>
Figure 12
Methods of informal child/adolescent self-report that participants indicated using in clinical practice.

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview with student regarding their speech-language skills</td>
<td>95.50%</td>
</tr>
<tr>
<td>Clinician-made checklist of speech-language skills that the student completes</td>
<td>47.40%</td>
</tr>
<tr>
<td>Clinician-made rating scale of speech-language skills that the student completes</td>
<td>40.40%</td>
</tr>
</tbody>
</table>
Table 2

*Number of different child/adolescent self-report measures utilized by participants in clinical practice.*

<table>
<thead>
<tr>
<th>Survey Statement</th>
<th>Mean</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter the approximate number of different child/adolescent self-report measures that you currently utilize in your clinical practice.</td>
<td>3.6</td>
<td>3</td>
<td>0-45</td>
</tr>
</tbody>
</table>
Frequency of Use of Pediatric Self-Report Measures

Table 3 summarizes the number of students that participants reported collecting self-report measures from as well as the percentage of time the participants collected self-report measures as part of the assessment process. Averaged, the participants had collected at least one self-report measure from 20.9 students on caseload, and collected self-report measures as part of the assessment process 37.9% of the time. A good number of participants (40%; \( n=142/410 \)) reported utilizing self-report measures at least 50% of the time when completing assessment batteries. Conversely, 32.6% of participants reported using child self-report measures less than 15% of the time when completing an assessment battery.

Participants also indicated how frequently they administered self-report measures to children and adolescents. Figure 13 shows the graphic representation of frequency of administration of self-report measures to students. Slightly over 100 participants (25.6%; \( n=103 \)) stated that they collected self-report measures from pediatric clients on a monthly basis. Similarly, 94 participants (23.3%) reported collecting self-report measures quarterly. Some participants (20.8%; \( n=84 \)) collected self-report measures from children and adolescents annually. Only 6 participants (1.5%) stated that they collected self-report measures from students daily.
Table 3

Number and percentage of children and adolescents to whom participants indicated administering self-report measures.

<table>
<thead>
<tr>
<th>Survey Statement</th>
<th>Mean</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter the approximate number of children and adolescents on your current caseload that you have collected at least ONE self-report measure from:</td>
<td>20.9</td>
<td>15</td>
<td>0-200</td>
</tr>
<tr>
<td>When you are completing an assessment battery with a child or adolescent, what percentage of the time do you collect self-report measures?</td>
<td>37.9%</td>
<td>25%</td>
<td>0-100</td>
</tr>
</tbody>
</table>
Figure 13
Frequency of administration of child/adolescent self-report measures as indicated by participants who utilize the measures in clinical practice.
**Participant Rationale for Not Utilizing Pediatric Self-Report Measures**

Participants who reported that they did not currently use pediatric self-report measures were asked to rank their reasons for not using these measures \(n=333\). Figure 14 shows the ranked reasons that participants indicated for not using the measures in clinical practice. The majority of participants stated reasons related to their own lack of training and education about self-report measures. Approximately 60.1% ranked having limited knowledge of child and adolescent self-report measures as the top reason for not employing the measures in clinical practice. Having no access to pediatric self-report measures in their current work setting was the next largest barrier (46.5%; \(n=155/333\)). Approximately one-third of participants (36%; \(n=121/333\)) cited being unaware of how to interpret the child and adolescent self-report measures as the third reason for not using the measures.

The survey also provided space for participants to share narrative opinions and reasons for not using pediatric self-report measures. After reviewing the comments provided by the participants, seven themes emerged among the responses. The narrative responses of the professionals included: (1) The measures are not valid (5.9%; \(n=16/272\)), (2) The measures are not reliable (2.6%; \(n=7\)), (3) Participant has limited knowledge of self-report measures (39.7%, \(n=103\)), (4) Participant has no access to self-report measures in work setting (20.6%; \(n=56\)), (5) Self-report measures are not appropriate for the participant’s current caseload (32%; \(n=87\)), (6) Participant does not have enough time to implement use of self-report measures (8.1%; \(n=22\)), (7) Participant only uses a limited number of informal self-report measures and no formal self-report measures are utilized (7.7%, \(n=21\)). Themes 1-4 echoed reasons that participants ranked in the previous question. The most frequently occurring themes were limited participant knowledge of pediatric self-report measures, limited access to self-report measures in the work setting and self-report measures inappropriate for current caseload. A sample of responses follows.

The most frequent category of limited participant knowledge of pediatric self-report measures consisted of responses such as:

“I do not remember ever learning about the child/adolescent self-report measures during undergraduate and graduate studies. At my work, I do not know of any self-report measures available. I would like to learn more about this and will be looking into what is
currently available on the market and how we can go about utilizing these in our practice.”

The second most frequent category of narrative responses cited limited access to pediatric self-report measures in the work setting as a reason for not using the measures. A participant shared:

“I am unaware of the evidence-base and interpretation of self-report measures, and there is not a requirement in the state guidelines to use them. Without a state guideline or mandate, my district is reluctant to purchase such materials.”

The third category of self-report measures being inappropriate for the participants’ current caseload consisted of several responses including:

“Most of my students are young and have very limited language skills. They are mainly able to request items in the immediate environment, and currently have limited abilities to self-reflect and self-report.”
Figure 14

Ranked reasons participants indicated for not utilizing child/adolescent self-report measures in clinical practice.
**Intervention for Pragmatic Language Disorders**

Section five of the survey collected information regarding the participants’ practice patterns for providing intervention to students who have pragmatic language disorders. The majority of participants \( n=699/789 \) provided such intervention. Participants who provided intervention to children and adolescents with pragmatic language disorders answered further specific questions about the provision of the intervention. Table 4 summarizes the participants’ experience in treating pragmatic language disorders as well as frequency of pragmatic language disorders in the participant’s caseload. On average, participants had 14.5 years of experience treating pragmatic language disorders, and had 10.2 students on caseload with the target diagnosis. Forty-four percent of participants \( n=310/699 \) had 10 years or less experience treating pragmatic language disorders.

