Perceptions and Intervention Practices of Speech-Language Pathologists Serving Students with Emotional/Behavioral Disorders

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PERCEPTIONS AND INTERVENTION PRACTICES OF SPEECH-LANGUAGE PATHOLOGISTS SERVING STUDENTS WITH EMOTIONAL/BEHAVIORAL DISORDERS

by

Laura A. Getty

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Education
Department of Special Education and Literacy Studies
Dr. Sarah E. Summy, Advisor

Western Michigan University
Kalamazoo, Michigan
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A relationship between emotional/behavioral disorders (E/BD) and language deficits has been validated by researchers in special education (Cantwell & Baker, 1991; Beichman, Cantwell, Forness, Kavale, & Kaufmann, 1998; Cohen, Barwick, Horodezky, Vallance, & Im, 1998) as well as researchers in speech-language pathology (Hyter, 2003; Hyter, Rogers-Adkinson, Self, Simmons, Jantz, 2001; Ruhl, Hughes, & Camarata, 1992; Gallagher, 1999; Fujiki, Brinton, Morgan, & Hart, 1999). The exact prevalence rate between E/BD and language deficits was not definitive as it varies between 35% and 97% depending on the study reviewed (Benner, Nelson, & Epstein, 2002). While it has been documented that a relationship exists between children with E/BD and language deficits, a current prevalence rate regarding the speech-language pathologists involvement with this population was nearly 20 years old (Casby, 1989). Furthermore, a gap in the research exists between the most effective therapy interventions for students with E/BD and language deficits.

The purpose of this investigation was two-fold; a) to determine a prevalence rate of speech-language pathologists in Michigan serving students diagnosed with E/BD and language deficits, and b) to explore the types of interventions speech-
language pathologists were employing with students with E/BD and language deficits. A survey was used to determine the extent to which speech-language pathologists provide services to students with E/BD and a focus group was employed to determine language interventions speech-pathologists use with this population. Survey results indicated 56.8% of the speech-language pathologists reported serving students with E/BD and language deficits. Focus group results indicated speech-language pathologists utilized a variety of language interventions while simultaneously incorporating behavioral management strategies into their service delivery.
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And finally, to Dad, I know you know.

Laura A. Getty
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CHAPTER I

INTRODUCTION

Statement of the Problem

Researchers indicated there were a significant number of children with co-occurring emotional/behavior disorders (E/BD) and language deficits (Benner, Nelson, & Epstein, 2002; Beichman, Cantwell, Forness, Kavale, & Kaufmann, 1998; Cantwell & Baker, 1991). While research findings have supported the co-occurrence of these disorders, there was a significant discrepancy in the reported prevalence rates of children with co-occurring disorders. The wide-ranging prevalence rates vary between 35% and 97% depending on how the disorders were measured, how the variables were defined, and the study reviewed (Benner, Nelson, & Epstein, 2002). This wide-ranging percentage rate was reported by Benner, Nelson, and Epstein (2002) in their review of 26 studies investigating children with E/BD and language deficits between the years of 1980 and 1998. Their study brought to light the fact that researchers were finding a relatively high percentage of children with E/BD and language deficits in the 1980s and 1990s yet, Casby (1989) reported only 9% of children diagnosed with E/BD received speech and language services on a national level.

Given these findings, it was necessary to determine whether speech-language pathologists were currently providing services to children with E/BD and if so, what interventions they employed. Students with E/BD have had a long-standing history
of the last group in special education to be integrated into general education settings as well as poor outcomes in the academic arena and after they leave the educational system. It then becomes important to understand the relationship between E/BD and language deficits. The purpose of this investigation was two-fold: to determine a) a current prevalence rate of speech-language pathologists serving children with E/BD, and b) which intervention practices speech-language pathologists employed with this population of children.

Significance of the Study

The Challenge Facing Researchers

Educators have been challenged to sufficiently address the language needs of children with E/BD given that studies have shown language deficits and emotional/behavior disorders coexist (Benner, Nelson, & Epstein, 2002; Beichman, Cantwell, Forness, Kavale, & Kaufmann, 1998; Cantwell & Baker, 1991; Schery, 1985). However, based on a digital search in the Educational Resources Information Center (ERIC) database from 1966 to the present and using the keywords “speech-language pathologist” and “perceptions” as well as “speech-language pathologists” and “emotional/behavioral disorders,” there was no published research whether speech-language pathologists perceive a relationship between E/BD and language deficits. Moreover, there were no studies found as to whether speech-language pathologists used specific interventions to address the needs of children with co-existing E/BD and language deficits as compared to other children with only language deficits. The disparity between scientifically corroborated data and the most effective
way to intervene for success when working with children with E/BD and language deficits was yet to be strongly empirically supported.

The Speech-Language Pathologist’s Involvement

Speech-language pathologists receive limited formal instruction on how to implement language programs for children with E/BD since the field focuses on communication disorders as primary conditions, and communication disorders in combination with concomitant educational labels receive less attention. For example, a review of four commonly used textbooks in child language disorders (Owens, Metz, & Haas, 2007; McCauley, 2001; Nelson, 1998; Paul, 1995) showed only an average of 0.6% of the pages devoted specifically to the needs of school-age children with emotional and behavioral needs that were primary to any communication difficulties. Subsequent to graduation, speech-language pathologists were not typically involved the educational plans of children with E/BD (Briton & Fujuki, 1993; Sanger, Magg, & Shapera, 1994) and as a result, language issues were undiagnosed and/or unaddressed (Cohen, Barwick, Horodezky, Vallance, & Im, 1998).

Nearly 20 years ago Casby (1989) reported only 9% of children with E/BD in special education programs were receiving services from a speech-language pathologist, which was incongruent with the prevalence rates reported by Benner, Nelson, & Epstein (2002). Given what has been learned about these concomitant disorders, a new statistic regarding speech-language pathology services for children with E/BD must be ascertained in order to address the issues facing this population of students. Additionally, the interventions speech-language pathologists utilize with this
population must also be examined to determine whether such practices are meeting
the needs these children.

Therapeutic Interventions

Researchers in the field of special education have suggested a variety of
academic and social-emotional interventions to address the needs children with E/BD
(Kleinheksel & Summy, 2003; Forgan, 2002; Redl, 1959; Meichenbaum & Goodman,
1971; Hoover & Oliver, 1996; Rhode, Morgan, & Young, 1983; Coleman & Weber,
1988). Language-based interventions to employ with children with language deficits
were suggested by researchers in the field of speech-language pathology (Yoder &
Stone, 2006; Kroeger & Nelson, 2006; Ingersoll, Dvortcsak, Whalen, & Sikora,
2005). Limited research was available on speech-language pathologists’ involvement
and successful interventions employed with children with co-occurring E/BD and
language deficits (Hyter, 2003; Hyter, Rogers-Adkinson, Self, Simmons, & Jantz,
2001; Keefe & Hoge, 1996; Giddan, 1991; Monast & Smith, 1987). Therefore, a gap
in the research was established regarding successful interventions with this
population.

No studies were found regarding how speech-language pathologists could best
intervene with students with E/BD and language deficits based on a digital search in
the Educational Resources Information Center (ERIC) database covering educational
research from 1966 to the present and using the keywords “speech-language
pathologist,” “interventions,” and “emotional/behavior disorders.” However, there
were a small number of studies (Hyter, 2003; Hyter, Rogers-Adkinson, Self,
Simmons, & Jantz, 2001; Keefe & Hoge, 1996; Giddan, 1991; Monast & Smith 1987) that addressed the issue of interventions with children E/BD and language deficits. It was necessary to systematically explore which therapeutic interventions were most effective for children with both E/BD and language deficits as educators were faced with the challenge to fulfill this documented need.

Research supports (Raver, 2005; Prelock, Beatson, Bitner, Broder, & Ducker, 2003; Wesley, 2002; Prelock, 2000; McGregor, 2000; Farber & Klein, 1999; Harn, Bradshaw, & Ogletree, 1999) and promotes the changing philosophy toward more inclusive, collaborative, and consultative models regarding intervention and assessment of speech and language issues. Speech and language intervention has moved toward a more inclusive model and away from the “pull-out” model (Dodge, 2004; Kaderavek & Justice, 2004; Hadley, Simmerman, Long, & Luna, 2000; Sanger, Hux, & Griess, 1995; Roberts, Prizant, & McWilliams, 1995; Farber, 1992; Magnotta, 1991) since the American Speech-Language-Hearing Association issued a position statement (“Guidelines for the roles,” 1993) addressing the need for therapy to be integrated into academics within the classroom setting. Collaborative models emerged in the literature over several years (Christensen & Luckett, 1990; Farber, Denenberg, Klyman, & Lachman, 1992) as well as the research on how to address the effectiveness of these models (Farber & Klein, 1999; Ellis, Schlaudecker, & Regimbal, 1995). These changes have been brought about in an effort to help students become more successful during their academic years.

This investigation was initiated to address two issues surrounding language deficits and children with E/BD. First, a current prevalence rate of speech-language
pathologists in southwest Michigan providing services to children with E/BD was
determined. Second, identifying which therapeutic interventions speech-language
pathologists utilize when working with children with E/BD were documented. In
addition to these two issues, data was collected regarding the perceptions of speech-
language pathologists regarding children with E/BD and language deficits.

Rationale for the Study

A current prevalence rate of speech-language pathologists working with
children with E/BD and language deficits must be determined to ascertain the scope
of this problem as the current statistic was nearly 20 years old (Casby, 1989).
Children with the label of E/BD have been found to have a high prevalence of
language deficits (Benner, Nelson, & Epstein, 2002). More specifically, researchers
(McDowell, Adamson, & Wood, 1982; Scruggs & Mastropieri, 1986) found
receptive, expressive, and pragmatic issues to be deficit areas for many children with
E/BD and language deficits. The most current prevalence rate, ranging between 35% and 97%, was offered by Benner, Nelson, and Epstein (2002) in their review of 26
studies of children with E/BD and language deficits. This wide-ranging prevalence
rate needs to be more accurately defined determine the severity of the problem of
these co-occurring disorders.

Educators, and more specifically speech-language pathologists, need to be
aware of the prevalence rates of co-occurring disorders so educational plans can be
designed to meet the needs of the children. Furthermore, it will be important to know
whether language services and specific interventions impact the traditionally poor
outcomes for this population of children. Second, the need to study currently utilized therapeutic practices must be addressed to learn how best to serve these children to prevent failure both academically and socially. Third, teachers and speech-language pathologists need to learn how to recognize characteristics of students with E/BD in order to accurately diagnose this population so they begin to receive suitable interventions as early as possible in their educational careers to avoid academic issues, social issues, and typical outcomes associated with children with E/BD.

Need for Current Prevalence Rate

One limitation of the research addressing the co-occurring conditions of E/BD and language deficits has focused on studying children in institutionalized and residential settings (Griffith, Rogers-Adkinson, & Cusick, 1997; Benner, Nelson, & Epstein, 2002). A relatively small body of research addresses the language needs of children with E/BD in school settings even though a review of 26 studies revealed a prevalence range for E/BD and language deficits between 35-97% (Benner, Nelson, & Epstein, 2002). A need to know more about the practices of speech-language pathologists with regard to this population of children exists given what has been reported about academic failure (Nelson, Benner, and Rogers-Adkinson, 2003), anti-social behavior (Gallagher, 1999; Asher & Gazelle, 1999), and graduation rates (U.S. Department of Education, 2005; Kronick & Hargis, 1998).

Given what has been previously reported a current prevalence rate of speech-language pathologists providing services to children with the label of E/BD must be ascertained. Furthermore, this investigation provided additional data regarding the
age levels at which speech-language pathologists provided therapy as well as whether speech-language pathologists recognized a relationship between E/BD and language deficits. Finally, in addition to collecting data on the extent to which speech-language pathologists were part of the educational plan and provide services to children with E/BD, it was also necessary to determine which interventions were utilized with this population of children. The practices and perceptions of speech-language pathologists warranted investigation in order to address language issues of children with E/BD since the majority of speech-language pathologists were employed in a school environment (ASHA Career Center).

Need to Study Intervention Practices

Research supports expressive, receptive, (Gualtieri, Koriath, Bourgondien, & Saleeby, 1983; Love, & Thompson, 1988; Warr-Leeper, Wright, & Mack, 1994) and pragmatic (McDonough, 1989) language deficits in children with E/BD. However, only preliminary research (Hyter, 2003; Hyter, Rogers-Adkinson, Self, Simmons, Jantz, 2001) or limited collaborative suggestions (Keefe & Hoge, 1996) have been documented in regard to meeting the needs of children with E/BD and language deficits.

Empirically proven academic and social-emotional interventions have been employed with children with E/BD (Kleinheksel & Summy, 2003; Forgan, 2002; Redl, 1959; Meichenbaum & Goodman, 1971; Hoover & Oliver, 1996; Rhode, Morgan, & Young, 1983; Coleman & Weber, 1988) and research-based interventions have been utilized with children with language deficits (Yoder & Stone, 2006; Kroeger & Nelson, 2006; Ingersoll, Dvortcsak, Whalen, & Sikora, 2005). However,
a deficiency in the literature was found regarding interventions for children with both E/BD and language deficits. Therefore, there was a need to study the specific interventions speech-language pathologists use with children who had been identified as E/BD with accompanying language deficits. Moreover there was a need to determine whether speech-language pathologists utilized different interventions with this population as compared to other children with language deficits.

Need for this Investigation

The need exists for data regarding the number of children with E/BD that a speech-language pathologist serves as the most recent information was nearly 20 years old (Casby, 1989). Additionally, there was a need to establish whether the interventions speech-language pathologists were employing with this population of children differed from those interventions utilized with children without E/BD. To assist in answering the research questions, additional data was gathered regarding the ages of those children served, the percentage of children with the label of E/BD on caseload, and the perceptions of speech-language pathologists regarding the relationship between children with E/BD and language deficits. This investigation addressed the need for a current prevalence rate of speech-language pathologists serving students with E/BD and language deficits as well as to determine which interventions they were utilizing in their approach to therapy.

Research Questions

The purpose of this investigation was to determine whether speech-language
pathologists practicing in Michigan served children with E/BD and language deficits and if so, what interventions were they employing in their practice. This study addressed the following two research questions:

R₁: Do speech-language pathologists perceive a relationship between emotional/behavioral disorders and language deficits?

R₂: Do speech-language pathologists use specific interventions when providing services to children with emotional/behavioral disorders and language deficits?

The corresponding null hypotheses were:

H₀₁: Speech-language pathologists do not perceive a relationship between emotional/behavioral disorders and language deficits.

H₀₂: Speech-language pathologists do not use specific interventions when providing services to children with emotional/behavioral disorders and language deficits?

Assumptions

In order to address the above stated research questions and corresponding null hypotheses, this study assumes:

1. The mailed questionnaires were answered accurately and truthfully by the person to which it was mailed.

2. Focus group participants were practicing speech-language pathologists working with students with E/BD and responded to questions and participated in the discussion providing accurate and truthful answers.
3. Focus group participants understood the needs of children with E/BD and had current knowledge of suitable intervention practices.

Summary

Chapter I reviewed a) the issues surrounding the educational needs of children with E/BD, specifically, how language needs in this population affect their academic and social outcomes, b) a need for an accurate prevalence rate as well as a need to learn which interventions speech-language pathologists were employing with children who have the label of E/BD and language deficits, c) the research questions to be addressed in this study, d) the assumptions made during this investigation, and e) the Michigan definition of emotional impairment, otherwise referred to as E/BD, and the federal definition of speech and language impaired. Chapter II will discuss the E/BD research within the field of special education and the speech and language pathology literature in regard to these co-occurring disorders. Finally, the need for further investigation of these concomitant disorders will be discussed and proposed.

Limitations of the Study

Limitations in the field of special education and speech and language pathology literature exist regarding children with E/BD and language deficits. Those limitations within the field of special education include the following:

1. Most studies on this population were conducted in institutional settings or residential settings (Griffith, Rogers-Adkinson, & Cusick, 1997; Benner, Nelson, & Epstein, 2002).
2. Most studies on this population were conducted in the 1980s and 1990s.

3. Limited information was available regarding types of language disorders associated with E/BD (Benner, Nelson, & Epstein, 2002).

4. The educational definition of E/BD can include children with a variety of disorders.

Limitations in the field of speech-language pathology include the following:

1. There was lack of a current prevalence rate of speech-language pathologists working with children with E/BD (Casby, 1989).

2. It was not known as to whether the interventions employed with children with E/BD differ from those interventions utilized with children without E/BD.

3. It was not known which interventions speech-language pathologists utilize with children with E/BD and language deficits.

Definition of Terms

The Michigan definition of an emotional impairment (Michigan Department of Education), or E/BD, states:

“Emotional impairment shall be determined through manifestation of behavioral problems primarily in the affective domain, over an extended period of time, which adversely affect the student's education to the extent that the student cannot profit from learning experiences without special education support. The problems result in behaviors manifested by 1 or more of the following characteristics:

a) Inability to build or maintain satisfactory interpersonal relationships within the school environment.
b) Inappropriate types of behavior or feelings under normal circumstances.

c) General pervasive mood of unhappiness or depression.

d) Tendency to develop physical symptoms or fears associated with personal or school problems.

Emotional impairment also includes students who, in addition to the characteristics specified in subrule (1) of this rule, exhibit maladaptive behaviors related to schizophrenia or similar disorders. The term "emotional impairment" does not include persons who are socially maladjusted, unless it is determined that the persons have an emotional impairment.

Emotional impairment does not include students whose behaviors are primarily the result of intellectual, sensory, or health factors.

When evaluating a student suspected of having an emotional impairment, the multidisciplinary evaluation team report shall include documentation of all of the following:

a) The student's performance in the educational setting and in other settings, such as adaptive behavior within the broader community.

b) The systematic observation of the behaviors of primary concern which interfere with educational and social needs.

c) The intervention strategies used to improve the behaviors and the length of time the strategies were utilized.

d) Relevant medical information, if any.
A determination of impairment shall be based on data provided by a multidisciplinary evaluation team, which shall include a comprehensive evaluation by both of the following:

a) A psychologist or psychiatrist.

b) A school social worker.”

The federal definition of speech and language impaired as defined by the Individual’s with Disabilities Education Improvement Act (2004) was as follows:

“A communication disorder such as stuttering, impaired articulation, severe disorders of syntax, semantics or vocabulary or a voice impairment, as determined by evaluation, to the extent that it calls attention to itself, interferes with communication, or causes the student to be maladjusted. In determining whether a child has a speech and/or language impairment, an assessment will be conducted by a certified speech-language pathologist. The written evaluation will criteria include:

a) An audiometric screening within the past calendar year,

b) A review of the student's academic history and classroom functioning,

c) An assessment of the student's functional communication skills, and

d) A review of the student's medical history, if appropriate.”
CHAPTER II

REVIEW OF THE LITERATURE

Introduction

The literature in the field of emotional/behavioral disorders (E/BD) addresses the issue of co-occurring language disorder; however, the scope was limited (Cantwell & Baker, 1991; Ruhl, Hughes, & Camarata, 1992; Beichman, Cantwell, Forness, Kavale, & Kaufmann, 1998; Cohen, Barwick, Horodezky, Vallance, & Im, 1998; Gallagher, 1999; Fujiki, Brinton, Morgan, & Hart, 1999; Benner, Nelson, & Epstein, 2002; Schery, 1985). There were numerous studies addressing language deficits in the field of speech-language pathology (Nathan, Stackhouse, Goulandris, & Strong, 2001; Casby, 1997; Toblim, Zhang, Buckwalter, & O'Brien, 2003; Greenhalgh & Strong; 2001). However, a limited body of research in the field of speech-language pathology exists in regard to the co-occurrence of E/BD and language deficits (Benner, Nelson, & Epstein, 2002) and of those, many were preliminary in nature (Hyter, 2003; Hyter, Rogers-Adkinson, Self, Simmons, Jantz, 2001).

Chapter II addresses the E/BD literature with regard to language deficits and the speech-language pathology literature in reference to E/BD and language deficits, prevalence rate as well as implications of co-occurring E/BD and language deficits. Additionally, limitations of the research and the need for future research also will be discussed.
Emotional/Behavior Disorders Literature

A limited body of research on the co-occurrence of language deficits in children with E/BD in the school setting has been conducted in the field of special education as well as speech-language pathology (Cantwell & Baker, 1991; Ruhl, Hughes, & Camarata, 1992; Beichman, Cantwell, Forness, Kavale, & Kaufmann, 1998; Cohen, Barwick, Horodezky, Vallance, & Im, 1998; Gallagher, 1999; Fujiki, Brinton, Morgan, & Hart, 1999; Benner, Nelson, & Epstein, 2002; Schery, 1985). Gaps in the literature still exist between what we know about the co-occurrence of these two disorders and the best way to intervene to serve students. Furthermore, an accurate prevalence rate was still yet to be determined; a range between 35% and 97% has been reported (Benner, Nelson, & Epstein, 2002). Furthermore, both fields of literature have proven the co-existence of these disorders were stable over time (Nelson, Benner & Cheney, 2005; Beichman, Cantwell, Forness, Kavale, & Kaufmann, 1998; Schery, 1985) and even increased as children developed (Cantwell & Baker, 1991). The variables associated with the development and perpetuation of these co-occurring disorders were yet to be determined empirically. A review of the speech-language pathology literature reveals approximately 25 studies addressing the concurrence of these disorders, while the special education literature encompassed approximately 40 studies addressing these co-occurring disorders. The number of studies in the field of special education increased greatly when other disorders, such as autism and psychiatric disorders, were included.
The speech-language pathology literature addresses different areas of language development in children. McDonough (1989) reported children diagnosed as having E/BD tended to have fewer conversational skills as compared their peers without an E/BD diagnosis. For those children diagnosed with E/BD their utterances were shorter and they had a more difficult time maintaining the topic of conversation which was an issue of pragmatic language. Furthermore, Rinaldi (2003) evaluated the language skills of children with E/BD and analyzed their test scores on a variety of language tests. The majority of the children had deficits in at least one area, social behavior, cognitive ability, or linguistic ability, on Abbeduto and Nuccio’s (1989) Model of Communicative Competence. The authors reported the model could be utilized to predict pragmatic language competence.

In a detailed examination of language, researchers (Griffith, Rogers-Adkinson, & Cusick, 1997; Warr-Leeper, Wright, & Mack, 1994) suggested children with emotional/behavior disorders have language concerns in all areas of language, which include syntax, semantics, phonology, and morphology, while others, (Hyter, 2003; Hyter, Rogers-Adkinson, Self, Simmons & Jantz, 2001) reported the area of language most affected for children with E/BD was pragmatics. Pragmatics was defined as “the study of the rules that govern the use of language in social situations” (Hedge, 2001) and involves the ability to use language for a variety of purposes, such as to initiate, maintain, and complete conversations, request, negotiate, describe, and to participate in engaging communication behaviors including turn taking, introducing topics of conversation, conveying the need for clarification.
Children with language difficulties often have a difficult time expressing
themselves and tend to use less elaborate utterances as compared to their typically
developing peers (Greenhalgh & Strong, 2001). This lack of ability to express
themselves leads to less developed socialization skills and behavioral issues (Hart,
Fujiki, Brinton, & Hart, 2004; Huaqing Qi & Kaiser, 2004). Such difficulties persist
through a child’s early developing years (Tomblin, Zhang, Buckwalter, & O’Brien,
2003; Casby, 1997) which may lead to academic difficulties and eventually to
students dropping out of school. Language deficits in children have compounding
effects as problems with expressive and receptive language skills often cross over into
literacy abilities (Nathan, Stackhouse, Goulandris, & Snowling, 2004; Marvin &
Wright, 1997). Children with language impairments were at a high risk for literacy
disabilities (Lewis, O’Donnell, Freebairn, & Taylor, 1998) and as many as 60% of
children with language impairment experience difficulties with learning literacy skills
(Wiig, Zureich, & Chan, 2000) due to underdeveloped pre-literacy and language
skills. This lack of skill development persists as children mature (Catts, Fey, Zhang,
& Tomblin, 1999).

In an effort to address the issue of language deficits in the classroom, the
American Speech, Language, Hearing Association (ASHA) holds that speech-
language pathologists provide therapy in the classroom environment (ASHA, 1993).
Collaborative interventions were beginning to appear as educators work together to
meet the needs of children with language deficits (Silliman & Wilkinson, 2004;
Hadley, Simmerman, Long, & Luna, 2000; Hyter, Rogers-Adkinson, Self, Simmons,
& Jantz, 2001; Farber & Klein, 1999).
E/BD and Speech-Language Literature

The Relationship Between E/BD and Language

A direct relationship between language deficits and E/BD has been established for nearly two decades (Baltaxe & Simmons, 1988). Researchers have conducted investigations on how best to identify risk factors, prevent the development of E/BD, and address a child's needs through early intervention (Trout, Epstein, Nelson, Reid, & Ohlund, 2006; Conroy & Brown, 2004; Kaiser & Hester, 1997). Concurrent to those investigations, researchers in the field of speech-language pathology (Griffith, Rogers-Adkinson, & Cusick, 1997; Warr-Leeper, Wright, & Mack, 1994; Hyter, 2003; Hyter, Rogers-Adkinson, Self, Simmons & Jantz, 2001) have identified expressive, receptive, and pragmatic language deficits which interfere with the development and progress of a child with E/BD. However, the body of research addressing the co-occurrence of E/BD and language deficits remains relatively small. The overarching issue lies in the identification of the co-occurrence of language deficits in children with E/BD and in the interventions most effective to meeting the needs of this population of children.

Researchers have shown there was a relationship between E/BD, or psychotic disorders, and language deficits (Baker & Cantwell, 1982; Camarata, Hughes, & Ruhl, 1988; Cantwell & Baker, 1977; Baker & Cantwell, 1987; Giddan, Trautman, & Hurst, 1989; Beitchman, Nair, Clegg, Ferguson, & Patel, 1986; Donahue, Cole, & Hartas, 1994). The relationship has been found to be stable over time supporting the argument for early identification and intervention (Beitchman, Cantwell, Forness, Kavale, & Kaufmann, 1998; Schery, 1985). Moreover, Cantwell and Baker (1991)
found the co-occurrence of children with E/BD and language deficits increased over
time as language difficulties were not addressed during the early educational years.
The manifestation of these concomitant disorders was observed in the language
abilities of children diagnosed with emotional/behavior disorders in clinical settings
wherein investigators reported expressive and receptive language deficits (Gualtieri,
Koriath, Bourgondien, & Saleeby, 1983; Love & Thompson, 1988; Warr-Leeper,
Wright, & Mack, 1994). Subsequent studies involving school aged children with the
label of E/BD indicated language skills that were one to two standard deviations
below their peers (Keef, Hoge, Shea, & Hoenig, 1992; Mack & Warr-Leeper, 1992;
Camarata, Hughes, & Ruhl, 1988).

Anti-social behaviors were often a product of a dual diagnosis of E/BD and
language deficits for children as a relatively large body of research addressed this
issue (Gallagher, 1999; Mack, & Warr-Leeper, 1992; Warr-Leeper, Wright, & Mack,
1994; Asher & Gazelle, 1999; Trautman, Giddan, & Jurs, 1990). Researchers
provided a variety of language-based rationale (Mack, & Warr-Leeper, 1992) as to
with aggressive behaviors used less verbal communication and more physical actions
in attempts to communicate. Fujiki, Brinton, Morgan, and Hart (1999) noted children
with non-compliance tendencies may have receptive language deficits that limit their
ability to comply to requests and directives from authority figures. Furthermore,
Ruhl, Hughes, and Camarata (1992) reported that children may misinterpret
communication, become frustrated, and as a result, develop anti-social behaviors.
A Landmark Review of the Literature

Benner, Nelson, and Epstein (2002) examined 26 studies (n = 2796) which addressed children with E/BD and language deficits in this landmark review. The authors examined studies conducted between the years of 1980 and 1998 which met their criteria. Only 26 of the 97 studies identified met the two criteria established by the authors which included, a) the study had to be quantitative in nature, and b) participants had to have a diagnosis of E/BD according to the Individuals with Disabilities Education Act or the Diagnostic and Statistical Manual of Mental Disorders used in the year of the study.

The authors reported three out of four, or 71%, of the children in the studies identified with a label of emotional/behavior disorders had concurrent language deficits. Furthermore, the authors reported two out of three, or 57%, of the children with diagnosed language deficits also were found to have a label of emotional/behavior disorders. In regard to the types of language disorders, approximately 71% of the children in the studies were identified as having pragmatic language deficits while 64% displayed expressive deficits, and 56% experienced receptive deficits.

The authors surmised five findings; a) children with E/BD tend to have high co-occurrence rates of antisocial behavior and language deficits, b) children with receptive language deficits have increased rates of behavior problems as compared to children with expressive language deficits, c) the estimate of co-occurring language deficits in children with emotional/behavior disorders was ten times greater than the general population, d) language disorders in children with emotional/behavior
disorders appear to have a devastating effect on interpersonal relationships, and e) the 
information gleaned from these studies was limited as there was incomplete 
information on such variables as ethnicity, socioeconomic status, and setting in which 
the data were collected. These findings, with emphasis on the last point made by the 
authors, indicate a need for further investigation in the area of children with 
emotional/behavioral disorders and language deficits and how educators, especially 
speech-language pathologists, meet the needs of these children in the educational 
system.

Prevalence Rates of E/BD

Emotional/behavior disorders was the fourth most common disability category 
under IDEA 2004 outranked by specific learning disabilities, speech and language 
impairments, and mental retardation (www.ideadata.org). Prevalence rates for 
children with emotional/behavioral disorders and language deficits have increased 
over time in public schools (www.ideadata.org). Children with E/BD enrolled in K-
12, federally funded, public schools have shown a steady increase in numbers from 
283,000, or 0.6% of school age children during the 1976-77 school year to 489,000, 
or 1.0% of the school age population during the 2003-2004 school year (U.S. 
Department of Education, 2006). See Table 1.
### Table 1
Number of Children with E/BD Educated in a Given Year

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Students with E/BD</th>
<th>Percent of Total School Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1976-1977</td>
<td>283,000</td>
<td>0.6%</td>
</tr>
<tr>
<td>1980-1981</td>
<td>347,000</td>
<td>0.8%</td>
</tr>
<tr>
<td>1990-1991</td>
<td>389,000</td>
<td>0.9%</td>
</tr>
<tr>
<td>1993-1994</td>
<td>414,000</td>
<td>1.0%</td>
</tr>
<tr>
<td>1999-2000</td>
<td>468,000</td>
<td>1.0%</td>
</tr>
<tr>
<td>2002-2003</td>
<td>485,000</td>
<td>1.0%</td>
</tr>
<tr>
<td>2003-2004</td>
<td>489,000</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

Further exploration of these statistics reveals that 80% of elementary and middle school children who had a label of E/BD were male while 75.8% of high school children with a label of E/BD were male. More than half, 56.9% of elementary and middle school children with a label of E/BD, were white, 27% were African-American and 12.8% were Hispanic. Approximately two thirds, or 61.4%, of children at the high school level with a label of E/BD were white, 25% were African-American, and 10.2% were Hispanic. None of the proportions changed significantly when comparing children with E/BD at the secondary level over time. However, it should be noted that the number of children who speak Spanish increased from 1.5% to 9% from 1987-2001 (Special Education and Elementary Longitudinal Study, 2003).
Prevalence Rates of E/BD and Language Deficits

The co-occurrence of E/BD and language deficits varies greatly in a 26-study review of the literature. Benner, Nelson, & Epstein, (2002) reported a wide range, between 35% and 97%, of children who were diagnosed with E/BD also had concomitant language disorders. Percentages as high as 95% have been reported in specialized educational settings (Camarata, Hughes, & Ruhl, 1988) for children with E/BD and language disorders with an especially high occurrence rate among preschool children; 65% in psychiatric outpatient family clinics (Love & Thompson, 1988). Minimal research has been conducted in settings that tend to be more inclusive despite the movement toward less inclusive settings. Co-morbidity rates were further supported when researchers found 54% of children in a day treatment program for children with E/BD demonstrated language difficulties (Trautman, Giddan, & Jurs, 1990). Furthermore, the authors noted that when children with specific psychiatric diagnoses were examined, 100% of those children with a label of pervasive developmental disorders had language deficits, 68% of the children with attention deficit disorders had language deficits, and 33% of those with a label of conduct disorder had language deficits. A limitation in the literature exists as variables were not consistently defined.

Educational Placements for Children with E/BD

Children with E/BD were placed in more restricted settings than other children with disabilities. Children were educated in a variety of settings. In 2004, (see Table 2) 32.3% of children with E/BD spent less than 21% outside of regular
class in a general education setting as compared to 22% who spent 21-60% of their school day outside of regular class and 28.4% who spent more than 60% outside regular class. These statistics were compared to 7.2% of children with E/BD who received educational services in a separate public school facility and 5.8% of children who receive educational services in separate private school facilities. Children educated in residential facilities comprise a small percentage of the total population of children with E/BD as 1.2% who receive their education in public residential facilities as compared to 2.0% who receive their education in private residential facilities. Lastly, 1.2% received services in a homebound or hospital setting (U.S. Department of Education, 2006). Statistics indicate that children with E/BD have been and continue to have the worst social, educational, and behavioral outcomes of any disability group (U.S. Department of Education, 2006; Bradley, Henderson, & Monfore, 2004).

Characteristics of Children with E/BD and Language Deficits

Effects on Academics

The diagnosis of concomitant E/BD and language deficits has been shown to play a role in a child’s academic performance (Nelson, Benner, & Rogers-Adkinson, 2003) as well as the child’s social-emotional development in regard to relating to others and building relationships (Ruhl, Hughes, & Camarata, 1992). In addition to the research which supports the existence of co-occurring E/BD and language deficits, reading, writing, and math deficits have been found to co-occur in this same population (Nelson, Benner, and Rogers-Adkinson, 2003). Classroom teachers
Table 2
Education of Children with E/BD by Setting

<table>
<thead>
<tr>
<th>Setting</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular School, Outside Regular Class</td>
<td></td>
</tr>
<tr>
<td>Less than 21%</td>
<td>32.3%</td>
</tr>
<tr>
<td>21-60%</td>
<td>22.0%</td>
</tr>
<tr>
<td>More than 60%</td>
<td>28.4%</td>
</tr>
<tr>
<td>Separate Public School Facility</td>
<td>7.2%</td>
</tr>
<tr>
<td>Separate Private School Facility</td>
<td>5.8%</td>
</tr>
<tr>
<td>Public Residential Facility</td>
<td>1.2%</td>
</tr>
<tr>
<td>Private Residential Facility</td>
<td>2.0%</td>
</tr>
<tr>
<td>Homebound/Hospital Placement</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

described children with behavioral issues as having difficulty with language related skills such as oral comprehension, retention, following directions, expressing thoughts, and listening comprehension (Kaufman, Swan, & Wood, 1979; Scruggs & Mastropieri, 1986). In an effort to address issues that persist in this population of children, researchers suggested curricular modifications which resulted in increased engagement and decreased levels of problem behaviors (Kern, Bambara, & Fogt, 2002; Lo, Loe, & Cartledge, 2002). Researchers have suggested children with mild/moderate behavior disorders should be considered at risk for potential language deficits especially given the fact that fewer than 6% of the children studied received
speech and language services and none had received a formal language assessment (Camarata, Hughes, & Ruhl, 1988).

Researchers (Reid, Gonzalez, Nordness, Trout, & Epstein, 2004; Rinaldi 2003; Sanger, Magg, & Shapera, 1994; Baltaxe & Simmons, 1988; Hummel & Prizant, 1993) have shown how a language deficit for a child with an E/BD can interfere with academic progress. Nelson, Benner, and Rogers-Adkinson (2003) reported children with emotional/behavior disorder who had language deficits were likely to exhibit concurrent written language, reading, and math deficits and that 45% of the 152 randomly chosen children with E/BD in their study had a language deficit. They reported children with emotional/behavior disorders had a high rate of other academic difficulties in addition to language. More specifically, the authors found 46% of the children had difficulties with written language, 41% had difficulties in reading, and 31% had difficulties in math. Furthermore, children with E/BD tend not to fare as well as their peers academically. They were less likely to receive grades of As and Bs at the secondary education level as compared with all their peers with and without disabilities. Approximately one quarter, or 28.3% of children with E/BD, received A’s or B’s and 13.6% receive D’s and F’s—the highest proportion of any disability category. Socially, approximately 41% of children at the secondary level scored in the low range on a social skills assessment as compared to their peers with other disabilities—only children with autism scored lower (U. S. Department of Education (2002a).
Effects on Social-Emotional Development

The diagnosis of E/BD and language deficits has implications on academics as well as the social-emotional arena. Anti-social behaviors (Gallagher, 1999; Asher & Gazelle, 1999) have been found to co-exist in this population of children often developing in the early years of a child’s education as a result of language difficulties (Cantwell, Baker, & Rutter, 1978). Conversely, Schery (1985) indicated the presence of a social-emotional issue corresponds to a failure to develop language skills at the expected rate. Moreover, McDowell, Adamson, & Wood, (1982) suggested deviant behaviors and academic problems may be the result of expressive and receptive language deficits. Poor social and pragmatic language skills have a negative impact on whether a child was capable of establishing, developing, and maintaining relationships. However researchers, (Hill & Coufal, 2005; Guess & Baer, 1973; Bricker & Bricker, 1974; Stainback & Stainback, 1978) have prescribed and demonstrated that teaching formal language to people with severe disabilities can result in changing negative behaviors thus allowing them to effectively communicate with teachers, peers, and family members. Poor social skills, in conjunction with unsuccessful academic performance, play a role in the end result of a child’s academic career.

Graduation Rates

The effects E/BD and concomitant language difficulties had on academics and social skills were ultimately evidenced in graduation rates. High school dropout rates for children with E/BD were elevated compared to their peers with and without
disabilities (Kronick & Hargis, 1998). Children with EBD have a graduation rate of 28.9% and their drop-out rates have varied less than 5% between 1993-94 and 2000-2001 (U.S. Department of Education, 2005). Furthermore, 17,798 of the 95,658, or 13%, of the students with E/BD who exited special education dropped out during the 2002-2003 school year. The future outcomes were not promising when children with E/BD exit the academic arena under poor circumstances.

Post High School Outcomes

The Office of Special Education and Rehabilitative Services, U. S. Department of Education, conducted postsecondary education studies for children with disabilities. An estimated 7.8%, (33,260 out of 428,280 children with disabilities) of children with emotional disturbance and mental illness (reported as one category) were enrolled at a 2-year and 4-year postsecondary education institution during 1997-1998 (nces.ed.gov). Approximately 39% of institutions enrolled children with emotional disturbance and mental illness. Seventy-two percent of 2-year and 4-year public institutions were more likely to enroll children with disabilities as compared to private institutions for all disability categories. Additionally, nearly all medium and large sized educational institutions, 99% and 100% respectively, admitted children with disabilities compared to only 63% of small institutions (nces.ed.gov). Educators need to help this population of children become successful through individualized and proven interventions in order to improve the statistic surrounding children with E/BD.
Need for Research-Based Interventions

Children with E/BD have a high incidence of language difficulties as prevalence rates range between 35% and 97% depending on placement and definition of a language deficit (Benner, Nelson, & Epstein, 2002). Effective interventions were necessary in order to meet the needs of children with these co-occurring disorders, reduce the prevalence rate, and meet the mandates of the law (IDEA, 2004). Collaborative interventions to serve children with language deficits have been proposed (Raver, 2005; Dodge, 2004; Hartas, 2004; Wesley, 2002) but given the continued poor outcomes for many children with E/BD and language deficits, the need has not been met. Few studies have addressed collaborative interventions between the speech-language pathologist and the classroom teacher for children with E/BD and language deficits (Hyter, Rogers-Adkinson, Self, Simmons, Jantz, 2001; Keefe & Hoge, 1996). Research-based interventions must be developed and implemented to meet the needs of the students, reduce the prevalence rate, and abide by the mandates of the law (IDEA 2004). IDEA 2004 stated educators must implement researched-based interventions in their teaching practices. This legislation was met with obstacles as there were few empirically supported intervention strategies designed specifically for students with E/BD and language deficits.

Research-based intervention methods were available to address the needs of children with E/BD and there were empirically supported interventions addressing the needs of children with language deficits. However, the research was nearly non-existent regarding research based intervention methods for students with co-occurring E/BD and language deficits. Hyter, Rogers-Adkinson, Self, Simmons, and Jantz
(2001) implemented a program to address the pragmatic needs of young children diagnosed with E/BD. Results of their preliminary study indicated children can be positively influenced when classroom-based pragmatic interventions were implemented, however, the authors noted there were limitations to the study. Thus, the need to identify language deficits in children with E/BD (Rinaldi, 2000) design, implement, and evaluate effective interventions for this population was warranted. Furthermore, much of the research conducted on the co-occurrence of E/BD and language deficits has been conducted in clinical settings (Benner, Nelson, & Epstein, 2003). The call for intervention becomes greater as more children with co-occurring E/BD and language deficits were identified in the educational setting and in light of the fact that educational outcomes continue to be bleak. The fields of speech-language pathology and special education need to collaboratively address the intervention issue for this population of children.

Bridging the Gap Between the Disciplines

A continued need exists for research that will marry the speech-language pathology and special education disciplines to better serve children with these co-occurring disorders. The gap between the fields has been narrowed through research efforts, as previously cited, although Cohen, Barwick, Horodezky, Vallance, and Im (1998) reported 40% of children with E/BD have language deficits that were undiagnosed and untreated. Preliminary research has focused on the identification of language deficits in children with E/BD (Hyter, 2003; Hyter, Rogers-Adkinson, Self, Simmons, Jantz, 2001; Toppelberg & Shapiro, 2000).
Understanding the Population

Children with emotional/behavioral disorders form a heterogeneous group (Kauffman, 1981) with common characteristics as children with a variety of specific disorders are grouped into this category in the educational arena. They relate to their environment in social ways that negatively impact social relationships and learning (Paul & Epanchin, 1982; Kaufman, 1981). There was empirical support for children who have a label of mild/moderate behavior disorder to be at risk for language deficits (Camarata, Hughes, & Ruhl, 1988). School children with emotional/behavioral disorders and language deficits were underserved (Casby, 1989) and most that were served in a school receive services in less restrictive settings such as special education classrooms (Friend & McNutt, 1984). However, small strides have been made suggesting how speech-language pathologists can best serve children with emotional/behavioral disorders and language deficits (Giddan, 1991).

Researchers have encouraged educators to examine the need for language services for children with E/BD as far back as the 1980s (Camarata, Hughes, & Ruhl, 1988). Still, others have attempted to predict the future for children with E/BD with regard to what has been learned and what society will and will not accept (Nelson, 2000). However, with all that has been learned children with E/BD continue to be the last group of children to be included in the general education classroom as well as the most under-identified and under-served group in education (Morse, 1994; Kaufman, 1997).

The need for early identification and intervention was brought to the forefront in the 1980s for children with E/BD (Kauffman & Landrum, 2006). Kauffman and
Landrum (2006) stated how mild deviant behaviors were indicative of future problems while Walker and Sprague (1999) described how antisocial behavior developed and what educators can do to intervene. However, despite what has been documented, albeit limited, regarding prevention, early identification, intervention, and educational outcomes for children with E/BD (Walker & Shinn, 2002), educators have continued to still strive toward meeting the needs of children with E/BD (Kauffman, 2006).

Implications of Co-Occurring Disorders

Growing Numbers by Category

The number of children in the federally defined categories of speech and/or language impaired and E/BD has continued to grow over the years. Speech and/or language (S/L) impairments were the second most common disability and E/BD as the fourth most common disability category. See Table 3.

Most children identified with a label of E/BD were not identified as having a co-occurring language deficit in the review by Benner, Nelson and Epstein (2002). Language deficits, especially those which were undiagnosed and untreated, have devastating effects on a child’s interpersonal (Rinaldi, 2003; Gallagher, 1999; Asher & Gazelle, 1999) and academic life (Nelson, Benner & Rogers-Adkinson, 2003). Children have shown difficulty initiating, developing, and maintaining relationships with peers, adults, and authority figures as they cannot convey thoughts and ideas in an effective manner due to language deficits.
Table 3
Numbers in Disability Categories Across Three Decades

<table>
<thead>
<tr>
<th>Disability</th>
<th>1980 Percent*</th>
<th>1990 Percent</th>
<th>2003 Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>S/L</td>
<td>1,168,000</td>
<td>985,000</td>
<td>1,441,000</td>
</tr>
<tr>
<td>E/BD</td>
<td>347,000</td>
<td>389,000</td>
<td>489,000</td>
</tr>
</tbody>
</table>

*Percent in K-12 education

Children with E/BD drop out of school before completing the requirements for graduation at a much higher rate as compared to their peers with and without disabilities (U.S. Department of Education Twenty-Sixth Annual Report to Congress, 2004; Kronick & Hargis, 1998). Children with E/BD have a graduation rate of 28.9% and have consistently had, along with children with mental retardation, low graduation rates. Furthermore, drop-out rates for children with E/BD have varied less than 5% between 1993-94 and 2000-01 (U.S. Department of Education Twenty-Fifth Annual Report to Congress, 2003).

Limitations and Future Research

As with any body of underdeveloped literature, limitations and suggestions for future investigations present themselves. These conclusions hold true for studies regarding children with E/BD and language deficits. Benner, Nelson, and Epstein...
(2002) conducted a meta-analysis of 26 studies in which they reported the various researchers utilized causal/comparative designs which did not address the strength of the relationship between E/BD and language deficits. It was difficult to ascertain which variables play a role in language deficits in children with E/BD without correlational and experimental design methods and as such, future studies need to address the issue of design. Additionally, it was difficult to understand which language interventions might reduce the occurrence and extent of E/BD. The authors suggested longitudinal studies, as do Kaiser and Hester (1997), to determine whether E/BD emerges as a result of a language deficit, whether a language deficit emerges as a result of E/BD, or whether the two variables were related through a common preceding variable. Additionally, information regarding socioeconomic status, ethnicity, and family status of the children studied were inconsistent. As Benner, Nelson, and Epstein (2002) noted, educational and mental health settings merit further investigation in addition to participant characteristics as studies were conducted mainly in speech clinics, psychiatric facilities, and residential treatment facilities. Lastly, future research to examine which components of language pose difficulty for children warranted further investigation to determine which interventions would prove most successful.

Researching Related Areas

Researchers (Beitchman, Cantwell, Forness, Kavale, & Kaufmann, 1998; Torgeson, 1998; Gillam, Hoffman, Marler, & Wynn-Dancy, 2002) suggested studying cognitive processes, such as auditory comprehension, memory, attention,
and visual perception as these underlying processes preced the onset of language development. Rogers-Adkinson (2003) suggested future research address underlying issues such as neurological pathology. More specifically, Vaughn, Levy, Coleman, and Bos (2002) suggested future studies examine specific needs of students with regard to reading and identifying interventions that allow for success. Additionally, the authors called for a need to bring research into classroom practice which was a step not always taken after conclusion of research.