The service delivery method for pragmatic language disorders was also explored. Figure 15 presents the graphic distribution of participants’ preferred service delivery methods for pragmatic language disorders. A good number of participants (37%; \( n=250/688 \)) reported using a combination of pull out and in-classroom therapy services. Approximately one-quarter of the participants (27.3%; \( n=187 \)) used a combination of pullout, in classroom, and indirect services to provide intervention for students with pragmatic language disorders. Figure 16 displays frequency of service delivery in the school setting for children with pragmatic language disorders. The majority of participants (72.5%, \( n=502/692 \)) provided intervention services to students with pragmatic language disorders 1-2 times per week. Only seven participants reported providing services to such students one time or less per month.
Table 4
Demographic characteristics of participants related to pragmatic language disorder intervention.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years of experience treating pragmatic language disorders</td>
<td>14.5 years</td>
<td>13 years</td>
<td>1-41 years</td>
</tr>
<tr>
<td>Number of children and adolescents being treated for pragmatic language disorders on current caseload</td>
<td>10.2 students</td>
<td>7 students</td>
<td>0-80 students</td>
</tr>
</tbody>
</table>
Service delivery model utilized by participants to treat pragmatic language disorders in the school setting.

<table>
<thead>
<tr>
<th>Service Delivery Model</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combination of pull-out and in-classroom services</td>
<td>36.50%</td>
</tr>
<tr>
<td>Combination of pull-out services, in-classroom services, and non-instructional time</td>
<td>27.30%</td>
</tr>
<tr>
<td>Combination of pull-out and indirect classroom services (i.e. consulting)</td>
<td>16.90%</td>
</tr>
<tr>
<td>Pull-out services only</td>
<td>12.70%</td>
</tr>
<tr>
<td>Non-instructional time (i.e. recess, lunch, after school)</td>
<td>7.30%</td>
</tr>
<tr>
<td>In-classroom services only</td>
<td>2.80%</td>
</tr>
<tr>
<td>Combination of classroom and indirect services</td>
<td>2.80%</td>
</tr>
<tr>
<td>N/A</td>
<td>0.30%</td>
</tr>
</tbody>
</table>
Figure 16

Frequency of service delivery indicated by participants when providing intervention services to children and adolescents with pragmatic language disorders.

![Bar Chart]

- 35.40% 1 time per week
- 37.40% 2 times per week
- 6.50% 3 times per week
- 4.10% 4 times per week
- 10.40% 5+ times per week
- 3.80% Biweekly
- 1.00% Biweekly or less
- 1.30% N/A
Chapter IV: Discussion

The WHO-ICF model served as the impetus to examine use of child and adolescent self-report measures in school-based speech-language pathology. This study gathered information from school-based speech-language pathologists (SLPs) regarding current use of child and adolescent self-report measures within the school setting as well as attitudes and opinions about these measures. Recruitment materials were designed to invite participants who both use and do not use self-report measures in practice. The results from the study’s sample of 791 speech-language pathologists revealed that pediatric self-report measures are used to varying degrees in school settings, and that SLPs held differing opinions about these measures.

Educational and Clinical Training

Many SLPs reported a lack of training regarding the advantages and disadvantages of child and adolescent self-report measures in previous academic coursework. Though many participants reported utilizing self-report measures with child and adolescent clients, only 27% of participants indicated any type of university training in the use of pediatric self-report measures. This finding was somewhat surprising. Self-report measures are endorsed by ASHA and the WHO-ICF model (ASHA, 2004; ASHA, 2007; WHO, 2001). Questions may be raised regarding how SLPs can effectively administer and interpret measures without adequate training. Slightly more participants (41.7%) reported that child and adolescent self-report measures were used during clinical training, including externships and practicum experiences. As such, it appears that preparation and practice in the use of pediatric self-report measures may occur more often in clinical training than in academic coursework. Yet 45.6% of the participants reported not using the measures during clinical training.

Use of the Multi-Informant Approach

Results showed that SLPs are most likely to consult a student’s classroom teacher during the assessment process. Teachers may be the most solicited informant for speech and language evaluations due to their knowledge of student’s academic performance and ease of access in school settings. Caregivers (79%) and related service providers (76%) were also consulted frequently by the SLP when completing an evaluation. The child or adolescent was the least likely informant to complete report measures when the SLP completed an evaluation. In fact, 32% of the participants reported not consulting the student when completing an evaluation; this stands in direct contrast to ASHA Preferred Practice Patterns (2004). Incorporating child and
adolescent self-report measures into the evaluation process would allow the SLP to better assess the activities and participation domains of the WHO-ICF model, as well as to evaluate the student’s self-awareness of current skills and abilities. No other informant is equipped to provide equivalent information.

Evidence-based practice also advocates for the consideration of client and family preferences and values when designing evaluation and intervention (ASHA, 2005). Twenty percent of participants reported that they did not consult the child’s caregiver when completing an assessment. Combined with the number of participants that did not consult the student, many practicing SLPs may not be implementing best practice principles into clinical practice if child and caregiver opinions and preferences are not considered during assessment and intervention.

Participants who collected third party report and self-report measures from multiple informants were more likely to use informal report measures. Selection of informal clinician developed measures instead of published, standardized measures likely reflects the limited number of formal, published report measures in the discipline of speech-language pathology. Child and adolescent self-report measures for areas of speech and language are even fewer in number (Threats, 2008). Limited access to published report measures for all informants creates an increased need for clinicians to use informal measures to gather each informant’s opinion of the student’s skills and abilities.

**Attitudes, Beliefs, and Knowledge About Child and Adolescent Self-Report Measures**

Attitudes towards pediatric self-report measures varied across participants. Reflecting responses in earlier sections of the survey, 58.6% of participants continued to indicate limited familiarity with the evidence-base that supports use of child and adolescent self-report measures. Combined with previous responses, the results suggest that SLPs have limited academic and clinical training in use of pediatric self-report measures and, as a whole, are unaware of literature that supports use of the measures in practice. Despite unfamiliarity with research evidence, many participants still perceived benefits to considering the student’s perspective. The majority of participants (94.4%) agreed that children and adolescent’s outlooks add important information to assessment and intervention. Participants’ perceptions suggest that pediatric self-report measures would add beneficial information to evaluation and treatment. This finding is consistent with evidence-based practice principles whereby client preferences and values are
considered as valued as research evidence and clinical expertise when designing assessment and therapy approaches (ASHA, 2005).