Data Collection

The research environment can prove a limiting factor in the collection of data as Lo, Loe, and Cartledge (2002) reported it was difficult to be discrete and unobtrusive when recording spontaneous verbal statements in noisy situations. Others (Kern, Bambara, & Fogt, 2002) have suggested future designs may consider soliciting data directly from students with E/BD and language deficits. Conroy and Brown (2004) reported a need for early identification and service implementation to a greater extent than what has been done to date necessitating the need for involvement in home and school environments. Furthermore, Getty and Summy (2004) suggested a need for continued research targeting the identification of language deficits and research-based intervention practices for preschool through secondary education who have a label of E/BD.

Addressing Limitations of the Research

An investigation into the practices of speech-language pathologists serving
students with E/BD and language deficits must be conducted in order to begin to address limitations in the current body of research. First, a current prevalence rate of speech-language pathologists serving students with the label of E/BD must be determined as previous research identified a relatively high percentage of students with E/BD as having language deficits. Next, in order to adequately address the needs of this population it was necessary to ascertain which interventions speech-language pathologists were employing in their current service delivery with these children. Lastly, this information was needed to determine whether the use of specific interventions utilized by speech-language pathologists when working with this population have an impact on their educational outcomes.

Summary

Chapter II reviewed the prevalence rates of E/BD, speech and language impairments, and the combination of the two disability areas in addition to pertinent literature in both fields, as well as the implications of these co-occurring disorders. Chapter III describes the methodology utilized in collecting the data to ascertain prevalence rates and intervention strategies when working with children with E/BD and language deficits from speech-language pathologists’ perspectives.
CHAPTER III

METHODOLOGY

Introduction

This investigation employed survey methodology (Krathwohl, 1997) in combination with focus group methodology (Krueger, 1994) to answer the following two research questions:

R₁: Do speech-language pathologists perceive a relationship between emotional/behavioral disorders and language deficits?

R₂: Do speech-language pathologists use specific interventions when providing services to children with emotional/behavioral disorders and language deficits?

This investigation utilized a combined survey and focus group methodology to ascertain a current prevalence rate of speech-language pathologists working with children with E/BD since the only known one was nearly 20 years old (Casby, 1989). Additionally, information was collected regarding the intervention practices utilized by speech-language pathologists when working with children with E/BD. Finally, perceptions of speech-language pathologists working with children with E/BD were documented through a focus group format.

A paper and pencil survey was used to collect descriptive statistical data as it was the most familiar to recipients and cost effective for the researcher (Porter, 2004; McMillan & Schumacher, 2006). Paper and pencil surveys were often utilized in the educational setting and were often utilized to describe the characteristics of a specific
population (McMillan, & Schumacher, 2006; Fink, 2003; Krathwohl, 1997). Focus
group research, also employed during this investigation, has been utilized in a variety
of disciplines (Morgan 1998) for a variety of purposes including to gain information
on a specific topic, generate ideas, obtain personal perspectives, as well as to obtain
information regarding the beliefs, practices, and attitudes regarding of a particular
group of people (Morgan, 1988; Krueger, 1994; Powell & Single, 1996; Stewart &
Shamdasani, 1990). Focus groups allowed researchers to collect information
regarding a person's feelings, attitudes, and beliefs which were not obtained through
other data collection methods (Litoselliti, 2003).

Chapter III begins with a research foundation for employing the survey
method to collect data for this study followed by the rationale for a follow-up focus
group to collect specific data from speech-language pathologists working with
children with E/BD. This chapter closes with the statement of the two null
hypotheses and explanation of the data analysis.

Research Foundation for Survey Method

Surveys were utilized for a variety of purposes (McMillan & Schumacher,
2006; Krathwohl, 1997). They can be used as the sole means of gathering data or in
conjunction with other research designs. Surveys can be simple descriptive in nature
as they gather information from one group of people at a given time, cross-sectional,
or longitudinal depending on the nature and purpose of the investigation (Mertens &
McLaughlin, 2004). They were used in education, business, politics, government,
sociology, public health, and psychology as information can be gathered from large
numbers of people and were most often utilized to describe the incidence, frequency, and distribution of the characteristics of an identified population (McMillan, & Schumacher, 2006). Surveys were employed to gather specific information on a particular topic from many respondents inexpensively as well as to learn about people’s beliefs, values, demographics, opinions, habits, desires, ideas, and compare and predict attitudes and behaviors (McMillan, & Schumacher, 2006; Fink, 2003; Krathwohl, 1997). Additionally, they were employed for their ease and cost effectiveness and were often employed in the educational setting (McMillan and Schumacher, 2006).

Investigators determine how the data will be collected when conducting survey research. Researchers have used mail, telephone, personal interviews, email or Web-based surveying or a combination of methods depending on their needs, resources, cost factors, nature of the data to be collected, size and characteristics of the sample, and timelines (Mertens & McLaughlin, 2004). Fill in the blank type surveys tend to be the most familiar and inexpensive approach of the different types of surveys (Porter, 2004). However, Web-based surveys were growing in popularity as more people were using email and the Web to conduct business and correspondence (Mertens & McLaughlin, 2004). Researchers must be cautious when utilizing this method of data collection as surveys that take a long time to load on a participant’s computer risk a low response rate.

Survey Response Rates

Research suggests an adequate response rate to surveys was 70% (Fink, 2003)
although investigators hope for high return rates of 95% to 100% and in some cases expect the high return rate depending on the survey questions and to whom it was sent. However, Fink (2003) reported unsolicited surveys receive low response rates and a 20% response rate for a mailed survey was not uncommon. Bourque and Fielder (2003) reported that mailed survey responses can be 30% or lower when follow-up measures were not employed. Follow-up contact by mail or telephone increase response rates with a 70% response rate, or more, being achievable (Mertens, 2004; Bourque and Fielder; 2003). Other factors that positively influenced response rates included preliminary notification and follow-ups, inclusion of a return envelope with postage, and monetary incentives (Mertens, 2004). Factors that play a role in response rates such as ability to locate respondents, repeated follow-ups, and previous beliefs and attitudes about the subject matter (Mertens, 2004) tended to diminish response rates in survey research.

Survey for Speech-Language Pathologists

A survey was utilized to obtain specific information from speech-language pathologists working with children with E/BD and language deficits in order to obtain an accurate, current prevalence rate. A survey design was chosen as it was cost effective (McMillian & Schumacher, 2006; Mertens & McLaughlin, 2004) and the objective of this investigation was to gain information which was straightforward in nature (Bourque & Fielder, 2003). Questions were developed for the survey based on guidelines provided in Bourque and Fielder (2003). A cover letter accompanied the survey as suggested by Mertens (2004) and a postage paid envelope was included in
each mailing in an effort to increase response rate (Mertens, 2004). Postcard reminders were mailed to speech-language pathologists who had not returned the survey after two weeks in an effort to increase the response rate (Mertens, 2004; Bourque & Fielder; 2003). Survey methodology was the utilized for the many advantages of collecting the type of data needed for this investigation.

**Rationale for Using Survey Method**

**Advantages of Survey Research**

The most advantageous reason for employing a survey design was the low cost as compared to other design methods. Other sample related advantages include coverage of a wider geographic area, larger sample size due to lower cost (Mertens & McLaughlin, 2004) and the mail survey's ability to cover a wider geographic area, and less apprehension regarding talking to someone during a phone interview (Bourque & Fielder, 2003). Further advantages of survey research include the choice of how the data will be collected whether it be through mail, telephone, personal interviews, email, or Web-based surveying or a combination of any of the previously stated methods (Mertens & McLaughlin, 2004). Implementation of a mailed survey was easier to undertake as less personnel was needed to carry out the investigation and were generally shorter and were more likely to be completed by individuals as compare to longer in-depth personal interviews or computer assisted telephone interviews (Bourque & Fielder, 2003). Finally, it was assumed all recipients receive the survey at the same time and will return them in approximately the same range of time (Bourque & Fielder, 2003).
Disadvantages of Survey Research

The greatest disadvantage of using mailed surveys was the low response rate. Investigators can expect approximately a 20% return rate when a single mailing was made with no incentives included or promised (Bourque & Fielder, 2003). However the researchers stated the response rate can increase when follow-up mailings or telephone calls were incorporated into the research design. Literacy and language can be an issue on mailed surveys as it was estimated that 20% of adults in the United States were illiterate (Bourque & Fielder, 2003). However, illiteracy was not an issue in this investigation as all surveys were mailed to practicing speech-language pathologists who held teaching certificates and Master’s degrees. An administrative disadvantage of using mailed self-administered surveys was the lack of control the investigator had over who responded. Recipients can complete the survey in a collaborative manner with a colleague thus biasing their responses.

Survey Questionnaire Validity and Reliability

A research design with internal validity results in knowledge which holds true for the situation under investigation (Mertens & McLaughlin, 2004) while external validity yields results which apply to the survey’s targeted population (Fink, 2003). This survey portion of this investigation was simple and preliminary in nature as it served as a foundation to understand the practices and perceptions of speech-language pathologists when working with students with E/BD and language deficits. Therefore, the results were generalized to practicing speech-language pathologists serving students with E/BD and language deficits in the public school system.
Effort was made to control for internal validity as surveys were mailed to all school-based speech-language pathologists who were members of the Michigan Speech-Language Hearing Association. All members had an equal chance of participating in this investigation. However, Fink (2003) reported it cannot be assumed that a random sample guaranteed that the survey produced truthful responses. The validity of the information collected was dependent of the honesty of the respondents (Mertens, 2004) and the cover letter stated responses would be kept confidential in an effort to increase truthful and accurate responses. An attempt to further control for internal validity, such as mailing surveys to speech-language pathologists of a certain age group or with a certain number years of experience, was not made so as not to limit external validity, or generalizability, of the results (Krathwohl, 1997). While the results of the survey were generalizable to practicing speech-language pathologists, Fink (2003) cautions that surveys should be conducted with a variety of places, with a variety of participants over a number of years in order to maximize application of the data.

It was assumed that all responding speech-language pathologists shared the same construct of emotional/behavioral disorders and language deficits, they understood each of the questions, and that they cared about participating in the survey (Fink, 2003). This assumption was made in an effort to control for reliability of answering the questions on the survey although respondents varied in the number of years of experience working with this population.
Instrumentation

The investigator was interested in the practices and perceptions of speech-language pathologists working with children with E/BD and language deficits. The first research question, “Do speech-language pathologists perceive a relationship between emotional/behavioral disorders and language deficits?” was formulated to address the perceptions of speech-language pathologists. This investigator was also interested in determining a current prevalence rate of practicing speech-language pathologists working with children with E/BD and language disorders in a school system.

A survey design was employed for its cost effectiveness (McMillian & Schumacher, 2006; Mertens & McLaughlin, 2004), because the data to be collected was simple in nature (Bourque & Fielder, 2003) and since survey was utilized to collect information about people’s beliefs and behaviors (McMillan & Schumacher, 2006; Fink, 2003; Krathwohl, 1997). Since this investigation sought to reach a large geographic area of practicing speech language pathologists, survey research employed as was suggested by Mertens and McLaughlin (2004). A current prevalence rate of a large number of speech-language pathologists working with children with E/BD was sought in conjunction with the age ranges they served and perceptions, therefore, survey research was chosen as these data were easily gathered using this method (McMillan, & Schumacher, 2006).

Survey recipients were asked to respond to a simple three-item survey (see Table 4) developed by the researcher in an effort to gain information about the practices and perceptions of speech-language pathologists working with children with
E/BD and language deficits. The investigator created a simple survey as participants were more likely to respond and return the survey (Bourque & Fielder, 2003). Recipients were asked to mark responses from given choices; written responses were not solicited. Speech-language pathologists were asked the questions in Table 4.

Recipients of the questionnaire (Appendix B) were asked to sign the consent form giving permission to use their responses, respond to the attached three-item questionnaire, and return their responses in the provided postage-paid envelope which was coded for tracking purposes. Recipients were asked to respond whether they worked with children with E/BD. If they answered “yes,” they completed the next questions that asked for the number of students with E/BD on their caseload, and the percentage of students with E/BD that comprise their caseload. The second question on the questionnaire asked participants whether they perceived a relationship between children with E/BD and language deficits and speech-language pathologists were asked to respond “yes” or “no.” The third and final question on the questionnaire asked recipients if they would be interested in participating in a focus group discussion on the topic of children with E/BD and language deficits. Respondents were asked to provide their name, phone number, email address, the best time to contact them, and their preference for contact method, either email, phone, or both.

The investigator employed survey methodology for several reasons. First, the information collected was straightforward in nature (Bourque & Fielder, 2003), a survey was cost effective (McMillan & Schumacher, 2006; Mertens & McLaughlin, 2004), and since surveys were often utilized to collect data on a large population’s beliefs and behaviors (McMillan & Schumacher, 2006; Fink 2003; Krathwohl, 1997).
Table 4
Three Item Survey Mailed to Speech-Language Pathologists

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Do you provide speech and language services to students who have diagnosed emotional/behavior disorders (EBD)? If yes, what percentage of your caseload is identified as EBD and what is the age range you serve?</td>
</tr>
<tr>
<td>2</td>
<td>Is there a relationship between emotional/behavioral disorders and language deficits?</td>
</tr>
<tr>
<td>3</td>
<td>Would you be interested in being part of a focus group to share your views on the topic of students with emotional/behavior disorders and language deficits?</td>
</tr>
</tbody>
</table>

The investigator sought to collect data from speech-language pathologists throughout the state of Michigan and survey research met the needs of this study. Secondly, survey research was utilized for generalizability purposes (Krathwohl, 1997). The investigator controlled for internal validity by mailing surveys to all school-based speech-language pathologists who were members of the Michigan Speech-Language Hearing Association. Further measures were taken to control for validity as the cover letter included with the survey indicated responses would be kept confidential (Mertens, 2004). Data was collected on a current prevalence rate of speech-language pathologists serving children with E/BD, what percentage of their caseload was comprised of this population, which age groups they served, and whether they perceived a relationship between E/BD and language deficits.
Gathering Participants for a Focus Group Discussion

Focus group methodology was employed in this investigation to gather information on a specific topic from a specific group of people (Vaughn, Schumm, & Sinagub, 1996) and as a means to gather information on the experiences and beliefs (Litoselliti, 2003; Powell & Single, 1996) as well as the practices of speech-language pathologists. A small number of focus group participants (Krueger, 1994) were gathered together so the moderator had ample opportunity to solicit qualitative data from each member (Berg, 2004).

Participants

A contact list of practicing speech-language pathologists was obtained from the Michigan’s Speech-Language, Hearing Association following approval of this investigation by Western Michigan University’s Human Subjects Institutional Review Board in November, 2006. Thirty speech-language pathologists, of the 206 returned surveys that were fully completed, who had indicated on the questionnaire that they would be interested in participating in a focus group, were contacted to determine whether they were still interested in participating in a focus group to discuss their beliefs and practices regarding students with emotional behavior disorders and language deficits. They were contacted by phone using a scripted format (Appendix H) and/or email also using a scripted format (Appendix I) to determine their availability to participate in the focus group. Thirty people indicated they would be interested in participating in a focus group but when contacted by phone and/or email
at least twice, they did not respond or indicated they would not be available to participate.

Due to low numbers (Krueger, 1994) of people who committed to participate in the focus group, the investigator submitted a request to Western Michigan University’s Human Subjects Institutional Review Board (Appendix J) requesting the participant search be expanded to the southwest portion of the state in an effort to recruit more participants who would be willing to travel a short distance to participate in the focus group. It was assumed that most speech-language pathologists practicing in Michigan were members of the Michigan Speech-Language Hearing Association and therefore would receive and complete the survey, however that assumption was incorrect. Therefore, local school directories were consulted to recruit potential focus group participants. Phone contacts were made to speech-language pathologists practicing in local school districts. This search resulted in six people willing to participate in the focus group in addition to the two participants who had already committed for a total of seven people who comprised the focus group. Researchers stated the ideal number of participants for a focus group discussion ranged between 6-10 people depending on a variety of variables including the type of information to be gathered, topic sensitivity, length of focus group, and confidentiality of the data (McMillan & Schumacher, 2006; Mertens, 2005, Krueger, 1994). Confirmation emails were sent and/or phone calls were made to remind people of the details of the focus group (Appendix K).
Research Foundation for Focus Group

A focus group was defined as having two elements: a) a moderator who sets the stage and poses prepared questions, and, b) a goal of eliciting feelings, attitudes, and perceptions from participants regarding a specific topic (Vaughn, Schumm, & Sinagub (1996). The facilitator for this investigation was a speech-language pathologist with 12-years experience as a clinician and 10 years experience as a state and national presenter. The moderator was a special education teacher with 22 years experience in the classroom. Together the facilitator and the moderator conducted as the investigator acted as the note-taker within the group of 6 participants. The intent of the focus group, most effectively comprised of seven to 10 people, was to provide a comfortable environment which promotes self-disclosure from participants as well as thought provoking ideas, responses, and comments as a result of input from other members (Krueger, 1994). The facilitator and the moderator were familiar with this interview-type atmosphere as they had a combined 34 years experience working in special education and were at ease with soliciting information without bias from participants.

Focus groups were initially referred to as focused interviews by Robert Merton at Columbia University in 1941. He later wrote an influential book on the topic of focus groups and his methods were still highly regarded in the area of focus group research (Puchta & Potter, 2004). Since then focus groups have been utilized by academic and applied social scientists, market researchers, and political scientists (Morgan 1998). Focus group research was used for a variety of purposes including to discover new information, brainstorm and generate new ideas, explore controversial
or sensitive topics, as well as to obtain different perspectives, beliefs, practices, and attitudes regarding a specific topic (Morgan, 1988; Krueger, 1994; Powell & Single, 1996; Stewart & Shamdasani, 1990). Focus groups allow researchers to obtain information regarding a person's experiences, feelings, attitudes and beliefs that may not be obtained when utilizing other data collection methods (Litoselliti, 2003) and as such, was chosen for this investigation to elicit specific information from speech-language pathologists.

Focus Group Validity and Reliability

Validity

"Validity is the degree to which the procedure really measures what it proposes to measure" (Krueger, 1994, p.31). Focus groups typically have high face validity as a result of the believability of comments from members of the group (Krueger, 1994). Potential threats to validity of focus group data includes the issues of compliance, identification, and internalization (Albrecht, Johnson, & Walther, 1993). To account for the issue of compliance the facilitator in this investigation encouraged members to speak from their point of view and not be swayed by trying to help the researcher collect an ideal set of data. The facilitator encouraged participants, before beginning of the focus group, not to attempt to identify with an opinion (Asch, 1952) or statement if they believed otherwise as it would provide inaccurate data. Lastly, the facilitator addressed internalization, deeply ingrained beliefs, by reminding participants that the focus group discussion could result in an acceptable changed opinion or belief. While focus groups and interviews tend to

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promote self-disclosure (Radmacher, & Azmitia, 2006; Morgan & Krueger, 1993)
Albrecht, Johnson, and Walther (1993) reported participants were less susceptible to
conform to group opinion.

Reliability

Fern (2001) stated focus group members were less likely to provide unreliable
or invalid responses to questions as they were unsure whether they would need to
explain or defend their views. Focus groups tend to show reliability and show
evidence of face validity because of members’ compulsion to provide accurate input
(Fern, 2001). The facilitator of this investigation’s focus group encouraged
participants to speak openly when they shared their thoughts and perceptions.

“Reliability requires conducting a systematic analysis of the transcripts or
tapes to check for the consistency, stability and equivalence of moderating procedures
across groups. The coding scheme is critical” (Fern, 2001). As such, Knodel (1993)
suggested an overview grid for analytical purposes when coding data. The researcher,
also the note taker during the focus groups, analyzed the transcript using a coding
system. A coding system was developed to record themes, pertinent quotations,
interventions, and noteworthy comments. In addition, the facilitator and moderator
were provided with the typed transcripts along with a coding sheet to analyze the
transcript data in order to address the issue of triangulation. Triangulation of the data
was utilized as a means of mutual confirmation when interpreting the data (Leedy,
2001) from the focus group.
Advantages of Focus Group Research

There were advantages and disadvantages to utilizing a focus group format to gather data (Litoselliti 2003; Stewart & Shamdasani, 1990). Krueger (1994) described six advantages to focus group discussions. First, people tend to be social and seek interaction with others which makes the informal environment of focus groups conducive to collecting elaborate qualitative data regarding a specified, common topic. Second, focus group discussions allow the moderator to probe to explore unanticipated questions and comments. Third, data gathered from focus group discussions have high face validity as the techniques and results were easily understood. Fourth, focus group discussions were generally low cost. Fifth, focus group discussions provide immediate results which allow the researcher to analyze data and report findings. The sixth advantage of focus group research was that it enabled the researcher to increase the sample size of qualitative studies without incurring financial and time costs as compared to other formats. Furthermore, focus groups yield qualitative data but also serve as a compliment to survey research (Reynolds & Johnson, 1978). The investigator chose to utilize focus group methodology to gather qualitative data from speech-language pathologists for the reasons stated above.

Disadvantages of Focus Group Research

While focus groups have been utilized for a variety of reasons, limitations to this method exist (Greenbaum, 2000; Stewart & Shamdasani, 1990; Morgan & Krueger, 1993). Krueger (1994) reports six limitations to utilizing focus group
discussions when gathering data. First, the researcher was in less control as compared to individual interviews. Second, data can be difficult to analyze as the social environment elicits comments that must be interpreted within the context and caution must be used not to report comments out of context as participants may modify or change position on a topic after interaction with other members. Third, focus group moderation requires the skill of trained interviewer as well as a person who was informed on the topic as it was often necessary to probe further into a comment or question posed by a member of the group. Fourth, a series of focus groups has the potential of varying depending on the personalities and knowledge of the members and therefore Krueger (1994) recommends holding enough groups to account for these differences. Fifth, focus groups can be difficult to assemble due to logistics or time constraints. Finally, focus groups must be conducted in an environment conducive to conversational exchanges which can be difficult to locate when accommodating participants by traveling to their location to hold the focus group.

Focus Group Question Development

Focus group questions were developed on the personal experience of the researcher, a speech-language pathologist, in conjunction with the previously defined needs of children with E/BD and language deficits, as well as suggestions provided in the research (Litoselliti, 2003; Krueger, 1994). The need to examine the practices of speech-language pathologists has become apparent due to the wide range of reported prevalence rates for children with E/BD and language deficits (Benner, Nelson, and Epstein, 2002).
Focus group questions were quantitative, as well as qualitative in nature and addressed the participants involvement with this population, in addition to the participants interactions with co-workers regarding children with E/BD and language deficits.

The first question posed to focus group participants was quantitative in order to determine the number and percentage of the speech-language pathologist's caseload which was comprised of students with E/BD. Participants were then asked to describe their therapeutic practices, specifically which strategies and techniques they employed, when serving this population of students in addition to whether these intervention strategies and techniques differed from those utilized with children without E/BD. Furthermore, participants were asked how those interventions with children with E/BD differed by age, grade, and cognitive ability. The participants were asked to describe their interactions with general education and special education co-workers related to working with this population of students. Additionally, the speech-language pathologists were asked to discuss barriers with co-workers in reference to serving this population of students. Finally, an open-ended question was posed to the participants in an effort to gather any additional information not solicited regarding students with E/BD and language deficits. For a complete list of questions, see Table 5.
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>What percentage of your caseload is comprised of students diagnosed with emotional/behavioral disorders? How many students diagnosed with emotional/behavioral disorders do you serve?</td>
</tr>
<tr>
<td>2</td>
<td>Describe how you provide speech and language services to students with emotional/behavioral disorders? What strategies or techniques do you use?</td>
</tr>
<tr>
<td>3</td>
<td>Describe your interactions with general education and special education co-workers related to students with emotional/behavioral disorders.</td>
</tr>
<tr>
<td>4</td>
<td>Describe the different interventions you use with students with emotional/behavioral disorders.</td>
</tr>
<tr>
<td>5</td>
<td>How do the intervention techniques you use with students with emotional/behavioral disorders differ from those interventions you use with other students on your caseload?</td>
</tr>
<tr>
<td>6</td>
<td>How do your speech and language interventions with students with emotional/behavioral disorders differ by age, grade, cognitive ability?</td>
</tr>
<tr>
<td>7</td>
<td>What barriers do you encounter when working with students with emotional/behavioral disorders?</td>
</tr>
<tr>
<td>8</td>
<td>What additional information would you like to share about your intervention with students who have emotional/behavioral disorders and language deficits?</td>
</tr>
</tbody>
</table>
Methodology

A cover letter and consent form (Appendix A), and a three-item questionnaire (Appendix B) were mailed to speech-language pathologists who were members of the Michigan Speech-Language, Hearing Association and who served students in a public school system. The consent form was stapled to the questionnaire to help ensure the return of both the questionnaire and the consent form.

Participants

A contact list of practicing speech-language pathologists was obtained from a Midwestern state’s Speech-Language, Hearing Association. Thirty speech-language pathologists, who had indicated on the questionnaire that they would be interested in participating in a focus group, were contacted to determine whether they were still interested in participating in a focus group to discuss their beliefs and practices regarding students with emotional behavior disorders and language deficits. They were contacted by phone using a scripted format (Appendix H) and/or email also using a scripted format (Appendix I) to determine their availability to participate in the focus group. There were 30 people who had indicated they would be interested in participating in a focus group but when contacted by phone and/or email at least twice, they did not respond or indicated they would not be available to participate. Due to low numbers of people who committed to participate in the focus group, the investigator submitted a request to Human Subjects Institutional Review Board (Appendix K) requesting the participant search be expanded to the southwest portion of the state in an effort to recruit more participants who would be willing to travel a
short distance to participate in the focus group. This search resulted in six people willing to participate in the focus group in addition to the two participants who had already committed for a total of seven people who comprised the focus group. Confirmation emails were sent and/or phone calls were made to remind people of the details of the focus group (Appendix L).

Format of Focus Groups

The focus group was comprised of six speech-language pathologists, a facilitator, and a moderator. The facilitator was a practicing speech-language pathologist with 13 years of experience working in a public school setting. The moderator was a senior special educator with 22 years of experience working in a public school setting. The investigator was the note taker and did not participate verbally or non-verbally in the discussion.

Participants were seated at one of four tables (Stewart, Shamdasani, & Rook, 2007) so all members were facing each other in a square formation (Mertens, 2005). They were then asked to read, and if they agreed to participate in the study, sign the consent form, (Appendix D), which included audio taping permission (Stewart, Shamdasani, & Rook, 2007; Berg, 2004) presented to them as they entered the room for the discussion. Discussion members were then asked to complete confidential, biographical information sheet (Appendix L) on which they provided professional biographical data, their age, gender, number of years practicing as a speech-language pathologist as well as the number of years working with students with emotional behavioral disorders, and any additional information they believe might be helpful to
the investigator. Once the participants signed the consent form (Berg, 2004) and completed the biographical information sheet they proceeded with participating in the focus group.

Consent forms and biographical information sheets were distributed to each participant, completed, and collected before the facilitator began the focus group discussion. The moderator assigned each participant a number (Krueger, 1994) at the beginning of each focus group session to preserve confidentiality (Berg, 2004) and anonymity (Sieber, 1992). An identification number tag was placed in front of each participant so that others may refer to that participant's comment during the discussion. Participants were asked to refer to themselves by number before they began their response each time they spoke. Referring to themselves by their assigned number allowed the investigator to know which participant made a specific comment when transcribing the discussion. Additionally, participants were provided with paper and pen on which to write notes or questions and comments should they wish to communicate with the facilitator or moderator without having to voice their questions or concerns aloud (Krueger, 1994).

Facilitating the Focus Group Sessions

The investigator held a discussion with the moderator and the facilitator before participants arrived regarding the importance of privacy and confidentiality of the participant's identity and comments during the discussion. The facilitator conducted the focus group while the moderator was responsible for starting and changing the audio tape, changing the flip chart questions as the discussion.
progressed, and directing people to speak in turn when several people wanted to talk at the same time. A third person, the investigator, took notes during the audio-taped session but did not participate either verbally or non-verbally so as not to bias the participants or the discussion. The investigator was able to observe both verbal and non-verbal acts of communication (Fern, 2001) which proved helpful during the transcription process.

The facilitator conducted the focus group utilizing the format specified by Krueger (1994). A welcome statement, an overview of the topic, and the format in which the discussion was to be conducted (Appendix M) was read by the facilitator ("Focus Groups, 1997). The facilitator expressed that all statements made by focus group participants were encouraged and acceptable and there were no right or wrong responses. Participants were encouraged to adhere to focus group etiquette in an effort to facilitate an orderly discussion.

Participants were asked a series of questions (Appendix G) to ascertain their beliefs regarding language deficits and students with emotional/behavioral disorders and their intervention practices with students with E/BD. The facilitator introduced each question verbally while the moderator displayed the pre-written questions on a flip-chart. Participants were able to refer to the question throughout the discussion. The session ensued with the facilitator asking probing questions to elicit more extensive responses or clarify points participants had made. The facilitator gave a brief summary of the points made in response to the question posed before introducing the next question as a means to gain confirmation or clarification. The moderator intervened if the topic of discussion became diverted or stalled. The note-
taker devoted attention to recording key points of the discussion, notable quotes, and important observations such as indications of group mood, ironic or contradictory statements, body language, times of silence, and other acts of communication that would be otherwise lost solely by reading the transcript. The facilitator posed each question and facilitated the discussion until the last question was asked and the discussion was completed (Litosseliti, 2003; Fern, 2001). The facilitator then summarized the discussion and thanked the members for participating in the focus group. The moderator turned off the audio tape and the investigator thanked everyone for participating in the discussion.

The facilitator, moderator, and note-taker met immediately following the conclusion of the focus group and after the participants had left the room to discuss any immediate concerns or issues that arose during the discussions (Litosseliti, 2003; Fern, 2001, Krueger, 1994). The discussion consisted of important themes, memorable quotes, and unexpected discussions. The note-taker documented any concerns or issues and included them as additional notes in the transcript analysis.

Data Analysis

Survey Analysis

The investigator analyzed the surveys to gather descriptive statistics. Surveys provided information regarding prevalence rates of speech-language pathologists working with children with E/BD, percentage of children with E/BD on their caseload, age ranges for whom they provided services as well as information on the perceptions of speech-language pathologists regarding the relationship between E/BD
and language deficits. This data provided a current prevalence rate of the number of children with E/BD receiving services from a speech-language pathologist in a public school setting. Additionally, the survey data provided information on the perceptions of speech-language pathologists regarding the relationship between E/BD and language deficits and was compared to the current prevalence rate range of 35%-97% (Benner, Nelson, & Epstein, 2003) of children with E/BD and language deficits.

The investigator determined which surveys were returned completed and put them in a notebook for future analysis. Returned surveys that had incomplete information were stored separately as they could not be included in the data analysis but were counted as returned surveys (Mertens, 2005). The investigator briefly reviewed the surveys as they were returned to informally analyze the data (Mertens & McLaughlin, 2004; Krathwohl, 1997).

The investigator tallied the responses to the survey using the statistical program SPSS (2005). “Yes” responses were coded as “1” and “no” responses were coded “2.” Participants who served children with E/BD were asked to specify an age range. Each age range was assigned a number and the response was coded as such. For example, if a speech-language pathologist indicated they served children at the preschool level, that response was coded as “1.” Some respondents provided written information, which was not requested, and as such, that information was not analyzed in this investigation.

Focus Group Analysis

The investigator transcribed the audio-tape recorded during the focus group
discussion taking care to ensure all participant identifiers, student’s names, and
school names were deleted (Mertens, 2005; Mertens & McLaughlin, 2004; Litosseliti,
2003 Fern, 2001). The focus group transcript (Appendix N) was disseminated to the
facilitator and the moderator for analysis according to suggestions in the literature
(Litosseliti, 2003; Fern, 2001; Krueger’s, 1994) for transcript-based analysis. The
transcript reviews from all three raters, the investigator, the facilitator, and the
moderator, were analyzed independently then compared and contrasted. All three
individuals analyzed the data as a measure of interrater reliability or triangulation
(Mertens, 2005) in an effort to find consistency across evaluators but not to disregard
multiple realities as suggested by Guba and Lincoln (1989). To ensure the evaluators
were comfortable with analyzing the transcript, the investigator met with the
facilitator and the moderator to review information they were to make note of while
reading the transcript.

The investigator met with the facilitator and the moderator independently to
review the instructions in which to analyze the transcript according to Krueger (1994)
and Mertens (2005). The investigator asked the facilitator and the moderator to first
read the transcript in its entirety. Next, the reviewers were asked to make notations,
either within the transcript margins, in between the text, and/or anywhere on the
document, of emerging themes (first by question then overall), notable quotes, topic
categories, and noteworthy comments. Each reviewer was reminded again to write on
the transcript as no one would see their comments other than the investigator.
Limitations of the Investigation

Limitations of this investigation were as follows:

1. Surveys were mailed to practicing speech-language pathologists in Michigan who were members of the Michigan Speech-Language, Hearing Association which limits generalizability of the survey findings. Not all practicing speech-language pathologists were members of this organization.

2. The simplicity of the survey was a limitation as more information could have been gathered and still met the criteria for a brief instrument.

3. The term “E/BD” was not defined and specific criteria for diagnosing a child with E/BD were not stated in the survey.

4. The information on the surveys was limited regarding personal and professional characteristics of the speech-language pathologist.

5. The number of speech-language pathologists who participated in the focus group discussion was relatively small as was the age range and the area of the state in which they practiced and therefore, generalizing the results of the focus group must be done so with caution.

6. The number of focus groups.

7. The first-time experience of the facilitator even though direction was provided in a meeting before the focus group was held.

8. There may have been a misunderstanding of the terms “strategy,” “intervention,” and “technique” during in the focus group questions.

9. Holding a follow-up focus group to clarify and probe participant responses would have provided additional information.
Summary

Chapter III described the foundation of survey and focus group research, participants, instruments and the reliability and validity of them, methodology employed in collecting the data, and analysis of the data. The study’s results were presented in Chapter IV.
CHAPTER IV
ANALYSIS OF THE DATA

Introduction

This investigation examined the prevalence rate of speech-language pathologists working with students identified as E/BD, as well as the perceptions and intervention practices employed while working with this population. The study proposed to answer the following research questions:

R₁: Do speech-language pathologists perceive a relationship between emotional/behavioral disorders and language deficits?

H₀₁: Speech-language pathologists do not perceive a relationship between emotional/behavioral disorders and language deficits.

The investigator rejected the null hypothesis for the first research question since 78.5% (162 surveys) of speech-language pathologists reported through survey methodology they perceived a relationship between language deficits and students with E/BD. These results, however, were interpreted conservatively and will be explained later.

R₂: Do speech-language pathologists use specific interventions when providing services to students with emotional/behavioral disorders and language deficits?

H₀₂: Speech-language pathologists do not use specific interventions when providing services to students with emotional/behavioral disorders and language deficits.
The investigator accepted the null hypothesis for the second research question as the interventions utilized by speech-language pathologists were behavioral in nature could have been implemented with any disorder type. They were reportedly not specifically implemented with the targeted population. Speech-language pathologists reported they used specific interventions when providing services to students with emotional/behavior disorders and language deficits. However, when the types of interventions were examined, they were behavioral in nature and not language based interventions. Additionally, there were limitations within the focus group which will be discussed later.

A description of the data, analysis procedures, and response to the investigations questions were provided in this chapter. The chapter contains the following sections: a) a description of the survey and responses to those questions, b) a description of the focus group participants c) the results of the focus group discussion, and c) an overall summary of the findings.

Description of Survey Return Rate

A total of 598 surveys were mailed to school speech-language pathologists who were members of the Michigan Speech Language Hearing Association. Two weeks after the surveys were mailed, 406 reminder postcards (Appendix C) were mailed to request that those who had not responded to the survey do so. A total of 250 surveys were returned for a final response rate of 41.8%. It is not uncommon for unsolicited surveys, such as the one in this investigation, to receive response rates around 20% (Fink, 2003). Bourque and Fielder (2003) reported mailed survey
responses can be 30% or lower when follow-up measures were not employed.

Two hundred and six, or 82.4%, of the returned surveys were completed in full while 17.6% of the returned surveys could not be used in the data analysis due to incomplete responses (see Table 6).

### Table 6

Survey Distribution and Collection

<table>
<thead>
<tr>
<th>Survey</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveys sent</td>
<td>598</td>
<td>100</td>
</tr>
<tr>
<td>Surveys returned</td>
<td>250</td>
<td>41.8</td>
</tr>
<tr>
<td>Surveys returned completed</td>
<td>206</td>
<td>82.4</td>
</tr>
<tr>
<td>Surveys returned incomplete</td>
<td>44</td>
<td>17.6</td>
</tr>
</tbody>
</table>

A Demographic Description of Survey and Focus Group Participants

Of the 206 returned and completed surveys, thirty respondents indicated they would be interested in participating in a focus group. However, when contacted only two speech-language pathologists indicated they would be interested and available to participate in a focus group discussion on the topic of students with E/BD and language deficits. The data may have differed had the investigator included a definition of E/BD in the survey. This omission may have proved to be a limitation of the survey. Permission was obtained from Western Michigan University’s Human Subjects Institutional Review Board (Appendix J) to contact speech-language pathologists in southwest Michigan in an attempt to recruit more focus group
participants due to the low number of people interested and available in participating in a focus group. A total of seven speech-language pathologists committed to being members of a focus group discussion.

Summary of Research Question One

The first item on the survey (see Appendix B) required recipients to respond to the following question: “Do you provide speech-language services to students who have diagnosed emotional/behavior disorders (E/BD)? If yes, what percentage of your caseload is identified as E/BD and what is the age range you serve?” Participants were asked to mark either “no” or “yes” to the first part of the question. If they marked “yes,” they were asked to indicate the percentage of their caseload that comprised students with E/BD as well as the age range they served. Results indicated 56.8% of speech-language pathologists reported they provided speech and language services to students who had a diagnosis of E/BD while 43.2% indicated they did not provide services to that population (see Table 7).

Thirty-seven percent of speech-language pathologists reported they served students with E/BD at the preschool/elementary level. Students with E/BD at the combined elementary/middle school level were the second highest served population by speech-language pathologists at a little more than 30%. Approximately 17% of speech-language pathologists reported they served students with E/BD at elementary, middle, and high school levels. The numbers dropped dramatically when examining the percentage of speech-language pathologists providing services for children with E/BD at middle and high school levels where less than 3% of reporting speech-
language pathologists indicated they provided language intervention for children with E/BD. Furthermore, 5.5% of speech-language pathologists served students at the middle school level and only 7.1% of the speech-language pathologists reported serving students at the high school level (see Table 8). Based on these figures 67.5% of surveyed speech-language pathologists serving students with E/BD and language deficits did so at the preschool/elementary and middle school level. Limited speech and language services were provided at the high school level. The survey was brief and was designed to elicit speech-language pathologists’ perceptions, as well as to recruit focus group members.
Table 8

Service Provision by Age Groups and as Percentage of Total Respondents Who Worked with Students with E/BD

<table>
<thead>
<tr>
<th>Level</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschool/Elementary</td>
<td>47</td>
<td>37.3</td>
</tr>
<tr>
<td>Middle School</td>
<td>7</td>
<td>5.5</td>
</tr>
<tr>
<td>High School</td>
<td>3</td>
<td>2.4</td>
</tr>
<tr>
<td>Elementary/Middle</td>
<td>38</td>
<td>30.2</td>
</tr>
<tr>
<td>Elementary/Middle/High</td>
<td>22</td>
<td>17.5</td>
</tr>
<tr>
<td>Middle/High</td>
<td>9</td>
<td>7.1</td>
</tr>
</tbody>
</table>

Question two on the survey asked participants to provide a dichotomous response to whether they perceived a relationship between these co-occurring disorders. Specifically, survey participants were asked, “Do you perceive a relationship between emotional/behavior disorders and language deficits?” There were 78.6% of the speech-language pathologists who indicated they perceived a relationship between emotional/behavior disorders and language deficits while 21.4% indicated they did not perceive a relationship between these disorders (see Table 9). Although many respondents provided written explanations as to why they did or did
not perceive a relationship these data were not analyzed since these responses were not solicited.

Table 9
Responses to Survey Item Two

<table>
<thead>
<tr>
<th>“Yes” response</th>
<th>“No” response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>Question 2</td>
<td>162</td>
</tr>
</tbody>
</table>

Focus Group Participants

Survey question three, asked participants “Would you be interested in learning more about participating in a focus group to share your views on the topic of students with emotional/behavior disorders and language deficits?” Thirty speech-language pathologists, or 14.6% of the respondents, indicated they would be interested in participating in a focus group while 176, or 85.4%, indicated they would not be interested in participating in a focus group (see Table 10).

Table 10
Responses to Survey Item Three

<table>
<thead>
<tr>
<th>Question</th>
<th>“Yes” response</th>
<th>“No” response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Percentage</td>
<td>Number</td>
</tr>
<tr>
<td>Question 3</td>
<td>30</td>
<td>14.6</td>
</tr>
</tbody>
</table>
Those 30 potential participants were contacted by the investigator to determine their availability and whether they were still interested in participating in a focus group to discuss their practices and perceptions regarding students with E/BD and language deficits. They were contacted, in accordance with their indicated preference on the survey, by phone using a scripted format (Appendix H) and/or email also using a scripted format (Appendix I). These contacts were made at least twice. Two of the 30 potential participants committed to being members of a focus group. The other 28 could not be reached or had declined to participate. Permission was sought from Western Michigan University’s Human Subjects Institutional Review Board to contact speech-language pathologists in southwest Michigan as they might be more inclined to agree to participate as the travel distance would be relatively short. An additional search yielded six speech-language pathologists who committed to participating in the discussion which provided an appropriate number of members for the focus group (Krueger, 1994). Researchers stated effective focus group discussion ranged between 6-10 people depending on the type of information to be collected (McMillan & Schumacher, 2006; Mertens, 2005, Krueger, 1994). Confirmation emails (Appendix K) were sent to inform participants of the details of the focus group.

Focus Group Description

The focus group was comprised of six speech-language pathologists, a facilitator, a moderator, and a note-taker. The investigator, who acted as the note-taker, took notes and did not participate verbally or non-verbally in the discussion so as not to bias the data (Mertens & McLaughlin, 2004; Krueger, 1994). Quantitative
data were collected through administration of the survey and biographical data sheets completed by each participant. Qualitative data were collected through the focus group discussion.

Six speech-language pathologists participated in the focus group which was adequate based on the focus group literature (Mertens, 2005; The Industrial Society, 1997; Krueger, 1994). The group was comprised of five females and one male and the average age of the group was 57.2 years. The average number of years a participant worked as a speech-language pathologist was 26.9 years while the average number of years working with students with EBD was 15.3 years (see Table 11). Each participant held a Master's degree and a teaching certificate. Additionally, each participant met state requirements to gain at least five professional development days for a total of at least 181.25 hours over a three year period for the group.

Table 11
Demographic Description of Focus Group Participants

<table>
<thead>
<tr>
<th>Subject</th>
<th>Gender</th>
<th>Age</th>
<th>Years Practicing</th>
<th>Years Working with E/BD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Female</td>
<td>55 years</td>
<td>22.5 years</td>
<td>3 years</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
<td>65 years</td>
<td>24 years</td>
<td>15 years</td>
</tr>
<tr>
<td>3</td>
<td>Female</td>
<td>57 years</td>
<td>17 years</td>
<td>17 years</td>
</tr>
<tr>
<td>4</td>
<td>Male</td>
<td>55 years</td>
<td>22 years</td>
<td>22 years</td>
</tr>
<tr>
<td>5</td>
<td>Female</td>
<td>51 years</td>
<td>30 years</td>
<td>30 years</td>
</tr>
<tr>
<td>6</td>
<td>Female</td>
<td>60 years</td>
<td>19 years</td>
<td>5 years</td>
</tr>
</tbody>
</table>
Five of six, or 83%, of the focus group participants indicated they provided language services for students at the elementary school level which is consistent with the responses from all the survey respondents. Four of the six focus group participants reported 1% of their caseload is comprised of students with E/BD and language deficits while one participant reported 10% of her caseload is comprised of students with E/BD and language deficits. Finally, one participant indicated 5% of her caseload was comprised of students with E/BD and language deficits (see Table 12).

<table>
<thead>
<tr>
<th>Participant</th>
<th>Percentage of Caseload</th>
<th>Age Groups Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10</td>
<td>Elementary</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>Elementary</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>Elementary</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>Elementary</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>Elementary</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>Middle/High School</td>
</tr>
</tbody>
</table>

The moderator assigned each participant a number (Stewart, Shamdasani, & Rook, 2007; Krueger, 1994) at the beginning of the focus group session to preserve confidentiality and anonymity. The moderator also distributed and collected consent forms and biographical data information sheets. Identification number tags were

75
placed in front of each participant in order that participants could refer to one another during the discussion. Additionally, participants were provided with paper and pen if they chose to use them or whatever purpose they desired.

The facilitator was a practicing speech-language pathologist with 13 years of experience working in a public school setting and was chosen to lead the group based on the skills and traits as outlined in Stewart, Shamdasani, and Rook, (2007) and Yukl (1981). The facilitator did not have experience running a focus group session which later proved to be a limitation because she did not probe for deeper discussion of topics. The moderator was a senior special educator with 22 years of experience working in a public school setting and met the criteria for this position as outlined in Fern (2001). Both the facilitator and the moderator had taught at the university level, taught classes of both adults and children, lead discussion groups, and given presentations throughout their careers.