Participants’ perceptions were mixed regarding the validity and reliability of pediatric self-report measures. Many were undecided (44.5%) about the validity of child and adolescent self-report measures, meaning that participants were uncertain that the student’s self report was accurate. Approximately half of the participants (49.8%) were also unsure of the reliability of such measures, implying that the SLPs doubted the child’s ability to rate themselves consistently over two weeks’ time. Current research has found varying rating consistency across teacher, parent, and child informants (Burgess & Turkstra, 2010; Cremeens et al., 2006; Herjanic et al., 1975; Kolko & Kazdin, 1993; Li & Bornholt, 2009). However, the difference in skill and ability ratings for the student can be attributed to a difference in experiences across parents, teachers, and children. This variation validates the importance of soliciting ratings from multiple informants. Despite potential disagreement among informant ratings, no one informant’s perspective should be valued above others, as each represents an individual viewpoint. The true value of self-report measures lies in the unique perspective provided through the measure, not the reporter’s ability to accurately rate personal behaviors (Kalyva, 2010; Li & Bornholt, 2009). Though research asserts that child self-reports should be considered regardless of accuracy, due to provision of the student’s unique perspective, results indicate that many participants may neglect to incorporate the measures into practice due to inaccurate perceptions of the measures’ validity and reliability.

Child and adolescent self-report measures would appear to be one of the most valid methods to assess the activities and participation domains of the WHO-ICF model as the student can report on behaviors across different environments and can convey personal perspective on communicative abilities (Beitchman & Corradini, 1988; Hartelius et al., 2003; Threats, 2008). In addition, self-report measures are an essential component of the multi-informant approach, endorsed by research and the American Speech-Language-Hearing Association (ASHA, 2004; Dowell & Ogles, 2008; Eiser & More, 2001; Gresham et al., 2011). The participants’ mixed opinions regarding validity and reliability of child and adolescent self-report measures could be attributed to minimal training in the use of such measures.
Current Use of Child and Adolescent Self-Report Measures

Though 94% of participants indicated that child and adolescent opinions add important information to speech/language assessment and intervention, only 54% of participants reported using pediatric self-report measures in clinical practice. Therefore, use of child and adolescent self-report measures as part of the assessment and/or intervention processes is not a universal practice among SLPs.

Participants cited the following reasons for using self-report measures in school-based practice: development of student self-monitoring skills, assessment of therapeutic outcomes, motivation for students, and helpful for planning intervention. Some participants (39%) reported using child and adolescent self-report measures to develop student’s self-monitoring and generalization skills. Self-monitoring of skill use in new situations places a focus on the Body Function and Structure and Activity domains of the WHO-ICF model, which have been traditionally assessed through objective clinician measures (Hartelius et al., 2008; McLeod & Threats, 2008; Threats, 2008). A limited number of participants (12%) reported gathering emotional information related to communicative abilities from pediatric self-report measures, which contributes information to the Participation domain of the WHO-ICF model. Current research supports the use of child and adolescent self-report measures to assess the Activities and, more importantly, Participation domains of the WHO-ICF model (Danielson & Phelps, 2003; Hartelius et al., 2008; McLeod & Threats, 2008; Threats, 2008). The results signify that SLPs utilize child and adolescent self-report measures for diverse reasons, but are unfamiliar with the correspondence between types of pediatric self-report measures and the WHO-ICF domains, as well as appropriate measures to assess the varying domains.

Participants who did not use pediatric self-report measures stated a variety of reasons for not using these measures. Most commonly ranked reasons included: limited knowledge of self-report measures (60.1%) and limited access to the measures in current work setting (46.5%). These responses were also echoed in participants’ open-ended narrative responses. Some participants reported that they would like to learn more about self-report measures in the future through continuing education or literature. This finding supports earlier testaments of participants’ limited academic and clinical training in the use of child and adolescent self-report measures.
Participants who reported use of self-report measures were asked to identify the types of measures used, which clients the measures were used with, and the frequency of implementation. Articulation and fluency were the most likely areas of speech and language to be assessed through child and adolescent self-report. The large number of participants (83.2%) who indicated using the measures with articulation clients likely parallels the large percentage of participants who reported using self-report measures to assess student’s self-monitoring and generalization. Many participants also reported using self-report measures for the area of fluency. A large body of research exists supporting the use of self-report measures from both adult and pediatric clients with fluency disorders, which may have elevated professional opinions of use of the measures for this clinical population. The high percentage of participants who used self-report measures with fluency cases may be connected to the evidence-base (Yaruss & Quesal, 2006; DeNil & Brutten, 1991; Vanryckeghem & Brutten, 2007). Accordingly, the most frequently utilized pediatric self-report forms were fluency self-report measures (e.g., Self-Evaluation Form Fluency, Williamson, 2001; Overall Assessment of the Speaker’s Experience of Stuttering-Ages 7-12 and 13-17, Yaruss, Coleman & Quesal, 2010) suggesting that the evidence-base and wide-spread use of these measures could be tied to the publication of speech and language specific child and adolescent self-report measures.

Students with articulation and fluency disorders often have high-level cognitive function, which could be another reason that SLPs report using self-report with this population. Other populations that SLPs were likely to utilize self-report measures with included: specific language impairment, learning disabilities, phonological disorders, and Asperger’s Syndrome. All of these populations are likely to have cognitive functioning within a typical range. This finding suggests that a student’s higher cognitive level may make the SLP more likely to utilize self-report measures with that client.

Participants were more likely to utilize informal measures for child and adolescent self-report than published, formal measures. Informal measures included clinician interviews of the student, as well as clinician-made checklists and rating scales. As the selection of published pediatric self-report measures is limited, the participants may have decreased access to formal measures, causing SLPs to gather self-report information through informal means.
**Intervention for Pragmatic Language Disorders**

Students with pragmatic language impairments are likely to experience participation restrictions during social interactions with peers. As such, it was important to examine this aspect of the SLP caseload more closely, due to the strong connection between pragmatic language disorders and limitations in the Participation domain of the WHO-ICF model. A large portion of participants (88.6%) reported that they provided intervention for students with pragmatic language disorders. Participants used a variety of service delivery models; the most common was a combination of pull out and in-classroom therapy. This service delivery model combines structured teaching of skills within the small group and generalization of these skills within the functional, everyday classroom environment. The majority of participants reported seeing students with pragmatic language disorders at least 1-2 times per week. This level of consistent intervention allows the SLP the opportunity to provide more intensive intervention for children with pragmatic language disorders. The large number of school-based SLPs who treat pragmatic language disorders, combined with the frequency of intervention reported by participants, indicate that the development of a pediatric self-report measure that corresponds with pragmatic language may be helpful to professionals when applying the WHO-ICF framework to assessment and intervention.