The moderator audio taped the focus group session so the discussion could be later transcribed and analyzed. A welcome statement and the format in which the discussion was to be conducted (Appendix M) was read by the facilitator. The facilitator posed the questions outlined in Table 13 in the order indicated to ascertain participants' amount and extent of service provision, perceptions regarding language deficits and students with E/BD, and intervention practices with this population.
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>What percentage of your caseload is comprised of students diagnosed with emotional/behavioral disorders? How many students diagnosed with emotional/behavioral disorders do you serve?</td>
</tr>
<tr>
<td>2</td>
<td>Describe how you provide speech and language services to students with emotional/behavioral disorders. What strategies or techniques do you use?</td>
</tr>
<tr>
<td>3</td>
<td>Describe your interactions with general education and special education co-workers related to students with emotional/behavioral disorders.</td>
</tr>
<tr>
<td>4</td>
<td>Describe the different interventions you use with students with emotional/behavioral disorders.</td>
</tr>
<tr>
<td>5</td>
<td>How do the intervention techniques you use with students with emotional/behavioral disorders differ from those interventions you use with other students on your caseload?</td>
</tr>
<tr>
<td>6</td>
<td>How do your speech and language interventions with students with emotional/behavioral disorders differ by age, grade, cognitive ability?</td>
</tr>
<tr>
<td>7</td>
<td>What barriers do you encounter when working with students with emotional/behavioral disorders?</td>
</tr>
<tr>
<td>8</td>
<td>What additional information would you like to share about your intervention with students who have emotional/behavioral disorders and language deficits?</td>
</tr>
</tbody>
</table>
The facilitator initiated the discussion while the moderator intervened when participants diverted from the discussion. The note-taker recorded key points of the discussion, notable quotes, and important observations such as indications of group mood, ironic or contradictory statements, body language, times of silence, and other acts of communication that would be otherwise lost solely by reading the transcript. The focus group length was held to two hours as suggested by Krueger (1994) in order to hold participant interest in the topic. A two hour focus group is accepted practice to address eight focus group questions (McMillan, & Schumacher, 2006). The facilitator summarized the discussion and thanked the members for participating in the focus group. The moderator turned off the audio tape and the investigator thanked everyone for participating in the discussion. The facilitator, moderator, and investigator met immediately following the conclusion of the focus group and after the participants had left the room to discuss any immediate concerns or issues which arose during the discussions.

Transcript Analysis

The investigator analyzed the focus group discussion transcript after transcribing the audiotape (Krueger, 1994) to ascertain common themes, perceptions and practices of speech-language pathologists, and noteworthy statements regarding working with students with emotional/behavior disorders and language deficits. The investigator met individually with the facilitator and moderator to discuss how to analyze the transcript using Krueger's (1994) methodology. They were asked to extrapolate common themes, perceptions and practices of speech-language pathologists, and noteworthy statements and were encouraged to write on the
document when doing so. The investigator, the facilitator, and the moderator analyzed the transcript independently so as not to bias one another and to create triangulation of the data (Mertens, 2005; Leedy, 2001). Three common themes were extrapolated by each of the independent raters and included, a) the use of behavioral interventions and reinforcements, b) collaboration and consultation among educators, and c) flexibility of therapy interventions.

Results of Focus Group

This investigation was initially planned to involve speech-language pathologists throughout the state of Michigan in both the survey and focus group portions of this study. Multiple focus groups were intended with speech-language pathologists throughout the state however, due to lack of participation those focus groups were not held. As such, this proved to be a limitation of the study as only one focus group was held with speech-language pathologists who practiced in the southwest part of the state. Participants were asked to base their responses on children with the label of E/BD however, the definition of E/BD was not read or provided for the participants which may have proved to be a limitation. Results of the focus group discussion indicated students with E/BD and language deficits comprise a relatively small portion of the speech-language pathologists' caseloads as noted in Table 8. Focus group members reported most students with an educational label of E/BD did not receive speech and language services. However, all focus group members reported they perceived a relationship between the two disorders. Furthermore, they noted that pragmatics, or the social aspect of language, was the
most affected area of language for students with E/BD and they targeted therapy interventions toward addressing those needs. Themes were noted throughout the discussion as focus group participants responded to the questions.

Common Themes

Three themes were extrapolated from the focus group transcript by each of the independent readers. Those themes included a) behavioral interventions and reinforcements, b) collaboration and consultation among educators, and c) flexibility of therapy interventions.

Behavioral Interventions and Reinforcements

All six of the focus group participants noted they employed some means of behavioral or reinforcement system when working with students with E/BD and language deficits. Speech-language pathologists reported the necessity of tangible rewards for children with E/BD. Members also reported the use of verbal praise was often times all that was necessary for a reinforcement or reward schedule. One participant remarked how informal conversation served as a reward while another participant shared the need for a highly structured environment during the therapy session and utilized a structured, task oriented format while reinforcing behaviors on a schedule. A third member of the discussion noted she also found the need to employ a strict, rigid reinforcement schedule for children with E/BD as compared to her interventions for students without E/BD.
Collaboration and Consultation Among Educators

The raters all noted the recurring theme of working in a collaborative or consultative manner with other professionals in the school. Participant 6 referred to her collaborative approach with the social worker when working with students with E/BD. Together they targeted problem solving activities as each professional employed their expertise during the therapy sessions. Other participants noted a collaborative approach with the general education and special education classroom teachers wherein, if the child with E/BD completed their set goal, the child was allowed special privileges such as computer time or other tangible rewards. Participant 3 reported how she utilized custodians, school secretaries, and other members of the school to assist in a child learning how to practice conversational skills in the context of real-life situations. Another speech-language pathologist reported how she worked with various school employees to help the child with E/BD both gain responsibility and manage his behavioral issues by utilizing an errand delivering approach to practice language skills and give the child a reprieve from his work when his behavior began to escalate.

Two focus group members noted consultative activities in addition to the collaborative activities. Speech-language pathologists stated they sought input from classroom teachers regarding therapy goals so they would coincide with classroom needs. In turn, the classroom teacher sought the knowledge of the speech-language pathologist when selecting language-based strategies to employ with the children in the classroom. This same focus group member, participant 3, also noted how she consulted with a child’s paraprofessional to give suggestions on how to address
language throughout the school day. Participant 1 reported consultative activities with the classroom teacher in an effort to provide carryover of language skills throughout the children’s school day.

Flexibility of Therapy Interventions

All three readers individually noted the flexibility theme throughout the transcript. Focus group participants reported they tended to give more therapy choices to this population of children as compared to children without E/BD. Participant 2 noted she gave choices to the children with E/BD during therapy sessions and tended to tell the children without E/BD what the plan was for the session. Participant 1 reported she tended to give children with E/BD more choice regarding the order in which activities were completed each therapy session in order to manage behavior, while always staying within the goals on the child’s individualized education plan (IEP). All other focus group members agreed with her statement but provided no further input.

Near the completion of the focus group the facilitator asked the last question regarding whether anyone had additional information they would like to share regarding interventions with students who have E/BD and language deficits. All raters found the statistics shared by Participant 5 near the end of the focus group noteworthy, as her comment citing the prevalence rates of students with these co-occurring disorders was one of the areas addressed in this investigation. Participant 5 quoted statistics from a meeting she recently attended to review the current Michigan Speech-Language, Hearing Association Guidelines for working with children in
schools. She noted that there was a high rate of language deficits in students with E/BD ranging from 62% to 95%. She further shared that 50-75% of the children with communication impairment exhibit emotional or behavioral problems.

Focus group members questioned the extent of their service to children with E/BD at the end of the discussion. Participant 6 suggested that speech-language pathologists were not serving many students with E/BD on their caseloads and was curious as to what age level that statistic addressed. Focus group member 5 suggested the need to go into the classroom to conduct observations as opposed to strictly testing and admitted this statistic warranted further investigation and that she had not engaged her suggested practices.

Analysis of Data by Question

The focus group transcript was analyzed for common themes as well as by specific questions. Some questions yielded more information than others as all participants did not consistently provide input for each question. As noted earlier, the facilitator needed to probe for more information in response to questions in addition to directly soliciting responses from participants who remained silent. As such, this proved to be a limitation. However, the facilitator was adhering to the two hour time block as suggested by Krueger (1994) for effective, interactive focus groups. Each question was individually addressed in the analysis followed by a summary of noteworthy quotes from the focus group discussion.
Focus Group Question 1

Focus group question 1: What percentage of your caseload is comprised of students diagnosed with emotional/behavioral disorders? How many students diagnosed with emotional/behavioral disorders do you serve?

Focus group members stated the number of children they served with the label of E/BD as well as the percentage of their caseload that comprised children with E/BD (see Table 14). It was noted that three of the speech-language pathologists reported having no children with E/BD on their caseloads but have served this population in previous years and therefore, participated in the discussion based on previous experiences.

A comment from participant 5 (see Table 15) was notable in light of the high and wide-ranging prevalence rate reported by Benner, Nelson, and Epstein (2003) in their review of 26 studies of children with E/BD and language deficits.
### Table 14
Descriptive Statistics for Question 1

<table>
<thead>
<tr>
<th>Participant</th>
<th>Children With E/BD on Caseload</th>
<th>Percentage of Caseload</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>5.4%</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>2.5%</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

### Table 15
Noteworthy Comment from Focus Group Question 1

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>&quot;I have one and I have, in the past, maybe had one every five years or so but it’s not a real prevalent impairment that I’ve seen.&quot;</td>
</tr>
</tbody>
</table>
Focus Group Question 2

Focus group question 2: Describe how you provide speech and language services to students with emotional/behavioral disorders. What strategies or techniques do you use?

Focus group members described a variety of methods which they utilized when working with students with E/BD followed by an example of how they implemented the strategy or technique. See Table 16 for a brief description of these methods by participant.

It was noted that participants may not have fully understood the difference between strategy and technique based on their responses. Responses were wide-ranging and included strategies, techniques, service delivery models, and behavioral management techniques. As such, this misunderstanding proved to be a limitation in responding to the question. Participants 1 and 2 noted they based their intervention around the children’s interests so they would participate in the planned activity. They appeared comfortable with student directed therapy within the confines of the goals on the individualized education plan. See Table 17.
<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Method</th>
</tr>
</thead>
</table>
| 1                  | Pull out model of therapy  
|                    | Consultation with classroom teacher  
|                    | Intervention based on child’s interest  
|                    | Role playing                                                             |
| 2                  | Using literacy to target language goal  
|                    | Intervention based on child’s interest                                   |
| 3                  | Pull out model of therapy  
|                    | Icons for schedules                                                      |
| 4                  | Pullout model of therapy  
|                    | Group model of therapy  
|                    | Consultation with teachers/paraprofessional  
|                    | Role playing                                                             |
| 5                  | Pull out model of therapy  
|                    | Behavioral system of rewards—tangible or praise                          |
| 6                  | Pull out model of therapy  
|                    | Collaboration with social worker  
|                    | Making choices  
|                    | Problem solving activities                                               |
Table 17
Noteworthy Comments from Focus Group Question 2

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>“...we would always take the boys’ interest at heart...and somehow incorporate that.”</td>
</tr>
<tr>
<td>2</td>
<td>“...what I found I had to do (was) read something that really interested him. It had to be something that really interested him before he would give any cooperation.”</td>
</tr>
</tbody>
</table>

Focus Group Question 3

Focus group question 3: Describe your interactions with general education and special education co-workers related to students with emotional/behavioral disorders.

Participants described a variety of ways in which they interacted with teachers in general education and special education when serving children with E/BD in addition to working closely with paraprofessional staff. A continuum of interactions, from a consultative model to direct planning of activities with teachers, was reported as noted in Table 18.
Table 18
Interactions with General Educators and Special Educators
by Focus Group Participant

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Interaction</th>
</tr>
</thead>
</table>
| 1                  | Reported paraprofessionals, general education and special education teachers working together
                  | Reported special education teacher provided in-services about emotional/behavior disorders to general education staff |
| 2                  | Planning with the general education teacher Planning with paraprofessionals |
| 3                  | Planning with “specials” teachers Implementing IEPs with paraprofessionals Planning with paraprofessionals |
| 4                  | Participant did not comment |
| 5                  | Planning with the special education teacher Planning with the general education teacher |
| 6                  | Reported general education, special education, and social worker working together |

Focus Group Question 4

Focus group question 4: Describe the different interventions you use with students with emotional/behavioral disorders.

Speech-language pathologists reported using few formal language interventions when serving students with E/BD. Participants reported using and supporting behavioral interventions established by the teacher or team of
professionals. Furthermore, when the facilitator probed and asked the participants whether they utilized research-based interventions, none of the participants were sure if the practices they employed were research based. A deeper probe here may have yielded more definitive responses, and again proved to be a limitation in responding to the question. See Table 19 for a description of reported interventions by focus group participants, again, most notably behavioral in nature.

Table 19
Speech-Language Pathologist’s Reported Interventions by Focus Group Participant

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Taught pragmatics as a subject</td>
</tr>
<tr>
<td>2</td>
<td>Reported children worked better if given a manipulative</td>
</tr>
<tr>
<td>3</td>
<td>Worked with the teacher and paraprofessional on behavioral interventions Social Stores by Carol Gray</td>
</tr>
<tr>
<td>4</td>
<td>Taught interpersonal interactions as a subject</td>
</tr>
<tr>
<td>5</td>
<td>No interventions reported</td>
</tr>
<tr>
<td>6</td>
<td>No interventions reported</td>
</tr>
</tbody>
</table>

Speech-language pathologists made comments throughout the discussion of question four regarding interventions they utilized with children with E/BD as well as research-based interventions. As few specific interventions were utilized participants
had little to add to this portion of the discussion. This question may have yielded
different responses if posed to speech-language pathologists recently entering the
field as their education and training would have been different compared to the focus
group participants'. The average age of focus group participants, 57.2 years, and the
average number of years practicing in the field, 26.9 years, may have proven to be a
limitation. Younger, less experienced speech-language pathologists may have
provided different responses however, it was difficult to gather speech-language
pathologists from a variety of age groups with varying years of experience in the
field. It should be noted that these speech-language pathologists were well educated
professionals who held Masters degrees, teaching certificates, and each had at least
108 hours of professional development in the last three years. Noteworthy comments
were reported in Table 20.

Table 20
Noteworthy Comments from Focus Group Question 4

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>“I’ve used the same books by Carol Gray—social stories—but I don’t know if they’re research based or not.”</td>
</tr>
<tr>
<td>5</td>
<td>“My intervention would just back up what the behavior intervention was—smile faces…it was a very behavior modification program…” “No, no, and no.” (regarding research-based strategies)</td>
</tr>
<tr>
<td>6</td>
<td>“I’m not sure…if her’s (social worker with whom Participant 6 collaborated) were research based or not”</td>
</tr>
</tbody>
</table>
Focus Group Question 5

Focus group question 5: How do the intervention techniques you use with students with emotional/behavioral disorders differ from those interventions you use with other students on your caseload?

Participants described how their intervention techniques differed when working with children with E/BD as compared to working with children without E/BD. While they did not note interventions they used specifically with children with E/BD, they noted a tendency toward being more task oriented, structured in their presentation of activities as well as more flexibility with a variety of activities from which the children could choose. As stated earlier, a focus group comprised of speech-language pathologists recently entering the field may have yielded specific language interventions in addition or in place of behavioral interventions. The statements noted below were in comparison to their work with students without E/BD. See Table 21 for a description of intervention differences.

Participant 1 stated how her interventions showed little variation when working with children with E/BD as compared to working with children without E/BD. She noted that her interventions were tailored to her students with the difference lying in the modification of the physical setting and in giving the students the ability to choose the activity for the session. See Table 22.
Table 21
Speech-Language Pathologists’ Interventions When Working with Children with E/BD by Focus Group Participant

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Variety of activities presented at a quick pace</td>
</tr>
<tr>
<td>2</td>
<td>Provided flexibility and choices</td>
</tr>
<tr>
<td>3</td>
<td>Reinforcement tailored to their desire</td>
</tr>
<tr>
<td></td>
<td>Intervention more pragmatic in nature</td>
</tr>
<tr>
<td>4</td>
<td>Maintains control of the physical environment</td>
</tr>
<tr>
<td>5</td>
<td>Task oriented and scheduled behavior reinforcement</td>
</tr>
<tr>
<td></td>
<td>Animated in presenting interventions</td>
</tr>
<tr>
<td></td>
<td>Quick pace</td>
</tr>
<tr>
<td>6</td>
<td>Task oriented</td>
</tr>
</tbody>
</table>

Table 22
Noteworthy Comments from Focus Group Question 5

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>“I find that most of the interventions I use with the students (with E/BD) I can use with all my students.”</td>
</tr>
<tr>
<td></td>
<td>“So, basically, the interventions were the same it’s just modifying the setting and giving them choices.”</td>
</tr>
</tbody>
</table>
Focus Group Question 6

Focus group question 6: How do your speech and language interventions with students with emotional/behavioral disorders differ by age, grade, and cognitive ability?

Focus group participants reported little differences in their interventions based on age, grade, and cognitive level. Three participants stated their interventions were similar given the above noted variables while two participants noted their interventions were based on the behavioral needs of the children. One participant noted her interventions were based on the ability level of the children with whom she worked. See Table 23.

Table 23

Interventions for Children with E/BD by Age, Grade, and Cognitive Ability by Focus Group Participant

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Same interventions with minor changes based on individual needs of the child</td>
</tr>
<tr>
<td>2</td>
<td>Interventions are similar</td>
</tr>
<tr>
<td>3</td>
<td>Interventions differed by behavioral needs</td>
</tr>
<tr>
<td>4</td>
<td>Interventions based on self-management skills at the younger grade levels</td>
</tr>
<tr>
<td>5</td>
<td>Interventions are similar</td>
</tr>
<tr>
<td>6</td>
<td>Based intervention on ability level</td>
</tr>
</tbody>
</table>
It was interesting to note that three of the speech-language pathologists remarked their interventions were similar and differed to a limited, if any, extent for students with E/BD. These comments were noteworthy given the high prevalence of children with E/BD and language deficits in addition to their documented behavioral needs. Participant comments were noted in Table 24.

Table 24

Noteworthy Comments from Focus Group Question 6

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>“I don’t have much to offer—the interventions are about the same.”</td>
</tr>
<tr>
<td>5</td>
<td>“Mine are pretty much the same from the very low cognitive ability to not much older than second grade.”</td>
</tr>
</tbody>
</table>

Focus Group Question 7

Focus group question 7: What barriers do you encounter when working with students with emotional/behavioral disorders?

Speech-language pathologists noted several barriers to providing services to children with E/BD both in the school environment and in the home environment. Focus group members noted the lack of an accurate diagnosis can pose difficulties for
the children when trying to learn as well as for the educators when they are teaching. Additionally, teachers, especially general education teachers, often do not have the knowledge or the skills to effectively address the needs of this population of children. Events that occur during the child’s school day in which they become agitated can pose barriers to learning for the remainder of the day. Moreover, events which occurred prior to entering the school either at home or on the bus can affect the child’s readiness to learn. Lastly, focus group participants noted medications, both lack thereof and insufficient doses, can have an impact on the child’s ability to learn. See Table 25, for a complete list of noted barriers when working with children with E/BD.

Table 25
Reported Barriers When Working with Children with E/BD
by Focus Group Participant

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Issues that occur prior to attending school Medications</td>
</tr>
<tr>
<td>2</td>
<td>Lack of accurate diagnosis in younger children</td>
</tr>
<tr>
<td>3</td>
<td>Fear/lack of knowledge of classroom teacher</td>
</tr>
<tr>
<td>4</td>
<td>No comment</td>
</tr>
<tr>
<td>5</td>
<td>Home environment, parents, medication</td>
</tr>
<tr>
<td>6</td>
<td>Events that occur during the day that lead to behavior issues</td>
</tr>
</tbody>
</table>
Focus group participants 2 and 5 noted school-based issues which challenged educators to meet the needs of this population of children. Children do not receive the services they need without an accurate diagnosis which can exacerbate the behavioral component of their disorder. Additionally, the statement made by participant 5 regarding teachers’ lack of knowledge was noteworthy. See Table 26 for comments made by focus group participants regarding barriers to serving children with E/BD.

Table 26

Noteworthy Comments from Focus Group Question 7

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>&quot;I think part of the barrier of helping these children initially is there is no diagnosis.&quot;</td>
</tr>
<tr>
<td>3</td>
<td>&quot;I find that fear is a real barrier especially for the classroom teacher maybe who is new to the system or has very little experience with these type of children.&quot;</td>
</tr>
</tbody>
</table>

Focus Group Question 8

Focus group question 8: What additional information would you like to share about your interventions with students who have emotional/behavioral disorders and language deficits?
A variety of information was shared and summarized (see Table 27) when question 8 was posed to the group. Most notably, participant 5 shared statistics she encountered at a Michigan Speech-Language, Hearing Association meeting regarding the prevalence of children with E/BD and language deficits. This information sparked conversation and suggestions for future practice. See Table 27.

Table 27

Additional Information Regarding Interventions for Children With E/BD by Focus Group Participant

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Comment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Summarized intervention strategies for children with E/BD</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Minimal comments</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Suggestions for future practices for children with E/BD</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Commented on emotional attachment and readiness to learn</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Shared statistics regarding prevalence of E/BD and language deficits as reported by MSHA</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Commented on middle and high school aged children with E/BD who use language skills to manipulate situations</td>
<td></td>
</tr>
</tbody>
</table>

Many noteworthy comments were shared by focus group members as the last question was presented. Participants 5 shared statistics regarding children with E/BD.
and language deficits which she recently encountered at a meeting. Additionally, participant 4 shared information learned at a workshop he had previously attended regarding “readiness to learn.” Participants 1 summarized intervention strategies for children with E/BD while participant 3 noted suggestions for future practice with this population. For specific comments regarding focus group question 8, see Table 28.

Summary of Research Question Two

Research question two of this investigation addressed whether speech-language pathologists utilized specific interventions when providing services to students with E/BD and language deficits. Results of the transcript analysis revealed four of the six speech-language pathologists utilized a different approach when working with children with E/BD and language deficits as compared to working with children without E/BD. However, it must be noted that those interventions differed by behavioral needs and not language needs. This conclusion was reached with some hesitation due to the two-hour time limit suggested by Krueger (1994). Additional information could have been gathered regarding the speech-language pathologists’ practices when working with students with E/BD had there been the opportunity for follow-up focus groups with more time to probe responses during those focus groups.

Structure and Flexibility

Participants spoke about the environment and how they modified it when working with students with E/BD. Participants stated they attempted to maintain control of the physical environment and present a structured format when they
Table 28
Noteworthy Comments from Focus Group Question 8

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>“I would say enhance choice making of the setting and adapt the curriculum and provide visual pictures of what their day might be like.”</td>
</tr>
<tr>
<td>3</td>
<td>“We got to get into the classroom and do more observation than just strictly testing. We should really check this out. And this is something personally I doing really well.” (referring to comment by participant 5)</td>
</tr>
<tr>
<td>4</td>
<td>“At a workshop I attended about brain development studies that were reported indicated you have to have an emotional attachment and security in order to be able to learn. I’m not surprised about the kids who have a hard time establishing or maintaining this.”</td>
</tr>
<tr>
<td>5</td>
<td>“Sixty two to 95% of the children with emotional impairment or behavioral problems exhibit moderate to severe language impairment and 50-75% with communication impairment exhibit emotional or behavioral problems.”</td>
</tr>
<tr>
<td>6</td>
<td>“That’s interesting because we’re obviously not seeing many EI students on our caseload if 60-95% of EI have language problems.” (referring to statement made by participant 5 above)</td>
</tr>
</tbody>
</table>

provided their services. Participants noted they attempted to control the therapeutic environment but also tended to provide flexibility when it permitted. One focus group
member reported she employed many of the same interventions with her students without E/BD but modified them to suit the needs of the children. In addition to a flexible schedule of activities, participant 1 noted she had to maintain a quick presentation style so students would not become bored or distracted while working to accomplish the goal for the session.

Meta-linguistic Approach

Three participants employed a meta-linguistic approach when working with students with E/BD and language deficits. Participant 3 found this approach to be necessary as the students with whom she worked had a difficult time generalizing information learned in the therapy room but when discussed and taught utilizing a meta-linguistic approach she noted successful results. Participant 4 also shared her experience as she taught interpersonal skills and self-management to a child with E/BD. Since the child had the ability to understand a meta-linguistic approach to language therapy she taught it as an academic subject providing contextual examples and practice opportunities. The students had the ability to use language at a more advanced level and therefore, using a meta-linguistic approach proved successful for students with E/BD and language deficits.

Modifying Therapy Intervention

Focus group members reflected on how they modified interventions based on the needs of the children. Participants 1 and 3 noted they modified their interventions to make them appropriate for a particular child. Participant 3 further added she
modified her interventions after problem solving with the general education or special education teacher. Another speech-language pathologist, participant 4, viewed the needs of younger students to be different from older students based on the different situations the children would encounter throughout their day and worked toward helping children deal with those situations through role playing. Again, it should be noted that modifying the interventions were done so to address the behavioral needs of the children.

None of the speech-language pathologists reported utilizing specific language-based interventions with students with E/BD and language difficulties. They discussed how interventions were modified and reported they made changes to the environment or to the method in which they implemented interventions, but did not report interventions that they employed solely with students with E/BD. While four of the speech-language pathologists indicated differences in their approaches to working with students with E/BD and language deficits, two focus group members made statements indicating they did not differentiate their intervention practices for this population of children.

Bars to Working with Children with E/BD

Speech-language pathologists responded to the question, “What barriers do you encounter when working with students with E/BD and language deficits?” with a variety of answers addressing the school environment as well as the home environment. These barriers included issues with general education and special education teachers, student issues, and parental issues.
The School Environment

Focus group members commented on the barriers found in the school environment when serving children with E/BD. Participant 2 reported her experience with young children who are exhibiting signs of E/BD but were not diagnosed formally and therefore did not receive appropriate services. Even when children with E/BD are diagnosed and an educational plan was implemented there were still barriers to meeting the needs of these students.

General education teachers typically have not received instruction in how to best plan for children with E/BD according to focus group members. Participant 3 noted general education teachers who were new to education were unfamiliar with how to address the needs of this population and/or have little experience with this population. As a result, this lack of knowledge can be a barrier to working with a particular child or explaining the needs of one student to another.

The Home Environment

Focus group participants differentiated school related barriers with home related barriers. Barriers to teaching a student with E/BD may not be solely based in the school environment according to two speech-language pathologists. Participant 5 noted the home environment, parents, and medications can be issues needing attention to help the child with E/BD in the school environment. Moreover, problems encountered at home, on the way to school, or during the child’s school day can pose problems for children with E/BD as they might not know how to cope with issues that arise, according to participant 1.
Summary of the Findings

The focus of this investigation was to determine the practices of speech-language pathologists in their work with students with E/BD and language deficits. The investigator was interested in the extent of services speech-language pathologists provided to this population, specific interventions employed with this population, and their perceptions regarding these co-occurring disorders. Furthermore, the investigator was interested in whether speech-language pathologists utilized different interventions with this population as compared to working with students without E/BD.

The investigator used a survey and focus group design to address the research questions. The survey yielded a 41.8% return rate with 82.4% of those deemed useful as they were completed in full. Nearly 57% (56.8%) of the speech-language pathologists questioned reported they provided services to students with E/BD while 43.2% reported they did not work with that population of children. Furthermore, 78.6% of the speech-language pathologists indicated they perceived a relationship between E/BD and language deficits while only 21.4% indicated they did not perceive a relationship between the disorders. Finally, 14.6% of the respondents indicated they would be interested in participating in a focus group discussion regarding children with E/BD and language deficits.

A focus group was held to discuss the topic of co-occurring E/BD and language deficits and intervention practices with this population. The average age of the six participants was 57.2 years, with an average of 26.9 years working as a speech-language pathologist, and 15.3 years working with children with E/BD.
Results of the focus group indicated a) children with E/BD comprise a small portion of the speech-language pathologists' caseloads, b) participants perceived a relationship between E/BD and language deficits, c) interventions with this population of students were directed toward the pragmatic area of language, and d) language interventions did not greatly differ for students with and without the label of E/BD.

The researcher rejected the first null hypothesis pertaining to the research questions in this investigation; speech-language pathologists do not perceive a relationship between emotional/behavioral disorders and language deficits. The second null hypothesis was accepted with reservations; speech-language pathologists do not use specific interventions when providing services to students with emotional/behavioral disorders and language deficits.

The investigator acknowledges the limitations in this study. The proposed methodology was followed but the lack of focus group participation was not anticipated. Multiple focus groups with a cross-section of speech-language pathologists would have been held if the study could have been conducted as proposed. Therefore, the results of this investigation were accepted with reservations.
CHAPTER V
SUMMARY AND CONCLUSIONS

This investigation was designed to ascertain speech-language pathologists’ perceptions and practices when serving students with E/BD and language deficits. The proposed methodology was to utilize 1) a mailed survey to ask speech-language pathologists in the state of Michigan whether they served students with E/BD and whether they believed a relationship existed between E/BD and language deficits, and 2) to hold multiple focus groups to discuss issues and practices surrounding service to students with E/BD and language deficits. The survey was utilized to request speech-language pathologists’ participation in a focus group to discuss the topic of E/BD and language deficits. Initially, 30 people agreed to participate in a focus group. Three potential focus groups were mapped out based on the location of the respondents; one group in the Grand Rapids area, one group in the Detroit area, and one group in the Kalamazoo area. Potential focus group participants were contacted to ascertain their availability but either declined or did not respond. As such, focus groups could not be conducted as was initially proposed. This investigator sought and received approval from Western Michigan University’s Human Subjects Institutional Review Board to directly contact speech-language pathologists in the southwest portion of the state. Twenty-six speech-language pathologists were contacted and six people agreed to participate in a focus group which was held in Kalamazoo, Michigan.

This chapter summarizes the investigation’s research questions and corresponding null hypotheses. The results of the survey indicated over half (56.8%) of the speech-language pathologists served children with E/BD with the largest portion of services (37.3%) provided at the preschool/elementary school level. The
next largest portion of services was provided at the elementary/middle school level (30.2%). The percentages dramatically decreased as children with E/BD progressed through their educational careers as noted in Chapter IV. Furthermore, 78.6% of the survey participants indicated they perceived a relationship between E/BD and language deficits yet it is known that as many as 97% of children with E/BD have language deficits (Benner, Nelson, & Epstein, 2002). In addition to the survey data, a focus group discussion was held to gather information on the practices of speech-language pathologists when working with children with E/BD.

It was learned through focus group discussion that speech-language pathologists differentiated behavioral interventions when working with children with E/BD. However, speech-language pathologists did not indicate dramatic differences in their service delivery regarding language interventions. Additionally, speech-language pathologists discussed the extent of their collaborative practices when working with educators to serve this population, the practices they employed when working with this population based on age, grade, and cognitive level, barriers to working with this population, as well as anecdotal information regarding their service to children with E/BD. The focus group discussion contributes to the special education and speech-language pathology literature albeit on a small scale. While this investigation provided a preliminary but limited data on the prevalence rate of speech-language pathologists working with children with E/BD as well as the practices and perceptions of speech-language pathologists in southwest Michigan, those data must be viewed with caution considering the limited group from which it
was gathered. As with any research there were limitations and unanswered questions in this investigation that must be considered in future research.

This investigation was preliminary in nature and as such, there were limitations in both the survey and focus group portions of the study. There were limitations in the survey portion of this investigation regarding the number of speech-language pathologists surveyed. Surveys were mailed to Michigan Speech-Language, Hearing Association members who were practicing in the school setting. It was learned that not all practicing speech-language pathologists were members of the state organization and therefore many practitioners were not included in the survey. As such, the generalizability of the survey results was limited. Moreover, question one on the survey asked recipients to respond to the number of students on their caseload who were diagnosed with E/BD. This may have proven to be a limitation as E/BD was not defined and the investigator did not clarify who diagnosed the child.

Limitations existed in the focus group portion of this investigation regarding the number of speech-language pathologists who participated in the focus group and the number of focus groups held. Six speech-language pathologists agreed to participate in the discussion which was adequate (Krueger, 1994) however, multiple focus groups, with additional members, would have provided data which was more generalizable. Furthermore, the average age of the focus group participant was 57.2 years. Novice speech-language pathology practitioners, who had gained their degrees in more recent years, may have provided different answers to some of the questions posed during the focus group given the changes and philosophical developments in the field and as such, the age of focus group participants was
considered a limitation. An additional, more probing, follow-up focus group may have proven beneficial in clarifying responses and delving deeper into conversations as the facilitator did not always prompt for further discussion. Given the suggested length of the focus group (Krueger, 1994) the need for additional probing proved to be a limitation. For example, analysis of the focus group transcript indicated speech-language pathologists may have not differentiated between the terms “strategy,” “technique,” “intervention,” and “service delivery option.” The facilitator did not probe to determine differentiation of these terms.

The investigator reviewed the facilitator duties in a separate meeting before the focus group was held, however it was the first time this facilitator directed a meeting of this type. And while the focus group data provided information in which to begin to address research question two, it was preliminary in nature. Future focus groups on this topic need to probe deeper into well-defined questions with speech-language pathologists of different ages, experiences, and years of service in the field as well as years of experience working with children with E/BD. Furthermore, the generalizability of the findings must be done so with caution as all focus group participants practiced in the southwest portion of the state. Therefore, reported data may be generalized with caution to one area of the state and to a specific age range of speech-language pathologists. These limitations served as opportunities for future studies.

Overview of the Significant Findings of the Study

The purpose of this investigation was two-fold: a) to determine a current prevalence rate in Michigan of speech-language pathologists working with children
with E/BD, and b) to determine whether speech-language pathologists use specific interventions when providing services to children with E/BD and language deficits. The investigator utilized the combined methodology of a survey and focus group to answer the following research questions:

R₁: Do speech-language pathologists perceive a relationship between emotional/behavioral disorders and language deficits?

R₂: Do speech-language pathologists use specific interventions when providing services to students with emotional/behavioral disorders and language deficits?

The investigator rejected the null first hypothesis for the corresponding research question indicating speech-language pathologists perceived a relationship between E/BD and language deficits as indicated from the results of the survey responses. The null hypothesis for the second research question was accepted as speech-language pathologists did not use specific interventions when providing services to children with E/BD and language deficits as learned from the focus group discussion.

Hypothesis One

The first null hypothesis was rejected which stated speech-language pathologists do not perceive a relationship between children with E/BD and language deficits. The results of the survey indicated while 56.8% of the respondents worked with children with E/BD, 78.6% of the speech-language pathologists perceived a relationship between these two disorders. These data must be considered with
reservation as the survey was distributed to only those members of the Michigan Speech-Language, Hearing Association and not all speech-language pathologists in the state. The statistic for the survey respondents' perception was higher than the actual practice. Therefore, in the nearly 20 years since Casby (1989) found only 9% of speech-language pathologists worked with children with E/BD based on a national statistic, speech-language pathologists have dramatically increased the services they have provided to this population on a state level although this statement must be viewed with caution as this investigation was representative of a portion of the state. Furthermore, the statistic (78.6%) of speech-language pathologists who perceived a relationship between the two disorders fell near the high end of the reported range (35%-97%) in the Benner, Nelson, and Epstein (2003) study wherein they studied the number of children with E/BD and language deficits but again, these data must be viewed with caution as only members of the Michigan Speech-Language, Hearing Association received the survey.

Additionally, the investigator sought to determine at what age level children with these co-occurring disorders were being served by the speech-language pathologist. Survey results indicated most children received services at the preschool/elementary school level (37.3%) and at the elementary/middle school level (30.2%). The numbers drastically decreased at the middle school level (5.5%) and the middle/high school level (7.1%) and showed a dramatic decrease at the high school level (2.4%). These findings indicated speech-language pathologists perceived a relationship between E/BD and language deficits and a decrease in speech and language services to children with E/BD as they progressed through their
educational careers. These data must be generalized with caution as only speech-language pathology practitioners who were members of the Michigan Speech-Language, Hearing Association participated in the survey.

Hypothesis Two

The second null hypothesis was accepted which stated speech-language pathologists do not use specific interventions when providing services to students with emotional/behavioral disorders and language deficits. The results of the focus group indicated speech-language pathologists did not modify their language interventions when providing services to this population of children but tended to modify their behavior management interventions. Two participants reported they modified their interventions based on the child's age and ability while other members of the discussion described ways they modified the therapy environment and the method of presentation. More specifically, speech-language pathologists reported key ways in which to work successfully with this population, in particular, a rapid, animated, and structured presentation of activities, flexibility in choosing activities, interventions that were pragmatic and task oriented, scheduled reinforcements, and a controlled physical environment which included limited interruptions and distractions. If more focus groups had been conducted as initially planned, additional and different data might have been gathered—a limitation of only holding one two-hour focus group.
Consideration of the Findings in Light of Existing Research

This investigation provided preliminary information regarding a current prevalence rate of speech-language pathologists working with children with E/BD in southwest Michigan. However, caution should be exercised when generalizing these results as all practicing school-based speech-language pathologists were not members of the Michigan Speech-Language, Hearing Association and therefore, did not receive the survey. Additionally, the reported findings indicated 78.6% of surveyed speech-language pathologists perceived a relationship between E/BD and language deficits but again, these results should be considered with caution. It should be noted that this finding was well within the reported range of the by Benner, Nelson, and Epstein (2003) of the number of children with co-occurring E/BD and language deficits.

Implications of the Study

Casby (1989) reported on a national level only 9% of speech-language pathologists worked with children with E/BD nearly 20 years ago. The survey portion of this investigation indicated that number had increased to 56.8% on a statewide level, which was a move in a positive direction but again, for reasons previously stated, this statistic should be considered with caution when generalizing to the whole state of Michigan. Although Casby’s (1989) research was based on a national statistic and this investigation was based on a state-wide statistic with limited generalizability, researchers need to question whether the national statistics have changed in nearly 20 years regarding speech-language pathologists serving students with E/BD. The focus group portion of this investigation indicated the six speech-language pathologists who participated in the focus group did not differentiate their
therapy interventions for children with and without E/BD. Researchers (Benner, Nelson, & Epstein, 2002; Gallagher, 1999) have shown the relationship exists between E/BD and language deficits and as such, educators need to question how they can address the language needs in an effort do decrease the effect of the E/BD. While the prevalence rate may have increased over time it remains unclear as to how speech-language pathologists provide services to this population of children.

Many studies have documented a relationship between the co-occurrence of E/BD and language deficits (Benner, Nelson, & Epstein, 2002; Gallagher, 1999; Fujiki, Brinton, Morgan, & Hart, 1999; Baltaxe & Simmons, 1988). However, limited research exists on the use of effective language interventions for children with E/BD and language deficits (Hyter, Rogers-Adkinson, Self, Simmons & Jantz, 2001). General educators and special educators need to question how to best serve this population of students in order to improve the typical outcomes usually associated with this group of children. Educators need to question, of the students receiving language intervention services who have E/BD, what types of services are they receiving and are those services meeting the needs of those students.

The findings of the focus group portion of this investigation showed speech-language pathologists did not utilize specific interventions for children with combined E/BD and language deficits. They tended to modify the physical environment, the method in which they present activities, and behavior management, but did not use specific interventions when providing services for children with E/BD. Furthermore, they reported they employed the same interventions for children with and without E/BD which could have long term effects.
Researchers (Nelson, Benner & Cheney, 2005; Beichman, Cantwell, Forness, Kavale, & Kaufmann, 1998; Schery, 1985) have found that E/BD and language deficits were stable over time and even increased as children developed (Cantwell & Baker, 1991) as previously discussed in Chapter 2. When children were not accurately diagnosed (Cohen, Barwick, Horodezky, Vallance, & Im, 1998) it made it difficult for them to receive the services they needed. In turn, academic performance suffered (Nelson, Beneer, & Rogers-Adkinson, 2003) which eventually lead to the highest dropout rate for any of the disability category (IDEA, 2004). Educators need to be aware of these statistics so they begin to recognize and address the issues and needs surrounding children with these concomitant disorders.

Limitations

There were unanswered questions and limitations to this investigation as is true with all research. Limitations of this investigation included a) only school-based speech-language pathologists who were members the Michigan Speech-Language, Hearing Association (MSHA) received surveys, b) not all practicing school-based clinicians were members of MSHA, c) limited information regarding characteristics of the speech-language pathologists were collected on the survey, d) the number of speech-language pathologists who participated in the focus group discussion was limited, e) only one focus group was held which represented the practices and perceptions of six speech-language pathologists in southwest Michigan and not perceptions of those throughout the state as the investigator initially planned, f) the average age and years of practice of focus group participants may have biased the data, and g) many of the focus group participants knew each other.
The first three concerns listed above related to the survey portion of the investigation. Survey recipients and characteristics of survey recipients were limitations of survey research. While mailing surveys to all speech-language pathologists who were members of the Michigan Speech-Language, Hearing Association provided for a random sampling (Mertens, 2005), the mailing did not account for all speech-language pathologists having an equal chance of participating in the survey (Fink, 2003). The survey was designed to intentionally be brief as the investigator wanted recipients to complete it in a timely fashion and not disregard it due to length (McMillan, & Schumacher, 2006; Fink, 2003; Krathwohl, 1997). As such, speech-language pathologists were not asked to complete personal information. The investigator might have extended the survey by three to five questions and still met the suggestions of the literature (McMillan, & Schumacher, 2006; Fink, 2003) while gaining additional data.

The last four issues listed above were limitations in the focus group portion of the investigation. The number of participants in the focus group, the number of focus groups, the geographic location where the participants practiced, the average age of the focus group participants, and years of practice of each participant, were limitations in this investigation. Research indicated between seven and ten members (Mertens, 2005; Fink, 2003; Krueger, 1997) was an ideal number of participants in a focus group in order for participants to express and discuss their views on a topic. Ideally, when the investigator seeks to gather information on beliefs, practices, and attitudes, (Litoselliti, 2003; Vaughn, Schumm, & Sinagub, 1996; Powell & Single, 1996; Stewart & Shamdasani, 1990) a need exists to collect data through a number of
focus groups over a period of time (Mertens & McLaughlin, 2004). Therefore, holding one focus group, while minimally representative, cannot be generalized to the whole population of speech-language pathologists providing services to children with E/BD in the public school setting. To ascertain a more representative sample, more focus groups organized throughout the state needed to be held over a period of time, with participants from varying age groups with differing years of experience in the field.

Further Exploration

Further exploration of the perceptions and practices of speech-language pathologists working with students labeled E/BD warrants investigation. The current investigation provided data that could be generalized to speech-language pathologists serving students with E/BD in southwest Michigan. This study needs to be replicated to address the perceptions and practices of a diverse group of speech-language pathology practitioners in the school setting throughout the state. Furthermore, multiple focus groups comprised of 6-10 people, held in a variety of locations within the state would provide a more complete set of data in which to respond to these research questions. Moreover focus group participants with various years of experience in the profession and those from different age groups, including novices and experienced practitioners, would provide a well-represented cross-section of the speech-language pathologists servicing students with E/BD and language deficits.

Students with E/BD and co-occurring language deficits have been an area of special education that warrants continued investigation for a variety of reasons. There are a limited number of studies about involving students with E/BD and language
disorders in the public school setting at different educational levels. Educators need information regarding students with E/BD in the school setting in order to begin to address the academic and social needs of children throughout their academic careers. Educators may believe they are utilizing best practices based on historical perspective but without research-driven strategies one must question the validity of the intervention.

Preliminary research has indicated a high rate of language disorders with students labeled E/BD specifically within the area of pragmatic language (Benner, Nelson, & Epstein, 2002). Language programs are necessary for all children but especially those suspected of, or diagnosed with, E/BD. However, speech–language pathologists are typically not involved in the educational plans of students with E/BD (Briton & Fujuki, 1993; Sanger, Magg, & Shapera, 1994) and classroom teachers may view other issues more important than language needs. Furthermore, speech–language pathologists may not receive formal instruction on how to implement language programs for students with E/BD.

A need exists for research in a variety of language areas in order to further understand of the role language plays in children with E/BD. Variables such as socioeconomic status, gender, grade level (preschool through high school and beyond), age, and setting have yet to be studied in depth. This proposed area of research bridges at least two disciplines, education and speech–language pathology, and involves a variety of others including counseling, social work, and vocational training.
More research is needed to understand how language skills play a role in the life of a child with E/BD. To date, studies have been based primarily on elementary aged children. Few studies have been conducted on the adolescent population. It is critical that educators understand that language deficits may add to the complex issues of students with E/BD and the need to examine the role that various components of language play and how best to address these issues depending on the identified problematic behaviors. Examining a student’s language skills and deficits must be conducted across the curriculum and throughout the student’s school day in both formal and informal settings with documented input from a variety of educators. Until educators understand the academic and social implications of these co-occurring disorders they will continue to strive to effectively teach students with E/BD and language disorders and more importantly, students will continue to struggle.

Conclusions

We know students with E/BD comprise the largest numbers for children dropping out of school (U.S. Department of Education Twenty-Sixth Annual Report to Congress, 2004). While not directly comparable to the national finding, the speech and language services to this population dropped to 7.1% at the middle/high school level and 2.4% at the high school level of the speech-language pathologist’s caseload, again, generalizing these findings with caution as previously stated. Knowing that E/BD and language deficits co-occur (Benner, Nelson, & Epstein, 2002; Beichman, Cantwell, Forness, Kavale, & Kaufman, 1998; Cantwell & Baker, 1991) and that they are stable over time (Nelson, Benner & Cheney, 2005; Beichman, Cantwell, Forness,
Kavale, & Kaufmann, 1998; Schery, 1985) and even increased as children developed (Cantwell & Baker, 1991), there is a need to further explore and develop effective interventions for this population of children. These data will continue to be consistent without the recognition of these co-occurring disorders and interventions that address the language needs of these children. As such, children with E/BD may continue to have the poorest outcomes in special education, as well as in their life after leaving the school setting. Special educators, general educators, and speech-language pathologists need to recognize the previous research regarding the prevalence rates of children with E/BD and language deficits. Furthermore, all educators need to increase their collaborative efforts in order for students with E/BD and language deficits to succeed in school and eventually become contributing members of society.
APPENDIX A

Recruitment Letter
November 1, 2006

Dear MSHA Member,

My name is Laura Getty and I am a practicing speech-language pathologist and a member of MSHA. I am currently working on my doctoral degree at Western Michigan University in the Department of Special Education and Literacy Studies.

I am investigating the perceptions and practices of speech-language pathologists serving students with emotional/behavior disorders—otherwise referred to as “emotional impairments” in the state of Michigan—and language deficits. I would greatly appreciate your assistance in completing the enclosed three-item questionnaire regarding your practice with this population. Your responses will be confidential. It would be very helpful to have your completed questionnaire returned to me as soon as possible in the enclosed self-addressed stamped envelope. Your input will take less than 5 minutes and will be greatly appreciated!

If you have questions or comments, please contact me at laura.getty@wmich.edu or 269-382-1469 or my dissertation committee advisor, Dr. Sarah Summy at sarah.summy@wmich.edu or 269-382-1469. You may also contact the chair of Human Subjects Institutional Review Board at 269-387-8293 or the vice president for research at 269-387-8298 with any concerns that you have. Thank you for taking a few minutes to assist me in my research!

Sincerely,

Laura A. Getty, M.A., CCC-SLP

You have been invited to participate in a research project entitled “Intervention Practices of Speech-Language Pathologists Serving Students with Emotional/Behavioral Disorders.” This research is intended to study how speech-language pathologists provide therapeutic services for students with emotional/behavioral disorders in the school system. This project is Laura Getty’s dissertation project.