**Limitations of the Study**

The design of the current study contains several limitations which must be considered when interpreting and evaluating the results obtained. As the sample was elicited through electronic mailing lists and online communities, a traditional response rate cannot be calculated because the exact number of distributed surveys is unknown. Making generalizations and larger conclusions with the data set is challenging without a response rate calculation. Though the sample size was not small, it may not represent the profession as a whole. As participation in the survey was voluntary, it is possible that SLPs who do not use self-report measures opted not to complete the survey. It is also possible that participants’ responses to questions from the beginning of the survey influenced responses on later sections. Though 41 states were represented in the geographic sample, 29 states were represented by less than 10 participants and only one participant was recruited from each of 12 states. A large majority of the participants were from Ohio, creating a concentrated sample of the Midwest region. This regional saturation may impact generalization of results to the national community of SLPs. Though many survey
findings attributed limited use of self-report measures to a lack of academic and clinical training, speech and language degree programs vary widely across states and universities, making it challenging to identify specific shortcomings or missing elements of training programs. Finally, the non-experimental design of survey research prohibits true generalization of the results to the entire population of SLPs.

**Clinical Recommendations**

Results of the survey signify limited academic and clinical preparation in the use of child and adolescent self-report measures. Insufficient training in the use of self-report measures may lead to less frequent implementation of the measures in clinical practice, which stands in contrast to Preferred Practice Patterns and the multi-informant approach (ASHA, 2004). Speech-language pathology training programs must address how the Activity and Participation domains of the WHO-ICF model may be impacted by various communicative disorders. In accordance, advantages and disadvantages of the use of self-report measures should be taught in the context of the WHO-ICF model. Programs should also explicitly address and teach graduate students about the WHO-ICF model for disability classification and methods of assessment that correspond to the varying domains. Though an exclusive course in the use of self-report measures is both unrealistic and unnecessary, it is reasonable to expect all graduate programs to address self-report measures, the evidence-base supporting their use, and how to utilize the measures in evaluation and treatment. Graduate programs could address self-report measures as parts of each class that addresses various speech, language, and hearing disorders. Teaching and modeling of the multi-informant approach during assessment and intervention planning is essential. Graduate students should understand the type of information provided by each informant, as well as different methods to evaluate the informant’s ratings. Further research on this topic should focus on development of additional formal, published child and adolescent self-report measures specific to the field of speech-language pathology. Creation of additional published self-report measures will increase professional awareness of the measures, as well as contribute to better assessment of all levels of the WHO-ICF framework for various communicative disorders.
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Appendix A

Survey Invitation Letter

Dear Speech-Language Pathologists,

My name is Lindsey Brown and I am currently in the second year of my graduate program in speech-language pathology at Miami University in Oxford, Ohio. As part of my Master’s thesis project under the direction of my advisor, Geralyn Timler, Ph.D., CCC-SLP, I am gathering information regarding use of child self-report measures by pediatric and school-based speech-language pathologists.

For the purpose of my survey, child self-report measures are defined as formal or informal measures that are completed by the child to assess their own speech-language, social, or behavior skills including their perceptions and attitudes about these skills. I will also be collecting information about populations that you serve in your practice, as well as some specific questions regarding pragmatic language disorders.

The results of this survey will provide information about how and why child self-report measures are currently being used in speech-language pathology, and will inform future development of self-report measures. I am interested in your opinions even if you do not currently use child self-report measures in your clinical practice.

I hope that you will take 10-15 minutes to complete this survey by copying and pasting the following link to your browser:

https://www.surveymonkey.com/s/VV2CGYB

Your participation in this study is completely voluntary.

I want to thank you in advance for your participation. I truly appreciate your time. If you have any questions about this survey, please contact me at brownlk3@miamioh.edu

Best,

Lindsey Brown, B.S.
Graduate Student, Miami University (Ohio)
Appendix B
Survey Instrument

Use of Self-Report Measures in Pediatric and School-Based Speech-

Participant Consent

This abbreviated consent form explains the study. If you would like further information or have any questions, please contact Lindsey Brown, B.S. (brownlk3@miamioh.edu) or my faculty advisor Geralyn Timler, Ph.D., CCC-SLP (513-529-2549; timlergr@miamioh.edu). If you have questions about your rights as a subject in a research project, you may contact (anonymously, if you wish) the Office for the Advancement of Research and Scholarship at Miami University at 513-529-3900 or by email at humansubjects@miamioh.edu.

1. The purpose of this study is to collect data about child/adolescent self-report measures currently used by speech-language pathologists (SLP), including the frequency of survey use. We are interested in your attitudes and perceptions about child/adolescent self-report measures. We will also ask you about your experience treating pragmatic language disorders.

Time Commitment: Your participation in this survey will take approximately 10-15 minutes.

Risks and Benefits: It is possible that you may experience minimal discomfort responding to some questions. You may select “no response” for any item that you do not wish to answer. There is likely no direct benefit to you for participating in this study, but it will help other clinicians to better understand how child/adolescent self-report measures are currently used and will inform future development of additional child/adolescent self-report measures.

Confidentiality: Your responses will remain confidential.

Compensation: Participants will not be compensated for completing the survey.

Voluntary Participation: Once you have completed the survey, you will not be able to withdraw from the study.

Participant Statement: I have read and understand the above consent form, I certify that I am 18 years old or older and by clicking the agree button to enter the survey, I indicate my willingness to voluntarily take part in the study.

☐ AGREE: I agree to take part in this survey

☐ DISAGREE: I do not agree to take part in this survey and will exit my browser
Use of Self-Report Measures in Pediatric and School-Based Speech-

Section 1: Your University Training

For the purpose of this survey, child/adolescent self-report measures are defined as formal or informal measures that are completed by clients between the ages of 5-18 to assess their own speech-language, social or behavior skills including their perceptions and attitudes about these skills.

Instructions: Please answer the following questions regarding your past educational training.

2. I was taught about the advantages and disadvantages of child/adolescent self-report measures during my university training.
   - [ ] Agree
   - [ ] Disagree
   - [ ] Do not remember
   - [ ] No Response

3. I used child/adolescent self-report measures in my clinical practica, internships, or externships.
   - [ ] Agree
   - [ ] Disagree
   - [ ] Do not remember
   - [ ] No Response
Section 2: Current Use of Report Measures Completed by Others

The next 3 questions ask about report measures in general including those completed by parents, teachers, or other professionals about school-age children/adolescents.

4. I routinely collect data from the following individuals when completing an assessment (Check all that apply):
   - [ ] Child/Adolescent's caregiver
   - [ ] Child/Adolescent's teacher
   - [ ] Other Professional (Psychologist, Occupational Therapist, etc.)
   - [ ] Child/Adolescent

5. Formal report measures include standardized and published rating forms that you might ask caregivers, teachers, other professionals, and children/adolescents to complete as part of a speech-language assessment or evaluation. If you use formal report measures, please indicate how frequently you collect such measures from each of the individuals below:

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Infrequently</th>
<th>Sometimes</th>
<th>Always</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/Adolescent's Caregiver</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child/Adolescent's Teacher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Professional (Psychologist, Occupational Therapist, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child/Adolescent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Informal report measures include non-standardized rating scales, clinician developed checklists, and interviews that you might ask caregivers, teachers, other professionals, and children/adolescents to complete as part of a speech-language assessment or evaluation. If you use informal report measures, please indicate how frequently you collect such measures from each of the individuals below:

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Infrequently</th>
<th>Sometimes</th>
<th>Always</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/Adolescent's Caregiver</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child/Adolescent's Teacher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Professional (Psychologist, Occupational Therapist, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child/Adolescent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 3: Attitudes and Beliefs Regarding Child/Adolescent Self-Report Measures

For the purpose of this survey, child/adolescent self-report measures are defined as formal or informal measures that are completed by clients between the ages of 5-18 to assess their own speech-language, social or behavior skills including their perceptions and attitudes about these skills.

Instructions: Please answer the following questions regarding your CURRENT perceptions and beliefs about child self-report measures.

7. I am familiar with the evidence base supporting the use of self-report measures.
   - Agree
   - Disagree
   - Do not remember
   - No Response

8. Children's and adolescent's perspectives and opinions regarding their communication skills add important information to the assessment and intervention process.
   - Strongly Agree
   - Agree
   - Undecided
   - Disagree
   - Strongly Disagree
   - No Response

9. Child and adolescent self-ratings are VALID (i.e. the child's or adolescent's self-report is generally accurate).
   - Strongly Agree
   - Agree
   - Undecided
   - Disagree
   - Strongly Disagree
   - No Response
10. Child and adolescent self-ratings are RELIABLE (i.e. the child’s or adolescent’s self-report would be consistent over two weeks’ time; in other words, if the child completed the same self-report measure two weeks later, the child’s responses would be similar to the first completion).

- Strongly Agree
- Agree
- Undecided
- Disagree
- Strongly Disagree
- No Response
### Use of Self-Report Measures in Pediatric and School-Based Speech-

#### Section 4: Current Use of Child/Adolescent Self-Report Measures

For the purpose of this survey, child/adolescent self-report measures are defined as formal or informal measures that are completed by clients between the ages of 5-18 to assess their own speech-language, social or behavior skills including their perceptions and attitudes about these skills.

Instructions: Please answer the following question regarding your CURRENT use of child or adolescent self-report measures in clinical practice.

### 11. Do you currently use child/adolescent self-report measures in your clinical practice?

- [ ] Yes
- [ ] No
For the purpose of this survey, child/adolescent self-report measures are defined as formal or informal measures that are completed by clients between the ages of 5-18 to assess their own speech-language, social or behavior skills including their perceptions and attitudes about these skills.

Instructions: Please answer the following questions regarding your use of child or adolescent self-report measures in clinical practice.

**12. The following statements reflect potential disadvantages of child self-report measures.**

Please rank your top three reasons for NOT using child self-report measures (rank the top reason as number 1, the second reason as number 2, and the third reason as number 3).

<table>
<thead>
<tr>
<th>Reason</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/Adolescent self-report measures do not add useful assessment information</td>
<td></td>
</tr>
<tr>
<td>Child/Adolescent self-report measures are not valid</td>
<td></td>
</tr>
<tr>
<td>Child/Adolescent self-report measures are not reliable</td>
<td></td>
</tr>
<tr>
<td>Results of child/adolescent self-report measures do not agree with standardized assessment results</td>
<td></td>
</tr>
<tr>
<td>I have little knowledge about available child/adolescent self-report measures</td>
<td></td>
</tr>
<tr>
<td>I do not have access to child/adolescent self-report measures in my work setting</td>
<td></td>
</tr>
<tr>
<td>I do not know how to interpret child/adolescent self report measures</td>
<td></td>
</tr>
<tr>
<td>Other (please list below)</td>
<td></td>
</tr>
</tbody>
</table>

**13. If you do not utilize child/adolescent self-report measures in your practice or do so infrequently, please list your reasons below:**
Section 4: Current Use of Child/Adolescent Self-Report Measures continued

For the purpose of this survey, child/adolescent self-report measures are defined as formal or informal measures that are completed by clients between the ages of 5-18 to assess their own speech-language, social or behavior skills including their perceptions and attitudes about these skills.

Instructions: Please answer the following questions regarding your CURRENT use of child or adolescent self-report measures in clinical practice.

14. Child/Adolescent self-report measures have added useful information during the ASSESSMENT PROCESS.
   - Strongly Agree
   - Agree
   - Undecided
   - Disagree
   - Strongly Disagree
   - No Response

15. Child/Adolescent self-report measures have improved my understanding of the child's or adolescent's communication strengths and challenges.
   - Strongly Agree
   - Agree
   - Undecided
   - Disagree
   - Strongly Disagree
   - No Response

16. Child/Adolescent self-report measures added useful information to develop effective INTERVENTION PLANS.
   - Strongly Agree
   - Agree
   - Undecided
   - Disagree
   - Strongly Disagree
   - No Response
17. Child/Adolescent self-report measures have provided useful information that improved INTERVENTION OUTCOMES.