All of the information collected from you on the attached questionnaire is confidential and will be stored in the principal investigator’s locked file cabinet for the duration of the study at which time the questionnaires will be destroyed. By signing this Recruitment Consent Form you are agreeing to allow Laura Getty, doctoral student, to use your responses on the three-item questionnaire as part of her dissertation project. There are no risks or benefits to you.

Your signature below indicates that you have read this consent form and that you agree to allow Laura Getty to use the information on the attached questionnaire for her dissertation.
APPENDIX B

Recruitment Survey
Please answer the following questions and return your responses in the enclosed self-addressed stamped envelope.

**Your responses to questions 1 and 2 would be appreciated even if you chose not to accept the focus group invitation.

1. Do you provide speech-language services to students who have diagnosed emotional/behavior disorders (E/BD)? If yes, what percentage of your caseload is identified as EBD and what is the age range you serve?
   
   ______ no
   
   ______ yes ______ percent  age range:______________________

2. Do you perceive a relationship between emotional/behavior disorders and language deficits?
   
   ______ no
   
   ______ yes

3. Would you be interested in learning more about participating in a focus group to share your views on the topic of students with emotional/behavior disorders and language deficits?

   The focus group would meet one time for a maximum of two hours, be audio-taped (audio-tapes will be destroyed upon transcription and confidentiality would be maintained at all times), and be held at Western Michigan University (parking passes provided). During the focus group you will be asked to share your views on the existence of co-occurring emotional/behavioral disorders and language deficits, your intervention practices with these students, collaboration with colleagues, and barriers to working with these students. You will also have the opportunity to pose questions regarding this subject.

   ______ no ***(Please note: If you chose not to participate in the focus group your responses to questions 1 and 2 would still be appreciated!)

   ______ yes Please provide
   
   Name:_________________________________________
   
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   Best time to contact:________________________
   
   Email:_______________________________________
   
   I prefer to be contacted by:
   
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APPENDIX C

Follow-up Postcard
Follow-Up Recruitment Postcard

A few weeks ago you I sent you a brief questionnaire asking for your input to assist me in completing my doctoral degree at Western Michigan University in Special Education and Literacy Studies. I am interested in your work as a speech-language pathologist with students with emotional/behavioral disorders.

If you have not mailed your responses, I would greatly appreciate you taking the time to complete it and mail it back to me in the self-addressed stamped envelope that was provided with the questionnaire. If you have already mailed your responses, thank you for your time!

If you have questions, please contact me at laura.getty@wmich.edu or 269-382-1469 or my dissertation chairperson Dr. Sarah Summy at sarah.summy@wmich.edu or 269-387-5943.

Sincerely,

Laura A. Getty, CCC-SLP
APPENDIX D

Focus Group Consent Form
You have been invited to participate in a research project entitled “Intervention Practices of Speech-Language Pathologists Serving Students with Emotional/Behavioral Disorders.” This research is intended to study how speech-language pathologists provide therapeutic services for students with emotional/behavioral disorders in the school system. This project is Laura Getty’s dissertation project.

You will be asked to attend one two-hour focus group session facilitated by a speech-language pathologist, moderated by a senior special education teacher, and Ms. Getty, who will take notes of the session but will not participate in the session, as well as 6-10 speech-language pathologists. You will be asked to meet Ms. Getty for this session at Western Michigan University—Sangren Hall. The audio-taped session will involve responding to questions posed by the facilitator and contributing to a discussion with your peers. Questions will address your views on the existence of co-occurring E/BD and language deficits, your intervention practices with these students, collaboration with colleagues, and barriers to working with these students. Your signature below indicates that you agree not to discuss outside of this focus group any comments made by the other participants. You also agree to abstain from using any identifying information about individual students during or subsequent to the focus group. The investigators cannot guarantee confidentiality that may be breached by participants. You will also be asked to provide general information about yourself, such as age, number of years as a speech-language pathologist, and employment status.

One way in which you may benefit from this activity is having the chance to engage in discourse with your colleagues about providing language interventions to students with emotional/behavioral disorders. Other speech-language pathologists and educators may benefit from the knowledge that is gained from this research.

All of the information collected from you is confidential. Your name will not appear on any papers on which this information is recorded. The forms will all be coded, and Ms. Getty will keep a separate master list with the names of participants and the corresponding code numbers. Once the data are collected and analyzed, the master list will be destroyed. All other forms will be retained for at least three years in a locked file in the principal investigator’s office. Audio-tapes will be destroyed after they have been transcribed.

You may refuse to participate or quit at any time during the study without prejudice or penalty. If you have any questions or concerns about this study, you may contact Dr. Sarah Summy at 269-387-5943 or Laura Getty at 269-382-1469. You may also
contact the chair of Human Subjects Institutional Review Board at 269-387-8293 or
the vice president for research at 269-387-8298 with any concerns that you have.

This consent document has been approved for use for one year by the Human
Subjects Institutional Review Board as indicated by the stamped date and signature of
the board chair in the upper right corner. Do not participate in this study if the
stamped date is more than one year old.

Your signature below indicates that you have read and/or had explained to you the
purpose and requirements of the study and that you agree to participate.

__________________________  ________________________
Signature                          Date

All information discussed in the focus groups is confidential and I will not discuss
the contents of the discussion or information about the participants outside of the
focus group.

__________________________  ________________________
Signature                          Date
APPENDIX E

Focus Group Participant Codes
Focus Group Participant Codes

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APPENDIX F

Focus Group Data Collection Sheet
Focus Group Data Collection Sheet

Focus Group #

Focus Group Participants: (number assigned):

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Comment:

Participant #: ____
Comment:
APPENDIX G

Focus Group Questions
Focus Group Questions

1. What percentage of your caseload is comprised of students diagnosed with emotional/behavioral disorders? How many students diagnosed with emotional/behavioral disorders do you serve?

2. Describe how you provide speech and language services to students with emotional/behavioral disorders? What strategies or techniques do you use?

3. Describe your interactions with general education and special education co-workers related to students with emotional/behavioral disorders.

4. Describe the different interventions you use with students with emotional/behavioral disorders.

5. Do intervention techniques you use with students with emotional/behavioral disorders differ from those interventions you use with other students on your caseload?

6. How do your speech and language interventions with students with emotional/behavioral disorders differ by age, grade, cognitive ability?

7. What barriers do you encounter when working with students diagnosed with emotional/behavioral disorders?

8. What, if any, are the barriers to collaboration with general education and special education teacher when working with students with diagnosed emotional/behavioral disorders and language deficits?

9. What additional information would you like to share about your intervention with students who have emotional/behavioral disorders and language deficits?
Identification statement: “Hello, my name is Laura Getty and I am a doctoral student in the Special Education and Literacy department at Western Michigan University. May I speak with ________________?”

Purpose of the phone call: “A few weeks ago you responded to the short questionnaire on which you indicated you may be interested in learning more about participating in one, maximum two-hour, focus group at Western Michigan University. I will be in attendance at the group as will a facilitator and moderator as well as 6-10 other speech-language pathologists. During the focus group you will be asked to share your views on the existence of co-occurring emotional/behavioral disorders and language deficits, your intervention practices with these students, collaboration with colleagues, and barriers to working with these students. I’d like to let you know the date, location, and time of the focus group if you are interested in learning more about participating in a focus group.”

Future contact: “I’d like to contact you a week before the focus group to remind you of our focus group. Do you prefer to be contacted by phone, email, or both?”

Closing statement: “Thank you for your time and assistance in helping to complete this research.”
APPENDIX I

E-mail Script
Email Script

Dear ____________,

My name is Laura Getty and I am a doctoral student in the Special Education and Literacy department at Western Michigan University. A few weeks ago you responded to the short questionnaire on which you indicated you would be interested in learning more about participating in a focus group (maximum two-hours) at Western Michigan University regarding students with emotional/behavioral disorders and language deficits. I will be in attendance at the group as will a facilitator and moderator in addition to 6-10 other speech-language pathologists. During the focus group you will be asked to share your views on the existence of co-occurring emotional/behavioral disorders and language deficits, your intervention practices with these students, collaboration with colleagues, and barriers to working with these students. I’d like to let you know the date, location, and time of the focus group if you are interested in learning more about participating in a focus group.

I will be emailing you again 3-5 days before our focus group discussion to remind you of the date, time, and location. If you have any questions or concerns please do not hesitate to contact me at 269-382-1469 or laura.getty@wmich.edu

Thank you for your time and assistance in helping to complete this research.

Sincerely,

Laura A. Getty, M. A., CCC-SLP
Doctoral Student
Western Michigan University
APPENDIX J

HSIRB Approval, Post Approval Change, and Consent
Date: October 24, 2006

To: Sarah Summy, Principal Investigator
    Laura Getty, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number: 06-10-03

This letter will serve as confirmation that your research project entitled “Intervention Practices of Speech-Pathologists Serving Students with Emotional/Behavioral Disorders” has been approved under the expedited category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: October 24, 2007
Memorandum

To: HSIRB  
From: Laura A. Getty  
Date: February 13, 2007  
Re: Post Approval Change for Protocol 06-10-03

As per my phone conversation on February 12, 2007 at 2:40 pm with Kristen from your office, I am submitting a post approval change for protocol number 06-10-03.

After mailing the focus group recruitment questionnaire, which resulted in a response rate of 41%, I have found that the number of people accepting the invitation to participate in focus group meeting is less than what I desire. I would like to extend my pool of potential focus group participants to the Region 3 area of the state of Michigan, which is specifically southwest Michigan. I am requesting permission from HSIRB to extend my pool of potential focus group participants in hope that I would be able to increase the numbers in my focus groups.

Thank you for your time and consideration of this request. If you have questions or concerns, please contact me through email at laura.getty@wmich.edu or by phone at (269) 674-8096 ext. 404 (work).
Date: February 14, 2007

To: Sarah Summy, Principal Investigator  
Laura Getty, Student Investigator for thesis

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number: 06-10-03

This letter will serve as confirmation that the changes to your research project “Intervention Practices of Speech-Pathologists Serving Students with Emotional/Behavioral Disorders” requested in your memo dated 2/13/2007 (extension of potential focus group participants to Southwest Michigan) have been approved by the Human Subjects Institutional Review Board.

The conditions and the duration of this approval are specified in the Policies of Western Michigan University.

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: October 5, 2007
APPENDIX K

Confirmation E-mail/Phone Call
Confirmation E-mail/Phone Call

Dear ________________ (insert participant name),

This is to confirm your participation in the focus group discussion for my doctoral dissertation regarding the practices and perceptions of speech-language pathologists working with students with emotional/behavior disorders (emotional impairments).

The focus group discussion will be held February 26 at the Kalamazoo Regional Education Service Agency (K/RESA) at 1819 Milham Road, Kalamazoo, Michigan, 49001.

The discussion will begin promptly at 5:00. Please plan to arrive by 4:45 at the latest as you will need to sign a consent form and complete a short biographical data sheet which will be confidential. As previously stated, the discussion will run no longer than 2 hours and sandwiches will be provided.

If you have any questions or concerns, please don’t hesitate to contact me at laura.getty@wmich.edu or (269) 382-1469.

Again, thank you for agreeing to participate in this focus group. I’m looking forward to seeing you on February 26 at 4:45.

Sincerely,

Laura A. Getty, CCC-SLP
Western Michigan University
Doctoral Candidate
Biographical Information

Please complete the following information. Your responses will be confidential.

Number: ______________________________________

Gender: ________________

Age: __________________

Years practicing as a speech-language pathologist: _________________

Years working with students with emotional/behavioral disorders: ______

Please provide any information that would be helpful. Again, this information will be confidential and will not be discussed in the focus group.
APPENDIX M

Welcome Statement
Welcome Statement

Thank you for agreeing to participate in this discussion which helps Laura Getty to complete her dissertation in special education at Western Michigan University. My name is Gayle Underwood and I will be facilitating this focus group discussion. Cindy Courtade will serve as moderator for the group. Laura Getty will be taking notes and will not be directly involved in the focus group discussion.

We would like to get your input on the topic of students with emotional/behavioral disorders, otherwise known as EI (emotional impairments) and language deficits. We are interested in your responses to a series of eight questions.

Please remember that this is a focus group discussion and all responses from members of the group are welcome. There are no “right” or “wrong” answers so please feel free to give your opinion or responses as we consider this an open discussion. Also, for purposes of taping, and later transcribing, please speak loud enough and one at a time so the each person’s responses gets recorded. The number you have in front of you is your assigned number for this discussion. Your responses will be confidential and referring to yourself and other participants by these numbers will help to protect confidentiality. Each time you speak, please say your number before you give your response or ask a question. For example, “This is 4 and I think……” Please feel free to refer to myself and Cindy by our names.

Feel free to use the paper and pens to make notes to yourself as you are waiting to speak. I will introduce each question but you may also refer to the chart paper on the wall. Does anyone have any questions before we begin? Let’s begin this discussion with our first question.
APPENDIX N

Focus Group Transcript
Focus Group Discussion Transcript

FACILITATOR: Thank you for agreeing to participate in this discussion which helps Laura Getty to complete her dissertation in special education at Western Michigan University. My name is Gayle Underwood and I will be facilitating this focus group discussion. Cindy Courtade will serve as moderator for the group. Laura Getty will be taking notes and will not be directly involved in the focus group discussion.

We would like to get your input on the topic of students with emotional/behavioral disorders, otherwise known as EI (emotional impairments) and language deficits. We are interested in your responses to a series of eight questions.

Please remember that this is a focus group discussion and all responses from members of the group are welcome. There are no “right” or “wrong” answers so please feel free to give your opinion or responses as we consider this an open discussion. Also, for purposes of taping, and later transcribing, please speak loud enough and one at a time so the each person’s responses gets recorded. The number you have in front of you is your assigned number for this discussion. Your responses will be confidential and referring to yourself and other participants by these numbers will help to protect confidentiality. Each time you speak, please say your number before you give your response or ask a question. For example, “This is 4 and I think……” Please feel free to refer to myself and Cindy by our names.

Feel free to use the paper and pens to make notes to yourself as you are waiting to speak. I will introduce each question but you may also refer to the chart paper on the wall. Does anyone have any questions before we begin? Let’s begin this discussion with our first question.
Participant 6: When you say number, do you mean this number?

FACILITATOR: Yes.

QUESTION 1

FACILITATOR: Let’s begin our discussion. Question 1. What percentage of your caseload is comprised of students diagnosed with emotional/behavioral disorders? How many students diagnosed with emotional/behavioral disorders do you serve?

Participant 3: Presently I have one on my caseload who is diagnosed emotionally impaired.

Participant 2: I don’t have any at this point.

Participant 4: I don’t have any.

Participant 5: I have one and I have in the past maybe had one every five years or so but it’s not a real prevalent impairment that I’ve seen.

Participant 1: Presently I do not have any on my caseload but when the self-contained emotionally impaired classroom was located in the building, one of the buildings I served, I would average three boys in that classroom and or I would see them individually or go into the classroom which comprised of 8-10 boys.

FACILITATOR: Of your entire caseload, you had three?

Participant 1: I had three.

Participant 6: I have one being tested right now but I might be getting one on caseload. Last year
FACILITATOR So, let’s talk about what that means percentage wise. So about how many students do you have on your caseload versus how many total.

Participant 1: I have 55 on my caseload, so 3 out of 55.

Participant 2: I have 0.

Participant 3: I have 0 but prior to this time, as Participant 1 I had 2 on my caseload when I was in schools with emotionally impaired classrooms.

Participant 4: Zero

Participant 5: I have 40 on my caseload and 1 of that total so less than 1%.

Participant 6: I have one that’s being tested so I don’t know but I have zero out of 55.

QUESTION 2

FACILITATOR Ok. Question 2. Describe how you provide speech and language services to students with emotional/behavioral disorders? What strategies or techniques do you use? And for our purposes, we’ll say, “Did you use?” when you worked with them.

Participant 5: I have worked with the students as pull-out and when I’m working on either articulation or language usually the only it’s implemented with, for the techniques I’m using because they’re emotional—students with emotional impairments, it’s just a very behavioral system of rewards either something tangible or something verbal. That’s my strategy.

Participant 6: It would be pull-out language and I work with the social worker and we would do problem solving activities with the student who was a male. He had to make choices, and healthy choices, out of different choices, and problem solving activities and using language with tangible rewards.
Participant 2: What I found I had to do with the kindergarten young man read something that really interested him. The only way he would name colors is if he were naming colors out of a Spiderman story book then he would tell you the colors but you try and introduce color cards, blocks, anything—it had to be something that he was interested in before would give any cooperation.

Participant 1: I would usually do pull-out where the aide would come and sit in the office with me so he would monitor behavior with a two-way walkie talkie or I would consult with the classroom teacher and she and I would be facilitators in the classroom and based on either what we thought would be of interest to the boys or certain language concepts that she was working on that she wanted developed a little bit more. But we would always take the boys’ interests at heart and some of the worked with XXXX, or as Participant 2 mentioned, certain things that were of interest like Spiderman and somehow we would incorporate that. But we also did a lot of role playing to get them involved. And this is a classroom where you could have kindergarten through 5th grade all within the same classroom so it had to be appealing to everyone.

Participant 4: I’ve used pull-out for these students and I’ve held individual and group with the same student depending on how they reacted to either situation. Some of these students if you see them individually they ask to be in a group but when you put them in a group they have a hard time dealing with the group. Also, in terms of rewards I like to generally have some kind of an activity where the outcome isn’t always predictable. I like to use games with a little bit of chance associated with so
you just don’t march down the game board because you’ve said your answer correctly. There’s a little bit of “how much of a reward are you going to get”? It keeps kids interest but with this group of kids they tend not to respond well to that because they can’t take losing very well. So, I guess I do tend to be a little bit more mechanical with those kids and make sure that they’re not exposed to losing because that doesn’t help their motivation.

**Participant 3:** I had twin boys, six years old. I’ve worked in the classroom. It was an emotionally impaired classroom so there were two separate rooms so I was working in one room while the class was in the other room so it wasn’t a pull-out in that sense that they were taken out of the classroom, it was still a familiar classroom to them. I worked with language reward for stickers. They accepted that very well and I’ve worked with strategies for the teacher. We did a lot of consultation with these young boys. They were very receptive to therapy. The other girl that I had—we worked with a lot of role playing I would also select someone from her classroom who was either invited to her birthday party or something on that order and we would do the role playing with what you do when your guests come, what you say when you receive a birthday gift, and those types of things. We had a lot of “girly” type things like tea parties, social interaction, I’d also work directly with the parapro who was assigned to her on a full time basis as to what she needed in the classroom—how to adjust either the curriculum or her behavior or what to do when behavior became out of hand and we worked also with the physical therapist who did some sensory integration.
FACILITATOR Was this in the public schools in an emotionally impaired classroom?

Participant 3: Yes

Participant 2: The young man I talked about. It was a pull-out situation. I chose not to have his aide in the room because it was like he could play one of us against the other. But if I was the only adult in the room then I was the last word, the only word, on what we were going to do and what was expected. And that worked better for me.

Participant 6: Are we allowed to ask the others something?

FACILITATOR Yes.

FACILITATOR Let's talk a little more specifically about some of the strategies you use, the interventions, that type of thing. Let's get into a little bit more detail. What are some specific strategies?

Participant 3: The one child that I had did very poorly with adjusting to changes in schedule. We used the strategy of icons for schedule adjustment. The paraprofessional would work every day and adjust her schedule to fit whatever specials there were so she was very well aware of what changes were going take place during the day because if it was not something she was not prepared for, she'd have a real hard time with that. So, one of the strategies we used was the icons for her schedule for the day.

Participant 1: I had to work on a lot of pragmatics with the boys' social skills and also the self-contained classroom teacher requested I work on are their writing skills. So that was based on whatever theme or topic they were working on in the classroom I would then continue to work on that with them—work on specific either grammar
skills or the main idea. I found the boys did not enjoy stickers so instead we worked,
I worked with the classroom teacher whereby if they had met their goals with me they
could choose computer time or perhaps eating lunch with me or other tangible
rewards.

Participant 5: The one student I had that had a behavior disorder, that was her
original label, but the longer we worked with her we were trying to sort out, “Is there
more cognitive impairment here?” and at the time I was working with her she seemed
to be seizing also so we were months just trying to sort out what was going on with
her so she was at a very low level and seemed to lose ground after having a skill so
we did “same” and “different” and basic colors so we were just doing red and white
chips. What’s red and what’s white and ....

Participant 3: How old is she?

Participant 5: She’s 5. And we worked a lot on doing just those two skills. And then
she moved. And, let me think. Oh, another boy that I did articulation therapy with, he
was very motivated by a little, what do you call it, counter, it’s like a little Kroger
counter, or what ever you want to call it, a little number counter, that he just loved to
be able to push the counter with what ever task we were doing. That was very
reinforcing enough for him. And then I was big on the verbal praise. That was one of
the few places I think he was getting much reward—whatever kind of reward—
because his behavior was very difficult of the time he was in the classroom setting
and at one point after I worked with him two or three months, went to the Behavioral
Center.

FACILITATOR Any other type of strategies?
Participant 3: The child I was just speaking of, the girl, some of the behaviors that were inappropriate within the classroom, I don’t know how specific you want me to be, the rules. We talked about it in my session and then I wrote up a little card that she was to go and ask five people during our session, people who were employees of the school—the school secretary, the custodian, the gym teacher—and I would tell these people ahead of time that they were going to be interviewed. We called it an interview. And she would go from person to person and ask them questions. Do you pick your nose? And I had warned these people ahead of time that this were the kind of question they were going to be asked and not to overreact to it but to be very adamant about what they did and if she asked the question, “Do you pick your nose?” and you said “no” then her second question was “Well, when there is something you need to do with your nose what do you do?” and then they would—I would prime all that, “You have a tissue with you” or “You go to the ladies restroom and get a tissue” or whatever. And that, she seemed to love going to person to person to interview each of the people in the school and that was a reward itself for doing a good job. And she looked forward to that every week. We’d have another type of a social skill that she needed to work on.

FACILITATOR Did it work?

Participant 3: Yes it did. And then with the result of the parapro at her side during the day she would remind her. And it did work in therapy, particularly that one was extinguished.

FACILITATOR Good!

Participant 3: That was enough!
Participant 6: When I said I had a student before with the social worker, one of the things we were working on, were, after we did actual activities and we had to make choices we got to do some work. She would love to talk about what we were doing so that was a reward within itself. After the hard work then we had her tell us about anything. She was a middle school aged child so it's different for her.

QUESTION 3

FACILITATOR Question number 3. Describe your interactions with general education and special education co-workers related to students with emotional/behavioral disorders.

Participant 2: The young man I talked about would be ok in the regular ed classroom but would start to be agitated and you could just about forget—something not good was about to happen soon. And we found out that if we just gave him a piece of paper and sent him on an errand, this would give him someplace to go, something to do and so different teachers would set up—and go to the office—and he would just, we had envelopes. The teacher had envelopes sitting on her desk and she would give him and envelop, maybe with a blank paper it or something and just “Take this to the office” and by the time he would get to the office, and she would send something back like, “This is the answer” and by the time he expended all his energy he could settle down in the classroom and he didn’t experience the one or two hour blow up that was probably going to come.

Participant 4: If I could ask a question, how often did he end up carrying the envelope from...
Participant 2: Oh daily, daily! At least daily. And I don’t really know for sure because it was something set up with the teacher, and so I don’t, that was just something they worked out. But I’m sure it was at least once a day. And I think it was especially useful getting him in from recess. You know, that the recess aide would say, “Somebody’s got, needs you do an errand, go to your classroom or go to the office. And that would be the way to get him off the playground and into the classroom without a knock-down drag out fight.