- [ ] Strongly Agree
- [ ] Agree
- [ ] Undecided
- [ ] Disagree
- [ ] Strongly Disagree
- [ ] No Response
Use of Self-Report Measures in Pediatric and School-Based Speech-

Section 4: Current Use of Child/Adolescent Self-Report Measures continued

For the purpose of this survey, child/adolescent self-report measures are defined as formal or informal measures that are completed by clients between the ages of 5-18 to assess their own speech-language, social or behavior skills including their perceptions and attitudes about these skills.

Instructions: Please answer the following questions regarding your CURRENT use of child or adolescent self-report measures in clinical practice.

16. I use child and adolescent self-report measures with (Check all that apply):

☐ Elementary students
☐ Middle school students
☐ High school students
☐ N/A

19. How many children and adolescents do you serve on your caseload?

20. Enter the approximate number of children and adolescents on your current caseload that you have collected at least ONE self-report measure from:

21. When you are completing an assessment battery with a child or adolescent, what PERCENTAGE of the time do you collect self-report measures? Please enter a number between 0-100.

22. For an individual child/adolescent, how frequently do you typically administer self-report measures?

☐ Daily
☐ Weekly
☐ Monthly
☐ Quarterly
☐ Bi-annually
☐ Annually
☐ N/A
☐ No Response
Use of Self-Report Measures in Pediatric and School-Based Speech-

23. I have children/adolescents complete self-report measures regarding the following communication and academic skills (Check all that apply):

- Articulation
- Voice
- Fluency
- Social/pragmatic language
- Expressive/receptive language
- Academic language

Other (please specify)

24. I use (or have used) child/adolescent self-report measures with the following populations (Check all that apply):

- Apraxia
- Articulation disorders
- Asperger's Syndrome
- Attention deficit hyperactivity disorder (ADD/ADHD)
- Auditory processing disorder
- Augmentative and alternative communication (AAC)
- Autism
- Cochlear implants
- Deaf/Hearing Impaired
- Down Syndrome
- Dyslexia

- Dysphagia
- Emotional-Behavioral Disturbance
- English as a Second Language (ESL)
- Fetal Alcohol Syndrome (FAS)
- Fluency
- Intellectual disabilities (MR/DD)
- Learning disabilities
- Phonological disorders
- Selective Mutism
- Specific Language Impairment (SLI)
- Traumatic Brain Injury (TBI)

Other (please specify)
Section 4: Current Use of Child/Adolescent Self-Report Measures continued

For the purpose of this survey, child/adolescent self-report measures are defined as formal or informal measures that are completed by a client between the ages of 5-18 to assess their own speech-language, social or behavior skills including their perceptions and attitudes about these skills.

Instructions. Please answer the following questions regarding your CURRENT use of child or adolescent self-report measures in clinical practice.

25. I use the following published child/adolescent self-report measures as part of the assessment and intervention process (Check all that apply):

- Matson Evaluation of Social Skills for Youngsters (MESSY; Matson, Rotatori, & Helzel, 1983)
- List of Social Situation Problems (LSSP; Spence, 1980)
- Youth Self Report (YSR; Achenbach & Edelbrock, 1987)
- Children’s Self-Report Social Skills Scale (CS4; Darerel & Phelps, 2003)
- Social-Emotional Skills Rating Scale (Gajewski, Harn, & Mayo, 1988)
- Social Skills Rating System (SSRS): Student Form, now called Social Skills Improvement System (SSIS; Gresham & Elliot, 2003)
- Conversational Skills Rating Scale (CSRQ; Spitzberg, 1985)
- My Life in School Checklist (MLISC; Arora & Thompson, 1987)
- Transition Behavior Scales- 2nd edition (TBS-2; McCarney & Anderson, 2000)
- Transition Planning Inventory-Updated Version (TPIUV; Clark & Patton, 2006)

- Self-Evaluation Form Fluency (SEFF; Williamson, 2011)
- Communication Attitude Test Revised (CAT-R; DeNel & Bruttin, 1991)
- Communication Attitude Test for Preschool and Kindergarten Children who Stutter (KidCAT; Vannickeghem & Bruttin, 2006)
- Self-Efficacy Scale for Adolescents (SEA Scale; Manning, 1994)
- Overall Assessment of the Speaker’s Experience of Stuttering-School Age Children (OASES-age 7-12; Yanuss, Coleman, & Quesal, 2010)
- Overall Assessment of the Speaker’s Experience of Stuttering-Teens (OASES-age 13-17; Yanuss, Coleman, & Quesal, 2010)
- I use published child self-report measures, but cannot remember the names at this time.
- I use a report measure that I have adapted for completion by children/adolescents (please list and describe below)
- No Response

Other (please specify)
Use of Self-Report Measures in Pediatric and School-Based Speech-

26. I use the following informal child/adolescent self-report measures as part of the assessment and intervention process (Check all that apply):

- [ ] Interview with student regarding their speech-language skills
- [ ] Clinician-made checklist of speech-language skills that the student completes
- [ ] Clinician-made rating scale of speech-language skills that the student completes

Other (please list and describe below; also include report measures that you have developed or were developed by your colleagues):

27. Enter the approximate number of different child/adolescent self-report measures that you currently utilize in your clinical practice.

28. Please share your overall opinion or general comments about child/adolescent self-report measures in the space below.


<table>
<thead>
<tr>
<th>Section 5: Intervention for Pragmatic Language Disorders</th>
</tr>
</thead>
</table>

Instructions: Please answer the following question regarding treatment of pragmatic language disorders in your current work setting.

29. Do you currently provide intervention for children/adolescents with pragmatic language disorders in your clinical practice?

- [ ] Yes
- [ ] No
Section 5: Intervention for Pragmatic Language Disorders continued

Instructions: Please answer the following questions regarding treatment of pragmatic language disorders in your current work setting.

30. Check the service delivery model that you use most frequently when providing intervention for children/adolescents with pragmatics/social language disorders:

- [ ] Pull-out services only
- [ ] In-classroom services only
- [ ] Non-instructional time (i.e. recess, lunch, after school)
- [ ] Combination of pull-out and in-classroom services
- [ ] Combination of pull-out and indirect classroom services (i.e. consulting)
- [ ] Combination of classroom and indirect services
- [ ] Combination of pull-out services, in-classroom services, and non-instructional time
- [ ] N/A
- [ ] No Response

Other (please specify)

31. Enter the number of years that you have worked with children/adolescents who have pragmatic language disorders:

32. Enter the number of children currently on your caseload who are receiving services for deficits in pragmatics/social language skills:
33. On average at your workplace, how many times per week do you address pragmatic language skills for a child/adolescent who has a pragmatic language disorder; (do not include treatment time for other disorders that the child may have):

- [ ] 1 time per week
- [ ] 2 times per week
- [ ] 3 times per week
- [ ] 4 times per week
- [ ] 5+ times per week
- [ ] Biweekly
- [ ] Monthly or less
- [ ] N/A
- [ ] No Response

Other (please specify):
## Use of Self-Report Measures in Pediatric and School-Based Speech-Language Pathology

### Section 6: Demographic Information

Instructions: Please answer the following questions regarding your clinical training, clinical experience, current employment setting, and current caseload.

34. **Check the highest degree that you have achieved:**

- [ ] Bachelors (B.A. or B.S.)
- [ ] Masters (M.A., M.S., or M.Ed.)
- [ ] Ph.D.
- [ ] Ed.D.
- [ ] Ed.S.
- [ ] No Response

35. **In what year was your highest degree completed?**

36. **I hold the Certificate of Clinical Competence (CCC) from ASHA.**

- [ ] Yes
- [ ] No
- [ ] No Response

37. **Including this year (2013), how many years have you practiced speech-language pathology?**

38. **What state/province do you practice in?**

39. **Check the statement which most accurately reflects your current employment setting:**

- [ ] I work as a school-based SLP.
- [ ] I work as an SLP serving school-age clients at a hospital (inpatient or outpatient).
- [ ] I work as an SLP serving school-age clients at a private practice.
- [ ] I work as an SLP serving school-age clients at an university speech-language clinic or university affiliated program.

Other (please specify)
### Use of Self-Report Measures in Pediatric and School-Based Speech-

#### 40. Enter the percentage of the time that you work in the following settings (Total should equal 100%):

<table>
<thead>
<tr>
<th>Setting</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Early intervention agency (center or home based)</td>
<td></td>
</tr>
<tr>
<td>% Preschool</td>
<td></td>
</tr>
<tr>
<td>% Elementary School</td>
<td></td>
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<tr>
<td>% Middle School</td>
<td></td>
</tr>
<tr>
<td>% High School</td>
<td></td>
</tr>
<tr>
<td>% Inpatient Hospital</td>
<td></td>
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<tr>
<td>% Outpatient Hospital</td>
<td></td>
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<tr>
<td>% Private Practice</td>
<td></td>
</tr>
<tr>
<td>% University based speech and language clinic</td>
<td></td>
</tr>
<tr>
<td>% Other</td>
<td></td>
</tr>
</tbody>
</table>

#### 41. Enter the total number of children and adolescents, ages 0 to 18 years, that you currently serve on your caseload:

- [ ]
Use of Self-Report Measures in Pediatric and School-Based Speech-

Survey Completed

Thank you so much for taking time to complete this survey. It is truly appreciated.

If you have any further questions about this survey and research project, or would like to request a copy of the final research paper, you are invited to contact Lindsey Brown via email at: brownlt3@miamioh.edu.

You may now exit the survey by closing your Internet browser.
Appendix C

Survey Distribution Timeline

1/28/13: Initial Survey Distribution- HCESC contact forwarded to Ohio Supervisory Network and HCESC

1/29/13: Emailed all SEACDC contacts with requests to distribute survey to SLPs in their states; OSLHA General office contacted with survey invitation; Emailed request for distribution to CCHMC employees

1/29/13: Survey invitation posted on ASHA SIG 16 online community

1/30/13: Survey distributed to CCHMC employees

1/30/13: Confirmed distribution to NC/WV/OK/CO through SEACDC representatives; several State Associations contacted (NJ, AK, AR, CA)

1/31/13: NJSHA denied distribution (organization policy)

2/1/13: OSLHA confirmed uploading survey information onto their website (Ohio)

2/4/13: Florida Department of Education Speech & Language Impairment contacts emailed

2/5/13: Confirmed distribution to the following Florida counties (Flagler, Franklin, Lee, Gulf)

2/6/13: Confirmed distribution to the following Florida counties (St. Johns, Okaloosa)

2/7/13: The following State Associations contacted with survey distribution request via email (AK, AR, CA, CT, DE, GA, IA, ID, IN, KS, KY, MA, ME, MN, MT, NE, NH, NJ, NM, NV, OR, PA, OH, RI, SD, TN, TX, WA, WY); Delaware SHA confirmed distribution to membership

2/8/13: NebraskaSHA & MassSHA confirmed posting survey notice onto their websites; MinnesotaSHA denied request to distribute

2/9/13: Second posting to ASHA SIG 16 community

2/13/13: Posted survey invitation to ASHA SIG 1

2/14/13: Confirmed distribution to the following Florida counties (Alachua, Columbia)

2/19/13: IowaSHA distribution to all members confirmed

2/24/13: Remaining State Associations contacted with survey distribution request via email (AL, AZ, FL, HI, IL, LA, MD, MI, MS, MO, NC, ND, OK, SC, UT, VT, VA, WV)
2/25/13: NDSHA confirmed distribution to all members

2/26/13: LouisianaSHA confirmed distribution to all members

2/28/13: SHAA (Alabama) confirmed distribution to all members

3/1/13: IllinoisSHA confirmed approval of survey; confirmed distribution between 3/4-3/8

3/5/13: Rhode IslandSHA confirmed distribution to all members

3/6/13: first 1500 Ohio Licensee email addresses contacted with survey link

3/7/13: next 1500 Ohio Licensee email addresses contacted with survey link

3/9/13: Remaining Ohio Licensee email addresses contacted with survey link
## Appendix D