Participant 5: Overall, I think most of the general education and special ed staff were willing to work with this student—mainly the special education staff who were trained in special education. Almost all of them I noticed that—my experience has been that they will work on any behavior plan that has been set up they’re wanting that help from other consulting people—the psychologist or anybody that would be able to sit with them to come up a good plan so that they would be able to get through their day with minimal amount of escalations. On occasion I do know some of the specials teachers that that is the most difficult place of the behavior disordered, or child with behavior disorders.

Participant 6: Where’s the most difficult place?

Participant 5: The specials. No, the specials

Participant 6: Because there’s more freedom.

Participant 5: Art class because they couldn’t necessarily follow what the directions were or weren’t very interested in it and she found it very difficult to monitor that, that everybody, you know, is pretty open to activities but she didn’t want to have to deal with the behavior. I think, I see the same thing happen in phys ed classes on
occasion. These kids are physically able to move a lot and they don't know how to behave—how to keep the behavior in check sometimes in specials. People aren't trained or don't have enough experience with that so I think that's one of the hardest places for those kids.

Participant 6: because the sense of freedom? With the big large areas?

Participant 3: I found the same thing as Participant 5, that the people are extremely receptive to any additional suggestions that people make for behavior control or whatever. We have found that the special teachers will use cue cards that are just not written if the child is young but will have a stop talking or anything like that. They will just hold it up without adding the verbal to it. The children seem to be responsive to that if it doesn't call attention to them, they seem to know that that's theirs and sometimes will—the verbal directions will cause even more confusion and they may be a little agitated or something. But I found that most of the time the paraprofessionals are the ones who seem so insecure about even these children and they are the ones who need the most support and the twins that I have were in an El classroom so that teacher was really familiar and knew exactly what to do and the paraprofessionals were, were very familiar with the day to day activities and what to do. Recently the girl I had—the paraprofessional really had to work a long time—and we worked well as a team just to problem solve. And we'd get together once every two weeks and we'd work to problem solve things that weren't going right like, some strategies to calm this child down, take her in the back room and do some brushing type techniques which is really agitating to her. So we had to problem solve this—it
sounded like a good strategy but it was back firing so we had to really do a lot of problem solving.

Participant 5: As an adjunct to this, I remembered as we were starting to talk, most, or the few children I worked with who had behavior disorders there was a one-on-one parapro hired at the time or one parapro was asked to be specifically with this child that has emotional disorders and I think the general education teacher was very accepting of another adult to be to able to monitor what the behavior was going on and would look to this parapro for the answer and to have—and in my situation, each parapro became very skilled at working with each of these children.

Participant 1: In my particular situation—this is a self-contained classroom—she had three paraprofessionals that were specifically trained to work with these students so they would always leave with the students as the student transitioned to specials or if they could spend some time in the age appropriate general classroom. And then we also participated if the teacher were to be absent the special—there would be a special set-up/directive so that child could still come to school that day even though there may be a sub in place. The parapros would be in the classroom with the child as an extra set of hands for specifically for the child until the child finished his assignment. And on the flip side the gen ed teachers, they would utilize the expertise of either the parapro or the El teacher to work through other situations with particular students in the classroom. The El teacher was very willing to have that child spend some time in her classroom so hopefully that behavior would gradually become modified. But, there was certainly a very receptive atmosphere in the building I was in.
Participant 2: I have kind of an interesting situation once. The child wasn’t labeled with emotional behavior problems but he definitely had them. And there was much time when he came from special education classroom back to his regular ed classroom and there was a substitute so there was mayhem and in the classroom to start with and I don’t think his aide was there either that day and to top that off a parent came in with lunch for her son and proceeded to set it out on the table and it was a McDonald’s happy meal. This child could not understand it was not his—he was hungry, they were delayed going to lunch and he was just about to have a melt down. And talking about not understanding, the parent did not understand because the aide in the room said, ya know, can you please put that away? And she was very upset, she said, “Well, have his parents buy him.” And she said, “That’s not the point, he just doesn’t understand, this is not his food, he’s hungry, the food is there, he puts one and one together and he gets two.” I think I physically took him out of the room because, and told him we were going to get in the lunch line before he just he just had a complete melt down. So I think you have to be prepared for unexpected situations like that and it’s better that everybody in the school knows that this is a possibility so if he ever happens to be walking by the classroom and feels comfortable enough to go in and say, something has to be done.

Participant 1: The other nice thing about the EI teacher that was in my particular building—she would do some in-services for these classrooms—for the gen ed teachers and teach them how to collect data so they knew when they—what triggered the child and that so that hopefully we could intervene more and not have the child sent down to the classroom to spend some time with.
**Participant 6:** From the student before again, one of the interactions that were very positive—two things, the special ed teacher had to work very close with the social worker to know exactly what was going on when the student was not in the special room or with the social worker. And if he did well, and didn’t have a melt down, or did his work—his problem was that he would just manipulate and manipulate the situation so he wouldn’t have to do his work. And if he did do his work he would get the last hour of the day to actually spend time and work with the janitor. That was a super reward and so that little interaction thing had to be between the general ed and special ed and the social worker so that they would know exactly what the student was doing and how the day was going and along with the assistant principal who was following that too. So there was very good interaction. And he probably liked working with janitor because he got out of doing work.

**QUESTION 4**

**FACILITATOR** Number 4. Describe the different interventions you use with students with emotional/behavioral disorders.

**Participant 4:** Last year at the middle school-high school level I had a student who was very advanced academically. —Did great on a Peabody, went all the way to the top. —Was getting As and Bs in his classes but did not do well with interpersonal interactions and the approach that I attempted to make with this student was that we would do, kind of a cognitive program and learn about it as a subject. I brought up the fact that successful business people still look into the areas of communication and understanding each others needs and being able to work as a team and that sort of thing. It was definitely not an area of his interest but hopefully
he was able to take some steps with that. I don’t have him at this point, he moved out of district, but it seemed like a logical way to present it—as just another topic of study since he was obviously interested learning. That’s a strategy that I’ve done. I can’t really report on the results of it because I don’t have him at this point.

Participant 5: I don’t think I have much different to say, I can repeat the belief. I don’t have information specific to this question. My interventions would just back up what the behavior intervention was—smile faces, a certain amount of time that the teacher was trying to do—that this child was focusing or accomplishing work then I would do that sort of system. It was a very behavior-modification program is what I’ve done.

Participant 6: Again, to describe what the social worker also with a past student—to stay on task to finish the task so he couldn’t just get away with manipulating the situation or talking about what he wanted to talk about instead of finishing the task. I was working alone with him or else together it would be to finish the task and then get rewarded for staying on task.

Participant 1: When I did in-class activities with them, we either had the whole group around the table. We would have group discussions based on the topics the teacher had selected relevant to possibly something that had transpired that week and they could all share their reactions. Or, I would do role playing with them. Or we worked with them on the floor in small groups and there was always some form of supervision.

Participant 3: I’ve done a couple different styles. Consultation with teachers and paraprofs to determine what behaviors need to be extinguished or what behavior needs
to be enriched. So then, from that point on I would give some consultation
suggestions to the parapro and the teachers or do direct service to that child. We
would do an activity or play a game one-on-one and then try and transfer out of the
therapy session in to either the classroom or directly with the people that were in the
hallway—pragmatics skills with social greetings or behavior or "How do you walk
down the hall?" or that type of thing. It depended a lot on the intervention strategies I
used whether what the child needed at that time. I used a lot of input from the teacher
herself as to what was going on in the classroom and out on the playground that was a
problem. Then from that point determine what goals needed to be addressed....for a
week or two weeks or three weeks until he saw that that behavior was being changed.

Participant 2: I think I remember always having to always have something for him
to do with his hands. It didn’t matter whether he was putting puzzle together, moving
cars around, just doing something. He was more likely to answer questions or to
cooperate verbally if he had something to manipulate with his hands.

FACILITATOR Did anyone use any research-based strategies?

Participant 6: I’m not sure if I’m taking a leave from the social worker who I worked
with, with this person, if her’s were research based or not because it’s certainly social
work kinds of problem solving and making good choices and I see her using these
with lots and lots of students but certainly with the EI student so I don’t know if that’s
research based.

Participant 1: One thing that I’ve used social skills by Carol Gray—social stories.

Participant 3: I’ve used the same books by Carol Gray—socials stories—but I don’t
know if they’re research based or not.
Participant 5: No, no and no. I think that I could say most of these children I work with, one starting 10 years ago, ones 12 years ago, I don’t think we were that knowledgeable that we needed to have a program that said, “Do this.” Other than being trained at Western and Skinner being my guru, I was all behavioral. I think he was very concerned with this, other than that, no.

Participant 2: I think that was even before that phrase was even probably used.

QUESTION 5

FACILITATOR Question 5. How do the intervention techniques you use with students with emotional/behavioral disorders differ from those interventions you use with other students on your caseload?

Participant 5: I feel as though when I’ve worked with kids with behavior disorders that I become much more task oriented and reinforce behaviors not on a very scheduled... I do it on a very scheduled set where it’s one to one, or one to two, when he responds three times and then I reinforce it then etcetera, etcetera. -Whatever the skill is that we’re after and maybe not to that degree. But I feel like I’m much more specific on what his goal that he knows his goal and that the reinforcement schedule is much tighter than a normal sort of setting where every once in a while that was just what you needed to do, sort of thing where other children that aren’t dealing with the behavioral issues doing what they have to do.

Participant 2: I think I tend to be more flexible as we are going to do, one, two, three, where any other child I would say, “This is what we’re going to do today.” I would usually have two or three different activities and see if I can convince that we
are going to do this or... and if that was a complete no go I’d be more likely to drop
the issue and I felt like I had to pick my battles more with that type of child. The plan
was just to get something done and not just have it be a complete non-productive
session. Let them choose. Where, the child without the emotional disorder, I would
choose the activity and they would do it just because they would.

Participant 4: With this population, and again, not that I have a lot of experience
with it but I do try to keep more control of the environment in terms of interruptions
and distractions which I generally feel I’m being with most students because it really
becomes a more realistic environment to work in but with some of those kids, you
really need to keep people from passing by or noises occurring because almost
invariably you need to do some kind of damage control once those things happen.

Participant 1: I found that most of the interventions I use with the students I can use
with all my students. The only thing I would have to modify is the structure of my
office sometimes I’d have to move the cable runners or certain materials were around
I had to make sure it was very sparse. And then also providing a number of choice
activities we could work on. Always staying in their IEP goals but just giving them a
choice, “Do you want to work on this today or that?” And if you don’t work on this
today then we’ll work on that. So, basically, the interventions were the same it’s just
modifying the setting and giving them choices.

Participant 3: I found that the strategy of reinforcement had to fit more what they
liked and disliked more than regular education students do. They’re very flexible
with whatever the reinforcement is or whatever their reward is. I found that these
children were much more...you had to really tap into what they liked and what they disliked or it wasn’t accepted very well. Like Participant 5 said, the reinforcement schedule had to be much more strict, and rigid, like one to two, or one to three over a period of time. The intervention was much more pragmatic nature rather than articulation or just language. It had to be taught directly. It wasn’t generalized easily. So it had to be discussed and talked about directly—an intervention had to be. You explained it and why the strategies they had to use and then you had to go out and practice it. With the language kids you could go to the classroom teacher and explain what they were learning and a lot of the kids would generalize naturally and articulation is certainly quite a bit different than pragmatics but you had to teach it then go out and practice it outside of the classroom so the intervention was scripted.

*Participant 1:* Sometimes when I would go and pick them up I would have to actually intervene prior to them coming to my office and let them know, “This is what we’re going to work on today.” because sometimes they would be unwilling to leave the classroom. The other thing I found very true with them—I had to keep a fairly quick pace because they would get board or stubborn. So as long as we kept it at a fairly good clip and they had enough variety, we got things accomplished.

*Participant 6:* Definitely more task oriented and not as spontaneous because I have to have it more structured so that he can control it or then just talk about what you want to do again and not finish the task. So I’d also tell him what we’re going to do—in the social group—what we’re going to try to accomplish so it wasn’t as playful or spontaneous or light as I could be with the kids need the structure.
Participant 5: I could probably throw out there, I was definitely more animated and probably that same thing like Participant 1 was saying, very quick paced and just very lively. I would make myself a little (made a face).

Participant 4: Show us Participant 5! Show us.

Participant 5: I was the happy pill with struggling kids.

QUESTION 6

FACILITATOR Number 6. How do your speech and language interventions with students with emotional/behavioral disorders differ by age, grade, and cognitive ability?

Participant 2: I don’t have too much to offer—the interventions are about the same.

Participant 5: Mine are also pretty much the same from the very low cognitive ability to not much older than second grade. So I would think that no difference into some of the higher level functioning and the pragmatics that some of the other people on this panel have discussed. It’s very straight forward and I was looking at mainly articulation or just those very early stages of language that’s very concrete. As I referred to before mainly colors and same and different.

---Tape turned over and recording restarted---

FACILITATOR Ok, again, question 6. How do your speech and language interventions with EI differ by age, grade, and cognitive ability?

Participant 4: Different from other students? Regular ed. students or different from each other?

FACILITATOR Different from each other.
Participant 4: I would bet different from each other. That was the question? Each other?

Participant 6: Like I said, most of these are males we’re talking about, correct? Almost all the students we’ve mentioned are all males. We’ve all talked about males, right?

FACILITATOR But again, of the students who have emotional/behavioral impairments that you’ve worked with, how have interventions differed from younger to older, so, or even grade?

Participant 1: Since my boys were in a self-contained classroom that was a wide variety, they were all fairly bright, most of them, and, so, I presented the same lesson I would just sort of just “tweek” it and change certain questions to make it age appropriate for that particular child. And too, being in a multi-grade classroom they could all benefit from it at least somewhat.

Participant 3: I found the interventions changed by the need—through problem solving mostly with the classroom teacher or the special education teacher, that’s where my interventions were focused. And I didn’t necessarily choose from test results. I chose from behavioral needs. So I would say, that’s why I changed it, mostly, that’s how it differed.

FACILITATOR Anyone else can compare the difference between EI kids and other kids they serve?

Participant 6: Compared to what Participant 5 said, that was not what we had to do with the middle school kids. We didn’t have to act or be “high” to get responses or anything like that. Now there could have been age different and he had some learning
problems, also, he was diagnosed EI, so he wasn’t super low but he wasn’t super high, either.

FACILITATOR So you worked with the ability level of the student?

Participant 6: Correct.

Participant 4: Again, not speaking from a lot of experience, but being in the placements where I am and not involved in an EI program, or a facility that generalizes with that, I tend to, you know, if I’m dealing with a younger student that has some of these problems they tend to act out more as opposed to older students who might have had some training already to deal with this, uh, or just because more subtle responses are expected at later ages and tend to have people identify, who when they are older, don’t necessarily act up the same way as a younger—I’m sure that there are people that age who do act out—but I don’t tend to see them in the areas that I work. And so in terms of the interventions we probably do have different goals in terms of fires that need to be put out immediately with some of the younger ones as opposed to just helping students be able to deal with their day to day pressures and situations with some of the older ones.

Participant 1: I found that I would agree with Participant 4 there, that with the younger group in this particular classroom, um their self-management skills are much poorer but having the other boys in the classroom they could learn from them. They were like their little mentors. And also the other thing that the older ones have learned to do that the younger ones were learning to do is, learn to read body language and certain responses that others have and learned more appropriate react.

QUESTION 7
FACILITATOR  Any differences that you’d like to share? Ok. Number 7: What barriers do you encounter when working with students with emotional/behavioral disorders and language deficits?

Participant 5: Probably the one biggest barrier I’ve seen with the students I’ve worked with is home environment, parents, and medication and sometimes it’s just so confused and messed up that there has to be a lot of sorting through that and working through before that barrier can be eliminated or at least, come down some so that you can get to what the child is struggling with. That’s been the biggest one, the biggest hurdle on initial contact with each of the students that I’ve seen.

Participant 2: I don’t know if I can express this well, but working with the younger children, I think part of the barrier of helping these children initially is there is no diagnosis. They present, you know, kindergarten first grade as just kind of out of control children and it takes a while before everything’s sorted out and they’re identified and um, I don’t think during that period their needs are being met very well usually ends up with them sitting in the principal’s office all day, you know, sitting in a closet in the classroom because they won’t come out. So the process, the pre-identification time I think is very difficult because we don’t have any, there’s no diagnosis, there’s no plan for how to deal with these children so everybody in the school is kind of on their own. And I think that is a very difficult time both for the children and the staff and the school.

FACILITATOR  And this is at what age?

Participant 2: Kindergarten....first grade.
Participant 6: So some things aren’t right but they’re acting out of it.

Participant 1: Other situations that I see with this as possible barriers—problems that they’ve experienced at home the night before that they bring to school. That’s why it’s important to possibly check in with the parents to find how the night before went or even that morning. Also, problems on the bus, do they ride a special bus? And the issues arise on the bus with the bus driver or other kids that are riding the bus. Things that may be out of our control.... The other thing to is, a lot of these kids have such a an array of medications they’re on we don’t know what they’re taking—if it was given that particular day, the amount and too as they age, it needs to be adjusted to help them function through the day.... and just illness, allergies and those types of things.

Participant 6: I was going to go on almost with what you said. We don’t know what happens... we can’t control what happens during the day and if something sets them off during the day, what ever your time was to talk with them or social work could be called down because we don’t have control of what happened during the day that could have been controlled. Or it could have been before he got to school, on the bus, or even during the day that something happened and now you’re supposed to work with him. He might have a stubborn attitude or a negative attitude or wasn’t going to be positive or even something else. Obviously not to be worked with that day.

Participant 3: I find that fear is a real barrier especially for the classroom teacher maybe who is new to the system or has very little experience with these type of children. The fear of what this child going to do especially if they do not have a paraprofessional with him. How do I handle this child? What do I do if? They need...
a lot of help and support to figure those kinds of things out. – A lack of understanding of what emotional/behavior problems are all about. – A lack of training. Most general education teachers don’t have any training in this area.

Second, I see a real barrier with the peers who don’t understand the behavior of this child. They think this child is “strange” or “weird” or “I don’t want to play with him.” Or that child is in a classroom with preschool, kindergarten, has some free time to play with toys and the child doesn’t know how to share or takes other children’s toys and someone wants to play with him but they don’t know how to interact, they don’t feel comfortable interacting, they want their own space, especially if they’re very, very young—preschool and kindergarten. That’s very hard to teach those kids. I’ve seen with older students they seem to accept especially if that child’s been in their classroom for years they accept their helpful but the young ones have a very time understanding why this child—and sometimes there are extenuating circumstances that there is a double standard. We’re trying to teach this child to share, we trying to teach them not to yell when someone else is using the toy they want. But for the other children in the classroom they don’t understand that because they don’t have the same standards, the same rules, and they don’t understand, they don’t know why.

QUESTION 8

FACILITATOR And now we can ask the last question. Number 8. What additional information would you like to share about your interventions with students who have emotional/behavioral disorders and language deficits?
Participant 5: I have one little tidbit. Here I go again, once again, Participant 5! It’s the first thing I think of so, if reviewing the MSHA (Michigan Speech-Language, Hearing Association) Guidelines right after ECCD they had emotional impairment and language deficits with those children, and Gallagher states in his findings from 1999, I don’t know what this is based on, it’s just stated as fact, and these are percentages, but I thought this was quite fascinating. Sixty two to 95% of the children with emotional impairment or behavioral problems exhibit moderate to severe language impairment and 50-75% with communication impairment exhibit emotional or behavioral problems. So I thought the second percentage was quite telling. So that was my…. 

FACILITATOR Say the percentages again.

Participant 5: Sixty two to 95% of the students that were EI exhibit moderate to severe language impairment. So the flip side of that, 50-75% with communication impairment exhibit emotional or behavioral problems. Just throwing it out. That’s my official information.

Participant 4: That’s interesting.

Participant 6: But that’s interesting because we’re obviously not seeing many, many EI students on our caseload and if it’s 60-95% of EI have language problems?

Participant 5: Right, so of the children that have emotional impairments, almost all of them have a speech and language impairment.

Participant 6: But that could also be articulation, not language.

Participant 5: Yes, well, they’re saying moderate to severe language impairment. But the flip side I think is even more interesting. Fifty to 75% of communication
impaired people—children—exhibit emotional and behavioral problems and I don’t know what the problems. And I don’t know what the problems—it wasn’t in quotes or anything but that’s how it was termed.

Participant 6: It would be interesting to see what age groups those percentages were at?

Participant 5: I’m just quoting. That’s all.

Participant 4: I’m sorry that I can’t tell you the source of this but is was at a workshop that I think both Participant 3 and I both attended in Cheboygan ISD couple years ago about brain development and studies that were reported that indicate you have to have an emotional attachment and security in order to be able to learn. So, I’m not surprised about the kids who have a hard time establishing or maintaining this. I would have difficult not only learning language but probably everything that’s going on in school. You got these kids who probably have language and other difficulties that they’re not able to maintain emotional stability.

Participant 2: Do you think that’s possibly a chicken and egg type thing? If they have communication problems that might have given them establishing the emotional, social interactions once they get to be even toddlers.

Participant 4: I’m not sure.

FACILITATOR What additional information would you like to share about your interventions with students with emotional/behavioral disorders and language deficits?

Participant 6: I’m not sure how to put this but, I was talking with our social worker who I work with and just as we were brainstorming and talking about this kind of
thing—language problems and EI—because she certainly works with EI students, in
her perspective—and she’s been doing it a long time—she see that the EI kids, she’s
at middle and high, not the young ones, have the good language skills and they
actually use it to manipulate situations and manipulate students, teachers, all the
workers there, social workers and everyone else. And certainly to manipulate the
parents because she works very closely with the parents and lots of times the parents
are in denial not even realizing that the student is manipulating them. So she’s seeing
the reverse of that information Participant 5 just shared. That maybe we should weed
through some of the kids on caseload that I do not see but she does and all the high
verbal, not the brightest kids, but the verbal skills are there and they use them to their
advantage. But this is up at middle and high school level so maybe that’s a difference
compared to the younger ones. Maybe the MSHA thing is more youngsters. But we
were talking about various students that she named we talked about and looked at and
they have high language skills.

Participant 1: On a light note, maybe then that’s a compliment to all the speech and
language therapy.

Participant 3: Just what Participant 5 said in the statistics you stated, we were talking
about MSHA standards, we got to get into the classroom and do more observation
rather than just strictly testing. We should really check this out. And this is
something, personally I haven’t been doing really well. You can’t really get a feel for
that unless you’re in the classroom talking a look at these kids. They will come to
teaming because they’re having behavior problems and then the social worker gets involved.

Participant 5: I want restate again that the question is talking about, what do you want to hear about the interventions you’ve had with your students. I hope I didn’t lead us in a whole other direction that I wasn’t supposed to go.

Participant 1: I guess sort of just going back to through the other questions and some of the answers that some of you have offered. I would say, enhance the choice making of the setting and adapt the curriculum and provide visual, visual picture of what their day might be like.

Participant 6: May I ask a question that any of us along with the interventions actually with the students, how much also is suggested or worked with the parents do to keep up the same guidelines whatever you want to say, parents can actually keep up some of the same rewards or tasks or finishing/completion or anything so that the child is successful. Just throwing that out there.

FACILITATOR At this time I’d like to thank all of you for participating in this focus group discussion on perceptions and intervention practices with students with emotional/behavioral disorders and language deficits. You’ve provided valuable information. Thank you.
REFERENCES


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