### Organizations That Distributed Survey Instrument

<table>
<thead>
<tr>
<th>Hamilton County Educational Services Center</th>
<th>ASHA SIG 1 Online Community (Language, Learning &amp; Education)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cincinnati Children's Hospital Medical Center</td>
<td>ASHA SIG 16 Online Community (School-Based Issues)</td>
</tr>
<tr>
<td>State Education Agencies Communication Disabilities Council</td>
<td>State Speech-Language-Hearing Organizations distributing via electronic mailing list</td>
</tr>
<tr>
<td>North Carolina representative</td>
<td>Ohio</td>
</tr>
<tr>
<td>West Virginia representative</td>
<td>Delaware</td>
</tr>
<tr>
<td>Oklahoma representative</td>
<td>Iowa</td>
</tr>
<tr>
<td>Colorado representative</td>
<td>North Dakota</td>
</tr>
<tr>
<td>State Speech-Language-Hearing Organizations posting research description on website</td>
<td>Louisiana</td>
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<tr>
<td></td>
<td>Alabama</td>
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<td></td>
<td>Illinois</td>
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<td></td>
<td>Rhode Island</td>
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<tr>
<td>Florida County School Districts</td>
<td>Nebraska</td>
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<tr>
<td>Flagler</td>
<td>Massachusetts</td>
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<td>Franklin</td>
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<td>Lee</td>
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<td>Gulf</td>
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<td>St. Johns</td>
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<td>Okaloosa</td>
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<td>Alachua</td>
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<tr>
<td>Columbia</td>
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<tr>
<td>Ohio Supervisory Network</td>
<td></td>
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</tbody>
</table>
Appendix E

Abbreviated Consent Form

The purpose of this study is to collect data about child/adolescent self-report measures currently used by speech-language pathologists (SLP), including the frequency of survey use. We are interested in your attitudes and perceptions about child/adolescent self-report measures. We will also ask you about your experience treating pragmatic language disorders. Time Commitment: Your participation in this survey will take approximately 10-15 minutes. Risks and Benefits: It is possible that you may experience minimal discomfort responding to some questions. You may select “no response” for any item that you do not wish to answer. There is likely no direct benefit to you for participating in this study, but it will help other clinicians to better understand how child/adolescent self-report measures are currently used and will inform future development of additional child/adolescent self-report measures. Confidentiality: Your responses will remain confidential. Compensation: Participants will not be compensated for completing the survey. Voluntary Participation: Once you have completed the survey, you will not be able to withdraw from the study. Participant Statement: I have read and understand the above consent form, I certify that I am 18 years old or older and by clicking the agree button to enter the survey, I indicate my willingness to voluntarily take part in the study.

___ AGREE- I agree to take part in the survey

___ DISAGREE- I do not agree to take part in this survey and will exit my browser
You have been invited to take part in a research study as described below. This consent form explains the study. Please read it carefully. If you have any questions, please do not hesitate to contact Lindsey Brown, B.S. (brownlk3@muohio.edu) or my faculty advisor Geralyn Timler, Ph.D., CCC-SLP (513-529-2549; timlergr@muohio.edu). If you have any questions about your rights as a subject in a research project, you should contact (anonymously, if you wish) the Office for the Advancement of Research and Scholarship at Miami University at 513-529-3600 or by email at humansubjects@muohio.edu.

**Purpose:** The purpose of this survey instrument is to collect data about: a) the type of child self-report measures currently used by speech-language pathologists, as well as their frequency of implementation; and b) speech-language pathologists’ attitudes and perceptions about child self-report measures. Demographic information will also be collected including: populations served in the speech-language pathologist’s practice and information about the speech-language pathologist’s experiences treating pragmatic language disorders.

*For the purpose of this survey, child self-report measures are defined as: formal or informal measures that are completed by the child to assess their own speech-language skills.* Formal measures refer to published, standardized rating forms (i.e. the Communication Attitude Test-Revised for stuttering or Social-Emotional Skills Rating Scale for social communication). Informal measures refer to non-standardized rating scales or checklists developed by individual speech-language pathologists that are completed by children to assess their own speech and language skills. You may have developed these yourself or use informal measures developed by your colleagues.

Completion of the surveys provides minimal risk to the participants; there is not a reasonable alternative method to gather this information. The findings of this survey will provide information about how and why child self-report measures are currently being used, and will inform future development of self-report measures.

**Procedures:** You have received a link to open the survey. You will be able to open the survey and answer questions on an Internet browser. You can terminate your participation at any time.
by closing the Internet browser containing the survey. You can decline to answer any question posed on the survey.

**Time Commitment:** Your participation in this survey will take approximately 5-10 minutes.

**Risks and Benefits:** It is possible that you may experience minimal discomfort responding to some questions. You may skip any item that you do not wish to answer. There is likely no direct benefit to you for participating in this study, but it will help other clinicians to better understand how child-self report measures are currently used and will inform future development of additional child self-report measures.

**Confidentiality:** This survey will be administered through SurveyMonkey®. The SurveyMonkey website states: “SurveyMonkey takes our users’ security and privacy concerns seriously. This Security Statement is aimed at being transparent about our security infrastructure and practices, to help reassure you that your data is sufficiently protected.

- When a user accesses secured areas of our site, Secure Sockets Layer (SSL) technology protects user information using both server authentication and data encryption, ensuring that user data is safe, secure, and available only to authorized persons
- Accounts which are SSL enabled ensure that the responses of survey participants are transmitted over a secure, encrypted connection
- Our data center is located in a SOC 2, Type II audited facility
- Data center secured by security guards, visitor logs, and entry requirements (passcards/biometric recognition)

Despite best efforts, no method of transmission over the Internet, or method of electronic storage, is perfectly secure. Therefore, we cannot guarantee absolute security.” To read SurveyMonkey’s complete Security Statement, go to [http://www.surveymonkey.com/mp/policy/security/](http://www.surveymonkey.com/mp/policy/security/).

Your individual privacy will be maintained in all published and written data resulting from the study. All individual responses will be anonymously collected and will only be shared with the research team. Data will be averaged and reported in aggregate. Nevertheless, despite these safeguards, there is always a remote possibility of other security breaches that could compromise the confidentiality of the information you provide. Thus, you should remember that you are free to decline to answer any question that makes you uncomfortable for any reason.

**Compensation:** Participants will not be compensated for completing the survey.

**Voluntary Participation:** Your participation in this survey is completely voluntary. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You have the right to refuse to answer particular questions. You may elect to withdraw from this
survey at any time and may do so by exiting the Internet browser. If you choose to not complete the survey, the information that we have collected from you will be destroyed.

**Participant Statement:** I have read and understand the above consent form, I certify that I am 18 years old or older and, by clicking the submit button to enter the survey, I indicate my willingness voluntarily take part in the study.

Please print a copy of this consent form for your records, if you so desire.